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HEALTH OVERVIEW AND SCRUTINY PANEL

Thursday, 28th April, 2016
at 6.00 pm

PLEASE NOTE TIME OF MEETING

Council Chamber - Civic Centre

This meeting is open to the public

Members

Councillor Bogle (Chair)
Councillor Furnell
Councillor Houghton
Councillor Noon
Councillor Parnell
Councillor Tucker
Councillor White (Vice-Chair)

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PUBLIC INFORMATION

Role of Health Overview Scrutiny Panel (Terms of Reference)

The Health Overview and Scrutiny Panel will have six 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 respond to proposals and consultations from NHS bodies in respect of substantial 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 and 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.
- To consider Councillor Calls for Action for health and social care matters.
- 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.

Mobile Telephones: - Please switch your mobile telephones to silent whilst in the meeting.

Use of Social Media: - The Council supports the video or audio recording of meetings open to the public, for either live or subsequent broadcast. However, if, in the Chair's opinion, a person filming or recording a meeting or taking photographs is interrupting proceedings or causing a disturbance, under the Council's Standing Orders the person can be ordered to stop their activity, or to leave the meeting. By entering the meeting room you are consenting to being recorded and to the use of those images and recordings for broadcasting and or/training purposes. The meeting may be recorded by the press or members of the public.
Any person or organisation filming, recording or broadcasting any meeting of the Council is responsible for any claims or other liability resulting from them doing so.
Details of the Council's Guidance on the recording of meetings is available on the Council's website.

Public Representations

At the discretion of the Chair, members of the public may address the meeting on any report included on the agenda in which they have a relevant interest. Any member of the public wishing to address the meeting should advise the Democratic Support Officer (DSO) whose contact details are on the front sheet of the agenda.

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

COUNCIL'S PRIORITIES:

- Jobs for local people
- Prevention and early intervention
- Protecting vulnerable people
- Affordable housing
- Services for all
- City pride
- A sustainable Council

CONDUCT OF MEETING

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.

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

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

DISCLOSURE OF INTERESTS

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

DISCLOSABLE PECUNIARY 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 of 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 an, ‘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.

Dates of Meetings: Municipal Year 2014/2015

2015	2016
23 July 2015	28 January 2016
1 October 2015	24 March 2016
26 November 2015	28 April 2016

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 **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.

3 **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.

4 **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.

5 **STATEMENT FROM THE CHAIR**

6 **MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)**
(Pages 1 - 2)

To approve and sign as a correct record the minutes of the meeting held on 24th March 2016 and to deal with any matters arising, attached.

7 **SOUTHAMPTON PROVIDER QUALITY ACCOUNTS 2015/16** (Pages 3 - 264)

Report of the Service Director, Legal and Governance introducing the 2015/16 draft Quality Accounts for NHS providers operating within Southampton.

8 **UPDATE ON PROGRESS - INDEPENDENT REVIEW OF DEATHS OF PEOPLE WITH A LEARNING DISABILITY OR MENTAL HEALTH PROBLEM IN CONTACT WITH SOUTHERN HEALTH NHS FOUNDATION TRUST APRIL 2011 TO MARCH 2015**
(Pages 265 - 278)

Report providing the Panel with the requested update on Southern Health's progress implementing the improvement plan and feedback from regulators.

9 MONITORING SCRUTINY RECOMMENDATIONS TO THE EXECUTIVE

(Pages 279 - 282)

Report of the Service Director, Legal and Governance detailing the actions of the Executive and monitoring progress of the recommendations of the Panel.

Wednesday, 20 April 2016 SERVICE DIRECTOR, LEGAL AND GOVERNANCE

SOUTHAMPTON CITY COUNCIL
HEALTH OVERVIEW AND SCRUTINY PANEL

MINUTES OF THE MEETING HELD ON 24 MARCH 2016

Present: Councillors Bogle (Chair), Houghton, Noon, Parnell and White (Vice-Chair)

Apologies: Councillors Furnell and Tucker

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

RESOLVED: that the minutes for the Panel meeting held on 28th January 2016 and the Extraordinary Meeting held on 1st February 2016 be approved and signed as a correct record.

31. **BUSINESS CASE FOR THE DEVELOPMENT OF A VASCULAR NETWORK FOR HAMPSHIRE**

The Panel considered the report of the Director of Commissioning Operations (Wessex), NHS England, presenting the case for change for sustainable vascular arterial services in Hampshire/Isle of Wight which is consistent with the NHS England Service Specification for Vascular Services.

The report detailed the findings of the Vascular Society Great Britain and Northern Ireland (VSGB) reviewing the business case and options appraisal for vascular services in the region. It was noted that the preferred option for the delivery of these services was for University Hospital Southampton (UHS) to act as the hub with the Queen Alexandra Hospital (Portsmouth), the St Mary's Hospital (Isle of Wight) and the Royal Hampshire County Hospital (Winchester) as spokes.

The Panel noted that the issue had been ongoing for a number of years and that all elements of the clinical side were supportive of the current proposals. The Panel questioned whether the proposals would put an additional demands on the UHS. It questioned whether the potential increase in patients would affect the capacity of the hospital overall and in particular the hospital's ability to achieve targets relating to the emergency department. In addition the Panel questioned whether there was a detailed implementation plan.

The Panel were assured that there was a detailed implementation plan which could circulated to Members. It was explained that it was not expected that the numbers of potential additional patients would be significant. It was noted that the any potential additional demand on the hospital would be addressed by the introduction of the planned, and budgeted for, new facilities which would lead to internal improvements to capacity.

RESOLVED that the Panel:

(i) felt that the proposed changes to vascular services set out in the business case did not constitute a major reconfiguration of the service and welcomed its introduction;

(ii) requested that the outline project implementation plan for the Vascular Services proposals, including timescales, finances and accountability be circulate to the Panel; and
(iii) be kept informed on progress as the business plan was rolled out to reconfigure the service across the region.

32. **HEALTH AND WELLBEING STRATEGY: UPDATE**

The Panel considered the report of the Acting Service Director, Intelligence, Insight and Communications requesting that the Panel consider the achievements from the Health and Wellbeing Strategy 2013-2016 and the progress and plans made to update the Joint Strategic Needs Assessment and a new Joint Health and Wellbeing Strategy for the City.

In relation to the current strategy the Panel felt that lessons could be learnt in the development of a new strategy. It was noted that the broad themes of the current Strategy were underpinned by 64 commitments. Whilst it was noted that the majority of these commitments had been achieved, the Panel indicated that it felt that a more targeted approach should be used in the development of any forthcoming strategy.

The Panel discussed the potential for Member involvement in the development of the aims for the forthcoming strategy and indicated that it would be helpful, after the election, to hold a workshop for elected Members.

RESOLVED that a workshop for elected members on the emerging Health and Wellbeing Strategy be scheduled following the elections in May 2016.

33. **MENTAL HEALTH MATTERS**

The Panel considered the report of the Director of Quality and Integration updating the Panel on the progress of the Mental Health Matters consultation.

The Panel acknowledged that the review had only just commenced and supported its aims. Panel Members requested that benchmarking data providing comparison with other areas be circulated.

The Panel noted the progress made by the review to date and indicated that they would like the matter to return when there is greater clarity with regards to key outcomes to be delivered.

RESOLVED that:

(i) benchmarking data identifying how Southampton performs in comparison to other areas with regards to mental health outcomes is circulated to the Panel;
(ii) the item returns to the Panel when there is greater clarity on key outcomes and service specifications.

34. **MONITORING SCRUTINY RECOMMENDATIONS TO THE EXECUTIVE**

The Panel received and noted the report of the Service Director, Legal and Governance detailing the actions of the Executive and monitoring progress of the recommendations of the Panel.

DECISION-MAKER:	HEALTH OVERVIEW AND SCRUTINY PANEL
SUBJECT:	SOUTHAMPTON PROVIDER QUALITY ACCOUNTS 2015/16
DATE OF DECISION:	28 APRIL 2016
REPORT OF:	SERVICE DIRECTOR - LEGAL AND GOVERNANCE

CONTACT DETAILS

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STATEMENT OF CONFIDENTIALITY

Not applicable

BRIEF SUMMARY

This report introduces the 2015/16 draft Quality Accounts for NHS providers operating within Southampton. As part of the formal consultation process representatives from the providers will present key achievements against plans for 2015/16 and highlight priorities for 2016/17.

The Panel are requested to review the appended draft quality accounts from University Hospital Southampton NHS Foundation Trust (UHS), Care UK, Solent NHS Trust and Southern Health NHS Foundation Trust and agree any feedback for the NHS providers to consider prior to publishing final Quality Accounts by 30 June 2016.

In addition, following a request at the March 2016 meeting of the Panel, attached as Appendix 2 is a briefing paper providing an update on Emergency Department performance at UHS.

RECOMMENDATIONS:

		That the Panel:
	(i)	Review the appended 2015/16 draft Quality Accounts for each of the City's NHS providers.
	(ii)	Agree a response to each Quality Account for inclusion within the final report.
	(iii)	Consider and agree if there are any matters arising within the appended documents, including the Emergency Department performance update from UHS, that the Panel would like to receive further information on as part of its future work programme.

REASONS FOR REPORT RECOMMENDATIONS

1.	NHS providers are required to send their draft Quality Accounts to the Health Overview and Scrutiny Panel. The Panel have an opportunity to comment on the documents prior to publication.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2.	None.

DETAIL (Including consultation carried out)		
3.	A Quality Account is a report about the quality of services by an NHS healthcare provider. The reports are published annually by each provider, including the independent sector, and are available to the public.	
4.	Quality Accounts are an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders.	
5.	The quality of the services is measured by looking at patient safety, the effectiveness of treatments that patients receive, and patient feedback about the care provided.	
6.	The Department of Health requires providers to submit their final Quality Account to the Secretary of State by uploading it to the NHS Choices website by June 30 each year. The requirement is set out in the Health Act 2009. The documents appended to this report are therefore draft reports subject to amendments, updating to incorporate data that is not yet available, and Board approval.	
7.	At the Panel meeting on the 28 April 2016 representatives from each of the NHS providers operating within Southampton will outline their key achievements against plans for 2015/16 and highlight their priorities for 2016/17. The information will be presented with a specific focus on the implications for Southampton patients and residents.	
8.	The Panel have an opportunity to discuss the draft Quality Accounts with the representatives from the NHS providers and to submit a response to the document for inclusion within the final version.	
9.	In addition, a briefing paper providing the Panel with the requested update on the performance of the Emergency Department at UHS is attached at Appendix 2 for discussion with the Director of Transformation at UHS.	
RESOURCE IMPLICATIONS		
Capital/Revenue		
10.	None.	
Property/Other		
11.	None.	
LEGAL IMPLICATIONS		
Statutory power to undertake proposals in the report:		
12.	The duty for local authorities to undertake health scrutiny is set out in National Health Service Act 2006. The duty to undertake overview and scrutiny is set out in Part 1A Section 9 of the Local Government Act 2000.	
Other Legal Implications:		
13.	None	
POLICY FRAMEWORK IMPLICATIONS		
14.	None	
KEY DECISION		No

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

SUPPORTING DOCUMENTATION

Appendices

1.	University Hospital Southampton NHS Foundation Trust – Draft Quality Account and Quality Report 2015/16
2.	Briefing Paper - UHS Emergency Department Performance Benchmarking
3.	Care UK – Draft Secondary Care Quality Account 2015/16
4.	Solent NHS Trust - Draft Quality Account 2015/16
5.	Southern Health NHS Foundation Trust – Draft Quality Report and Quality Account 2015/16

Documents In Members' Rooms

1.	None

Equality Impact Assessment

Do the implications/subject of the report require an Equality and Safety Impact Assessments (ESIA) to be carried out.	No

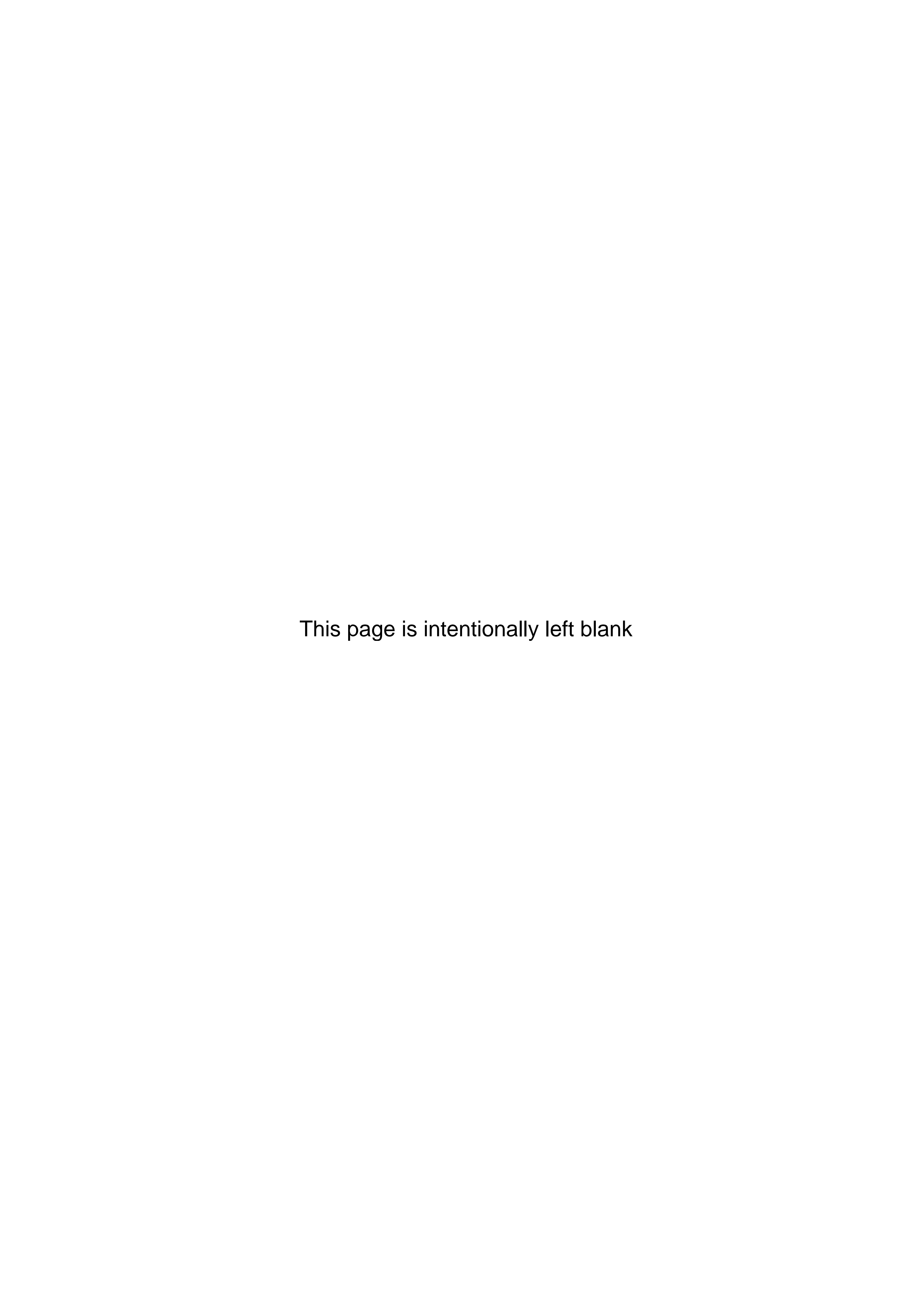
Privacy Impact Assessment

Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.	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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University Hospital Southampton NHS Foundation Trust

Our Quality Account & Quality Report 2015/2016

DRAFT

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- Chief Executive's Statement
- Overview of University Hospital Southampton NHS Foundation Trust

Part Two: Quality Priorities for Improvement

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- A review of our performance against the quality priorities in 2015/2016
- Our quality priorities for 2016/2017
- Participation in national Audit and National Confidential Inquiries
- Participation in National and Local Clinical Audit
- Participation in Clinical Research
- Data quality
- Proportion of Income achieving commissioning for quality, innovation payment framework
- Registration with the Care Quality Commission

Part Three: Other Information

- Overview of Performance
- Further Information about our trust
- Conclusion
- Appendixes
- Statements from our clinical commissioning groups, local Health watch and Board Of Governors
- Statement of directors responsibilities in respect of the Quality Report

Tables highlighted in yellow in the report are incomplete as certain quarter 4 data will not be complete and collated until the end of April/May 2016.

Quality account CEO welcome

Welcome to our quality account for the year 2015/2016. This document summarises our progress against the quality objectives that we set ourselves last year, and outlines our priorities for 2016/2017.

In 2015 we launched "Forward" our new vision to be a forward-thinking hospital working with partners at the leading edge of healthcare for the benefit of our patients. Crucially for our quality improvement journey, we outlined our mission to 'be better every day', and we will continue to talk to our patients, staff and partners to find new and innovative ways to improve patient care.
In 2015 we are proud that:

- We have some of the best clinical outcomes in the country. These include areas such as Intensive Care, Major Trauma and Cardiac Surgery
- Overall 95% of people surveyed rated their overall care as good, very good or excellent (Family & Friends Test, 2015/2016 Month 11)
- We delivered the majority of access standards, including cancer patients.
- Our performance against the 4-hour emergency access standard has improved since 2014/2015.
- In the National Staff Survey, we were in the top 20% for staff engagement where 79% of staff would recommend the Trust as a place to work and 90% would recommend the Trust to their friends and family if they required Care or treatment
- We have revised the care processes and equipment for patients that have visual or sensory loss to provide a better patient experience
- We continued to develop an extensive research portfolio working closely with the National Institute of Health Research and the University of Southampton. This has allowed many of our patients access to trials in ground breaking treatments
- We are is a lead player in the creation of the National Skills Academy for Health Southampton and Solent Excellence Centre, the Trailblazer Health apprenticeship steering group and the Talent for Care implementation group
- We continue to strengthen our patient safety agenda and deliver on our duty of candour requirements

In this document we will outline some of our quality priorities for 2015/2016, and where we will continue to improve in terms of our clinical outcomes, our safety and our patient experience.

We have also been selected for two national initiatives, which we believe will directly contribute to the quality of care that we can provide for patients. Firstly, we have been asked to be one of the national leaders in meeting the new 7-day service standards. We have already invested significantly in ensuring emergency services work fully across all 7 days. We are excited about continuing to focus on this area, and improve care for patients.

Secondly, we have been selected to be one of the national leaders for staff health and wellbeing. We passionately believe that we need to care for our staff as well as caring for our patients, and this national initiative is enabling us to pay even greater attention to the health and wellbeing of everyone who works at UHS, giving them the opportunity to take part in a number of initiatives to help their mind, body and soul. We know that looking after our staff has a positive impact on patients.

This report holds our organisation to account for the quality of healthcare services we deliver. We believe it's crucial for the future development of the hospital to be fully transparent and accountable; acknowledging and celebrating our achievements, as well as being open about the areas requiring improvement.

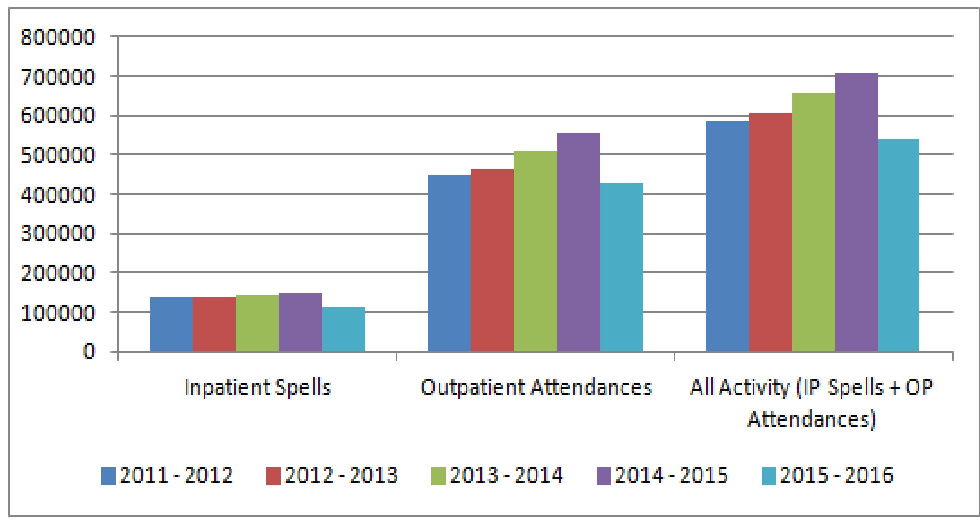
We have shared and developed this report in conjunction with our staff, patients, carers and external stakeholders. To the best of my knowledge and belief the information in this document is accurate.

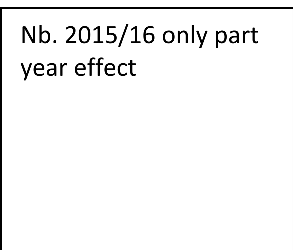
Fiona Dalton, Chief Executive

- **Provides:** hospital services for people with acute health problems
- **Employs** over 10,000 staff
- **Serves:** 650,000 people who live in Southampton, the New Forest, Eastleigh and the Test Valley
- **Serves:** the residents of Dorset, the Isle of Wight and the Channel Islands with specialist services.
- **Delivers:** A regional specialist hospital services for central Southern England
- **Delivers :** major research programmes to develop the treatments of tomorrow
- **Delivers:** training and education of the next generation of hospital staff

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

Activity levels during 2015/2016





The graph above demonstrates our activity levels at the end of quarter 3 of 2015/2016. The results will be updated to reflect the final position at the end of quarter 4. This is reflected for inpatients (which include those whose care does not require an overnight stay), outpatients and overall numbers. In summary, we have seen 683,458 patients as either inpatients or outpatients with 121,285 passing through our Emergency Department.

Our priorities for improving quality

This section outlines our performance in the delivery of our 2015/2016 quality priorities and explains how we have developed and agreed our priorities for 2016/2017.

A collaborative approach

Each year a team, which includes our patient representatives; staff; council of governors; clinical commissioners; community partners; and other key stakeholders, work together to agree the quality improvements we will prioritise for the coming year.

Deciding our priorities

Patient feedback plays a key role in the development of our patient improvement framework (PIF) as it is crucial that the priorities deliver an improvement in patient care and experience. However, as well as reflecting our patient and staff feedback, the PIF also reflects national priorities - the Department of Health operating framework (2016) and the Commissioning for Quality, Innovation and Improvement (CQUIN) priorities both at a national and local level.

After consultation we asses each 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?

This year, the format of the PIF 2016/2017 has changed to reflect the Care Quality Commissions' (CQC) inspection ratings to ensure we present our priorities under each of the CQC's key domains - safe, effective, caring and responsive – all of which sit beneath an overarching theme of being well led.

How we use the Patient Improvement Framework (PIF)

We are proud of what we do well, but understand that we must keep improving to provide better care and to stay at the forefront of healthcare provision in an increasingly complex environment. The Patient Improvement Framework enables us to achieve this by focusing our attention on key areas . Below are some examples of the types of comments that have influenced the development of our PIF priorities

Communication:

- 'My husband didn't know where he was supposed to go. It's such a big hospital'.
- 'Sometimes different staff say different things'.
- 'Very caring and everyone is very good at listening and responding, everyone always speaks to me'

Compassion:

- 'I have had kindness and help, everyone has been so kind and caring. They have all been wonderful'.
- 'A big thank you for all the care and kindness shown towards mum during her stay'.
- 'The whole team were very caring and thoughtful throughout my stay'.

Emergency Department:

- 'The waiting time was brilliant all the staff are friendly, the hospital was clean all over'.
- 'I had to wait 4 hours in waiting room before I seen doctor. This puts you off going'.
- 'Seen quickly and told what was going on. Friendly staff with a helpful team'.

(Comments taken from FFT data, 2015/2016 to date)

A review of our performance in 2015/2016
Priorities for Outcomes and Clinical Effectiveness

In 2015/2016, there were several priorities for clinical outcomes and clinical effectiveness. One areas we focused upon was that every clinical specialty would identify an outcome measure with an aim to improve clinical services against this measure. Further work was undertaken to improve standards of coding and data collection related to standardized mortality ratios (HSMR).

Priority 1: Every clinical speciality will identify an outcome measure

For each division to identify clinical outcome measures that measures improvement to both the clinical service and patient experience was an ambitious project for UHS. Whilst the aims were initially identified for this project, it required much more resource and infrastructure then was originally anticipated.

A number of areas in the trust contribute to national outcomes data collection to assess our performance against other specialist services. UHS has demonstrated excellent performance in Paediatric Intensive Care, General Intensive Care and Cardiac Intensive Care.

This is a high priority for the coming year and a detailed plan for implementing this tool will be taken forward during the year 2016/2017.

Priority 2: Making appropriate improvements in mortality rates and the way in which mortality is measured and evaluated.

The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the mortality rate at a hospital is higher or lower than you would expect. Like all statistical indicators, HSMR is not perfect. If a hospital has a high HSMR, it cannot be said for certain that this reflects failings in the care provided by the hospital. However, it can be a warning sign that things are going wrong.

The HSMR is a ratio of the observed number of in-hospital deaths to the expected number of in hospital deaths (multiplied by 100) for 56 specific Clinical Classification System (CCS) groups; in a specified patient group. The expected deaths are calculated from logistical regression models taking into account and adjusting for a casemix of: age band, sex, deprivation, interaction between age band and co-morbidities, month of admission, admission method, source of admission, the presence of palliative care, number of previous emergency admissions and financial year of discharge.

The Summary Hospital-level Mortality Indicator (SHMI) is a high level hospital mortality indicator that is published by the Department of Health on a quarterly basis. The SHMI follows a similar principle to HSMR however there are some differences in the casemix model and the two should not be compared directly but used in conjunction to monitor mortality outcomes. SHMI can also be used as a potential smoke alarm for potential deviations away from regular practice.

In 2015/2016, our priority was to improve Hospital Standardised Mortality Rate to below 100 through improving coding accuracy and working more collaboratively with specialities, care groups and divisions.

Overall the Trust has improved its HSMR position from 108.81 (2014/2016) to 98.85 (most recent 12 months data December 14 – November 15). The SHMI position has also improved from 99.26 (2014/2016) to 96.72 (most recent 12 months data – July 14 – June 15)

The data used to derive HSMR and SHMI is taken from the Hospital Episodes Statistics (HES) data therefore capturing the primary diagnosis as the main conditions treated by the clinician, it is recognised any secondary diagnosis and comorbidities can have a direct impact on HSMR and SHMI.

As part of an annual assessment the Trust undertakes an internal Information Governance audit submitted to the Department of Health. One of the Information Governance Toolkit audits looks at the information processes involved in the collection of data for clinical coding purpose ensuring information is accurate, consistent and complete. The main findings from the 2015 audit highlighted that the number of secondary diagnosis and comorbidities has risen substantially. Coding errors reduced and for the first time in the Trusts Information Governance audit history the Trust achieved level 3 (Highest level of attainment possible) based on the targets set by the Clinical Classification Service (CCS) regarding coding accuracy. This has been a result of many improvements including access to additional information systems and the introduction of clinical coding awareness programs for clinical staff. This has enabled the Trust to achieve continuous data quality improvements which can be seen through improved HSMR and SHMI.

The other priority for 2015/2016 involved working with specialities, care groups and divisions to improve knowledge and understanding on HSMR. Benchmarked HSMR and SHMI data is monitored monthly by our central team, all outliers are investigated thoroughly and where necessary clinically validated to ensure clinical standards of care have not been compromised. HSMR continues to be monitored and reported to the Trust Executive Committee, divisional management teams and divisional governance managers on a monthly basis.

The central team have also produced a HSMR report for each Division on a monthly basis. The report summarizes HSMR outcomes at Care Group and Speciality level which provides focus to management teams and enables further clinical validation and scrutiny where appropriate and put actions in place to address any issues. Engagement from clinical teams has improved dramatically across the organisation and thus understanding on HSMR has also improved. The central team will continue to work collaboratively with each speciality, care group and division in 2016/2017.

Priority 3: Promote learning from reviews of hospital death certification

The Interim Medical Examiner's Group (IMEG), was established within UHS during 2014/2016. The group was established to review all adult inpatient deaths at UHS in response to the recommendations of the various national reviews and inquiries. The report of a fundamental review of Death Certification and Investigation in England, Wales and Northern Ireland (2003), the third report of The Shipman Enquiry (2003) and the Francis Report (2013) all recommended that additional scrutiny of deaths and an overhaul of the death certification process was required. The purpose was to ensure that the organisation learnt lessons where required and improved the quality of death certification.

During 2015/2016 the Trust intended to develop further the IMEG by exploring funding streams to secure and develop the service, enhance eDischarge and Hospital Standardized Mortality Rate (HSMR). Additionally, aiming to support research by the University and Hospital Palliative Care Team (HPCT) and widen the group remit to Include reviews of maternal, peri-natal, paediatric and hospice death.

The group has had continued success, sustaining the quality of completed death certificates during Q1 – Q3 of 2015/2016. This is attributed to a combination of education and increased consultant involvement in discussions over cause of death prior to the meeting. Prior to the introduction of IMEG it was a regular occurrence for adverse events to be brought to our notice for the first time via HM Coroner review or at inquest. This has effectively been eliminated since this process was introduced.

The group aimed to support research with the University of Southampton and HPCT during 2015/2016 and collaboration has commenced auditing IMEG, with a particular focus on End of life care.

It was an aim that IMEG which focused on reviewing adult deaths could be expanded and we have now introduced a paediatric version of IMEG called the child review of death and deterioration (C-DAD), this started during Q3 2015/2016, and now captures all inpatient paediatric and neonatal deaths in a weekly review process. We have also introduced a daily review of deaths at the Countess Mountbatten hospice (started in Q2).

The pathway for introducing and enhancing eDischarge and HMR has been commenced and written. The aim being that the eDischarge summary, would serve as the document referral to IMEG, be modified further during the IMEG meeting and then used as the basis for HM coroner referrals. At our CQC Inspection, the CQC noted the IMEG process as exemplary.

Priorities for Patient Experience

There were several focal areas for patient experience in 2014-2015 one key area was the improvement of the patient experience during meals. A further focus was on supporting patients who have auditory and visual impairment. Additionally, we also prioritised improving the care of patients at the end of their life and promoting safe and timely discharge of our patients from UHS.

Priority 1: Improve the patient experience during meals.

Improving the meal experience for our patients has been a priority for us over previous years and detailed work has been undertaken. Patients continue to provide feedback to us on the meal service they receive and whilst improvements have been made, this area of patient care remained a key focus with more work to be done.

During 2015/2016 we aimed to

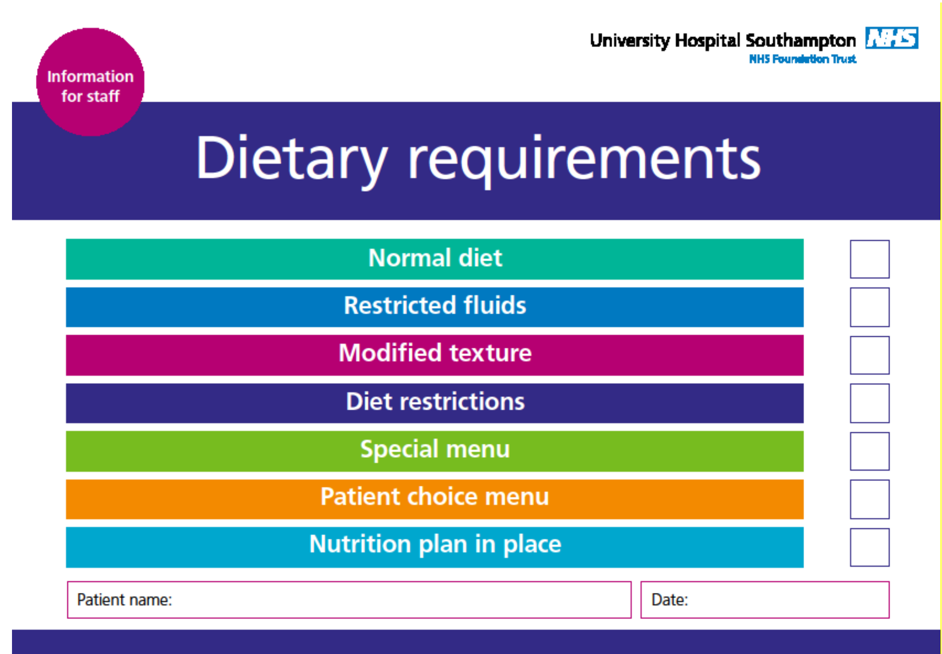
- Review the role of meal time coordinator
- Review of the nutrition screening policy and e learning
- Develop a UHS strategy to shift to protected meals rather than protected mealtimes, to allow patient attendance at scheduled investigations and treatment that may need to occur around a mealtime. This is important to balance patient flow and attendance at important clinical sessions with protected nutritional intake
- Review and update bed signage for nutrition
- Improve the utilisation of patient fluid balance charts
- Sustain actions developed in 2014/2016

Throughout the year we have been reviewing the role of the Mealtime Coordinator, through observation of care and through working groups of Mealtime Coordinators within clinical areas. In order to maximise mealtime benefits to patients, a designated member of nursing staff known as the Mealtime Coordinator (MTC) is allocated for each relevant ward/clinical area. The MTC ensures patients have the correct nutrition by coordinating with ward hosts for the protected mealtime and red tray systems. The fundamental aspects of the role has been relaunched during Nutrition & hydration week in March 2016.

The relaunch of aspects of care that support patient's nutrition and hydration needs will include the MTC role, but also our nutritional screening policy, our plans for protected meals and our nutritional bed signage.

Within UHS we have been using a system of protected mealtimes for patients over previous years. This has benefits to our patients; ensuring mealtimes are protected from unnecessary and avoidable interruptions, providing an environment conducive to eating, and assisting staff to provide patients/clients with support and assistance with meals however the focus on meal times meant that if a patient that had to be off the ward there was a risk of them missing the protected meal time. Our aim during 2015/2016 was to shift the concept of protected mealtimes to one of protected meals. The patient, whilst eating their meal would not be interrupted, however if a patient was scheduled to have an investigation over a mealtime then they could attend this appointment, with the assurance that they would receive their meal after the investigation. This would enable patients to still receive routine tests but also ensure they do not miss their meals.

Patients who require a specific meal are identified through a diet sign displayed above their beds. We have reviewed the diet signs that are available and have redesigned the sign, making it easier to use for staff and more visible for patients and their relatives. Every bed within UHS will have a diet sign displayed above the bed, making it the norm for all patients to have their dietary preference displayed.



During 2014 UHS commenced the Southampton Mealtime Assistance Roll-out trial (SMART). This continued during 2015/2016 with over 100 volunteers recruited and trained to work at lunchtime and evenings, supporting patients with their meals. Patients are assessed and their dietary intake measured at separate mealtimes to assess if their nutritional intake has increased. The project has developed and mealtime assistance by the volunteers can now be seen in five clinical areas of Southampton General Hospital, these include Medicine for Older People, the Acute Medical Admission areas, Trauma and orthopaedic wards and emergency medicine wards.

The patient feedback from the 2015 National Inpatient survey has demonstrated that 66% of patients feel supported at their mealtimes. This is 1% increase from 2014, we recognise this needs to improve further and this is a focus for 2016 .

Priority 2: Support and protect patients who have visual and auditory impairment

Throughout 2015/2016 a small group was formed to focus on the aims identified at the start of the year to support patients with sensory loss who attend UHS.

The group consisted of staff from within UHS and volunteers from the community. The members had experience of attending the hospital and could identify whether their needs had been met in relation to their visual or auditory loss.

The initial aim was to ensure that patients who have a specific care need are identified prior to admission to hospital, this being either as an inpatient or during an outpatient visit. To address this, the group are in the process of developing a care card that patients can request, which details their specific needs on admission. Linking in with the hospital admissions team we have been able to flag on the admission system that the patient has a care card and requires support when attending the hospital.

Patients who are registered physically disabled, have a hearing loss, are visually impaired, have a learning disability, a mental health difficulty, dementia and those who require an interpreter will be identified prior to admission so that appropriate actions can be taken to ensure their needs are met.

This it has enabled us to redesign our hospital information booklet ensuring it is available to patients in different languages, in Braille or made into an audio booklet.

Throughout the group meetings it became clear that there are many support groups and resources that are available to guide clinical staff. An information page on the hospital website is being developed with information from members of the group. Additionally training resources have been explored which can be provided to staff within the hospital, this will focus on the training for key hospital staff, volunteer guides and front of hospital staff.

Working with external organisations we have been able to identify equipment that can be utilised to support patients with hearing impairment whilst in hospital.

The introduction of the nurses' tool kit in all clinical areas enables nurses to change hearing aid batteries, piping of hearing aids and includes a sonoside device. This device enables patients who wear a hearing aid to hear more effectively in situations that are more challenging to their hearing, for example, where several people may be in conversation such as multi-disciplinary ward rounds.

We are installing a permanent hearing loop system in the new entrance to the hospital and the need for hearing loops has been identified as a potential requisite when parts of the hospital are updated.

Members of the group have been able to review areas that already have local hearing loops and advise on their effectiveness and appropriate posters displaying that a hearing loop is present.

Priority 3: Improving end of life care for our patients

We continue to work hard in improving end of life care for our patients and those important to them. Current work that we are undertaking include the development of an individualised end of life care plan for the last days or hours of life is now available across the Trust for supporting patient care while dying and is informed by the five priorities for care.

To assist staff in managing this vital aspect of care a palliative /end of life care web page is now available for staff to access with education and training resources together with information pertaining to Countess Mountbatten House hospice.

The Executive End of Life Care Steering Group is well established and is currently identifying priorities that will inform the Trust's three to five year end of life care strategy. This is in line with the six ambitions published by the National Palliative and End of Life Care Partnership (2015) and new NICE Clinical Guideline 31. The final report has been submitted to Marie Curie end of life care project identifying the importance of effective communication, partnership working and coordination of discharge planning and care across health and social care boundaries.

Our aims for 2016/2017

- Education and Training programme delivering sessions on each of the five priorities for care, difficult conversation skills and advance care planning.
- Participate in and inform the National work stream around the Emergency Care & Treatment Plan, working alongside Wessex CLAHRC into the use of Treatment Escalation Plans (TEP).
- Develop an end of life care competency framework based on the new recommendations set out within the latest NICE Clinical Guideline 31 (2015) ensuring that staff caring for the dying, within the acute hospital, are supported in developing the skills, knowledge and attitudes required in the delivery of excellence in end of life care.
- Develop information for relatives and carers for those individuals whose wish it is die at home supporting them in who to contact and who will be there for support in their bereavement.

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

Priority 4: To promote safe and timely discharge of all patients from UHS.

This year we have focused on improving the number of patients that are discharged before lunch with a target of 19%. This not only supports patient flow in the hospital but also effects patient experience and improved discharge. We have worked on improving our processes to achieve this, by identifying patients the day before, auditing the reasons why we have not achieved this and taken action. We monitor performance on a weekly basis and share learning from wards who are sustaining performance. We will have achieved our target by the end of the year and will continue to focus on improving this even further.

Before the implementation of this project, the trust averaged a discharge by lunch time of 8-9%. Currently we are achieving an average of 16.83 %. This has been working especially well in areas such as Medicine for Older People and Cardiovascular and Thoracic medicine.

Interestingly, the improvement in the overall length of stay in the Trust has proved a confounding factor in this measurement. Patients who have a shorter overall stay in terms of days may be kept later on the day of discharge to ensure they are fully recovered; this is a trend seen in surgery. One of the ways this is being managed is the opening of a discharge area for surgical patients.

We acknowledge this is an ongoing priority and there is more work to be done in all areas.

Priorities for Patient Safety

Our priorities for patient safety last year were to continue to

- Focus on improving reporting of incidents and learning.
- To build on and sustain our safety culture.
- To reduce the number of avoidable high harm pressure ulcers and falls
- To reduce complications from failure to interpret or act on abnormal cardiotocography CTG tracing in labour.

Priority 1: To continue to improve reporting of incidents and learning. Build on and sustain our safety culture.

The Electronic reporting of incidents, including “near misses” has been fully embedded across the organisation. A near miss is defined as any incident that had the potential to cause harm but was prevented, resulting in no harm.

We have developed a wide range of reports that allow staff to look at the volume, type of incident and degree of harm in their wards and departments.

We have and continue to improve the feedback to reporters using an automated part of the electronic system as we know that good feedback encourages staff to report incidents.

An electronic newsletter outlining the lessons learned from more significant incidents is sent to all clinical staff monthly and includes an example of a favourable event (an incident or an event which went particularly well) for

instance an individual member of staff being particularly compassionate, or a team working especially well together, or an innovative approach to an old problem. This allows us to learn from when things go well.

We have conducted safety culture surveys which assess a ward or departments safety climate. Safety climate is a subset of the broader culture and refers to staff attitudes and perceptions about patient safety within the ward or department, for example how easy they find it to report incidents and whether they feel they are supported in raising concerns about patient safety by senior leaders in the area. This is important because the culture of an area and the perceptions and attitudes of staff have been found to affect patient safety outcomes. These have been conducted in wards and departments as part of our internal quality reviews and all wards and departments will complete a survey as part of their clinical accreditation scheme going forward in 2016.

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

We are achieving the target for 2015/2016 of a 20% reduction in avoidable high harm falls. The year to date (YTD) figure is 3 avoidable harm high falls against a trajectory of 15 high harms falls .

UHS took part in the National Audit of Inpatient Falls which examined organisational and clinical practice in over 90% of eligible NHS Trusts. Our reported falls rate per 1000 bed days was 7.30 (mean result in acute hospitals 5.6). We feel this reflects a strong reporting culture. This is supported by the number of falls resulting in moderate/severe harm at UHS being 0.17 against a mean national average for similar trusts of 0.19.

This improvement has been achieved by support from a falls nurse specialist to deliver education and training and to improve the reliability of risk assessment and falls prevention interventions such as use of low profile beds, intentional rounding and culprit medication reviews

In 2015/2016, we have seen an 11% improvement in the reductions of incidences of pressure ulcers from 2014 /2015 but are disappointed not to have achieved the 20% reduction we have aimed for. This has refocused us on reduction of pressure ulcers for the coming year. Strategies to improve in this area includes the implementation of a new risk assessment tool developed at UHS We believe that this tool will be key in more accurate identification of patients at risk and linking this risk to care bundles. Senior nursing teams are working hard to constantly monitor and improve the reliability of care processes.

Priority 3: Reduce complications from failure to interpret or act on abnormal cardiotocography (CTG) tracing in labour

As part of the Sign up to Safety campaign we received £220,000 from the National Health Service Litigation Authority to install ten additional state-of-the-art computer systems to monitor the health of women and babies during the birthing process. The technology, known as the Guardian and developed by K2 Medical Systems, provides continuous analysis of a baby's heart rate immediately before and during birth. The data is collected via sensors and automatically uploaded to a secure portal where it is made available to midwives and doctors at the Princess Anne Hospital outside of the delivery room at any time. Conventional monitoring occurs only within the delivery room and it is up to the clinician at the bedside to involve other senior staff at their discretion.

In addition to providing earlier alerts to clinicians about situations where additional support or intervention is needed, it means staff can minimise interruptions for women during their labour. The information is also securely accessible in real-time to midwives and consultants anywhere in the world via PC, laptop, smartphone or tablet devices.

The maternity unit has four Guardian systems that cover 14 labour wards, so the additional monitors will ensure the system is available permanently in each ward. All new K2 guardian systems were installed at the beginning of March.

Never Events

Never Events are a particular type of serious incident that are largely preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level. We have had five of these incidents reported in this year although one case was historic and relates to an operation performed in 2013. We take these events extremely seriously. Although the actual harm to the patient has not been serious, in these events they identify risks in our systems and provide an opportunity for learning and improving patient safety.

In the next year, we will be working hard to ensure that National Safety Standards for Invasive Procedures (NatSSIPs) are used to create our own, more detailed, standardised Local Safety Standards for Invasive Procedures (LocSSIPs). We will then focus on training procedural teams to allow safe, effective and consistent safety steps and include training in human factors and non-technical skills such as situational awareness, stress management, decision-making and teamwork.

Priorities for Quality for 2016/2017

We have developed this year's Patient Improvement Framework by listening to staff and patients to identify the most important priorities. We have consulted on these with patient groups, our commissioners and staff to gain real ownership of adopting and achieving the priorities that matter to patients.

This year we have developed the Framework to reflect the five domains set out by the Care Quality Commission of Well Led, Safe, Effective, Caring and Responsive.

The Patient Improvement Framework and our priorities are contained in Appendix C.

Participation in National clinical audits and confidential enquiries

During 2015/2016 47 national clinical audits and 3 national confidential enquiries covered NHS services that UHS provides.
During 2015/2016 UHS participated in 100% of national clinical audits and 100% national confidential enquiries of which it was eligible to participate in.

The NCEPOD studies that UHS participated in during 2015/2016 were:
NCEPOD Acute Pancreatitis study
NCEPOD Mental Health study
NCEPOD Child health review inc. Chronic Neurodisability and Young Person's Mental Health

The national clinical audits that UHS participated in, and for which data collection was completed during 2015/2016, are listed below (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

Table A.

	Total number of NCAs UHS were eligible to participate in (n=47)	Eligible (47)	Participated (100%)	% Actual cases submitted / expected submissions
1.	Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	✓	✓	100%
2.	Bowel cancer (NBOCAP)	✓	✓	Ongoing
3.	Cardiac Rhythm Management (CRM)	✓	✓	Ongoing

4.	Case Mix Programme (CMP)	✓	✓	Ongoing
5.	College of Emergency Medicine (CEM)- Procedural Sedation in Adults	✓	✓	Ongoing
6.	College of Emergency Medicine (CEM)- Vital signs in Children	✓	✓	Ongoing
7.	College of Emergency Medicine (CEM)- VTE risk in lower limb immobilisation	✓	✓	Ongoing
8.	Child health clinical outcome review programme (NCEPOD)	✓	✓	Ongoing
9.	Congenital Heart Disease (Paediatric cardiac surgery) (CHD)	✓	✓	100%
10.	Coronary Angioplasty/National Audit of PCI	✓	✓	100%
11.	Diabetes Footcare	✓	✓	Ongoing
12.	Diabetes in pregancy (NPID)	✓	✓	100%
13.	Diabetes Inpatient Audit (NADIA)	✓	✓	Ongoing
14.	Diabetes (Paediatric) RCPCH NPDA	✓	✓	Ongoing
15.	Elective surgery (National PROMs Programme) Varicose Vein surgery and hernia surgery	✓	✓	Ongoing
16.	Elective surgery (National PROMs Programme) Hip and Knee replacement	✓	✓	Ongoing
17.	Falls and Fragility Fractures Audit Programme (FFFAP) national hip fracture database	✓	✓	Ongoing
18.	Falls and Fragility Fractures Audit Programme (FFFAP) fracture liaison database	✓	✓	Ongoing
19.	Falls and Fragility Fractures Audit Programme (FFFAP) national inpatient falls	✓	✓	Ongoing
20.	Inflammatory Bowel Disease (IBD) programme - Biological therapies adult and paeds	✓	✓	Ongoing
21.	Lung cancer (NLCA) (LUCADA)	✓	✓	Ongoing
22.	Major Trauma: The Trauma Audit & Research Network (TARN)	✓	✓	100%
23.	Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	✓	✓	100%
24.	National Adult Cardiac Surgery Audit	✓	✓	Ongoing
25.	National Cardiac Arrest Audit (NCAA)	✓	✓	100%
26.	National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme - Secondary Workstream	✓	✓	Ongoing
27.	National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme - Pulmonary Rehabilitation Audit	✓	✓	Not specified
28.	2015 Audit of Patient Blood Management in Scheduled Surgery (NCABT)	✓	✓	Ongoing
29.	2015 Audit of Lower GI Bleeding and the use of blood (NCABT)	✓	✓	100%
30.	2016 Audit of Red Cell and Platelet Transfusion in Haematology (NCABT)	✓	✓	100%
31.	National Complicated Diverticulitis Audit (CAD)	✓	✓	Ongoing
32.	National Emergency Laparotomy Audit (NELA)	✓	✓	100%
33.	National Emergency Oxygen Audit (BTS)	✓	✓	Ongoing
34.	National Heart Failure Audit	✓	✓	69%
35.	National Joint Registry (NJR)	✓	✓	Ongoing

36.	National Prostate Cancer Audit (NPCA) (2nd year)	✓	✓	Ongoing
37.	National Vascular Registry (NVR)	✓	✓	100%
38.	Neonatal Intensive and Special Care (NNAP)	✓	✓	Ongoing
39.	Oesophago-gastric cancer (NAOGC) (NOGGA)	✓	✓	Ongoing
40.	Paediatric Asthma (BTS)	✓	✓	Ongoing
41.	Paediatric Intensive Care Audit Network (PICANet)	✓	✓	Ongoing
42.	Renal replacement therapy (Renal Registry)	✓	✓	100%
43.	Rheumatoid and Early Inflammatory Arthritis	✓	✓	Ongoing
44.	Sentinel Stroke National Audit Programme (SSNAP) continuous SSNAP Clinical patient Audit	✓	✓	Ongoing
45.	Sentinel Stroke National Audit Programme (SSNAP) SSNAP Post Acute Organisational Audit	✓	✓	Ongoing
46.	UK Cystic Fibrosis Registry (Adults and Paeds)	✓	✓	Ongoing
47.	UK Parkinson's Audit (previously known as National Parkinson's Audit)	✓	✓	Ongoing

The reports of [13] national clinical audits were reviewed by the provider in 2015/2016 and UHS intends to take the following actions to improve the quality of healthcare provided (See Appendix A).

The reports of [69] Trustwide and local clinical audits were reviewed in 2015/2016 and as result the Trust will take action to improve the quality of healthcare provided (See Appendix B)

Participation in Clinical Research

In 2015/2016 we further expanded and integrated our research activities across our clinical services, improving access to new treatment options and advancing care. We have long believed that asking important questions improves our patient outcomes and services, something recognised as a key feature of top performing Trusts (NHS England 2014).

18,560 patients receiving relevant health services provided or subcontracted by UHS in 2015/2016 were recruited to national portfolio trials, the second highest recruitment rate in England. Adding participants in our wider research partnerships to this takes our total recruitment to 25,816 – the highest number of people we have ever involved in clinical research in a single year.

Five Southampton patients were the first in the UK to access to potentially ground breaking new treatment through research participation, including two who were the first worldwide to receive trial treatments. In June 2015 we also recruited our first family into the national 100,000 Genomes project, as hosts to one of 13 regional centres laying the foundations for personalised medicine in the NHS.

Our recruitment and delivery performance secured over £20M in research funding for further investment into research in clinical areas, and underpinned a preferred partner deal with a commercial research organisation, securing priority on new trial contracts. Additional regular contracts were secured through continuation of strategic partnership meetings with major pharmaceutical companies, ensuring Southampton remains a key site for drug and vaccine studies.

A £4m deal has been signed between the National Institute of Health Research(NIHR), Southampton Respiratory Biomedical Research Unit and Novartis and NIHR Translational Research Partnership programme, to elucidate the mechanism of action of Xolair, Novartis' drug for control of exacerbations in allergic asthma.
The research programme will investigate biomarkers modulated by Xolair, in order to identify the mechanism of action and to provide clinical indicators of efficacy/patient response.

In support of quality early stage research, our clinical research facility underwent relicensing inspection for Medicine and Healthcare Regulatory Agency (MRHA) phase I research accreditation for quality and safety, aimed at continuing its status as the only NIHR facility with this accreditation in England and underscoring the quality of our clinical research activities. Further development of our translational research capability was progressed through compilation of a full bid for a combined NIHR Biomedical Research Facility, due for submission on 2016/2017. The proposed centre will consolidate our strengths in cancer, nutrition, musculoskeletal and respiratory experimental medicine, conducted in partnership with the University of Southampton.

Data quality:

University Hospital Southampton NHS Foundation Trust submitted records between April 2015 and March 2016 to the NHS-wide Secondary Uses Service for inclusion in Hospital Episode Statistics. As at November 2015 (latest national report) the percentage of records in the published data:

Which included a valid NHS number was:
- 99.2 % for admitted patient care;
- 99.4 % for outpatient care; and
- 95.3 % for accident and emergency care.

Which included a valid General Medical Practice Code was:
- 99.9 % for admitted patient care;
- 99.8 % for outpatient care; and
- 99.6 % for accident and emergency care.

University Hospital Southampton NHS Foundation Trust Information Governance Toolkit Assessment Report overall score for 2015/6 was 73%and was graded Satisfactory.

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.

UHS recognises that good quality health services depend on the provision of high quality information. UHS took the following actions to improve data quality in 2015/2016:

- Continued performance management of data quality via Trust and divisional meetings, the Clinical Coding function, and the IM&T Information Team. These groups use audit reports of patient data and key performance indicators on internal and external timeliness, validity and completion, including Dr Foster comparative analysis information. Areas of poor performance are identified, investigated and plans agreed for improvement.
- A data quality review programme working closely with clinical areas and clinicians to review the quality, timeliness and accuracy of patient level data collection.
- Continued work to reduce data quality problems at the point of data entry through improved system design, changes to software, and targeted support for system users.
- Supported training and education programmes for all staff involved in data collection, including Information Governance training and the provision of information collection guidance.
- Maintained a programme of regular internal audit, including data quality, record keeping, health records management, information governance and clinical coding audit.
- Continued to maintain and develop improved compliance with the Information Governance Toolkit standards.
- Began a programme of education, training and data quality work to support improved collection and management of patient pathways and waiting times

Review of Services:

During 2015/2016 the University Hospital Southampton NHS Foundation Trust (UHS) provided and/or sub-contracted 107 relevant health services (from Total Trust activity by specialty cumulative 2015/2016 contractual report).

UHS has reviewed all the data available on the quality of care in all of these NHS services.

The income generated by the NHS services reviewed in 2015/2016 represents 100% of the total income generated from the provision of NHS services by University Hospital Southampton NHS Foundation Trust for 2015/2016.

Proportion of income for achieving commission quality, innovation payment framework (CQUIN)

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

A proportion of UHS income in 2015/2016 was conditional upon achieving quality improvement and innovation goals agreed between UHS and any person or body they entered a contract, agreement or arrangement with for the provisions of relevant health services, through the CQUIN framework. Further details of the agreed goals for 2016/2017 are currently being determined between UHS and clinical commissioning groups.

The monetary total for the amount income in 2015/2016 conditional upon achieving quality improvements and innovation goals was £11,309,000

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.

Our CQUIN priorities for 2015/2016

Clinical	CQUIN Scheme	CQUIN Target	National or Local Scheme	Financial Reward for Achieving Scheme
NHSE & CCGs	Acute Kidney Injury	Focussing on AKI diagnosis and treatment in hospital and the plan of care to monitor kidney function after discharge	National	£1,240,000
NHSE & CCGs	Sepsis 2a	Screening all patients whom sepsis screening is appropriate who arrive through the Emergency Department/ or by direct admission to any other unit	National	£513,000
NHSE & CCGs	Sepsis 2b	Initiate intravenous antibiotics within 1 hour of presentation, for those patients who have suspected severe sepsis, Red Flag or septic shock	National	£512,000
NHSE & CCGs	Emergency urgent Care 8a	Improving recording of diagnoses in A&E of patients with mental health needs, whilst this still includes mental health re-attendances within A&E there is no longer a risk of a financial penalty	National	£1,186,000
NHSE & CCGs	3a Dementia – Find, assess, investigate, refer & inform	Extension of 14/15, Find, Assess patients > 75 to whom case finding is applied, identify those as potentially have dementia, appropriately assess and refer onto specialist services and inform (written care plan on discharge which is shared	National	£341,000

		with patients GP)		
NHSE & CCGs	3b Dementia – Staff training	To ensure that appropriate dementia training is available to staff through a locally determined training programme	National	£342,000
NHSE & CCGs	3c Dementia - Supporting Carers	Ensure carers of people with dementia feel adequately supported	National	£342,000
SCCCG & WHCCG	Follow up Reform	Review current practice of routine face to face follow ups with aim to stop routine face to face follow ups and commence patient initiated follow up	Local	£1,160.000
SCCCG	Falls & Bone Health	Reduce injuries due to falls in people >65 in collaboration with Solent/SCAS	Local	£203,000
WHCCG	Managing Delayed Transfer of Care	A reduction in delayed transfers of care and non elective excess bed days. The aim is to accelerate the integration of health and social care and provide increased care in the community.	Local	£318,000
SCCCG & WHCCG	Choose and Book	Deliver directly-bookable services to all patients referred from GP and community services	Local	£833,000
SCCCG	Person Centred Planning	To develop the previous years CQUIN and collect patients views and improve through training and sharing of good practices	Local	£204,000
SCCCG	End of Life Care	Improving quality of care for patients whose recovery is uncertain and may be towards the end of life care	Local	£254,000
NHSE	Intravenous Immunoglobulin Panel (IVIg)	Implementation and management of a regional clinical IVIg panel set up by the regional centre and involving the local District General Hospitals.	Local	£431,000
NHSE	Intravenous Immunoglobulin Panel Database	Database of IVIG data	Local	£431,000
NHSE	Neonatal	To identify babies with a gestation age 24 to 36 weeks with an SO postcode who may be suitable for short-term nasogastric tube feeding at home whilst breast or bottle feeding is established and to provide an outreach service to allow this to happen.	Local	£431,000
NHSE	Highly Specialist Services	Providers of highly specialist services will hold a clinical outcome collaborative audit workshop and produce a single provider report.	Local	£861,000
NHSE	Dental	A local Dental Network is in place within Wessex and requires engagement by all local dental professional.	Local	£76,000
NHSE	Screening	Highly specialised services clinical outcome collaborative audit workshop	Local	£124,000
NHSE	Haemoglobinopathy network	Developing partnerships working across services which treat patients with Haemoglobinopathies to define pathways & protocols	Local	£431,000
NHSE	Hep C Network	Developing partnerships working within networks and co-ordination of data collection alongside the procurement process	Local	£269,000
NHSE	Clinical Utilisation Tool	Introduction of software system to assess if a patient required acute care	Local	£807,000
			Total	£11,309,00

Registration with the Care Quality Commission

Care Quality Commission

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

Regulated activity:
Surgical procedures

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

Regulated activity: Treatment of disease, disorder or injury

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

Regulated activity: Maternity and midwifery services

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

Regulated activity: Diagnostic and screening services

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

Regulated activity: Transport services, triage and medical advice provided remotely

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

Regulated activity: Assessment or medical treatment for persons detained under the 1983 (Mental Health) Act

Provider conditions: This regulated activity may only be carried on at the following locations:
• Countess Mountbatten House, Moorgreen Hospital, Botley Road, West End, Southampton, SO23 3JB
• Princess Anne Hospital, Coxford Road, Southampton, SO16 5YA
• Southampton General Hospital, Tremona Road, Southampton, SO16 6YD

UHS has no conditions on registration and the Care Quality Commission has not taken enforcement action against University Hospital Southampton NHS Foundation Trust during 2014/2016.

The CQC undertook a review of compliance at the Southampton General Hospital (SGH) site in December 2014 and January 2015. The inspections covered all the UHS sites

UHS

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

CMH

Overall rating for this service	Good
Are services at this location safe?	Good
Are services at this location effective?	Good
Are services at this location caring?	Good
Are services at this location responsive?	Good
Are services at this location well-led?	Good

SGH

Overall rating for this hospital	Requires improvement
Urgent and emergency care	Good
Medical care	Good
Surgery	Requires improvement
Critical care	Requires improvement
Services for children & young people	Good
End of life care	Requires improvement
Outpatients & diagnostic imaging	Requires improvement

PAH

Overall rating for this hospital	Good
Maternity & gynaecology	Good

The Trust has been implementing a plan of action based on the recommendations of the CQC and our progress was reviewed in a Summit meeting with Monitor, CQC, our Care Commissioning groups and representatives from Healthwatch. It was agreed that good progress has been made against the recommendations, the majority have been completed with some ongoing but being progressed.

A review meeting was held on 11th January 2016 with the CQC and the Director of Nursing (DoN), Medical Director (MD) and Deputy Director of Nursing (DDoN). The purpose of the meeting was to review progress against the action plan. The DoN proposed that certain actions should be subject to regular scrutiny once the initial action had been achieved, therefore a new colour (blue) was added to the RAG rating and agreed to reflect actions complete but in need of ongoing review.

Several actions from the CQC visit and subsequent action plan involves updating the current estate and infrastructure, several building and remodelling projects are now underway. This is excellent news for improving our

care delivery but has created some significant disruption to the site at the current time. The estates team and all teams are working hard to minimise the impact of this activity

CQC Safeguarding Children Visit

As part of a multi agency review by the CQC into safeguarding children, UHS participated in a multiagency inspection. The CQC team visited the Emergency department, the Maternity hospital and the paediatric admissions wards and inspected services under the following key lines of enquiry:

- Early help
- Child protection
- Looked after children,
- Children in need
- Leadership and governance
- Training and supervision

A formal report has being compiled and was published April 2016. An improvement plan has been formulated and commenced in response to the initial feedback.

Deanery Visit

During 2013 Wessex Deanery raised concerns about training and supervision for junior doctors in trauma and orthopaedics (T&O), requesting actions to address the issues. After an initial review in 2014 the Deanery acknowledged that the Trust had made tremendous efforts to address the concerns and work continued on improvement of the service and the training experience it offers for doctors. Since then T&O are no longer an outlier in any area of the GMC survey for 2015, this is a commendable turnaround. T&O are being used as a positive example by the GMC and will be revisiting in the new financial year to check the improvement has been maintained.

Our standard core indicators of quality

From 2012/2013 all trusts were required to report against a core set of indicators relevant to the services they provide, for at least the last three 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

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

	January 14 - December 14		April 14 - March 15		July 14 - June 15	
	Value	OD Banding	Value	OD Banding	Value	OD Banding
UHS	1.01	2	0.99	2	0.96	2
National Ave	1	2	1	2	0.99	2
Highest Trust Score	1.24	1	1.2	1	1.2	1
Lowest Trust Score	0.65	3	0.67	3	0.66	3

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

	Jan 14 - Dec 15			Apr 14 - Mar 15			Jul 14 - Jun 15		
Deaths	Treatment Rate	Diagnosis Rate	Combined Rate	Treatment Rate	Diagnosis Rate	Combined Rate	Treatment Rate	Diagnosis Rate	Combined Rate
UHS	15.6	41.8	42.5	15.1	39.7	40.6	15.6	41.8	42.5
National Ave	1.4	25.8	25.9	1.4	25.7	25.8	1.4	25.8	25.9
Highest Trust Score	18.3	52.9	48.7	17.6	47.4	47.4	18.3	52.9	52.9
Lowest Trust Score	0	0	0	0	0	0	0	0	0

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

	Jan 14 - Dec 15			Apr 14 - Mar 15			Jul 14 - Jun 15		
Spells	Treatment Rate	Diagnosis Rate	Combined Rate	Treatment Rate	Diagnosis Rate	Combined Rate	Treatment Rate	Diagnosis Rate	Combined Rate
UHS	0.6	1.9	1.9	0.6	2.1	2.2	0.6	2.2	2.3
National Ave	0.08	1.3	1.4	0.08	1.4	1.4	0.08	1.4	1.4
Highest Trust Score	1.2	3.2	3.2	1.25	3.3	3.4	1.3	3.3	3.4
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,

Adjusted health gain

	Reporting Period					
	Apr 2012 - Mar 2013 (Published Aug 14)		Apr 2013 - Mar 2014 (Published Aug 15)		Apr 2014 - Mar 2015 (Provisional, published Nov 15)	
	UHS	Eng. Ave.	UHS	Eng. Ave.	UHS	Eng. Ave.
Hips	20.707	21.299	21.671	21.380	21.214	21.455
Knees	15.448	15.996	14.975	16.273	15.71	16.142

Participation rates

	Reporting Period					
	Apr 2012 - Mar 2013 (Published Aug 14)		Apr 2013 - Mar 2014 (Published Aug 15)		Apr 2014 - Mar 2015 (Provisional, published Nov 15)	
	UHS	Eng. Ave.	UHS	Eng. Ave.	UHS	Eng. Ave.
Overall	70.1%	75.5%	82.4%	77.2%	85.8%	75.4%
Hips	55.6%	83.2%	67.0%	87.0%	73.8%	85.6%
Knees	104.0%*	90.4%	107.0%*	95.0%	104.8%*	94.8%

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

*Participation rates above 100% occur when the number of questionnaires returned for a period exceeds the number of cases undertaken.

Our readmissions rate for children and young adults

The Heath and Social Information Centre (HSCIC) have previously provided readmission data for children and young adults. Since the publication of child readmission figures in 2013/2014, this data has been on hold as they review their data collection processes with assurances that this data publication will commence again in the near future. Despite several requests to get this data by the Information Team at UHS , we have been unsuccessful. The Trust team have been informed that several other Healthcare Trusts across the United Kingdom have been requesting this data for their Quality Accounts and currently sit in the same position as UHS.

The following table provides local data but does not have the national bench marking we normally assess against if we receive the information from HSCIC.

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.

	Reporting Period Awaiting results of the 2014 National Inpatient survey			
	2010/11	2011/12	2012/13	2013/14
	Composite Score			
UHS	6.48	6.42	6.8	6.4
National Ave	6.73	6.74	7.0	6.8
Highest Trust Score	8.26	8.5	8.6	8.2
Lowest Trust Score	5.67	5.65	5.4	5.3

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

Supporting and listening to our staff is essential to ensure we provide a safe, effective and quality service.
In April 2014 the national Friends and Family Test survey for staff was introduced. This is a quarterly survey which focuses on the advocacy element of staff experience and runs in tandem with the national annual staff satisfaction survey which also asks similar questions. The UHS results for quarter 4 (January/February 2016) show the highest scores for both questions since the survey was introduced in April 2014.

Question	**Quarter 1 May 2014**	**Quarter 2 August 2014**	**Quarter 4 February 2015**	**Quarter 1 May 2015**	**Quarter 2 August 2015**	**Quarter 4 Jan/Feb 2016**	**National average scores to date**
How likely are you to recommend UHS to friends and family if they needed care or treatment?	86%	88%	90%	90%	89%	90%	Not yet known
How likely are you to recommend UHS to friends and family as a place to work?	74%	73%	72%	75%	73%	76%	Not yet Known

The national annual staff survey also asks similar questions and the Trust results are shown below.

Question	**UHS 2012**	**UHS 2013**	**UHS 2014**	**UHS 2015**	**National average for all acute Trusts 2015**
I would recommend my organisation as a place to work.	64%	63%	68%	68%	61%
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	67%	71%	77%	79%	70%
Staff recommendation of the Trust as a place to work or receive treatment.	3.64	3.79	3.89	3.94	3.76

Workforce Race Equality Standard (WRES)

Question		**UHS 2014**	**Average (median) for Acute Trusts**	**UHS 2015**
% staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.	White	26%	28%	26%
	BME	22%	28%	24%
% staff experiencing harassment, bullying or abuse from staff in the last 12 months.	White	23%	25%	22%
	BME	22%	28%	25%

The percentage of staff believing that the trust provides equal opportunities for career progression or promotion

Workforce Race Equality Standard (WRES)

Question		UHS 2014	Average (median) for Acute Trusts	UHS 2015
% staff believing that UHS provides equal opportunities for career progression or promotion.	White	91%	89%	90%
	BME	83%	75%	73%
% staff experiencing discrimination at work from their manager / team leader or other colleagues	White	7%	6%	6%
	BME	13%	13%	16%

The workforce race equality standard data for 2014 – 2015 showed we have a higher percentage of BME members of staff in the lower bandings within the organisation. They are more likely to be involved in a grievance or a disciplinary proceeding, less likely to be appointed following interview, more likely to experience bullying and harassment and are less likely to access non mandatory training. The Trust board did not reflect the ethnic diversity of the population of Southampton city. We are taking a multi-pronged approach to address this disparity.

- We have updated our data collection of monitoring information of disciplinary proceedings and grievances, so we are able to access this information more easily

Career progression:

- We are running a project to evaluate interview results from a two-week period. The proposal is to discuss with the interviewers to understand their reasoning for not appointing the BME applicant
- We will run a listening exercise with all BME staff – to understand the barriers from the applicant's point of view
- Equality Diversity and Inclusivity has been incorporated in the interview process of all senior management interviews to ensure that successful candidates reflect the Trust Values.
- We plan to update the recruitment policy with the following updates included:
    - When there is a BME candidate being interviewed the panel must include a BME member on the panel. (This would be a BME member of staff from within the organisation, who is trained by the recruitment and retention team)
    - When a BME candidate is unsuccessful at the interview stage – the chair of the panel must offer and meet with the individual and provide constructive feedback, and access to training opportunities that they feel would benefit the applicant in the future.

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.

	2014/2015 Q1	2014/2015 Q2	2014/2015 Q3	2014/2015 Q4	2015/2016 Q1	2015/2016 Q2
UHS	95.560%	95.10%	95.23%	95.38%	95.10%	95.30%
National Average (Acute Providers)	96.40%	96.50%	96.34%	96.30%	96.30%	96.20%
Highest Trust score (Acute Providers)	100%	100%	100%	100%	100%	100%
Lowest Trust score (Acute Providers)	87.20%	90.50%	81.91%	79.235	86.10%	75%

The rate per 100,000 bed days of cases of Clostridium 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 Clostridium 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.

	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015
UHS	25.8	18.9	11.3	9	11.9
National Average	29.7	22.2	17.3	14.7	14.5
Highest Trust score	71.2	58.2	30.8	37.1	62.2
Lowest Trust score	0	0	0	0	0
Lowest Trust score (non zero)	2.6	1.2	1.2	1.2	2.6

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.

The data produced is for 2 quarters only as the measurement has changed from incidents per 100 admissions to rate per 1000 bed days in April 2014

	Apr-14 to Sept14			Oct 14 to March 15		
	Rates Per 1000 bed days	Severe and death	Severe and death %	Rates Per 1000 bed days	Severe and death	Severe and death %
UHS	32.3	57	0.85%	35.41	61	0.90%
National Average (Acute teaching trusts)	33.29	20	0.52%	37.15	23	0.58%
Highest Trust score (Acute teaching trusts)	74.96	97	3.05%	82.21	128	5.19%
Lowest Trust score (Acute teaching trusts)	0.24	0	0.00%	3.57	2	0.05%

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.

NHS Improvement published the first annual report 'Learning from Mistakes League'. Drawing on a range of data this will identified the level of openness and transparency in NHS provider organisations for the first time:

This year's League shows that 120 organisations were rated as outstanding or good, 78 had significant concerns and 32 had a poor reporting culture.

We are pleased to note that UHS rated as having good levels of openness and transparency and the second highest of a university teaching hospital.

Overview of Performance

The information below summarizes our achievement for performance across all of the performance indicators that are fully reported each month in our trust board performance reports. These indicators are also included in the development of our patient improvement framework since 2011/12 and the Monitor compliance framework requirements. These are.

Key Performance Indicators								
Key targets	2012/13	2013/14	2014/15	2015/16 (Up to Dec 14)	2015/16 Target	Met / Not Met	Proposed 2014/15 target	Comment
A&E patients, % admitted, transferred or discharged < 4 hours (UHS & Partners)	94.30%	93.30%	88.85%	89.75%	95%	Not Met	>95%	
18 weeks – Admitted patients treated within 18 weeks	92.38%	88.62%	86.07%	88.72%	90%	Not Met	>90%	
18 weeks – Non admitted patients treated within 18 weeks	95.24%	88.56%	93.44%	94.34%	95%	Not Met	>=95%	
18 weeks - Patients currently waiting on an 18 week pathway within 18 weeks (Incomplete pathways)	91.45%	90.57%	93.23%	93.93%	Achieve 92%	Met	92%	On Target
6 weeks - Maximum waiting times for 15 key diagnostics tests	0.06%	0.03%	0.38%	0.55%	<1%	Met	<1%	On Target
Cancers: 2 week wait (Urgent GP/ GDP referral) to first hospital assessment	95.35%	94.20%	94.98%	96.40%	93%	Met	93%	On Target
All breast symptoms: referral to first hospital assessment	96.83%	94.74%	95.03%	98.20%	93%	Met	93%	On Target
Cancers: 31 days (Decision to treat) to first treatment	98.53%	96.25%	96.34%	96.99%	96%	Met	96%	On Target
Cancers: 31 days (decision to treat) to 2nd or subsequent treatment (drugs)	99.69%	99.90%	99.48%	99.88%	98%	Met	98%	On Target
Cancers: 31 days (decision to treat) to 2nd or subsequent treatment (surgery)	97.73%	97.61%	96.38%	95.94%	94%	Met	94%	On Target
Cancers: 31 days (decision to treat) to 2nd or subsequent treatment (radiotherapy)	99.03%	99.47%	97.96%	99.41%	94%	Met	94%	On Target
Cancers: 62 days Urgent GP referral to treatment	90.11%	87.93%	80.50%	86.63%	85%	Not Met	85%	

Patient Safety Indicators

Patient Safety Indicators							
Key targets	2012/13	2013/14	2014/2016	2015/2016 (YTD)	2015/2016 Target	Met / Not Met	Proposed 2016/2017 target
Serious Incidents Requiring Investigation (SIRI)	127	195	35	51	31	Not met	Target should be set on the indicator 0.05 per 100 admissions resulting in severe harm or death
Never Events	2	2	2	5	0	Not met	0
Healthcare Associated Infection MRSA bacteraemia reduction	3	5	5	1	0	Not Met	2015/2016 target will remain zero.
Healthcare Associated Infection Census") (as average of monthly %)	375%	354%	3.57	>100%	100%	Met	2015/2016 target will remain 100%

Healthcare Associated Infection Clostridium difficile reduction	40	33	37	23-26	49	Met	2015/2016 - Target is yet to be confirmed.
Avoidable Hospital Acquired 33* Grade III and IV Pressure Ulcers	41	42	26	37	32	Not met	Target for 2016/2017 is 30
Falls Avoidable Falls	5	19	9	3	15	Met	Further 20% reduction 4 less = 15
Fall Assessment tool) Compliance (as average of monthly %)	94.5%	95.00%	95.70%				>95% fully completed not partial
Thromboprophylaxis (VTE) % Patients Assessed (CQUIN)	95.31%	95.41%	95.35%	95.00%	95.05	Met	95%
Thromboprophylaxis (VTE) Pharmacological prophylaxis (as average of monthly %)	96.16%	97.32%	99.46%	95.00%	98.86%	Met	95%

Patient Experience Indicators

Patient Experience Indicators							
Key targets	**2012/13**	**2013/14**	**2014/2016**	**2015/2016 (YTD)**	**2015/2016 Target**	**Met / Not Met**	**Proposed 2016/2017 target**
Total complaints	585	578	579	473	<600	Met	<550
Percentage of complaints closed in target time (due this month) (As average of monthly 5)	92%	96.7%	93%	93%	>=90%	Met	>=93%
National Friends & Family Test Response Rate UHS Emergency Department Inpatients Maternity		21.7%	27.9% 37.94% 25.15%	9.91% 22.51% 23.38%	15% 30% 30%	Not met	Internal targets >15% >30% >30%
Percentage of patients recommending UHS to their friends & family UHS Emergency Department Inpatients Maternity					92.26% 95.49% 95.81%	n/a	Internal targets >93% >96% >96%
Monthly Real time Survey Have you ever shared a sleeping area with patients of the opposite sex during this stay in hospital? (Those who gave an answer, as average of monthly %)	7%	13%	13.47 %	12%	<=15%	Yes	<12%
Same Sex Accommodation (Non clinically justified breaches)	10	16	10	5	<=360 (<=30 per month)	Yes	<10
Nutrition % of patients with Nutritional screening in 24hrs (as average of monthly %)	91.9%	89.1%	89%	82%	>95%	Not met	>95%

Patient Outcome Indicators

Patient Outcome Indicators							
Key targets	**2012/13**	**2013/14**	**2014/2015**	**2015/2016 (YTD)**	**2015/2016 Target**	**Met / Not Met**	**Proposed 2016/2017 Target**
Hospital Standardised Mortality Rate (HSMR) University Hospital Southampton NHS Foundation Trust	114.97	113.15	104.35	97.04*	100	Met	100
Hospital Standardised Mortality Rate (HSMR) Southampton General Hospital	107.38	108.45	96.67	86.97*	<90.1	Met	<90.1
Hospital mortality Rate	1.86	1.83	1.75	1.57			
Emergency readmissions, within 28days (as average of monthly %)	10.3%	10.7%	10.4%		7.5%		
Patient Reported outcome measures. PROMS hip replacement data contributed	55.6%	53.9%	67.6%	Q1And 2 Only available from HSCIC 74.8%	80%	To be confirmed once Q3/4 data is available	80%
Knee replacement data contributed.	104%	117%	107%	94.7%	80%	Met	80%

Further Information about our Trust

Duty of Candour

The Trust is committed to 'Being Open' and candid; about communicating with patients, their relatives and carers about any failure in care or treatment, whether they be the results via a Patient Safety Incident (PSI), Complaint or Claim.

In order to support patients and families we have developed written information to explain our process and what they can expect from us along with clear contact details to support them.

To support and educate staff Duty of candour is included in all our induction training and regularly on our education sessions and we monitor compliance with Duty of candour regularly. UHS has not declared any breach of the duty since it came into force.

Raising a concern (Whistle blowing)

The Trust has a robust Whistle Blowing Policy in place which is compliant with current legislation and best practice arising from the Francis Report.

In October 2013 the Trust launched an internal whistle blowing helpline to help facilitate the reporting of incidents and protected disclosures. This helpline is manned from 08.00 to 18.00 Monday to Sunday by a group of senior managers from Human Resources and from the Risk and Patient Safety Team. There is also a dedicated email

address for staff to use if they prefer.Since its commencement the helpline has managed 3 protected whistle blowing disclosures and 8 other disclosures which have been made directly to the CQC.

The Trust has developed a staff information leaflet to assist whistle blowers, highlighting the internal and external support mechanisms available to them during the process of making a protected disclosure.
In line with the recommendations of the Francis Report the Trust has appointed 2 Freedom to Speak Up Guardians who report directly to the Chief Executive and oversee any complex or high risk cases. In addition to the 2 Freedom to Speak Up Guardians the Trust has an identified Non-Executive Director who takes the lead on whistle blowing and provides independent guidance and support to the process.

The Trust is currently in the process of refreshing its whistle blowing policy in line with the development of a national whistle blowing policy and will re-launch the helpline with a series of awareness campaigns during May 2016.

Sign up to Safety

UHS joined the NHS England sign up to safety campaign in January 2015 and to demonstrate our commitment we have made public 5 key pledges

We will:

- Put safety first. Commit to reduce avoidable harm in the NHS by half and make public our goals and plans developed locally
- Continually learn. Make our organisation more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe our services are
- Be honest and transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong
- Collaborate. Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use
- Support. Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress

In order to support the national aim of reducing avoidable harm in the NHS by 50% in the next 3-5 years we will focus on 5 key safety topics. A safety improvement plan was developed for each key initiative to provide clarity about what we want to achieve and when we want to achieve it by. It is recognised that improvement is a cycle of plan, do, study, act and these plans should and will develop as we learn what works and what doesn't.

5 key initiatives: -

1. Reducing avoidable harm to patients who have an inpatient fall
2. Reducing avoidable harm to patients caused by pressure damage in adults and children
3. Improve the recognition and timely management of Sepsis in adults and children
4. Prevent and minimise the impact of Acute Kidney Injury in adults and children
5. Reduce complications from failure to interpret or act on abnormal CTG tracing in labour

Patient feedback & Listening Events

Patient and public feedback and engagement is proactively promoted in the Trust in a variety of different ways. These include:

- CEO patient lunches
- FFT comments
- Have Your Say feedback

- Real-time feedback surveys
- National Patient Surveys
- NHS choices feedback
- Concerns and complaints
- Clinical specialty ad hoc surveys
- Feedback directly to clinical areas

Results from our national inpatient survey (2014/2016) and data collected from our real-time surveys told us that patients are disturbed by noise at night. This included noise from clinical staff (22% of respondents) as well as from other patients (37% of respondents).

In response to this feedback, during 2015 we developed guidance to help patients rest and sleep whilst in hospital. A “Noise at night” pledge sets out standards of clinical practice, identifying measures that can be taken to reduce the amount of noise at night and promote relaxation, rest and recovery for our patients. This includes availability of eye masks and ear plugs.

Education and training of UHS Staff

The development, monitoring and enhancement of quality learning is central to the organisation’s ability to ensure that staff are fit for practice and purpose and equipped with the knowledge and skills needed for their role. Ultimately, regardless of role, this education/ training should contribute to patient safety and experience.

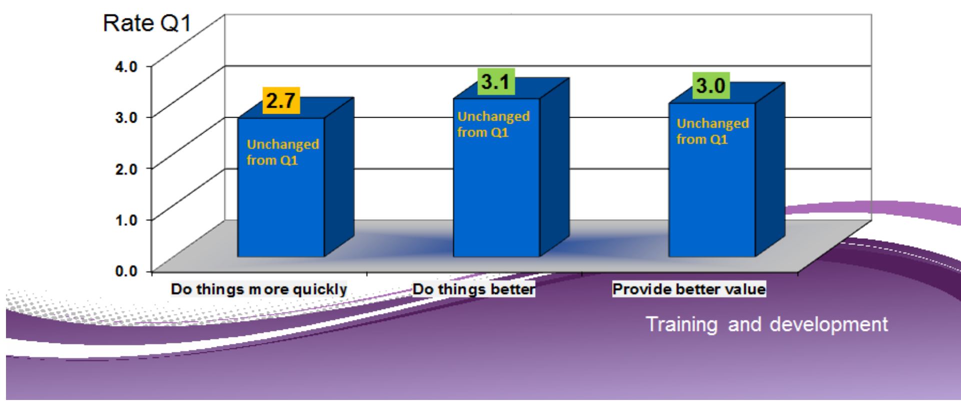
During this year, a new strategy for training and development evaluation has been developed and agreed in September 2015. It is in the process of being implemented across the organisation.

The courses that the training and development team provide are constantly evaluated by the course attendees and the results are below

Expected effectiveness of performance post education

Average rate
2.94

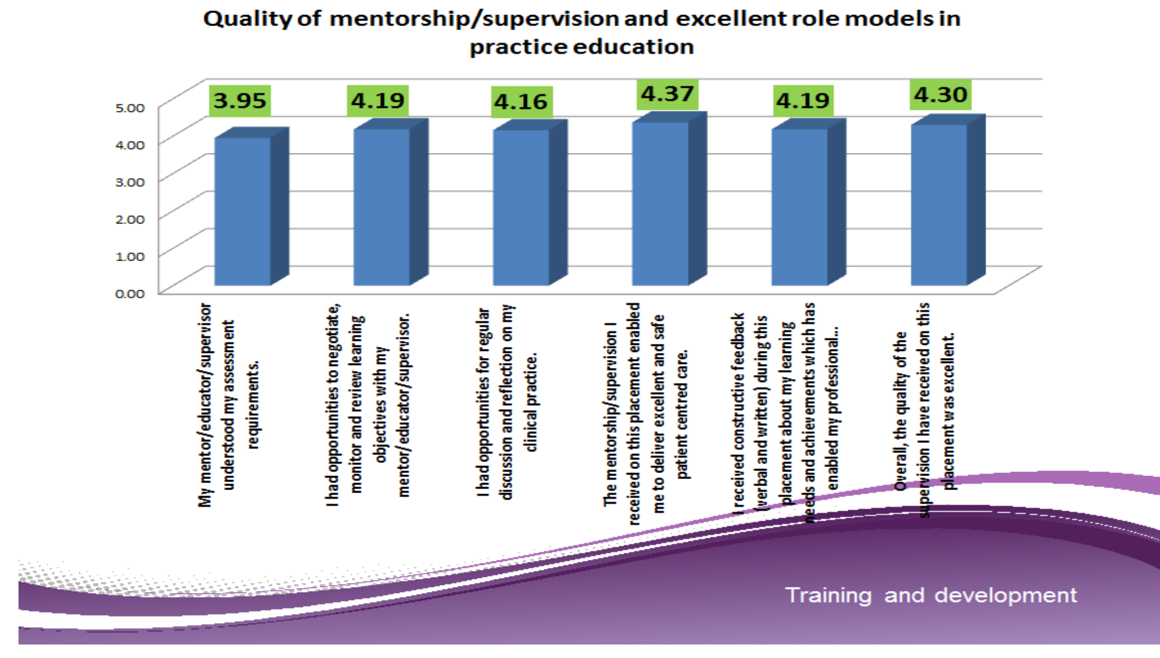
Degree of expected impact on performance

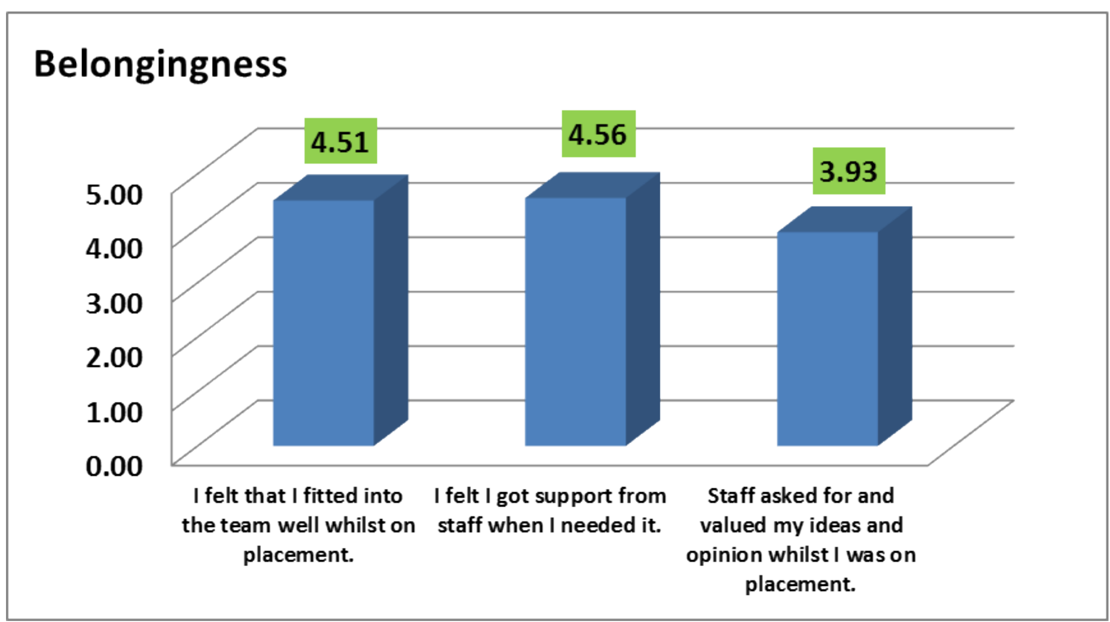


Student Placement Evaluation

The student placement evaluations have been aligned with an ongoing Health Education England Wessex office evaluation project. The Education Quality Team is active members of the regional task and finish group. Further work is still needed to support this development which will continue into 2016.

The latest student evaluation report relevant for period from July to December 2015 makes an evidence of excellent mentorship/supervision quality provided to students by the UHS staff:





A number of work streams that were identified for completion during 2015/2016 have been have completed and are established. Those include:

- Development of evaluation suitable for Child Health care group local education and training provision
- Development of extended role survey for Radiographers including the training and education needs relating to extended roles

- Development and implementation of statutory and mandatory training questionnaire for PhD students in practice at UHS for Welcome Trust
- Development and implementation of Medical Interpreters Course evaluation
- Creating HCA training evaluation questionnaire for Theatres
- Supporting workforce development related surveys across the Trust
- Supporting divisional ad hoc evaluation requirements
- Health Education England (Wessex Office) visited UHSFT to complete the Education Quality Review. This was a very positive meeting and one that clearly demonstrated the commitment and quality of the education and training provided by the organisation.
- UHS continues to be involved in national work around the development needs of health support staff, including being a lead player in the creation of the National Skills Academy for Health Southampton and Solent Excellence Centre, the Trailblazer Health apprenticeship steering group and the Talent for Care implementation group. The Talent for Care Partnership pledge was signed by Fiona Dalton, Jo Mountfield and Tina Lanning (for staff side) in January 2016 which commits the Trust to implementing the Talent for Care strategic intentions which forms the structure of the Trust's new Health Support Staff development strategy.

Conclusion

We are proud of the advances we have made in the quality of services we provide. However, our mission is to be better every day and 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 2015/2016. We see this as an essential vehicle for us to work closely with our Governors Council, 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 leading healthcare for the benefit of our patients.

Appendix A

National Clinical Audit: actions to improve quality

National audit title	Actions
1. Renal replacement therapy (Renal Registry)	• Aim to continuously improve quality. There are no initiatives arising specifically from the renal registry data
2. Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	• On-going individual case review - stillbirths & neonatal deaths looking for clinical and organisational lessons. • There is on-going work within the Maternity Network looking at improved detection of in utero growth restriction.
3. National Emergency Laparotomy Audit (NELA)	• Work on maintaining and improving data entry. • Enrolled on a supraregional QI initiative called the emergency laparotomy collaborative • Changes to booking processes for emergency cases (done) • Development of an integrated care pathway for emergency laparotomy (work in progress) • Introduction for policy for consultant led care for high risk cases (done)
4. Major Trauma: The Trauma Audit & Research Network (TARN)	• Continuous improvements using a quarterly dashboard and monthly Best Practice Tariff report.
5. National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme - Pulmonary Rehabilitation Audit	• To look at the provision of muscle strength testing to ensure the patients are worked at the correct level when doing resistance training.
6. Diabetes in pregancy (NPID)	• Work towards implementation of current NICE guidance
7. Coronary Angioplasty/National Audit of PCI	• No action required as all results within acceptable outcome intervals
8. Bowel cancer NBOCAP	• No actions needed
9. National Vascular Registry (NVR)	• Review surgeon specific outcome data
10. Congenital Heart Disease (Paediatric cardiac surgery) (CHD)	• No actions needed
11. National Heart Failure Audit	• We have now employed a data clerk to enter the data on patients not referred to the HF team; thus aiming to achieve 100% of HES admissions. • We are looking at making contact with some of the consultants to ensure referrals are increased.
12. Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	• Involvement in teaching sessions on ACS to South Central Ambulance Service to improve identification of appropriate patients and earlier pre-alert so that the ACS Nurse team can get the Cardiac Catheter Lab staff in sooner. • Plan to talk with commissioning group for the local Wessex Cardiac Network (at their next meeting) regarding the management of all patients with chest pain to improve i.d. and screening of patients with potential ACS and early discharge of those with non-cardiac chest pain. • All cases where reperfusion standards are breached are reviewed regarding route cause to highlight awareness in hospital and with primary care.
13. Oesophago-gastric cancer (NAOGC) (NOGGA)	• Continued focus on Enhanced Recovery.

Appendix B

Local Clinical Audit: actions to improve quality

Audit Title	Actions
1. Re-audit of physiotherapy intervention for total knee replacement	• Agree appropriate intervention timescale for cryotherapy and liaise with team and gain consensus. • Adjust core standards in line with consensus if appropriate • Quad and Hamstring strength-education and training to therapy team. • Re-implement use of notes templates. • Team education to include awareness of core standards. • Daily physio input to continue to record daily statistics to be able to monitor staffing and activity. • Re-audit to assess impact of increased weekend service. • Adjust Discharge section to include Knee triage and 1:1 OPR. • To add unavailable to CPM/Hydro. • To re-look at gait analysis section.
2. A re- audit of Physiotherapy Adherence to the Association of Chartered Physiotherapists in Cystic Fibrosis Inpatient Exercise Guidelines	• Improve documentation to see why patients are not carrying out the variety of exercises set. • To carry out a patient questionnaire to ask why patients are declining exercise and have their views on exercise.
3. Standardized acute adult green card audit	• Standards to be updated to reflect current guidance and improvements in practice before re-audit in 6 months. • Feedback to the department on standards not met and education to team about the need for correct documentation as records are a legal document at a team meeting within the next six months.
4. An audit of the SPPOST used by Therapy Services and Physiotherapy interventions for patients who are screened as 'low Risk' for PPC and are therefore not routinely treated by Physiotherapy	• To re-audit to ascertain why patients that had a laparotomy were not screened day 1 post op.
5. Care of women undergoing repair of perineal trauma	• To email all midwifery staff reminding them of the patient information leaflets available and to document in the case notes when a leaflet is given as per best practice.
6. Post total knee replacement: pillow audit	• To place a sign above elective knee patients bed stating that they should not have pillows beneath their knee.
7. Nutrition on GICU 2015	• A consultant meeting with dieticians is planned to discuss difference between feed that is prescribed and what is actually given. • Guidelines will be produced for a catch-up protocol. • Consultants and GICU nurses will meet to discuss protocols for feed during nursing turns and physio. • The need to stop feed awaiting theatre will be discussed with the anaesthetic department. • A review of the evidence behind GICU nutritional guidelines will be undertaken and new guidelines written if required.
8. Transfusion practices on Critical care	• Departmental education by presentation at teaching sessions and local meetings to form a local guideline. • To roll out the audit as a regional audit in November via SPARC ICM (South Coast Audit and Peri-operative Research Collaboration in Intensive Care

	Medicine).
9. Warfarin management in Endoscopy	• To repeat audit at the same time of year once changes implemented with a larger sample size. • To review the current policy particularly in terms of when INRs need to be checked, to consider a range of days as opposed to the current policy which states a specific day. • Further/clearer guidance for patients and GPs regarding when INRs need to be checked. • To review which patients are put into correct group re: diagnostic or therapeutic on request. • Clarification of where the information for patients who had the procedure at RSH is documented.
10. Use of red alert bands	• Results of audit to be shared with Band 6 & 7 Senior Nursing Teams, Surgical Matrons & Education & Practice Development Teams. • Senior Nursing Teams to share audit results with their nursing teams for information, learning & discussion of standards. • Senior Nursing Teams led by Ward Managers to lead initiatives at ward level to ensure 100% compliance is standard practice with no exceptions. Initiatives may include collaboration with Education & Practice Development Team. • Surgical Audit Facilitator to re-audit to monitor for compliance December 2014. • Identification bands not worn by all patients. • Each Band 7 Ward Leader to scrutinise their audit data & investigate ward practice to understand what constraints exist which may be preventing their staff achieving 100% or to identify education & training needs. • Each Band 7 Ward leader to generate an action plan to address issues with time line & present this via exception reporting at Care Group Governance. • Each ward leader to lead on the delivery of re- education of all nursing staff re UHS policy. • Checking of ID bands on every medication round to be mandatory. • Wards to ensure appropriate bands in place before transferring to another ward, receiving patients from another area (e.g. theatre, SHDU, ASU). • Wards to collect and analyse data weekly and include on exception reporting to care group governance on a monthly basis until compliance consistently at 100%.
11. Re-Audit Blood transfusion at Countess Mountbatten	• Leaflets to be available with blood transfusion forms in the MDT office to be given out. • To document risks and benefits explained in notes. • Dissemination of information regarding blood transfusion requirements to future SHOs. • To standardise of audit measures. • Up to date transfusion leaflets to be distributed.
12. To audit the use of nutrition risk screening tool and weight gain during a hospital admission for children with congenital heart disease admitted to Ocean Ward	• Develop a business case for investment in Dietetic/ Specialist Nursing time. • Develop a research proposal – NIHR/ Heart Foundation looking at Telemedicine (App) on growth in children with CHD. • Develop a CQUIN for growth. • Develop a 6 month notice letter to start charging for OPD appointments.
13. Recording of quality control of glucose meters	• Surgical Care Group currently not achieving 100% compliance with this standard, this has safety implications for patient care & treatment planning. • Feedback to be delivered at next Band 7 Business Day. • Discussion of results to be facilitated on the same day.
14. Patient status at a glance (PSAG) board and patient bed-head information	• Surgical Care Group currently not achieving 100% compliance with UHS standards for PSAG board use, thus creating safety implications for the patients & service delivery implications for staff. • Actions to be delivered by either Matron or Risk Coordinator at next Band 7 Business Day. • Band 7 Managers to agree responsibility for disseminating results to their staff. • Band 7 Managers to be tasked with continuing to drive further improvements

	to achieve 100% compliance, including re-education or refresher education of their staff. • Ongoing results to be included in monthly exception reporting to governance meetings. • Re audit to be completed after 4 months to ensure compliance has improved or achieved 100% compliance. • Incident forms to be monitored for issues.
15. Nurse in charge ward rounds re-audit	• No clinical area in the Surgical Care Group currently achieves 100% compliance with nurse in charge ward rounds since the Care Group standards were reconfigured to promote compliance. • Feedback to be delivered by either Matron or Risk Coordinator at next possible Band 7 Business Day. • Band 7 Managers to agree responsibility for disseminating results to their staff. • Band 7 Managers to be tasked with continuing to drive further improvements & to achieve 100% compliance. • Ongoing results to be included in monthly exception reporting to governance meetings. • Re audit to be completed after 4 months to ensure compliance has improved/achieved 100% compliance. • Incident forms /RCA investigations/spot checks & notes reviews to be monitored for issues.
16. An audit to determine the prevalence of overweight/obesity amongst children with diabetes	• To develop kilocalorie controlled diets and prescriptive portion size (diet sheets) to support overweight and obese patients to loose weight. • To develop a table indicating recommendations for carbohydrate portions to support patients to identify appropriate portion size in post diagnosis of diabetes. • Dietetic annual review paperwork to include an annual summary sheet of a patient's diet including analysis of a diet history.
17. To audit the efficacy of paediatric dietetic shared care for children with cystic fibrosis at Portsmouth regional clinic on achieving a BMI on the 50th centile	• For under nutrition children to continue recently established shared care clinic with Portsmouth Hospital. • To ensure all patients have a local dietetic review at least every 2 months. • Add paragraph to Wessex Regional Nutritional Guidelines advising on frequency of dietetic review i.e. every 2 months.
18. A&E waiting times for OMFS patients: Dental Abscesses: Retrospective and Prospective quality improvement project from December 2014 to July 2015. (re-audit)	• Hand over algorithm to team leaders and finalise data capture form, including 'arrival time' and 'breach – y/n' for re-audit. • Teach the new OMFS SHOs to take over and continue this cycle and ensure that each SHO will collect data on their on-call shift to maximise prospective 'n' number. . • Formally arrange teaching the triage and EP nurses, the key members of the team who will encounter these patients first and enable Maxillofacial to intervene earlier. • Construct a questionnaire for OMFS SHOs to show if the system has helped improve their management of dental abscesses / feedback form for patients to elicit their experience of waiting in ED. • Re-audit prospectively, noting the arrival, bleep and triage times for dental abscesses from December.
19. NICE CG174 Audit examining the current standard of intravenous fluid prescribing in Southampton General Hospital.	• A new column to be added on the IV fluids prescription chart labelled 'patient's fluid status' and a description of what a fluid status assessment should include at the bottom of the IV fluids prescription chart. • A new column on the IV fluids prescription chart labelled 'indication', which will require doctors to tick one of the following boxes: Resus, Replacement and Redistribution and maintenance. A new box on the IV fluids prescription chart explaining the requirements of maintenance fluids. • When 0.9% NaCl is prescribed, serum chloride levels are not checked, teaching to be given on intravenous fluids prescribing early on in the 1st rotation of foundation year doctors. • The development of a mobile phone app which will provide education on prescribing intravenous fluids.

20. Anticoagulation in AF in stroke patients	• Patients to be commenced on anticoagulation at a date after the discharge date, should go home with anticoagulation medication as part of their TTA medications. • Anticoagulation planned to start at a later date to be prescribed with TTA medications and to be supplied by the hospital pharmacy at the time of discharge.
21. A&E waiting times for OMFS patients: Dental abscesses: Quality improvement re-audit	• Hand over algorithm to team leaders and finalise data capture form, including 'arrival time' and 'breach – y/n' for re-audit. • Teach the new OMFS SHO' to take over and continue this cycle and ensure that each SHO will collect data on their on-call shift to maximise prospective 'n' number. • Formally arrange teaching the triage and EP nurses, to enable Maxillofacial to intervene earlier. • Construct a questionnaire for OMFS SHOs to show if the system has helped improve their management of dental abscesses / feedback form for patients to elicit their experience of waiting in ED. • Re-audit prospectively, noting the arrival, bleep and triage times for dental abscesses from December. • Re-pull retrospective data from December 2014 to July 2016 when able, for analysis of longer time period from when the algorithm was first proposed.
22. Quantify proportion of patients that are able to provide accurate drug history and optimise medical therapy of cardiology outpatients	• Change appointment letter by adding a reminder for patients to bring list of medication.
23. Patients knowledge and understanding of their opiods medication an audit based on NICE guidance CG140	• Implementation of opiods leaflet and education of patients by clinical staff when prescribing opiods to their patients.
24. Audit of pyloric stewosis guideline (2009) and outcomes	• Review guidelines and amend to include antimicrobial body washes pre and post op. • Re-educate staff within the department regarding use of antimicrobial prophylaxis to increase compliance.
25. Antenatal Screening Tests	• KPI ST2 – Timeliness of testing for Sickle Cell and Thalassaemia decisions is needed as to whether we can improve this KPI lie with senior management including the Head of Midwifery as, due to competing priorities, booking before 10 weeks for most women is not possible. • Senior leaders are looking at options around direct referral by women to maternity services thus removing any delay in seeing a GP but there are risks around communication of significant comorbidities, safeguarding etc and we are watching Portsmouth's experiences regarding this. • KPI NB1 – Avoidable repeat rate for newborn bloodspot screening • Review of staff experience of current lancets • Trial of new style of lancets x3 • Evaluation of new lancets.
26. NICE CG151 Re-audit management of Neutropenic sepsis	• Incomplete documentation on eDocs - Education on MAOS study day. • IV antibiotics not given in 1 hour - Education on MAOS study day.
27. Adherence to post-operative antibiotic therapy in orthopaedic patients protocol	• We are currently in the process of implementing change in the orthopaedic department through education about the importance of post-operative antibiotic prophylaxis.
28. Audit of the residual radiopharmaceutical in Nuclear Medicine syringes - is there a requirement to re-measure?	• Data needs to be analysed by physics team and approval to change practice obtained. Physics to look at data and approve change in practice. • Nuclear medicine staff need regular updates on audit. Disseminate information to the nuclear medicine team. • Nuclear medicine staff need to be aware of new doses. Create new dose chart for the dispensing room. • Policies and procedures on QMS need to be updated in view of changes made. Change departmental policies and procedures to include change in practice.
29. Auditing communication referrals to SLT on the acute stroke unit	• Standard 1, 2 & 3 Identify F8 SSP Champion to lead on SSP matters and support SSP's in ensuring annual updates take place.

against the Sentinel Stroke National Audit programme (SSNAP) standards	• F8 Ward Manager/Stroke Specialist Nurse Manager to identify appropriate member of the team to help identify reasons that communication needs are not being identified/referred. • SLT team to provide training regarding communication screening during a swallow screen or to check for comments/scores made by medical team. • LT SSP trainer to support F8 SSP Champion - ongoing. • Offer additional training slots as require. SLT SSP trainer to liaise with ward manager and F8 SSP champion to book training slots to highlight the results of the audit and give the opportunity for staff to raise questions/queries. • Design project/audit for SLT staff to complete in order to check back against data collected in this audit. • SLT stroke lead to support SLT assistants/band 5's in carrying out a project and re-audit for communication screening in order to further develop the stroke service.
30. Recording smoking status in emergency gynaecology admissions	• Implement and continue to use new proforma to state smoking status of all emergency gynae admissions.
31. Temporal artery biopsy-Are we following the international guidelines for size of specimen and referral time	• All Vascular surgeons are being informed about required size of specimen which should be 10-20mm. • Rheumatology team are being informed through Trust emails that patients for referral must have an ACR score of 3 or more.
32. T&O Departmental audit of timely VTE risk assessment and thromboprophylaxis	• Dissemination of results to all medical staff to raise awareness and increase compliance (Checking VTE assessments during the handover and on the post take ward round). • Post take ward round dictation pro forma, • Sisters/ nurse practitioners to follow up the VTE assessments of the new admissions, so as to ensure their completion
33. Unlicensed Medicines	• To identify the ten injections that have been issued in the last 6 months, that do not have administration details in the PIL, to determine what information is available to nurses at the point of administration. • To ensure that the above injections have available administration details available on JAC. • To consider whether the injections that do not have administration details provided in the PIL and that have not been issued in the last 6 months are still required to be kept at UHS.
34. Do Not Attempt Cardiac Pulmonary Resuscitation audit	• The patient details on the DNACPR forms have to have documented 2 identifiers as a minimum. • Include the date DNACPR form to be completed in all cases. • To provide education and support in enabling staff to understand the reasons a DNACPR decision may be made. • Need for all DNACPR decisions to be discussed with patients unless this would lead to physiological and psychological harm. • Requirement of All DNACPR decisions to be raised by a Registrar or above. Identify through documentation whether the DNACPR decision is indefinite or requires review.
35. Environment at night	• Discuss with stores to investigate possibility of shortening lead time on getting the soft closing lid bins for wards. • Estates to repair the ward overhead and patient lights. • Daily checks to be completed and inform estates of any repair work needed on a daily basis.
36. Diagnosis and management of idiopathic intracranial hypertension (IIH): a local audit of current practice at SGH	• Clinicians to ensure weight and advice to lose weight is recorded in patients notes. • Additional resources needed for visual field testing in neurophysiology.
37. Audit of use of consent forms for genetic testing and storage of genetic material	• Increase awareness amongst professionals working within the Wessex Clinic Genetics Service of the professional JCMG on documenting consent for genetic testing. • Present the guidelines and audit results at a Clinical Genetics departmental audit meeting.

	• This audit to be put forward to the Clinical Genetics Society (CGS) as a suitable National audit. • Further consideration to be given to adding mention of VUS to the consent form. • Revision and simplification of the syntax of section two.
38. Emergency information located on Anaesthetic machines	• Decision on what information needed to be documented for anaesthetic machine to be completed by anaesthetic department. • Theatres to provide the funding for printing of information for anaesthetic machine. • Gain quotes for printing the information from printing company. • Laminate, distribute and add information to anaesthetic machines.
39. Prospective audit of disease modifying therapy prescribing in multiple sclerosis	• Ongoing team education about the guidance at MS group meetings and the MS MDTs. • Audit to be completed annually.
40. Documentation of stem cell harvesting reagent and equipment expiry audit	• Apheresis staff to continue to be educated regarding completion of white cell procedure forms appropriately.
41. Hospital Management of major trauma patients aged 16 and 17	• To use audit data to discuss results with adult orthopaedics to implement changes for them to take over the 16 and 17 year olds.
42. Abdomen x-ray dose audit	• Radiographers should record the height and weight of each patient on CRIS, so that more accurate dose audits can be carried out in future.
43. An Audit of venous thromboembolism assessment on admission to the acute medical unit	• Update AMU consultants with re-audit results of lack of venous thromboembolism assessments. • Organise formal induction for junior doctors in AMU. • Findings & recommendations to be presented to the thrombosis committee. • Print more posters for AMU office.
44. An audit to investigate the use of the Malnutrition Universal Screening Tool "MUST" on cardiac wards	• Charge nurses / ANTs to monitor their ward's compliance. • Charge nurses / ANTs to monitor their ward's accuracy. • Dieticians to provide refresher MUST training sessions.
45. Comparison of Emergency Department attendance summaries and Emergency Department notes for those patients admitted to the Clinical Decisions Unit	• Symphony and E-docs to be investigated for any IT issues precluding auto completion of these areas in attendance summaries. • Whether data sample has an appreciable effect on coding and accurate income generation. • Data to be passed to coding team. • Investigation of clinical relevance of variances in attendance summaries and emergency data passed to Dr M. Smethhurst.
46. To audit the use of the paediatric nutrition screening tool amongst children admitted to Piam Brown	• Charge nurses to monitor wards compliance against the nutrition screening tool. • Dieticians to provide training course for staff.
47. Drug driving: Are we counselling our patients?	• To start using the CMH admissions clerking proforma to prompt clinicians to identify people who are driving. • New patient information leaflet on drug driving from Department for Transport to be given to patients who are identified as drug driving. • To add a free text box to HMR discharge summary to inform other healthcare professionals. • To change trust HMR to include sections on driving
48. Severity scores in pancreatitis.	• Ensure the APACHE score sheet is completed and available for all staff to complete.
49. Audit of standardised neurodevelopment follow-up of preterm infants & high risk newborns after 1 year at UHS.	• A 12 month time window has been set at 11 to 13 months CGA to be able to audit compliance. • Assessment tools will be scanned into the electronic system (E-Docs) by secretaries to enhance accessibility and facilitate future audit and research • A follow up co-ordinator to log when patient miss their clinic windows and why i.e. in-patient, parents cancel etc.
50. Compliance of G-CSF doses in stem cell mobilization policies and harvest schedules	• GCSF prescription not filed in patient's notes, prescription copied in pharmacy and then subsequently filed in patient's notes.

51. NICE CG32 Audit of malnutrition screening rates within Acute Medical Admissions Unit in SGH	• ANTs and ward Sisters to monitor ward compliance with MUST. • Dieticians/dietetic assistants to offer refresher training on the ward to ensure MUST completed within 24 hours of admission. • ANTs and ward Sisters to monitor ward compliance to ensure all information relating to scores are included. • Dieticians/dietetic assistants to offer refresher training on scoring.
52. Paracentesis for malignant ascited in the palliative care setting	• Discuss at team meeting regarding practice around ascitic drains and how we could improve this.
53. Elective caesarean section list timings	• Suggest multidisciplinary proforma formalising pre operative routine. • Establish methods to improve turnaround times.
54. Patient triggered follow-up (PTFU) for colorectal, breast and testis	• Policy documents reviewed and in the process of being revised and updated. • Revised policy to be circulated to clinical leads for PTFU, CNS and Support worker. • Signatures to be requested agreeing the accuracy of the policy and compliance. • CNS's and Support Worker to ensure all patients have tests and results otherwise the patient will be asked to come in to out-patients for a review.
55. A re-audit of the bony mallets treated in RSH hand therapy against the bony mallet protocol	• Educate staff re: importance of issuing patient information leaflet, a reduction in compliance may have a direct relationship with increased DNA rate. • The mallet service and pathway needs to be reviewed in light of patients voting with their feet, recent evidence on self management of mallet injuries and use of various splints (Zimmer and thermoplastic) to immobilise the DIPJ. • Investigate feasibility of patient satisfaction questionnaire of current mallet service (those who attended and DNA's).
56. Discharge planning	• All patients to have an appropriate baseline discharge assessment undertaken, providing their medical condition allows. • Weekly measure the EDD documented on Doctor Worklist and a report will be sent monthly to all oncology doctors. • By the estimated date of discharge all members of the multi-disciplinary team should have completed their assessments to ensure that the patient is ready for discharge. • Doctors will communicate with nurse in charge daily. • Nurse in charge to attend or be available for handover. • Out of hours (after 8 pm and weekends) discharges should be pre-planned where possible. • Friday handover will include possible discharges and those patients should have HMR finalised
57. NICE CG92 Accuracy of VTE risk assessment in thoracic surgical patients	• To continue education & training of junior staff.
58. A clinical audit on the use of weekend Atropine occlusion for the treatment of Amblyopia in Children	• Use of a proforma to ensure all appropriate orthoptic tests performed at follow-up. • Advise GP to provide repeat atropine prescription when needed. • Design a template letter to GP for repeat prescription.
59. NICE CG172 An audit of eplerenone prescribing in patients diagnosed with ACS and left ventricular failure	• Bundle on EDOCS to ensure patients post-MI with EF<40% are routinely being prescribed MRA. • Develop departmental protocol for patients post-MI with EF<40% to routinely be prescribed MRA.
60. NICE CG170 guideline based audit to assess patient knowledge of opioids in palliative care	• Implementation of opioid leaflet for patients. • Education of patients by clinical staff when prescribing opioids to them.
61. NICE CG83 Documentation of critical care rehabilitation for those patients admitted to general intensive care	• Design and implement a critical care rehabilitation pathway to record compliance with the NICE CG83 guidelines. • To include within the pathway all patients who are I&V for > 3 days and are expected to survive their intensive care stay.
62. An audit of Acute Respiratory Distress Syndrome in General Intensive Care unit	• Present audit findings at the GICU consultants meeting. • Obtain agreement for use of a "prompt" sticker to be included in the notes upon diagnosis of ARDS to aid optimal management. • To re-audit to evaluate impact in one year.

63. Cauda Equina Syndrome: Audit of Post-operative Screening, Documentation and Action	• All staff made aware of the need to ask every CES patient about Cauda Equina issues. • All staff made aware of the need to provide the booklet to Cauda Equina patients. • Post-discharge plan for management of ongoing Cauda Equina issues not always documented - All staff made aware of need to document plan for Cauda Equina problems
64. NICE CG101 What percentage of patients admitted with an exacerbation of COPD are offered pulmonary rehab and agree to attend a pulmonary rehab course provided by UHS or either the Solent or Southern NHS Trusts?	• Agree with the medical teams to highlight via referral or message to our answer-phone when there is a potential patient, who is likely to be discharged before assessment.
65. Donor pregnancy assessment audit	• BMT team to be reminded of importance of completing relevant documentation. • BMT team to be reminded of appropriate use of pregnancy assessment stickers.
66. Audit of pyloric stenosis guideline (2009) and outcomes	• Review the guideline flowchart at each new surgical registrar induction meeting.
67. An audit of Ankylosing Spondylitis (AS) services against national standards	• A specific AS Clinic will be set up for patients to ensure they receive consistent treatment. • Physiotherapist routinely in the Clinic so all patients will have access to Physiotherapy. • Further review of the Outpatient Physiotherapy services is needed and discussion with management on improving this. • Further Assessment into the impact of AS in the workplace is needed, therefore WPAI to be used in AS clinic to start to assess workplace impact in more depth.
68. NICE CG79 Physical activity participation and access to physiotherapy services among patients with rheumatoid arthritis (RA).	• Physiotherapist to work within clinic, specific physio-led clinic. • Physiotherapist education session / audit feedback. • Discuss with rheumatology team to ensure that patient receive self-management advice within the given guidelines and feedback audit report results
69. Venous sinus stenting in with idiopathic intracranial hypertension.	• Presentation to highlight inconsistency in their non-visual fields. • Review eligibility criteria for VSS and educate the neurosciences team with a presentation regarding who to refer for VSS

Patient Improvement Framework (PIF) Priorities for 2016 / 2017 V3

COMMUNICATION

Collective Leadership, Culture of Caring, Organisational Development

Effective

- **Enhance clinical handover between internal teams**
  - Documentation audit
  - Synergy of transfer documents
  - Standards for sharing information internally
- **Report available outcome measures**
  - Develop a platform for the recording of patient reported outcome measures for each clinical service
  - Monitor and report on the outcomes and progress towards improvement
- **Deliver Safeguarding Strategy**
  - Identify gaps and address concerns in care of all vulnerable patients

Caring

- **Promote clarity of communications**
  - Review all letters to patients for parity
  - Signpost patients to additional information
  - Explore opportunities for wayfinding
- **Promote and deliver leaders in care**
  - Energise key nurse project
  - Roll-out "Hello my name is"
  - Roll-out John's campaign
- **Develop our culture of compassion**
  - Review essential standards of practice booklet
  - Develop programme of observation of care
  - Deliver end of life care strategy

Safe

- **Deliver our Safety Strategy**
  - Develop work streams to deliver on the standards applicable to acute kidney injury, pressure ulcers, patient falls.
  - Ensure that action has been taken to mitigate against Never Events
- **Reduce non-clinical transfers of care**
  - Analyse the current non clinical patient moves out of hours.
  - Identify actions to ensure reduction
- **Enhance medication safety**
  - Review the discharge process of patients taking home medication

Responsive

- **ED responsiveness**
  - Further improve 4 hour access
  - Promote discharge leaflet and learning from patient use
  - The patient experience in ED
- **Access to hospital care**
  - To deliver the referral time to treatment (RTT)
- **Promote the Home B4 Lunch initiative, supporting patients on discharge.**
  - Establish local discharge lounges
  - Identify champion wards
  - Participate in "Always Events" programme

Well Led

- **Patient leader programme**
  - Launch the role of patient leader within UHS
- **Promote and develop patient and public involvement**
  - Develop strategy
  - Learn from good practice
  - Roll out model of Patient and Public involvement across UHS
- **Learning organisation**
  - Review process of responding to patients complaints
  - Develop a programme of learning from patient feedback.
  - Share learning internally & externally

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

Response to the Quality Account from our Council of Governors

Response to the Quality Account from Healthwatch Southampton

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

Board minutes and papers for the period xxxx
Papers relating to Quality reported to the Board over the period xxxxx
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 xxxxxx
The [latest] national patient survey xxxx
The [latest] national staff survey xxxxxx
The Head of Internal Audit's annual opinion over the trust's control environment dated XX/XX/20XX
CQC quality and risk profiles dated xxxxxx

- 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.
- The Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

By order of the board

Xx/xx/2015

Chair

Chief executive

University Hospital Southampton NHS Foundation Trust

UHS ED Performance Benchmarking 2015/16

Southampton Health Overview & Scrutiny Panel Briefing Paper – 28 April 2016

1. Emergency Department Types

There are three nationally defined Emergency Department types:

Type 1 – Emergency departments with a consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients.

Type 2 – Consultant led mono-specialty accident and emergency service (e.g. ophthalmology, dental) with designated accommodation for the reception of patients.

Type 3 – Other type of A&E/minor injury activity with designated accommodation for the reception of accident and emergency patients. The department may be doctor led or nurse led and treats at least minor injuries and illnesses and can be routinely accessed without appointment.

The table below shows national performance for each type of unit for January 2016 (the most recent published national data).

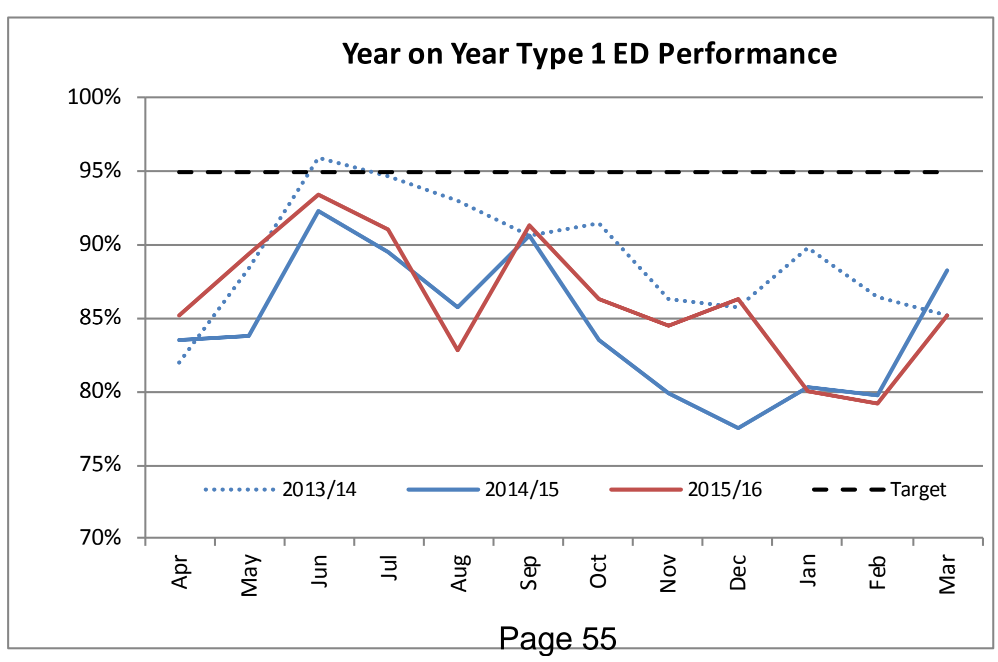
Unit Type	Attendances	Breaches	Performance
Type 1	1,250,005	212,136	83.0%
Type 2	47,208	435	99.1%
Type 3	609,707	3,716	99.4%

UHS operates two Emergency Departments – Main ED (type 1) and Eye Casualty (type 2). Until July 2014, UHS also operated the MIU (type 3) based at the Royal South Hants Hospital which is now run by Care UK.

Depending on how Hospital Emergency Departments are structured, some Type 1 units may treat patients that are treated in separate type 2 or 3 units elsewhere in the country, meaning direct comparison may not be appropriate.

2. UHS ED Performance

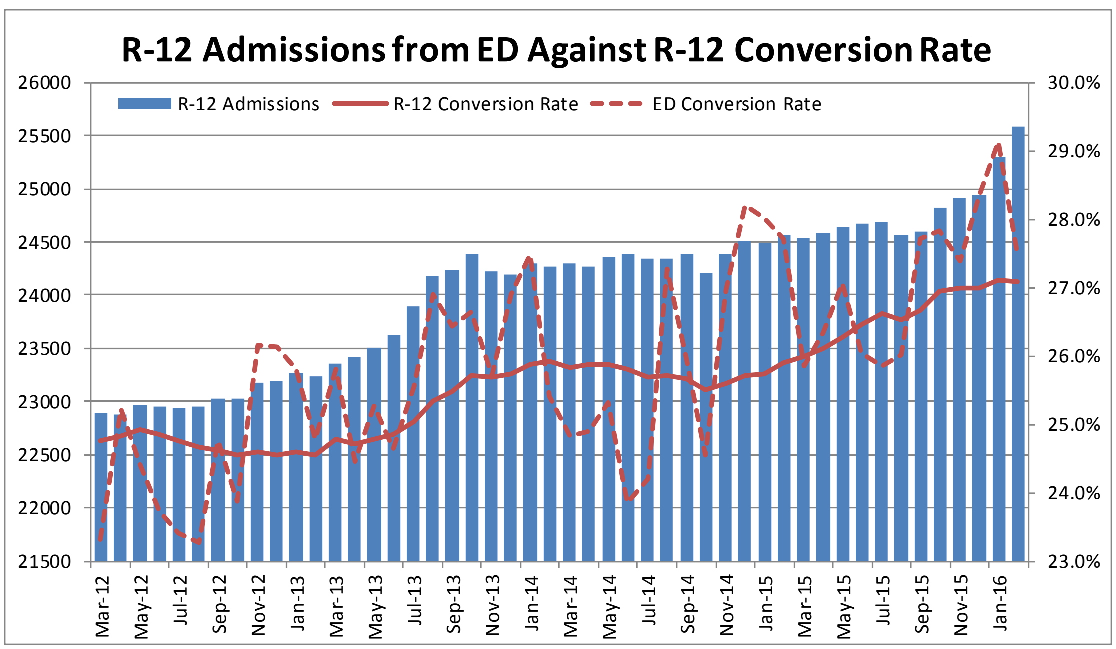
The primary factor in governing overall UHS ED performance is the performance in Main ED. In 2015/16, the Main ED accounted for 83.8% of the A&E activity seen by the Trust. Year on year performance against the 4hr target for solely Main ED (type 1) activity can be seen in the chart below.



Performance against the 4hr target for the year as a whole rose from 84.7% in 2014/15 to 86.2% in 2015/16.

This increase in performance needs to be set against a rise in activity. In 2014/15 there were a total of 94,376 attendances to main ED. In 2015/16 this rose to 95,218, an increase of 842 (+0.9%). However, this rise was primarily seen in January to March, which went from 21,830 to 24,642, an increase of 2,812 (+12.9%).

These winter months are when the Trust typically sees patients with more serious and complex conditions and the fact that additional attendances were not solely patients with more simple complaints is borne out by the conversion rate data (the conversion rate is the percentage of attendances which result in a patient requiring an admission for further treatment). The chart below shows the rise in admissions and the conversion rate.



3. Performance Against Peers

NHS England publishes monthly data on ED performance for all Trusts in England. Prior to June 2015 this data was collected and reported weekly. Currently the available data runs to January 2016. The tables on the next page demonstrate UHS performance against 3 different groups of peers since June – firstly local NHS Trusts, then Major Trauma Centres and finally a select peer group of University Teaching Hospital Trusts.

These show UHS as performing in the middle of each peer group but straight comparisons are not necessarily appropriate across these groups. A simple example is that the Southampton Treatment Centre listed is the MIU run by Care UK and formerly run by UHS. The aggregated performance of 99.7% for June to January is only for the simple cases appropriate to attend an MIU. Likewise, even a comparison to an NHS Hospital Foundation Trust such as Bournemouth is not truly comparable as while that centre does not have a separate type 3 unit, there is no type 3 unit in Bournemouth and so the equivalent attendances will arrive as part of their type 1 activity. By contrast, UHS performance figures do not benefit from the same proportions of lower complexity patients as part of type 1 ED activity.

Local Providers:

	UHS	B'mouth	Hamphire Hospitals	IoW	Poole	Portsmouth	Salisbury	Solent	Soton Treatment Centre	Southern	England
Jun-15	94.5%	93.5%	93.0%	92.1%	96.0%	85.3%	97.4%	100.0%	100.0%	98.6%	**94.8%**
Jul-15	92.5%	97.4%	92.9%	88.7%	95.6%	82.2%	97.5%	100.0%	99.9%	98.8%	**95.0%**
Aug-15	85.6%	96.0%	90.1%	88.9%	94.8%	86.9%	95.9%	100.0%	100.0%	99.4%	**94.3%**
Sep-15	92.7%	93.8%	90.1%	86.0%	95.8%	83.9%	95.1%	100.0%	99.1%	98.8%	**93.4%**
Oct-15	88.5%	91.3%	88.5%	87.3%	90.1%	77.8%	94.5%	100.0%	99.7%	99.5%	**92.3%**
Nov-15	86.9%	92.8%	88.8%	86.2%	92.5%	78.4%	93.9%	N/A	99.9%	99.2%	**91.3%**
Dec-15	88.4%	95.7%	85.8%	91.7%	90.7%	78.3%	93.9%	N/A	99.1%	99.2%	**91.0%**
Jan-16	82.8%	90.9%	82.6%	86.8%	87.1%	75.1%	94.1%	N/A	99.7%	99.4%	**88.7%**
Grand Total	**89.0%**	**93.9%**	**89.0%**	**88.5%**	**92.9%**	**81.0%**	**95.3%**	**100.0%**	**99.7%**	**99.1%**	**92.6%**

NB: Southampton Treatment Centre is the MIU run by Care UK, formerly managed by UHS.
Solent NHS Trust provide community and mental health services in Southampton, Portsmouth and southern Hampshire
Southern Health NHS Trust provide community health, mental health, learning disability and social care services in Hampshire, Berkshire and Oxfordshire
Hampshire Hospitals NHS Trust run Winchester and Basingstoke Hospitals.

Major Trauma Centres:

	UHS	Barts	Cambridge	Imperial	King's	Leeds	Newcastle	North Bristol	Nottingham	Oxford	South Tees	St George's	England
Jun 15	94.5%	90.5%	91.7%	95.4%	92.9%	95.7%	94.6%	97.2%	96.1%	96.2%	96.3%	91.3%	**94.8%**
Jul 15	92.5%	89.1%	89.8%	94.7%	92.4%	96.2%	95.7%	96.5%	94.1%	96.5%	96.4%	92.2%	**95.0%**
Aug 15	85.6%	90.9%	92.3%	94.9%	93.2%	96.2%	96.6%	95.4%	93.2%	93.8%	97.0%	94.4%	**94.3%**
Sep 15	92.7%	89.0%	93.5%	93.5%	89.9%	95.1%	94.7%	88.5%	92.5%	90.6%	97.3%	90.7%	**93.4%**
Oct 15	88.5%	86.7%	93.8%	92.1%	91.7%	93.8%	95.3%	86.3%	86.9%	88.0%	96.4%	91.9%	**92.3%**
Nov 15	86.9%	86.5%	92.5%	89.1%	88.8%	92.2%	92.7%	80.3%	81.1%	88.8%	95.7%	89.1%	**91.3%**
Dec 15	88.4%	86.5%	95.5%	88.5%	87.5%	90.6%	92.7%	79.9%	80.5%	88.2%	95.0%	89.8%	**91.0%**
Jan 16	82.8%	86.4%	92.8%	89.7%	86.2%	87.8%	92.2%	74.9%	76.2%	84.4%	93.8%	88.7%	**88.7%**
Grand Total	**89.0%**	**88.1%**	**92.7%**	**92.2%**	**90.3%**	**93.4%**	**94.3%**	**87.4%**	**87.5%**	**90.8%**	**96.0%**	**91.0%**	**92.6%**

University Teaching Hospitals Peer Group:

	UHS	Birmingham	Bristol	Cambridge	Derby	Leicester	Newcastle	Nottingham	Oxford	Sheffield	England
Jun-15	94.5%	95.8%	95.2%	91.7%	95.0%	92.6%	94.6%	96.1%	96.2%	96.4%	**94.8%**
Jul-15	92.5%	94.4%	95.5%	89.8%	96.0%	92.2%	95.7%	94.1%	96.5%	94.5%	**95.0%**
Aug-15	85.6%	94.3%	95.0%	92.3%	95.3%	90.6%	96.6%	93.2%	93.8%	94.3%	**94.3%**
Sep-15	92.7%	93.6%	91.7%	93.5%	95.2%	90.3%	94.7%	92.5%	90.6%	N/A	**93.4%**
Oct-15	88.5%	92.7%	92.2%	93.8%	94.1%	88.9%	95.3%	86.9%	88.0%	N/A	**92.3%**
Nov-15	86.9%	91.0%	89.6%	92.5%	94.1%	81.7%	92.7%	81.1%	88.8%	N/A	**91.3%**
Dec-15	88.4%	90.2%	88.9%	95.5%	94.3%	85.1%	92.7%	80.5%	88.2%	N/A	**91.0%**
Jan-16	82.8%	87.4%	83.8%	92.8%	88.4%	81.2%	92.2%	76.2%	84.4%	N/A	**88.7%**
Grand Total	**89.0%**	**92.4%**	**91.4%**	**92.7%**	**94.0%**	**87.7%**	**94.3%**	**87.5%**	**90.8%**	**95.1%**	**92.6%**

4. Impact of MIU Activity

The lack of type 3 activity in UHS performance figures has a significant effect on the performance against the 95% target for treatment with 4 hours. The nationally published A&E data includes activity volumes and so it is possible to demonstrate the impact MIU activity would have on UHS performance figures.

	UHS	UHS+MIU	Difference
Jun-15	94.5%	96.0%	1.5%
Jul-15	92.5%	94.5%	2.0%
Aug-15	85.6%	89.5%	3.9%
Sep-15	92.7%	94.4%	1.8%
Oct-15	88.5%	91.7%	3.2%
Nov-15	86.9%	90.8%	3.9%
Dec-15	88.4%	91.4%	3.0%
Jan-16	82.8%	87.5%	4.7%
Grand Total	**89.0%**	**92.0%**	**3.0%**

This level of performance would put UHS into the top half of Major Trauma Centre providers.

5. Hospital Flow

The hospital alert status is an indicator of the levels of flow being attained by the Trust. When the Trust has a black alert this indicates that there are no available beds and that flows into and out of the hospital are compromised. Through a long and ongoing programme of work focusing on patient flow through the hospital, UHS has significantly reduced the number of occasions when a black alert has been declared (alert status is recorded twice a day, though may be changed more frequently). In 2014/15, a black alert was declared on 91 occasions. In 2015/16 this was reduced to only 7. This indicates that the Trust was in a much better position to support timely admission of patients through our Main ED, but also on occasions accept diverted ambulances from other Trusts in the region who declared a black alert.

The primary pressure on hospital flow is the number of Delayed Transfers of Care. These are patients who no longer need to be cared for in an acute hospital setting but do need ongoing care, ranging from assisted living in a care home to daily visits from a healthcare practitioner. UHS cannot discharge these patients until a community care package is in place, which must be organised with community healthcare providers and local authorities. The Trust provides a monthly submission to the Department of Health. In the returns for January to March 2015 the Trust reported a total of 5,005 bed days lost to delayed transfers. For the same period in 2016 the Trust reported a total of 8,001 bed days lost. This rise in lost bed days creates additional pressure on the Trust's ability to flow patients into the hospitals from ED.

The Trust has been working with local providers and commissioners to address the challenges brought by Delayed Transfers of Care. This has succeeded in reducing the pressure felt from those patients within Southampton but the number of delayed patients from the wider Hampshire area have continued to rise despite this focused work.

In addition, pressure has increased on all emergency departments across the country. When other local Trusts struggle to admit patients attending their departments, ambulances can be re-routed to alternative providers. As the largest hospital Trust in the region, and the Major Trauma Centre, UHS is often the Trust to receive these diverted patients, increasing demand for services. Anecdotal evidence suggests the number of ambulance diverts increased in 2015/16. It is often difficult to then repatriate these patients to their local hospital after they have been stabilised.

6. Improvement Plans

Despite these mitigations, there are still improvements to be made to UHS ED performance, with returning to 2013/14 type 1 performance levels the first step. In order to achieve this, the Trust, working with the wider healthcare community, will put the following plans into place:

- Increased overnight and weekend cover in ED
- CCGs and Southern Health have agreed a plan to improve the Psychiatric Liaison Service at UHS ED to achieve the presence of a Psychiatric Liaison Nurse on site 24/7 (overnight cover is not currently based at UHS)
- Redesigning care pathways through and out of ED for patients requiring admission, with best practice learning from other Trusts
- Relocation of Emergency CT Scanner into the Emergency Department
- Increased focus on pre-noon discharge to open capacity and aid flow into the hospital
- Ongoing work with Commissioners and Local Authorities to improve discharge pathways for complex discharge patients
- Increase weekend discharge rates

7. Conclusion

UHS performance against the 4hr ED target has improved in the most recent year despite an increase in activity and patients requiring admission into the Trust.

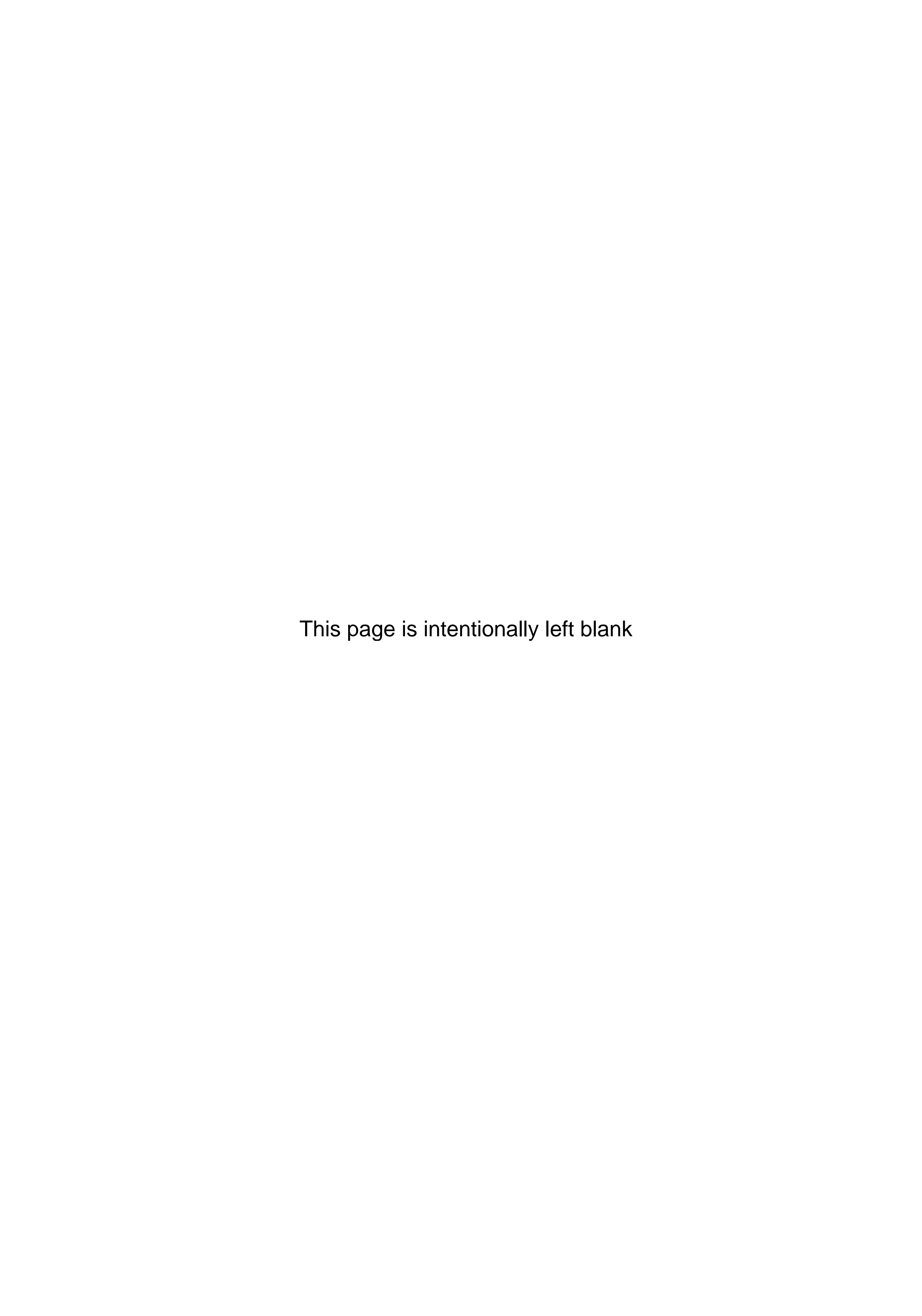
Comparisons of performance between departments are difficult without the appropriate context to understand the casemix of patients attending. The lack of type 3 activity in UHS figures means that performance should be expected to be lower than other hospitals which run a type 3 department or include that activity within their own type 1 activity.

UHS A&E performance would be approximately 3% higher with the inclusions of activity from the Southampton Minor Injuries Unit.

There are external factors, primarily Delayed Transfers of Care, which impact on the Hospital's patient flow and reduce the Trust's ability to admit patients in a timely manner.

The Trust can evidence improved internal processes by the reduction in black alerts issued in 2015/16.

The Trust have been working with the local healthcare providers to build a sustainable plan for improving future performance with a continuation of the year-on-year improvements anticipated in 2016/17.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Secondary Care Quality Account 2015-2016

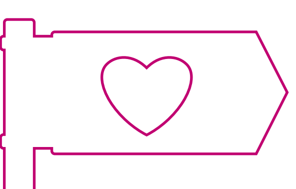
Commitment to quality

Agenda Item 7

Appendix 3

Our locations

1. Barlborough NHS Treatment Centre (AGW)
2. Buckinghamshire Musculoskeletal Integrated Care Service
3. Cirencester Hospital Outreach Clinic
4. Devizes NHS Treatment Centre
5. East and West Lincolnshire Musculoskeletal Clinical Assessment and Treatment Service
6. Emersons Green NHS Treatment Centre (AGW)
7. Greater Manchester Clinical Assessment and Treatment Service (GM CATS)
8. Havant Diagnostics
9. Lincolnshire Musculoskeletal Pain Assessment and Treatment Service (LPATS)
10. Mid and South Buckinghamshire NHS Diagnostic Centre
11. NHS Community Diagnostics
12. North East London NHS Treatment Centre
13. Peninsula NHS Treatment Centre
14. Rochdale Ophthalmology Clinical Assessment and Treatment Service
15. Rotherham NHS Diagnostic Centre
16. Royal South Hants Minor Injuries Unit
17. Shepton Mallet NHS Treatment Centre
18. Southampton NHS Treatment Centre
19. St Mary's Minor Injuries and Ailments Unit
20. St Mary's NHS Treatment Centre
21. Will Adams NHS Treatment Centre



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Foreword by Jim Easton

Quality is at the heart of everything we do at Care UK, and we are determined to deliver high quality healthcare that meets the diverse needs of the UK population in the twenty-first century.

We already provide a uniquely diverse range of healthcare services for NHS patients, commissioned by, or working with, our NHS partners. Throughout our business, you will find colleagues who continuously demonstrate Care UK's values by delivering effective care that achieves the best possible outcome for each patient.

We remain committed to improving quality across all of our services, and aim to be in the top 10% of all NHS providers for the key quality measures of the services we provide. Experience tells us that this can only be achieved through a process of continual improvement, responding to patient feedback, shared learning and new developments in best practice.

During the coming year, we look forward to fully engaging with our stakeholder groups and increasing their involvement in our service delivery as we continue on our path to excellence.

This Quality Account

This Quality Account sets out our performance on a range of key measures for our patients, the wider public, commissioners and partners. It demonstrates what we have achieved in 2015-2016, and plan to achieve in 2016-2017, within our Secondary Care Division, which currently provides NHS services across:

- Elective Surgery Independent Sector Treatment Centres
- Minor Injury Units/Walk-in Centres
- Community-based Musculoskeletal and Diagnostic Centres
- Clinical Assessment Treatment Centre (Greater Manchester)
- NB: We transferred our Mental Health Recovery Services in June of 2015 to the Partnerships in Care organisation

In line with Department of Health guidance 2010-2011, this document focuses mainly upon the following areas:

- Independent Sector Treatment Centres (ISTCs)

Care UK operates:

- Nine Treatment Centres on behalf of the NHS (one ceased to operate under Care UK in 2015)
- Four Clinical Assessment and Treatment services (three Musculoskeletal and Diagnostic Centres, plus the Greater Manchester Clinical Assessment and Treatment Centre)

In the year April 2015 to March 2016 Care UK's Treatment Centres carried out:

- 48,626 day case procedures
- 55,054 inpatient procedures
- 145,946 outpatient consultations, including telephone consultations

Achievements 2015-2016

Over the past year, our achievements have included zero reports of MRSA or Clostridium difficile infection.

We have also demonstrated, using NHS Partners Network benchmarking data, that Care UK is one of the top performing NHS provider organisations in a range of quality indicators, including:

- Friends and Family scores
- Patient Reported Outcome Measures
- Access to services and PLACE inspections - where the feedback has been exceptional across all of our services
- Care Quality Commission (CQC) compliance. CQC inspectors have rated our Treatment Centres as 'Good', with Barlborough and Southampton Treatment Centres rated as 'Outstanding' for patient care.

Priorities 2016-2017

Our priorities for the coming year are outlined within this Quality Account and once again reflect the 5 key lines of enquiry set by the Care Quality Commission:

- Safe
- Effective
- Caring
- Responsive
- Well-led

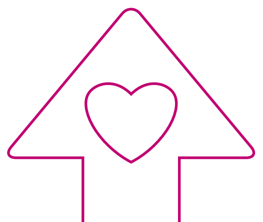
This provides a well-rounded view of the factors that influence quality, and I am confident that, as we continue to listen and respond to our patients and service users, invest in our staff and keep quality-focused in all that we do, we will provide a positive experience for those we are here to care for and help recover.

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

Jim Easton

Managing Director, Health Care

Part 1
What is quality?



What is a Quality Account?

Quality Accounts were introduced under the Health Act (2009) to strengthen healthcare providers' board-level accountability for quality, and place quality reporting on an equal footing with financial reporting.

Quality Accounts are both retrospective and forward-looking. They look back on the previous year's information about service quality to explain where a provider is doing well and where improvement is needed. Crucially, they also look forward, to explain what a provider has identified (through evidence and/or engagement) as the priorities for improvement over the coming year and how these priorities will be achieved and measured.

The legal duty to publish an annual Quality Account applies to all providers of NHS- funded healthcare services (whether they are NHS, independent or voluntary sector organisations). Only those providing primary care services or NHS continuing care are currently exempt under the regulations. The required content is set by the NHS (Quality Accounts) Regulations 2012 and Monitor's, Detailed requirements for quality reports 2015-2016.

At Care UK we are committed to transparency in all our reporting and follow the NHS guidance, as applicable, for our Quality Account.

This encompasses our adoption of the single common definition of quality that encompasses three equally important parts:

- Care that is **clinically effective** - not just in the eyes of clinicians but in the eyes of patients themselves;
- Care that is **safe**; and,
- Care that provides as positive an **experience** for patients as possible

Our mission and values

Our values are:

- Our patients are at the heart of everything we do
- Every one of us makes a difference
- Together we make things better

Each of us at Care UK is committed to delivering the highest standards of quality and best practice, and to meeting and exceeding our compliance with all relevant quality standards across the healthcare sector.

Our mission is 'fulfilling lives', and each of us works to achieve this every day.

By supporting our teams to focus on three key aims we will fulfil our mission. These are to:

1. Focus on quality

We want to be renowned for providing high quality services. We must always seek to be the best provider of each of our services, meeting – and, ideally, exceeding – our service commitments. Constantly engaging with commissioners and patients to understand and meet their needs will help us to achieve this aim.

2. Lead change

The way healthcare is organised across the NHS is often inefficient for commissioners and frustrating for patients. As a major organisation delivering healthcare and social care, we have an unrivalled opportunity – even a responsibility – to work with commissioners to spearhead a more integrated approach.

3. Drive innovation

We have a key part to play in driving innovation, efficiency and effectiveness. We can do this by:

- Attracting, engaging, training and rewarding talented, compassionate and proactive employees
- Investing in the development of new services aimed at providing the right care in the right place, integrated for convenience to patients
- Continuing to work closely with partners, suppliers and the many organisations and people we connect with

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Introduction

Care UK's approach to quality builds upon the three domains of quality outlined above. It also aligns with the five key lines of enquiry (KLOE) defined by the Care Quality Commission (CQC) to inform the quality and governance of healthcare services, namely:

Safe We embrace and adhere to the principles outlined within the 2013 report from the National Advisory Group on the Safety of Patients in England, *'A promise to learn – a commitment to act', and to the ambitions defined within the 2013 Keogh Mortality Review.*

Caring We place a high emphasis on compassionate care.

Responsive We constantly seek to improve the timeliness and efficacy of care through careful planning and use of patient feedback to improve services.

Effective We continue to monitor and audit our services regularly to ensure we are effective in our delivery and that care delivery is informed by NICE/best practice guidance.

Well-led Care UK's in-house 'Academy of Excellence' provides a suite of eLearning modules for all of our staff, with a specific focus on further enhancing managers' leadership skills during the coming year.

Care UK is a nationally-recognised independent provider of healthcare services across England, on behalf of the NHS. Our NHS Treatment Centres provide inpatient and day surgery for a range of planned surgery, endoscopy procedures, diagnostic tests and post-operative rehabilitation. Our Treatment Centre facilities are modern and purpose-built and are situated close to public transport links or in redesigned buildings close to, or within, NHS hospitals.

Our Clinical Assessment and Treatment Services (CATS) provide clinical assessment, expert consultation, diagnostic services and minor treatments in convenient locations close to patients' homes - ensuring patients receive first class, quality care.

Quality priorities 2016-2017

Health care quality priorities for 2016-2017

Care UK's Secondary Care Health Care Division has identified six new quality improvement priorities for 2016-2017.

These will be monitored through our internal reporting programme, shared with commissioners as part of our joint quality reviews and achievements monitored through our internal governance structures at a local and national level.

Achievements and outcomes will be reported in next year's Quality Account.

The identification and development of our new quality objectives involved numerous stakeholders, and took into account patient feedback, complaints, incidents that occurred throughout the past year, as well as new national guidance.

As well as focusing on these new priorities, will also continue to expand our achievements against some of last year's quality objectives – where we have already: invested in our employees' learning and development; provided them with the best of the equipment they require to deliver care of the expected quality standard; and responded to feedback from patients, service users, staff and other key stakeholders.

Our overall aim is always to provide the best possible experiences for those choosing to use Care UK's services.

Quality priorities 2016-2017

Quality priority domain	Priority detail	Measure
Safe	1. Establish a frailty scoring system and associated outcomes framework for patients aged over 75 years undergoing planned inpatient surgery 2. Implement the National Safety Standards for Invasive Procedures (NATSSIPs) programme 3. Improve our reporting mechanisms for medication interventions and subsequent action planning	1. All sites to complete a frailty score for patients over 75 who are undergoing elective inpatient procedures. 100% of patients with scores over 7 will have care plans in place 2. Local services to have LOCSSIPs in place in line with NATSSIPs requirements identified centrally 3. All medication interventions to be recorded at all sites and action plans discussed at Quality Governance meetings
Caring	1. To continue to improve Friends and Family Test response rates from outpatients 2. Maintain a supportive environment for those living with dementia by implementing a dementia strategy and introducing dementia link nurses for all services	1. To achieve a 60% response rate for 1st outpatient attendances 2. Dementia link nurses identified within all services to support the roll out of key priorities within the dementia strategy
Responsive	1. Continue to respond consistently to patients' complaints and feedback 2. To deliver services free from discrimination and meet the needs of the Equality Act (2010)	1. The introduction of 'You said, we did' feedback mechanisms within all services so that is visible to patients in key patient areas 2. Continuation of our staff survey to identify areas for improvement. Implement the Workforce Race Equality Standard (WRES) and EDS2
Effective	1. The implementation of electronic discharge (EDS) via our patient administration system (PAS) for improved continuity of care and to reduce unplanned follow up in primary care 2. To implement an antibiotic stewardship programme and strategy across secondary care	1.All Treatment Centres to have electronic discharge capabilities within their services 2. All services to have an antibiotic stewardship lead to support the delivery of key priorities within the strategyy
Well-led	1. Prepare secondary care diagnostic imaging services for Imaging Services Accreditation Scheme (ISAS) accreditation 2. To develop and implement a training programme for clinical staff in middle management roles	1. Develop a framework to support the ISAS application (through gathering supportive evidence, process review etc.) 2. Identification and enrolment of key managers to undertake a bespokwe 12 month training programme

Safe

1. Record frailty scores for patients having planned inpatient surgery who are aged over 75 years Why have we chosen this priority

The rate of surgical procedures amongst older people is rising. Those who are also frail have a greater risk of poor surgical outcomes. The introduction of frailty scores, based on individual assessment, will help us to carefully plan each patient's care with a view to their achieving the best possible results.

What are we trying to improve?

Our elderly population is set to increase even further and we need to ensure that the support we put in place is as good as it can be and will continue to meet national guidelines.

What will success look like?

All patients aged over 75 who choose to have their surgery with us will have a scored frailty assessment. If they score 7 or more, we will work with them to develop an individual care plan designed to address particular needs arising from their frailty and prevent problems after surgery.

How will we monitor progress?

We will closely monitor patients' progress and review results at our Quality Governance meetings. This will also help us to also refine and improve our approach over time.

2. To implement the National Safety Standards for Invasive Procedures (NATSSIPs) in all our secondary care services

Why have we chosen this priority?

Care UK is committed to the delivery of this national programme aimed at providing safer care for people having invasive procedures such as surgery, and preventing incidents/mistakes.

What are we trying to improve?

We want to make any necessary improvements to our surgical processes to ensure that they fully comply with this new national guidance and that we achieve best practice.

What will success look like?

We will develop and introduce local safety standards for invasive procedures (LocSSIPs) based on the national guidelines. These local standards will be jointly developed by clinical teams and patients, so that they fit local circumstances and requirements.

How will we monitor progress?

We will monitor compliance with these standards alongside any incidents that occur and review results at our Quality Governance meetings. This will also help us refine and improve compliance with standards, over time.

3. An improved reporting mechanism for medication interventions undertaken in Treatment Centres

Why have we chosen this priority?

The detailed and accurate recording and monitoring of patients' medications is an important aspect of patient safety. We want to improve this within our services and raise standards, where necessary.

What are we trying to improve?

We want to improve the quality of the information we record about medications and make certain they all medications are used appropriately for patients' benefit.

What will success look like?

An improved reporting tool will be introduced across all our services. This will ensure all medication interventions are being appropriately recorded and managed by all relevant staff.

How will we monitor progress?

Results will be monitored and reviewed through our Medicines Management and Quality Governance arrangements.

Caring

1. To continue to improve on friends and family responses within outpatients

Why have we chosen this priority?

Responses to the NHS Friends and Family (FFT) provide valuable feedback about patients' experiences of care. We have achieved high response rates for our inpatient services and want to replicate these within outpatient areas.

What are we trying to improve?

We are trying to increase the number of patients providing us with information about the quality of our care, using a recognised feedback mechanisms i.e. the FFT.

What will success look like?

A response rate of 60% or higher amongst those attending booked first outpatient appointments (with high or increasing levels of patient satisfaction demonstrated within responses).

How will we monitor progress?

Progress will be monitored through our Friends and Family Forum and reported to the Patient Experience Committee.

2. Maintain a supportive environment for those living with dementia

Why have we chosen this priority?

We recognise that within an increasing elderly population that the prevalence of dementia is on the rise and we need to ensure the support we put in place is robust and in-line with national guidance.

What are we trying to improve?

We are trying to improve the care and experience patients and service users will have whilst in our services.

What will success look like?

Success will be measured through the introduction of dementia Link nurses within services to support the delivery of the key priorities outlined in the dementia strategy.

How will we monitor progress?

We will closely monitor progress through our Quality Governance meetings.

Responsive

1. To continue to respond to concerns and complaints in a timely manner

Why have we chosen this priority?

Care UK has developed a culture that values transparency and accountability. When we get things wrong we want to resolve it with our patients within an acceptable time period.

What are we trying to improve?

We want to improve the quality of the information patients receive in response their concerns and complaints.

What will success look like?

Success will be measured in terms of the implementation of 'You said, we did' feedback mechanisms within our services. This tells patients what we did in response to the issues they raised, e.g. through poster displays in service areas.

How will we monitor progress?

We will monitor progress through our Quality Governance meetings.

2. To deliver services free from discrimination and meets the needs of the Equality Act (2010)

Why have we chosen this priority?

It is recognised that organisations with a diverse leadership are more successful and innovative than those without. We want to ensure that all Care UK employees can make the best of their abilities and rise through the organisation, without experiencing prejudice.

What are we trying to improve?

We want to make certain that our employees have equal access to training and development within a supportive and fair working environment.

What will success look like?

Success will be measured in terms of our implementation of the Workforce Race Equality Standard (WRES). Our in-house staff survey will contain specific questions on how we are doing in relation to this, and where we can improve things.

How will we monitor progress?

The results of the staff survey will be fed back to services. Where areas for improvement are identified, service staff will develop improvement action plans.

Action plans will be monitored through local Quality Governance meetings and reported quarterly to the Quality Governance Assurance Committee.

Effective

1. The implementation of electronic discharge (EDS) via PAS for improved continuity of care

Why have we chosen this priority?

EDS benefits patients by providing their GPs/referrers with up-to-date information about the care they have received from us as soon as they are discharged. It also improves the efficiency of our patient administration system (PAS).

What are we trying to improve?

The speed with which discharge information is sent to GPs/referrers.

What will success look like?

All Care UK services will send discharge documentation electronically and securely.

How will we monitor progress?

The Care UK Business Systems Team will develop and implement a series of project plans for setting up EDS within each service area. Progress will be monitored through the achievement of project goals within set timescales and will be reviewed at monthly performance meetings.

2. To implement an antibiotic stewardship programme and strategy across secondary care Services

Why have we chosen this priority?

We want to support the national antibiotic stewardship programme and related local microbiology strategies designed to reduce the number of drug-resistant infections.

What are we trying to improve?

We want to ensure that we use antibiotics appropriately and in accordance with national and local guidelines.

What will success look like?

We will set up clinical forums for each service to ensure that the all of the key priorities for good antibiotic stewardship put into practice.

How will we monitor progress?

Progress will be monitored and reviewed through our Medicines Management and Quality Governance arrangements.

Well-led

1. Preparation of diagnostic services for the Imaging Services Accreditation Scheme (ISAS)

Why have we chosen this priority?

ISAS will help us to compare and evaluate the quality of our diagnostic imaging services using a nationally recognised accreditation scheme.

What are we trying to improve?

We want to assure our patients, commissioners and ourselves of the quality, safety and clinical effectiveness of our diagnostic imaging services.

ISAS will allow us to effectively demonstrate this. It will also be a valuable tool for driving the continuous improvement and development of our diagnostic imaging services over the years to come.

What will success look like?

This year, at least one of our diagnostic imaging services will complete the initial 'Traffic Light Ready' stage (to determine our current level of compliance and what we still need to do to achieve accreditation), with the goal of achieving full ISAS accreditation over the next two years.

How will we monitor progress?

Progress will be monitored at our quarterly Diagnostic Imaging Quality Governance and Professional Development meetings.

2. Develop and implement a training programme for clinical staff in a middle management role

Why have we chosen this priority?

We want to ensure that all our nursing and allied healthcare professionals (AHPs) are well led, and that all our teams are caring and responsive to the needs of patients. The training programme will help us achieve this through the development of efficient and competent nursing and AHP managers and leaders.

What are we trying to improve?

We already have a strong confident and competent leadership team but we want to improve the framework within which we deliver leadership training.

We want to create an innovative and bespoke training programme for nurse and AHP managers (using the Care UK Management Essentials Programme as a foundation) that reflects Care UK's patient-centred values and is transferable across service lines and teams.

What will success look like?

We will have implemented a 12-month bespoke management training programme for identified clinical managers.

How will we monitor progress?

Progress will be monitored at Professional Leads meetings and reported quarterly to the Quality Governance Assurance Committee. Feedback will also be sought from course participants and through our annual staff survey.

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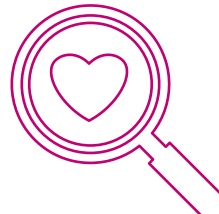
70

Part 2
Review of priorities for improvement 2015-2016



Reporting back on 2015-2016 quality priorities

In our 2015-2016 Quality Account we set out our priorities for improving the quality of our services during 2015-2016, and, have provided updates and a review of our progress for each priority below.

Safe- Priority 1:

Quality priority domain	Priority detail	Measure
Safe	Improve the quality of incident reporting on our Datix system, ensuring action is taken promptly To extend shared learning into national forums Change from using MEWS (Modified Early Warning Score) to using the National Early Warning Score (NEWS) without affecting our performance in recognising patients whose condition is deteriorating	72-hour reviews by a manager or director and bi-annual audits of submissions by service At least 6 national shared learning events with evidence of change in practice or policy All Treatment Centres to change over to NEWS within 12 months
Caring	To utilise patient stories across all services as a mechanism for enhancing staff reflection and personal development Continue to improve Friends and Family Test scores in inpatient and other areas To ensure our mental health service users have a voice, and that the quality of the care they receive is equitable	Each service to provide evidence of at least 4 examples where patient stories have been used for staff development Friends & Family Tests for inpatients to achieve 90% and others areas to reach 80% Each mental health service will receive at least 4 Quality Assurance Visits per annum
Responsive	To respond to concerns and complaints in a timely manner Establish a supportive environment for those living with dementia	Response to complainant within 3 working days to acknowledge the complaint, explain the process of managing the complaint and complete the investigation within 20 working days. 100% of patients presenting with a diagnosis of dementia to have a dementia care plan in place
Effective	Establish a zero tolerance to surgical site infections Establish a zero tolerance of non-compliance with the Mental Health Act	100% compliance with KPIs of good practice (e.g. room temperature) and Root Cause Analysis for any deep surgical site infections reported with evidence of follow on actions. All patients detained under the MHA will have documentation fully completed to comply with legal detention regulations
Well-led	Mandatory training to be completed by all eligible staff To establish a culture of informed leadership	Compliance 100% for staff who are eligible (exception for those on maternity leave, long term sickness absence etc.) To introduce 360 degree feedback for all senior managers and respond to the staff surveys to improve leadership where common themes are identified

Safe- Priority 1:

Quality objective: to improve the quality of incident reporting on our Datix system.

Following a benchmarking exercise in December 2014 a bi-annual quality audit of our incident reporting system, Datix, was undertaken between March and December 2015 to measure our Treatment Centres' (TCs) performance against key criteria that are integral to high quality incident reporting. The audit looked at:

- The time taken for incidents to be initially reviewed on Datix. This should be done within 72 hours of the incident being reported
- Whether incidents were correctly classified. In this context we found that: serious Incidents (SIs) were often classified incorrectly as SI's on Datix making it difficult for us to track whether root cause analysis investigations had been adequately managed; and, inappropriate use of the 'Other' sub-category on Datix was an obstacle to the identification of incident trends and hotspots.

The outcomes of all audits were collated by our Central Support Team before being: shared amongst all services; discussed at local Quality Governance and national Professional Leads meetings; reviewed at a divisional level. The audit findings led to us commissioning changes to the Datix system, including removing the 'Other' sub-category as an option for incident classification - with no adverse impact on reporting rates (see Table 1).

Datix was updated in November 2015 to capture the serious incident category, with prompts based on National Reporting and Learning System (NRLS) and National Patient Safety Agency (NPSA) definitions to guide users towards correct classification. This has led to visible improvements (see Table 2).

To enhance quality assurance, improvements are still required to ensure that Datix is used to hold all relevant documentation relating to SI investigations. We will closely monitor this in the coming year and beyond, using reports that became available following a recent Datix upgrade, in February 2016.

Table 1

	Mar-Dec 2014		Mar-Dec 2015	
	All Incidents	% Categorised as 'Other'	All Incidents	% Categorised as 'Other'
Emersons Green NHS Treatment Centre	451	17.07%	462	0.87%
Devizes NHSTreatment Centre	105	15.24%	142	1.41%
Barlborough NHS Treatment Centre	278	39.93%	279	23.30%
Havant NHS Diagnostic Centre	12	16.67%	19	5.26%
North East London NHS Treatment Centre	117	23.93%	119	23.53%
Peninsula NHS Treatment Centre	126	29.37%	139	25.90%
Shepton Mallet NHS Treatment Centre	196	33.67%	319	7.52%
Southampton NHS Treatment Centre	147	19.05%	154	16.88%
St Mary's NHSTreatment Centre	208	43.75%	250	22.40%
Will Adams NHS Treatment Centre	115	39.13%	106	32.08%

Table 2

Quality Indicator	Dec 2014 Audit	Mar 2015 Audit	Sept 2015 Audit
Reviewed within 72 hours	39%	99%	94%
Correctly categorised as an SI	33%	17%	100%

Safe - Priority 2:

Quality objective: to extend shared learning into national forums

Opportunities for shared learning are identified at a local level following incident investigations or complaints. Lessons learned are then cascaded

across services and discussed at the local Quality Governance meetings as a standard agenda item. This enables local services to determine any actions they need to take to prevent similar occurrences.

Learning is also now shared at bi-monthly national Professional Leads meetings and quarterly Secondary Care Safeguarding meetings, to ensure relevant information is widely disseminated.

Safe - Priority 3:

Quality objective: Care UK wide change from using MEWS (Modified Early Warning Score) to using the National Early Warning Score (NEWS) without affecting our performance in recognizing the deteriorating patient.

Care UK has successfully achieved its priority of changing from the Modified Early Warning Score (MEWS) to the National Early Warning Score (NEWS). NEWS is a nationally recognised system that is being introduced across the NHS to standardise the assessment of acute illness severity and rapidly alert clinicians to any deterioration in a patient's condition. This key change has now been achieved within all of our Treatment Centres.

We audited performance at all of our Treatment Centres to ensure that NEWS was being appropriately implemented and to provide assurance that any deterioration in a patient's condition would be escalated appropriately. The table below demonstrates high levels of compliance in the use of NEWS, in line with best practice.

	May-15	Jul-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16
Barlborough NHS Treatment Centre	99%	96%	94%	99%	99%	95%	99%
North East London NHS Treatment Centre	96%	99%	98%	100%	100%	96%	100%
Southampton NHS Treatment Centre	100%	100%	100%	98%	96%	100%	98%
St Mary's NHS Treatment Centre	97%	98%	100%	91%	92%	92%	99%
Will Adams NHS Treatment Centre	100%	99%	100%	100%	100%	100%	Non-Sub
Devizes NHS Treatment Centre	100%	100%	100%	100%	100%	100%	99%
Emersons Green NHS Treatment Centre	100%	84%	99%	94%	98%	97%	96%
Peninsula NHS Treatment Centre	90%	99%	96%	100%	99%	100%	94%
Shepton Mallet NHS Treatment Centre	94%	96%	100%	80%	89%	89%	91%

Caring - Priority 1

Quality objective: to use patient stories across all services as a method for staff reflection and personal development.

All our secondary care services begin their local Quality Governance meetings with a patient story that reflects learning or feedback we have received about a patient's care.

Stories are collated (locally and at a divisional level) to ensure that any themes are identified and improvements made, where indicated.

Staff are encouraged to also reflect on their own practice as part of their appraisal, revalidation and development process, to ensure they maintain a focus on safe patient care.

All of our Treatment Centres have submitted patient stories for this Quality Account, which are included in Appendix 1.

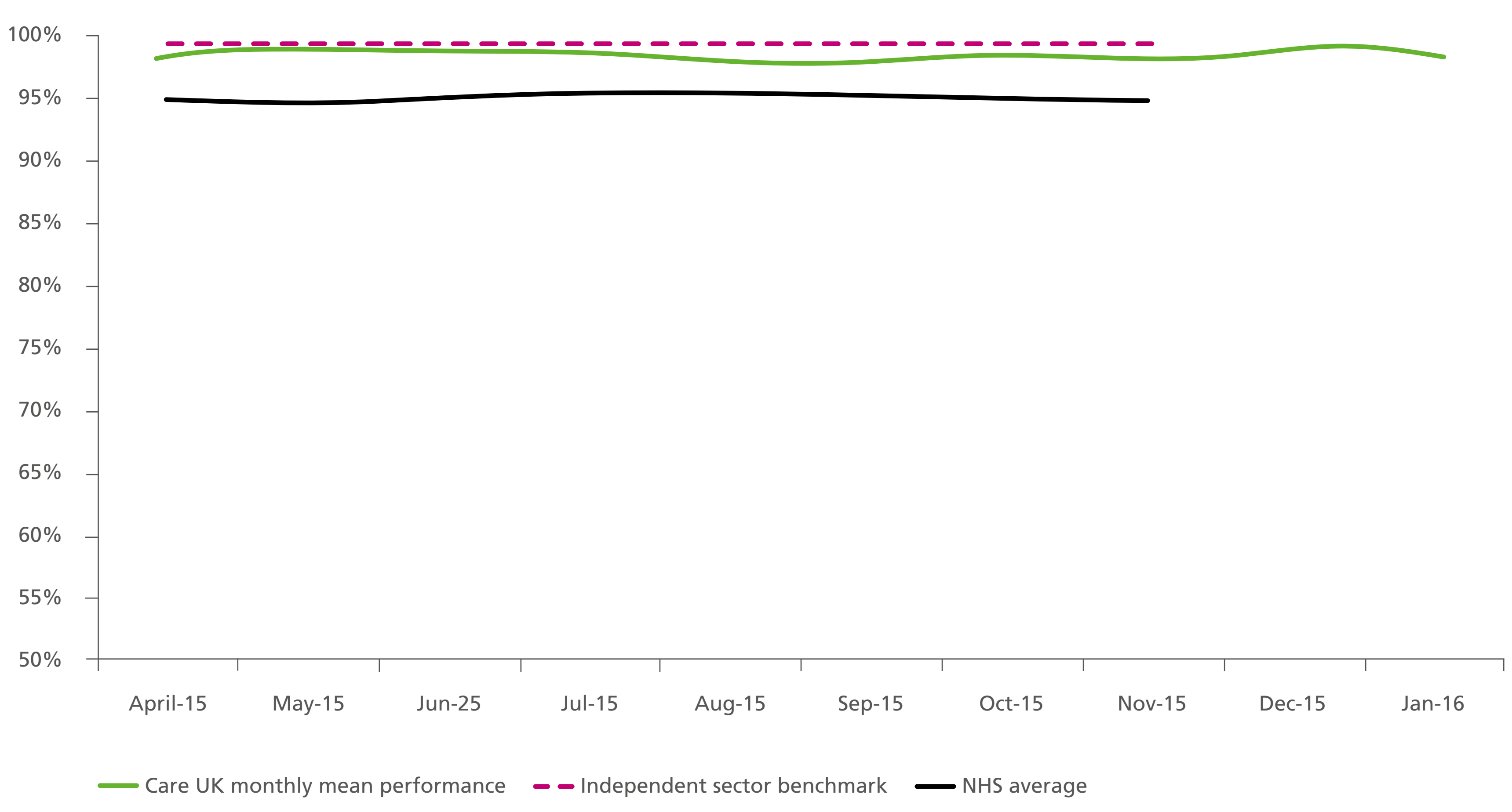
Caring - Priority 2

Quality objective: to continue to improve Friends and Family Test (FFT) scores in inpatient and other areas.

The tables below show we have had consistently positive feedback in relation to the NHS Friends and Family Test questions, in both our inpatient and day surgery settings. This test asks patients how likely they would be to recommend our services to others. Care UK welcomes feedback from all our patients and aims to increase the number of people completing the FFT in our outpatient settings during the coming year.

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16
Barlborough NHS Treatment Centre	97%	99%	99%	96%	94%	99%	97%	97%	100%	98%
Emersons Green NHS Treatment Centre	99%	100%	99%	99%	99%	98%	100%	98%	98%	99%
North East London NHS Treatment Centre	100%	100%	95%	98%	100%	97%	100%	98%	100%	99%
Peninsula NHS Treatment Centre	99%	100%	96%	100%	100%	94%	98%	99%	99%	97%
Shepton Mallet NHS Treatment Centre	98%	100%	99%	99%	99%	97%	97%	98%	100%	100%
Southampton NHS Treatment Centre	100%	99%	100%	99%	100%	100%	100%	100%	98%	98%
Independent Sector Average*	99%	99%	99%	99%	99%	99%	99%	99%	-	-
NHS Average*	95%	95%	95%	96%	96%	96%	95%	95%	-	-

***Source:** *NHS England Friends and Family Test Data, Organisational Level Tables, Inpatient and Daycase FFT Data. Published at www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data*



Source: *NHS England Friends and Family Test Data, Organisational Level Tables, Inpatient and Daycase FFT Data Published at www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data (Note that there is a 3 month delay in publication of nationally collated data)*

Friends and Family Test – 'would recommend' scores – patients having day surgery

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16
Barlborough NHS Treatment Centre	100%	97%	97%	100%	98%	100%	98%	99%	100%	98%
Devizes NHS Treatment Centre	99%	98%	99%	99%	99%	99%	99%	99%	99%	100%
Emersons Green NHS Treatment Centre	99%	99%	98%	99%	99%	99%	98%	99%	98%	100%
North East London NHS Treatment Centre	98%	98%	97%	99%	95%	90%	97%	99%	97%	96%
Peninsula NHS Treatment Centre	100%	100%	98%	99%	99%	98%	98%	98%	98%	98%
Shepton Mallet NHS Treatment Centre	99%	99%	99%	100%	99%	99%	99%	98%	100%	100%
St Mary's NHS Treatment Centre	100%	98%	99%	97%	99%	99%	99%	99%	98%	98%
Southampton NHS Treatment Centre	98%	98%	99%	99%	99%	98%	98%	97%	98%	97%
Will Adams NHS Treatment Centre	100%	100%	100%	99%	99%	100%	100%	99%	100%	99%
Independent Sector Average*	99%	99%	99%	99%	99%	99%	99%	99%	-	-
NHS Average*	95%	95%	95%	95%	95%	95%	95%	95%	-	-

**Source:* *NHS England Friends and Family Test Data, Organisational Level Tables, Inpatient and Daycase FFT Data. Published at www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data*

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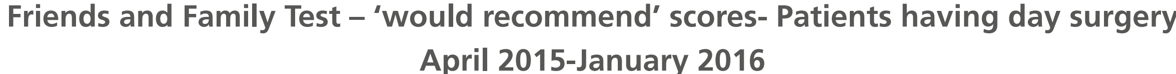

100%
95%
90%
85%
80%
75%
70%
65%
60%
55%
50%

April-15 May-15 Jun-25 Jul-15 Aug-15 Sep-15 Oct-15 Nov-15 Dec-15 Jan-16

ISTC monthly mean performance
Independent sector benchmark
NHS average

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In June 2015, the management of mental health services previously delivered by Care UK was transferred to Partners in Care. This means we are unable to report on achievements related to the quality priorities for mental health that we identified in our 2014-2015 Quality Account.

Caring - Priority 3:

Quality objective: to ensure our mental health service users have a voice and quality of care is equitable.

Effective - Priority 2:

Quality objective: to establish a zero tolerance to non-compliance with the Mental Health Act.

Responsive - Priority 1:

Quality objective: to respond to concerns and complaints in a timely manner

We know from the data available to us that our services are not always responding to patients' complaints within 20 days. In 2015 we identified an issue with our complaints management system, Datix, which made it difficult for local services to accurately record and monitor their complaint response times, and for us to capture consistent data centrally. This was addressed through a system upgrade in February 2016. It should also be noted that complaint response timescales are agreed with the patient, and may sit outside the target of 20 days. With more reliable and consistent data available in 2016/17 we will be able to accurately monitor whether complaints were responded to within the agreed timescale, providing a more useful measure of success.

Complaints management is an area that Care UK is continuing to focus upon, with key measures being monitored within our monthly Quality Governance meetings and addressed through staff training and quality governance communications.

Replied within 20 working days?	Total	Yes	No	Investigation Ongoing
Emersons Green NHS Treatment Centre	28	32%	68%	0%
Devizes NHS Treatment Centre	5	20%	80%	0%
Barlborough NHS Treatment Centre	27	48%	44%	7%
Havant NHS Diagnostic Centre	9	78%	22%	0%
Peninsula NHS Treatment Centre	5	60%	40%	0%
Shepton Mallet NHS Treatment Centre	18	44%	44%	11%
Southampton NHS Treatment Centre	57	30%	63%	7%
Royal South Hants Minor Injuries Unit	18	100%	0%	0%
St Mary's NHS Treatment Centre	73	90%	10%	0%
Will Adams NHS Treatment Centre	69	40%	0%	60%
North East London NHS Treatment Centre	46	41%	54%	4%
Grand Total	295	56%	40%	4%

Acknowledged Within 3 Working Days?	Total	Yes	No	Investigation Ongoing
Emersons Green NHS Treatment Centre	28	96%	0%	4%
Devizes NHS Treatment Centre	5	60%	0%	40%
Barlborough NHS Treatment Centre	27	89%	7%	4%
Havant NHS Diagnostic Centre	9	56%	0%	44%
Peninsula NHS Treatment Centre	46	78%	9%	13%
Shepton Mallet NHS Treatment Centre	5	40%	20%	40%
Southampton NHS Treatment Centre	18	61%	33%	6%
Royal South Hants Minor Injuries Unit	57	74%	26%	0%
St Mary's NHS Treatment Centre	18	89%	6%	6%
Will Adams NHS Treatment Centre	73	56%	10%	34%
North East London NHS Treatment Centre	69	100%	0%	0%
Grand Total	295	73%	12%	15%

Responsive - Priority 2:

Quality objective: Establish a supportive environment for those living with dementia

During 2015-2016, three of our nine Treatment Centres audited their performance against this objective – see table.

Two services used the standard Excel reporting template. One with a non- standard word document.

Site	Comments
Emersons Green Treatment Centre	There were 6 patients who required 1:1 supervision, but did not have a diagnosis of dementia. 14 patients required a review by our multi-disciplinary team and as a result changes were made to our Integrated Care Pathway to accommodate their needs. This was communicated to all relevant staff.
Shepton Mallet Treatment Centre	15 patients were identified with a diagnosis of dementia. All of them had a Dementia Care Plan put in place.
Will Adams Treatment Centre	During a 3 month period, between October and December 2015, 5 patients were identified with a diagnosis of dementia. All of those patients had a falls assessment carried out. Four of the patients required a Falls Prevention Plan as their score was above 9, and plans were put in place for all four. 'Falls alert' stickers were also attached to the front cover of their notes. Three of the patients audited were observed as having a 'helping hands' sticker on their notes.

Effective - Priority 1:

Quality objective: to establish a zero tolerance to surgical site infections

Care UK offers hip and knee replacement surgery at six NHS Treatment Centres across the country, with exceptional standards of post-operative recovery demonstrated through surgical site infection rates well below the national average.

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This year we introduced a policy of zero tolerance for surgical site infections. In practice, this means that we actively follow up each patient's experience by:

- Asking all patients having hip or knee replacement surgery to complete and return a post-discharge questionnaire, so we have a better knowledge and understanding of their outcomes
- If patients report any symptoms of infection, we call them
- If they have had antibiotics prescribed, we contact their GPs to clarify whether these were prescribed for a surgical site infection

We perform an investigation every time a patient is readmitted after surgery with an infection. This helps us identify possible factors that that could have led to the infection. Where there are lessons to be learned these are shared throughout Care UK via our Professional Leadership, Quality Governance and Infection Prevention and Control forums.

In 2016-2017, we intend to provide more visibility about patients' experience of infections, by increasing the number of patient responses to the post-discharge questionnaire. Encouraging more patients to do this will enable us to better capture the true quality of our care.

Well- Led – Priority 1:

Quality objective: mandatory training to be completed by all eligible staff

Secondary Care	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Year average	92
Treatment Centres	87	89	91	91	89	91	91	92	92	92	90	
Barlborough NHS Treatment Centre	85	90	92	90	91	91	95	93	91	91	91	
Cirencester NHS Treatment Centre	88	90	96	92	90	90	86	N/A	N/A	N/A	90	
Devizes NHS Treatment Centre	95	93	97	96	92	92	94	98	98	98	95	
North East London NHS Treatment Centre	84	85	90	90	90	90	96	98	96	96	91	
Peninsula NHS Treatment Centre	85	85	86	90	85	90	91	87	89	90	88	
Shepton Mallet NHS Treatment Centre	87	86	90	90	85	90	86	90	88	90	88	
Royal South Hants Minor Injuries Unit	88	91	87	91	90	91	90	88	90	90	90	
Emersons Green NHS Treatment Centre	86	91	90	90	88	89	88	90	92	91	90	
Southampton NHS Treatment Centre	86	89	89	90	86	91	89	90	90	90	89	
St Mary's NHS Treatment Centre	84	89	90	91	90	92	90	90	91	91	90	
Will Adams NHS Treatment Centre	89	91	94	93	92	92	96	94	95	94	93	

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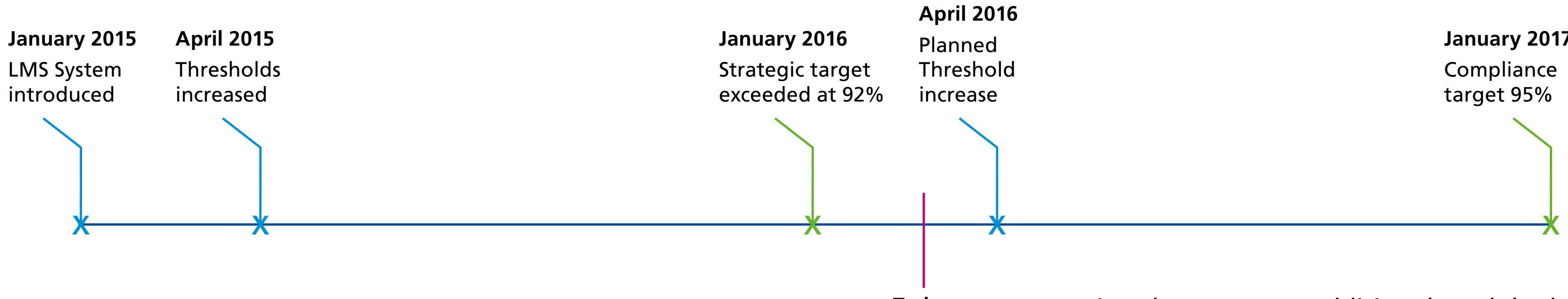
Statutory and Mandatory Compliance Commentary

All statutory and mandatory training requirements for all our staff are captured within the Care UK Education and Training Matrix. This matrix covers all job roles/posts within our services and the associated training requirements/assigned courses. Courses are provided through both face-to-face sessions and eLearning. The matrix is reviewed every six months and is ratified by the Care UK Clinical Education and Training Committee. Training requirements that are outlined in the matrix are programmed into the Care UK Academy of Excellence Learning Management System (LMS) to aid training delivery and helps us to monitor and reports staff members' compliance with the required training.

The LMS system was introduced in January 2015 with the following compliance thresholds:



Milestone Threshold	Date	Non-Compliant	Partial Compliance	Compliant
LMS System introduced	January 2015	0% to 79.9%	80% to 84.9%	85% to 100%
Thresholds increased	April 2015	0% to 84.9%	85% to 89.9%	90% to 100%
Planned further threshold increase	April 2016	0% to 89.9%	90% to 94.9%	95% to 100%

During the past year, additional modules have been added to the statutory and mandatory training sets, including Duty of Candour and Prevent training. These modules were given a three-month grace period following their introduction, so staff could complete them before they become non-compliant (overdue).

Well-led - Priority 2:

Quality objective: establish a culture of informed leadership.

Care UK continues to establish a culture of 'informed leadership' wherein all Senior Managers complete a 360 degree feedback review by their line managers, peers and staff who report to them. This gives a good overview of their leadership performance and helps them identify areas that they can work to improve.

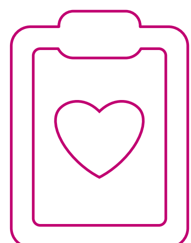
Results of the 360 degree feedback reviews are incorporated into managers' annual appraisal, enabling them to set personal development goals that align with Care UK's organisational goals and values – with progress monitored throughout the year.

This also helps further strengthen senior management and leadership commitment within the organisation.

The annual staff survey was completed within all Care UK departments, and action plans were developed to address trends/recurring themes identified by staff. This feedback has also guided our introduction of additional survey questions for the June 2016 survey, to explore topics further.

In addition, we have held a series of workshops to develop strategic action plans for each service.

Part 3
Regulatory Statements for our services 2016-2017



Regulatory Statements for our services 2016-2017

In line with the National Health Service (Quality Account) Regulations 2011, Care UK is required to provide information on a range of quality activities.

From April 2015-March 2016, Care UK provided or sub-contracted all of the services listed in Appendix 4 at the locations specified.

Duty of Candour

Promoting a culture of openness is a prerequisite to improving patient safety and the quality of healthcare systems. It involves explaining and apologising for what happened to patients who have been harmed or involved in an incident as a result of their healthcare treatment. It ensures communication is open, honest and occurs as soon as possible following an incident. It encompasses communication between healthcare organisations, healthcare teams and patients and/or their carers.

Care UK have robust appropriate processes for communicating with a patient and/or family/carer following a reportable patient safety incident and these are followed in conjunction with Care UK Incident Reporting Policy and Procedure.

There is clear guidance for staff which outlines Care UK's policy on its duty of candour and the processes by which openness will be supported. This support allows Care UK to meet its obligations to patients, relatives and the public by being open and honest about any mistakes that are made whilst Care UK staff care for and treat patients.

Safeguarding

The Department of Health requires all healthcare providers to safeguard all those using their services from abuse. The Care Quality Commission (CQC) outcome statement similarly states that: 'People who use services should be protected from abuse, or the risk of abuse, and their human rights respected and upheld'.

To ensure that we fulfil this guidance, all staff working in our NHS Treatment Centres and Clinical Assessment and Treatment Services (CATS) complete annual mandatory Level 1 safeguarding training via online courses (eLearning). All patient- facing staff also complete Level 2 safeguarding training designed to protect both children and adults. In addition, all clinical staff complete Level 3 safeguarding training for children.

In line with the Department of Health's guidance on Quality Accounts, the statement below summarises our approach to safeguarding within our Treatment Centres and CATS:

- Care UK meets the statutory requirement to conduct Disclosure and Barring Service (DBS) checks on all staff
- Safeguarding policies for children, vulnerable adults and allegations against staff are robust, up-to-date, and have been reviewed within the last year

- Safeguarding training, which encompasses the Mental Capacity Act, forms part of every staff member's induction and mandatory training schedule
- Named professionals are clear about their roles with regard to safeguarding and have sufficient time and support to fulfil them
- There is a named Safeguarding Lead for vulnerable people, including children, who has direct access to the Board, if required

Participation in clinical research

No patients receiving NHS services provided or subcontracted by Care UK at any of our Treatment Centres from April 2015 to March 2016, were recruited to participate in research approved by a research ethics committee.

Our Treatment Centres participated in national audits and confidential enquiries appropriate to the services we deliver (see section below).

Care Quality Commission (CQC) registration

Care UK is required to register with the CQC and must comply with the Health and Social Care Act 2008 (regulated activities) Regulations (2010) and the CQC (Registration) Regulations 2009 (Essential standards of quality and safety 2010).

All of our services are registered with the CQC and work to ensure they remain compliant with the essential standards of quality and safety.

The CQC inspected four of our service locations between 1st December 2014 and 2nd October 2015. Three were found to be fully compliant with standards, whilst two services (Barlborough NHS Treatment Centre and Southampton NHS Treatment Centre) were judged 'outstanding' within the caring domain.

The CQC reports for Barlborough and Southampton NHS Treatment Centres highlighted several examples of good practice, including:

"Patients were involved in their care and were treated with dignity and respect by staff. Staff were polite, kind and professional"

"There were reliable systems, processes and practices in place to protect patients from avoidable harm and abuse".

The results of CQC visits and reports are discussed at our local Quality Governance and national Quality Governance Assurance meetings.

The CQC has not taken any enforcement action against Care UK between April 2015 and March 2016.

Will Adams NHS Treatment Centre, North East London Treatment Centre, Peninsula NHS Treatment Centre and Emersons Green NHS Treatment Centre have not yet been inspected by CQC internal monitoring, reviews and audits indicate the following results would be attributed to these services:

Safe
Good

Caring
Good

Responsive
Good

Effective
Good

Well-led
Good

Participation in Commissioning for Quality and Innovation (CQUIN)

In April 2009, the Department of Health launched the CQUIN framework to encourage healthcare providers to continuously demonstrate improvements and innovation in the quality of the care they provide. The framework supports the vision set out in 'High Quality Care for All' (Darzi, 2008) where quality is viewed an organisational principle.

CQUIN rewards excellence by linking a proportion of the provider's income to the achievement of local quality improvement goals. A proportion of our income in 2015/16 was conditional upon us achieving pre-agreed quality improvement and innovation goals as set out in the CQUIN payment framework. We are pleased to report that we have consistently achieved these goals, demonstrating our active engagement in quality improvement with our commissioners.

Examples of our CQUIN goal attainments, include:

- Measuring and reporting on the number of patients having a venous thromboembolism (VTE) risk assessment on admission
- Measuring the responsiveness of our Treatment Centres to patients' personal needs, captured through five questions that measure patient experience
- Implementing patient reported outcome measures (PROMs) using the Oxford Shoulder Score
- Improving the awareness and diagnosis of patients with dementia, using a pre- screening questionnaire for all eligible patients
- Improving communication with GPs, ensuring they have both 'real time' and constructive feedback on every referral that is rejected by a Treatment Centre

Details of the agreed CQUIN goals for each of our services for both 2015/16 and the coming year can be requested from the Hospital Directors at each Treatment Centre or from our CATS Directors.

(NB: as CQUIN targets are locally agreed they may vary between Treatment Centres).

Participation in clinical audits and national confidential enquiries

The reports of the two national clinical audits (National Joint Registry (NJR) and Patient Reported Outcome Measures (PROMS) were reviewed for April 2015 – March 2016 (see table below).

Patients' participation in national PROMS was lower than we would like, and Care UK will seek to improve participation rates by sharing and implementing processes that have been shown to produce a high response rate in comparable services.

Category	Name of National Clinical audit	% of cases submitted
Acute	National Joint Registry (NJR)	99%
Other	Elective surgery (National PROMs Programme)	65% - Varicose veins

Details of the national clinical audits and national confidential enquiries that Care UK participated in during April 2015 to March 2016 can be found in Appendix 2. This also lists those we did not participate in, with a rationale i.e. we are not commissioned to provide the service being audited.

Reporting against core indicators

The Department of Health requires independent healthcare providers such as Care UK to report against a core set of quality indicators, using information that is provided by the Health and Social Care Information Centre (HSCIC) to compare our results to others.

The tables below show how well we have done by comparing our achievements to the national average and to the best and worst performers.

Patient Reported Outcome Measures (PROMs)

The NHS requires providers to ask patients having one of four specific procedures to complete questionnaires before and after their operation, to find out how much difference the operation has made to them. The four procedures are hip replacement, knee replacement, groin hernia surgery and varicose vein surgery.

Indicator	Care UK overall data		Health and Social Care Information Centre (HSCIC) data April 2014-March 2015		
Patient reported outcome measures (PROMS) participation rates	**April-March 2013-14**	**April-Sept 2014**	**Highest reported nationally (best performing)**	**Lowest reported nationally (worst performing)**	**National average**
Hip replacement surgery	100%	98%	100%*	0%	95%
Knee replacement surgery	92.9%	100%*	100%*	0%	100%*
Groin hernia surgery	100%*	90%	100%*	0%	67%
Varicose vein surgery	100%*	68%	100%*	0%	41%
Data source: *HSCIC April 2014 - March 2015 Provisional PROMs data (published January 2016) / HSCIC April 2013 - March 2014 Provisional PROMs data (published February 2015)*					

* 100% = rate adjusted down to 100% as volume of Q1s received exceeded number of episodes submitted to SUS

Indicator	Care UK overall data		Health and Social Care Information Centre (HSCIC) data April to March 2014-2015		
Patient reported outcome measures (PROMS) adjusted health gain	April-March 2013-14	April-March 2014-15	Highest reported nationally (best performing)	Lowest reported nationally (worst performing)	National average
Hip replacement surgery - Oxford hip score	22.476	22.585	24.683	16.029	21.455
Knee replacement surgery - Oxford Knee Score	16.691	16.662	19.960	11.153	16.142
Groin hernia surgery - EQ-5D Score	0.067	0.082	0.154	0	0.084
Varicose vein surgery - Aberdeen Questionnaire	No score**	-13.431	-14.758	5.588	-8.281
Data source: *HSCIC April 2015-March 2015 provisional PROMs data (published February 2015) / HSCIC April 2013-March 2014 provisional PROMs data (published August 2014)*					

** Varicose Vein surgery - needs more than 30 submissions to carry out statistical analysis. Care UK Treatment Centres that carry out this type of surgery submitted less than 30 records. (Please note a negative score shows an improvement in health)

Care UK considers that this data is as described for the following reasons:-

It is taken from a national information provider.

PROMS are an important quality indicator as they assess care quality from the patient's perspective. For this reason, Care UK is already taking the following action to improve our PROMS scores:

- PROMs information is regularly reported to the Senior Leadership Team in a similar format to the table shown, so that areas for improvement can be swiftly identified

Treatment Centres with PROMs scores that require improvement analyse their data with the assistance of Quality Health Ltd, who provide specialist knowledge of PROMs information. This analysis forms the basis for improvement action planning

- The success of each improvement action plan is tracked by the Senior Leadership Team

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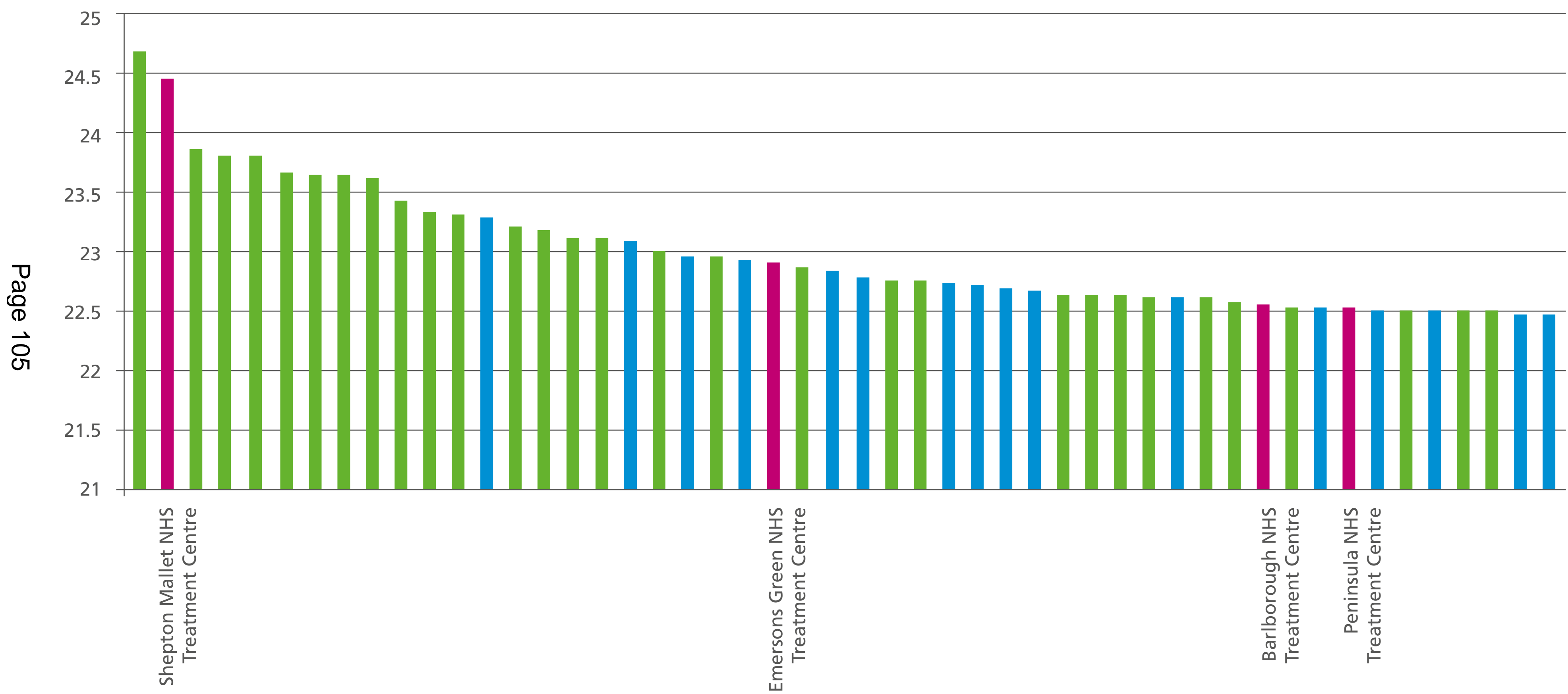


Graph shows average adjusted health gain on Patient Reported Outcome Measures (PROMS) reported by the Health and Social Care Information Centre.

Care UK — Private providers — NHS

Data Source: HSCIC April 2014-March 2015 Provisional PROMs data (published January 2016)

Emergency readmissions rate for patients aged 16 or over

This indicator looks at the number of patients who have been readmitted to our Treatment Centres within 30 days of surgery. Reasons for readmission can include infection, pain or other complications arising from their surgery.

Indicator	Care UK Overall local data*		Health and Social Care Information Centre Data Independent Sector 2011-12		
Emergency readmission to hospital within 30 days of discharge - Percentage of patients aged 16 or over readmitted within	Apr - Mar 2014-15	Apr-Jan 2014-15	Highest reported local authority (Worst performing)**	Lowest reported local authority (Best performing)**	National Average
All Treatment Centres		0.33%	14.53%	7.91%	11.78%
Data Source:	Local data		HSCIC Indicator portal Data set: '3b Emergency readmissions within 30 days of discharge from hospital'		

* This rate includes only patients readmitted to our Treatment Centres. We currently do not have access to readmissions to other providers.

** Lower tier local authority is the lowest level of detail provided by HSCIC.

Care UK considers that this data is as described for the following reasons:-

It is taken from local data that is submitted to the department of health.

Care UK has taken and will continue to take the following actions to improve our scores and so the quality of its services:-

- Emergency readmission rates are tracked monthly for each Treatment Centre and reported to the Senior Leadership Team and Board
- Each month the Senior Leadership Team examines every instance of emergency readmission that occurred and discusses the causes and what can be done to avoid similar readmissions in future.

Risk assessment of venous thromboembolism (VTE) for people admitted to hospital

People who undergo operations may have a risk of developing a potentially harmful blood clot or venous thromboembolism (VTE).

This indicator looks at how efficiently Care UK assesses their risk of developing a VTE.

Indicator	Care UK Overall local data		Health and Social Care Information Centre Data Q2 2015-16 July to September		
Percentage of admitted who were admitted to hospital and who were risk-assessed for venous thromboembolism	Q1 2015-16 Apr-Jun	Q2 2015-16 Jul-Sep	Highest reported nationally (Best performing)	Lowest reported nationally (Worst performing)	National Average
All Treatment Centres	93.3%	99.5%	100%	75.0%	95.9%

Data Source: www.england.nhs.uk/statistics/statistical-work-areas/vte/vte-risk-assessment-2015-16/
NHS England website

Care UK considers that this data is as described for the following reasons:-

It is taken from a national information provider.

Care UK has taken and will continue to take the following actions to improve our scores and so the quality of its services:-

- VTE risk assessment rates are tracked monthly for each Treatment Centre and reported to the Senior Leadership Team and Board.
- We set ourselves a target of 100% for this indicator and compare ourselves in this area against the independent sector (average 99.0%) and the NHS every three months.
- Reasons for not achieving 100% are examined each month by the Senior Leadership Team and explained to the Board

Infection with Clostridium Difficile

Indicator	Care UK Overall data		Health and Social Care Information Centre Data April to March 2013-2014		
Rate of Clostridium difficile (number of infections/100,000 bed days)	Apr-Mar 2014-15	Aggregate 2008-15	Apr-Mar 2013-14	Apr-Mar 2014-15	Differential 2013-14 v 2014-15
All Treatment Centres	0	0	14.7	15.1	2.9% ↑
Data Source:	Local data		Public Health England July 2015 annual report Ref: www.gov.uk/government/uploads/system/uploads/attachment_data/file/442952/Annual_Epidemiological_Commentary_FY_2014_2015.pdf		

Care UK considers that this data is as described for the following reasons:-
It is extracted from published verified local data that is submitted to Public Health England.

Care UK has taken and will continue to take the following actions to improve our scores and so the quality of its services:-

- Care UK has a Director of Infection Prevention and Control (DIPC) who provides Board oversight and leadership on all infection prevention and control issues
- This is further strengthened with a Deputy Director of Infection Prevention and Control who provides detailed guidance to our Treatment Centres, each of which have a trained local Infection Prevention and Control lead with identified time and resource to carry out their role
- Care UK policies are implemented to: ensure effective antibiotic stewardship; facilitate the adoption of local prescribing formularies; and monitor antibiotic usage and patient outcomes.

Patient safety incidents

Patient safety incidents	2014-2015 April 2014-March 2015	2015-2016 to date April 2015-December 2015
Rate of patient safety incidents that occurred across the trust (per 100 admissions)	1.8928	1.7802
Number of such patient safety incidents reported that resulted in severe harm or death	16	1
Rate of patient safety incidents resulting in severe harm or death (per 100 admissions)	0.0169	0.0014

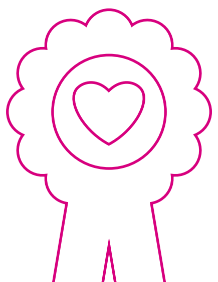
Care UK considers that this data is as described for the following reasons:-

It is extracted from published verified local data that is taken to a national body.

Care UK has taken and will continue to take the following actions to improve our scores and so the quality of its services:

- Each Treatment Centre has a dedicated Health and Safety lead who has appropriate Health and Safety training and protected time to carry out their role
- An incident reporting system, DATIX, is used to report all incidents
- All incidents that are reported must be examined, and the initial lessons learned must be noted, within 72 hours of the incident taking place. Compliance against this target is examined by the Senior Leadership Team and reported monthly to the Board
- Serious incidents are subject to root cause analysis, with results reported to the Board. Lessons learned are shared with all other relevant sites using a shared learning tool. The Head of Governance and Quality ensures that the lessons learned have been embedded in practice through compliance checks at a later date
- Care UK also checks and compares its Accident Frequency Rate (AFR) each year and reports this to the Board.

Part 4
How we ensure quality



How we ensure quality

Throughout Care UK we have policies and procedures to guide staff in their everyday work caring and managing each patient’s pathway.

We continually monitor our quality through: audit (local/national); governance meetings (local/national); and at monthly business reviews. Core performance indicators are developed from this to underpin all our senior leadership team’s annual performance appraisals and objective setting.

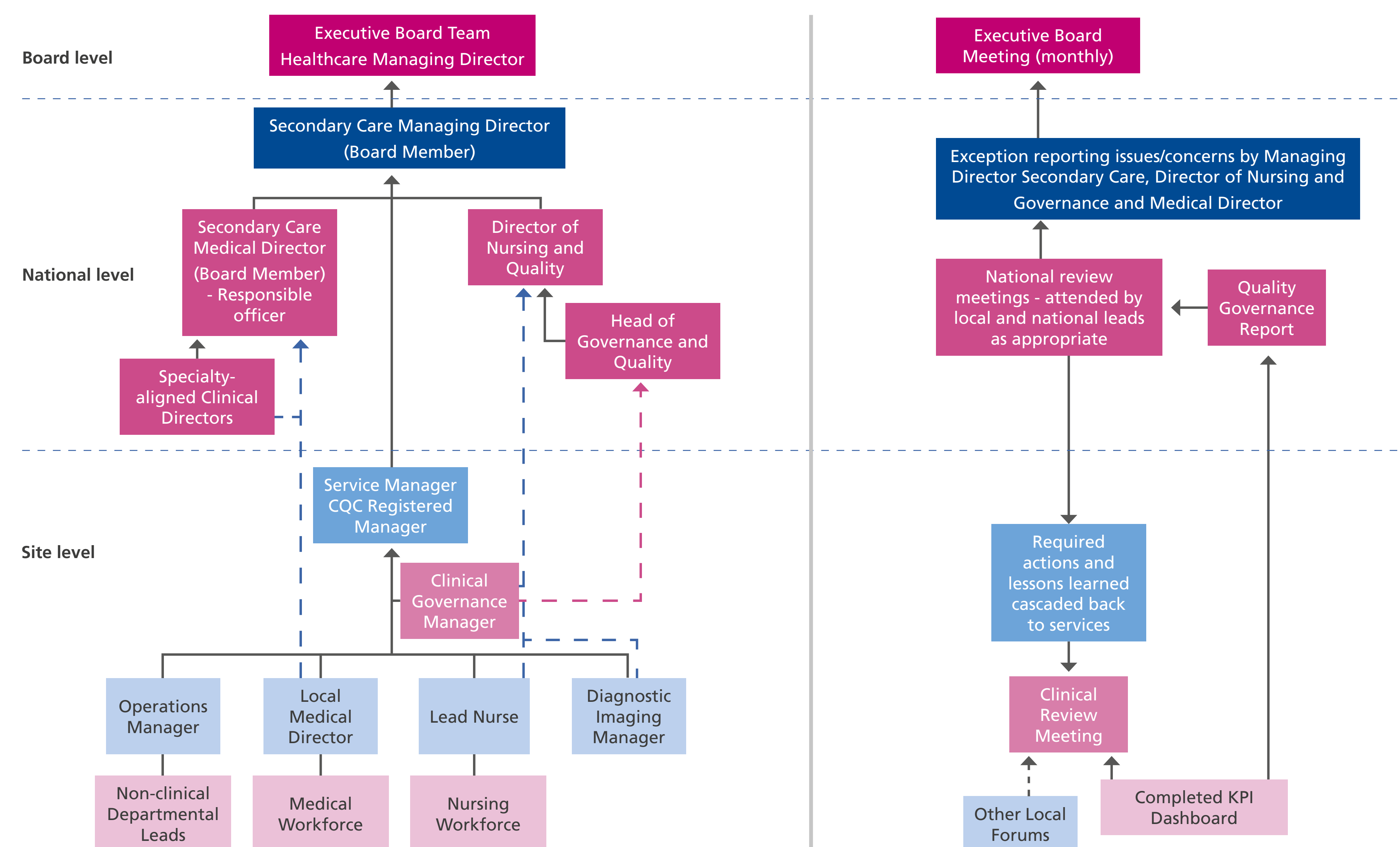
We learn lessons from where things have not gone well, both at a local level through monthly Quality Governance meetings, and at a national level through quarterly Quality Governance Assurance Meetings, chaired by the Director of Nursing and Quality. ‘Lessons shared’ is a fixed agenda item at our bi-monthly Professional Leads Meeting and monthly Senior Leadership Team Meeting.

We focus on maintaining high quality patient care and endeavour to embed consistently safe, high quality standards, and an understanding of what ‘good’ looks like, across all our secondary care services.

Exception reports are received and reviewed from all key service areas, with particular attention being paid to patients’ safety.

We have adopted a number of approaches to ensure the services we provide are the best they can be, including accreditation with national bodies - achieving, for example, Joint Advisory Group (JAG) accreditation across all of our endoscopy services. Our aim is to continuously improve the care that we offer and achieve excellent experiences for all patients choosing our services, as described throughout this Quality Account.

Below is a representation of the reporting and management structures within secondary care:



Diagnostic services

Care UK provides a range of diagnostic imaging services within its NHS Treatment Centres and Clinical Assessment and Treatment Services (CATS), including: plain film X-ray; non- obstetric ultrasound (NOUS); magnetic resonance imaging (MRI); computerized tomography (CT); and dual-energy X-ray absorptiometry (DXA).

These services are delivered using state of the art imaging systems at both fixed and mobile locations. Flexible opening hours, which include weekends and evenings, offer patients greater accessibility and convenience. Our team of dedicated imaging staff, comprising consultant radiologists, radiographers and sonographers, are all highly experienced healthcare professionals, registered with their respective professional bodies.

Referrals to our imaging services come from a range of healthcare professionals - doctors, nurses and allied health professionals - and the results of completed imaging examinations are available to them within 24 hours of the patient's examination.

Care UK's robust quality governance framework for diagnostic imaging includes elements, such as: clinical audit; use of latest evidence based policies, protocols and NICE guidance; competency assessment of staff; and, a unique Quality Assurance (QA) programme.

This framework ensures that services delivered by our operational teams are safe and clinically effective. Service-based teams are ably supported by an experienced divisional team which includes: a Clinical Advisor; a highly experienced Consultant Radiologist; and a Diagnostics Lead responsible for all diagnostic imaging services within Care UK's Health Care Division.

The QA programme comprises an enhanced quality improvement and audit tool that we use to review and evaluate the quality of three key components of the clinical pathway for imaging examinations, namely: referral; imaging; and reporting.

We review a minimum of 10% of completed imaging cases, scoring each of the three key components on a scale from one to five (one being the lowest and five highest).

This provides valuable feedback for referrers, clinicians undertaking examinations and the reporting clinicians.

In summary, our QA programme helps us to:

- Ensure quality is continuously assessed at all key points of the imaging pathway (referrals/images/reports)
- Identify whether the correct management of the patient is achieved following diagnostic examination
- Identify any areas that might require improvement in the imaging pathway
- Offer assurances to our commissioners, patients and to our own organisation regarding the quality of the imaging services we provide and the reports that we send to our patients and referring clinicians

During the reporting period (April2015-March 2016) our QA programme has helped us review a significant number of cases as part of our quality improvement initiative. This has provided assurance about the quality of the services that we deliver to patients. It has also provided valuable feedback and opportunities for shared learning, both internally across Care UK and also externally with our key stakeholders.

For example, we have been able to give important feedback to our referring clinicians about the appropriateness of imaging referrals, and whether the images they have requested are the 'gold standard' for answering the clinical question posed. It has also enabled us to review the quality of images produced by our radiographers and sonographers, and the content and accuracy of imaging reports provided by consultant radiologists and sonographers.

The QA programme allows us to monitor the trends and outcomes of imaging examinations, and to quickly identify any discrepancies or errors in reporting practice, ensuring that the clinical outcomes for patients are always the primary focus of this valuable quality improvement tool.

Outcomes from the QA programme continue to be excellent:

- 99.9% of referrals reviewed and accepted by Care UK were scored as appropriate against national imaging referral guidelines (iRefer) developed by the Royal College of Radiologists. There were only minor comments on how the quality of information provided by our referrers could be improved (about the importance of providing relevant patient history and previous imaging undertaken for the patient)
- 99.9% of cases reviewed during this period show the quality of images produced by our radiographers and sonographers to be excellent. This clearly demonstrates that our clinical teams are delivering high quality diagnostic images/ examinations that enable accurate and prompt diagnosis to be achieved for our patients

- 99.2% of reports reviewed were also deemed to be accurate, clear and precise - offering a targeted response to the clinical question being asked by the referring clinician.

Where the QA programme reveals any discrepancies or errors from examinations undertaken within Care UK, a robust process including a full investigation, case review and the sharing of any lessons learned, is always undertaken.

Any significant errors are also formally reviewed as part of a focused Discrepancy Meeting, which includes the review of cases completed by both sonographers and consultant radiologists.

Our QA programme also allows us to track any trends in reporting errors and to identify where additional training or education may be indicated.

Our discrepancy/error rates for the reporting of imaging examinations remain at a very low rate. Although, this rate is hard to benchmark as QA programmes are not widely implemented across NHS Radiology Departments and thresholds for error are not clearly defined by the professional body (Royal College of Radiologists). We are wholly assured that the quality of our reporting is well above any suggested thresholds within the published evidence on this topic, and that we continue to excel in this area.

Patient led assessment of the care environment (PLACE)

Care UK are delighted that the care environments within all of our facilities scored above 80% for every PLACE category in 2015.

Cleanliness

The patient-led assessors gave us an overall score of 99% for the cleanliness of our secondary care and mental health sites. We are immensely proud of this score, which was complemented by an overall score of 96% for the condition, appearance and maintenance of the buildings from which we provide care.

In 2016 we expect to maintain these high quality ratings across all of our NHS Treatment Centres.

Dementia friendly

This was the first year that how environments support the care of people with dementia was assessed – in accordance with criteria laid down by the Health and Social Care Information Centre (HSCIC). Whilst a positive 85% was scored across our secondary care premises overall, we have started working to improve signage and environmental clues across our Treatment Centres. For example, at Peninsula NHS Treatment Centre, designated rooms have been allocated for patients with dementia, with: clear, colour-supported signage identifying toilet and bathroom facilities; large wall -mounted clocks; and softer colour tones.

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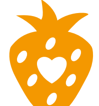
PLACE Results 2015

Cleanliness

99.22%



Food

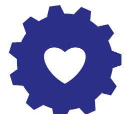
92.23%

Ward food

97.54%

Privacy, dignity and wellbeing

88.31%



Dementia

80.07%

Condition, appearance and maintenance

93.23%

Employee engagement

Each year we carry out a staff survey, 'Over to You'. This survey not only informs us about what staff think, but also helps us measure the effectiveness of our employee engagement strategy. Each unit, department, and team must formulate action plans based on survey results, and report on their progress. Each action plan has sections detailing: 'issues to celebrate'; 'areas where we need to make improvements'; and other factors that appear to merit further investigation. The key measure generated by the survey is an engagement index, expressed as a percentage. Divisional targets are set year on year to increase our engagement index score – with outcomes stripped down as far as service line, unit, and teams within units, to support improvement action planning.

Survey content is proposed by Care UK's Human Resources (HR) Director in conjunction with our Divisional HR Directors. Their proposals are then adjusted and approved by the Divisional Managing Directors. The same questions are used across all services to ensure consistent measurement.

In 2014 our engagement index for Health Care was 58%, this rose to 64% in 2015.

This year the 'Over to You' survey is planned for May and results will be shared with commissioners as part of our routine joint reviews.

Infection prevention and control

Care UK is committed to ever-improving standards of safe practice and environmental hygiene in order to prevent and control infection. This not only enhances service users' safety, it also means that they benefit from visibly clean, high quality service environments.

Organisational management

Following the recommendations of the Health and Social Care Act 2008 (2010; 2015), Care UK maintains a robust, hierarchical structure of infection prevention and control (IPC) guidance and supervision, provided by our IPC Committee, which is chaired by the Director of IPC.

Our IPC strategy is delivered through a range of operational processes that consistently assess, measure and audit infection risks and use outcome information to plan and deliver actions designed to reduce avoidable infections, in line with the national agenda. Each service has a named IPC lead, and the Deputy Director of IPC brings this network of practitioners together on a quarterly basis for clinical supervision, shared learning and peer support.

Systems of assurance

Our internal IPC assurance systems include a monthly audit schedule specifically designed to monitor relevant areas of risk within each service stream. Incidences of surgical site and healthcare associated infections are reported and collated monthly. This information and contributory factors are reviewed locally and are assessed by the Deputy Director. Lessons are shared via our governance framework, which incorporates quality governance, professional forums, the IPC committee and the Health Care Board.

Performance 2014 - 2015

Healthcare Associated Infections (HCAIs): Care UK had no reported cases of Clostridium difficile infection and no incidences of meticillin resistant or sensitive Staphylococcus aureus bacteraemia attributable to their care during 2015.

This is our fifth consecutive year of zero HCAIs.

Health care associated infections (HCAI) 2011-2015

MRSA bacteraemias

0 infections

MSSA bacteraemias

0 infections

E.coli bacteraemias

0 infections

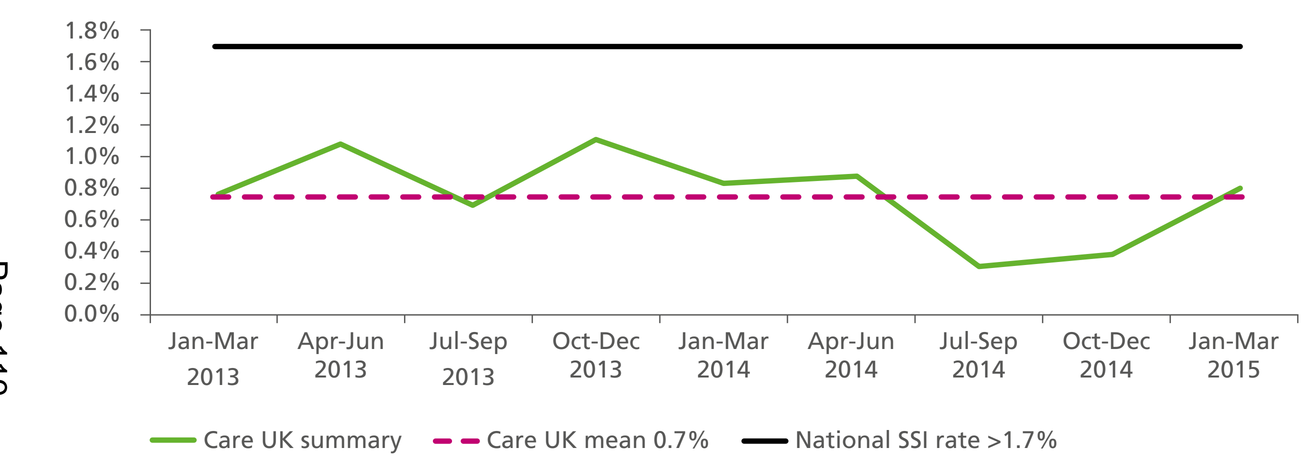
Clostridium difficile incidence

0 infections

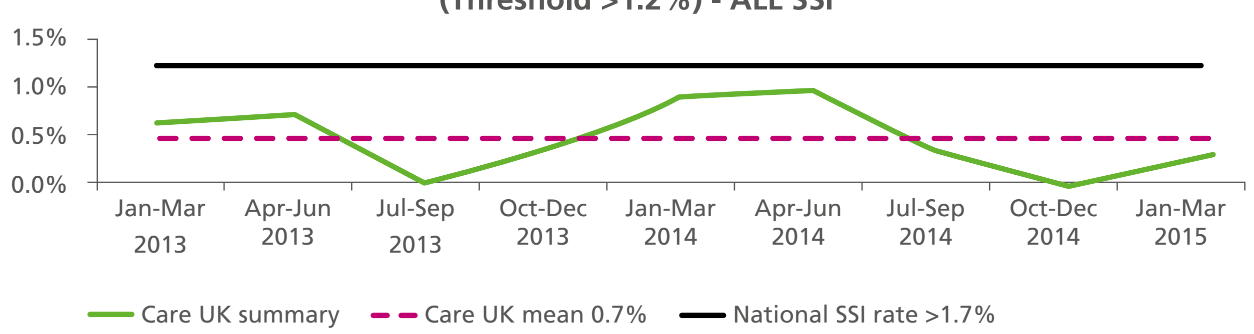
Surgical site Infection (SSI) rates (hip and knee replacement)

Surgical site infections:

Care UK's secondary care services implement continuous surveillance of our hip and knee replacement outcomes via the Public Health England (PHE) National Surgical Site Infection Surveillance Scheme (NSSISS). We report every incidence.



PHE hip replacement surgical site infections (Threshold >1.2%) - ALL SSI

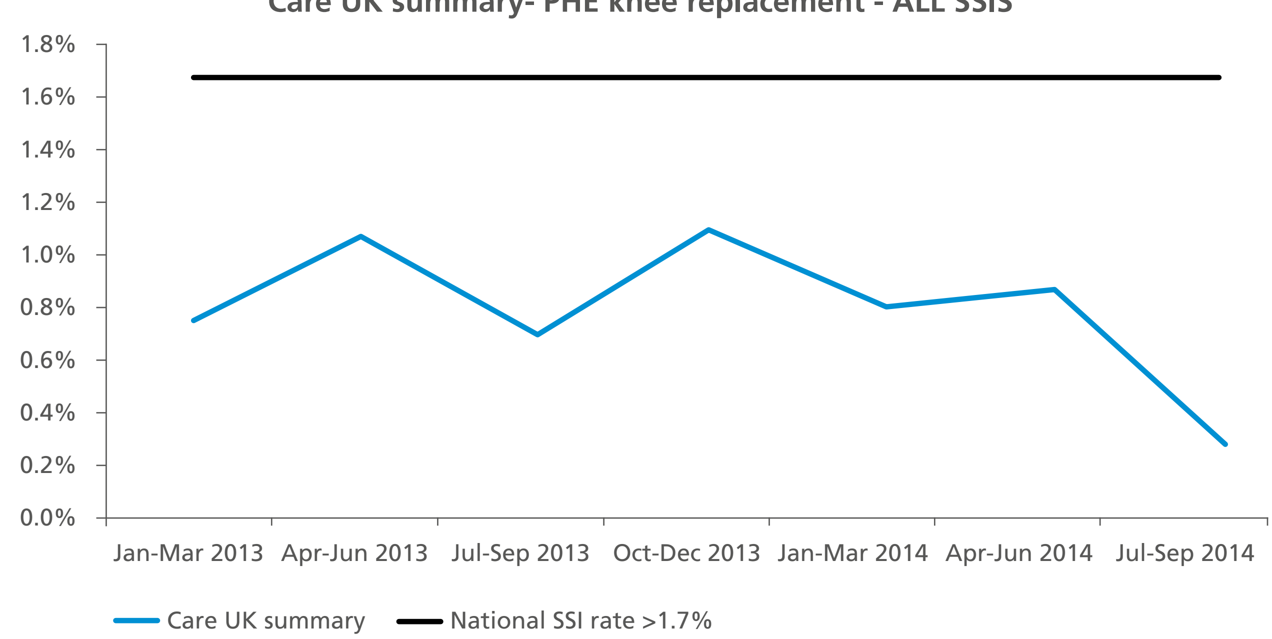


Surgical site infection rates (hips and knees replacements)

Each Care UK secondary care hospital/ Treatment Centre undertaking hip and knee surgery contributes to the national database of post discharge outcomes under the Public Health England National Surgical Site Infection Surveillance Scheme (NSSISS).

Care UK report incidence of surgical site infections on a monthly basis; this exceeds the national minimum requirement of quarterly reporting.

This enhanced visibility of the post discharge outcomes of our patients undergoing hip and knee replacement promotes transparency and confidence in the true values of our reported rates of infection. We have had a numberof surgical site infections at North East London NHS Treatment Centre. These have been investigated thoroughly and improvements are being made. These results have helped inform our quality priorities for this year.



Secondary care hand hygiene audit results by unit

Hand hygiene is a very important element of our comprehensive infection prevention and control (IPC) strategy, policies and procedures – all of which are designed to minimise the risk of infection arising amongst our patients.

An annual training and audit schedule covers standard infection prevention and control precautions, including hand hygiene, use of personal protective equipment (PPE), decontamination and environmental cleanliness.

Our IPC leads and link practitioners conduct quarterly audits of the hand hygiene practice of staff within each service area. Continuous improvement is driven through focused action planning based on audit results, coupled with re-audit. Audits are interspersed with staff training on all aspects of essential hand hygiene practices.

As a result, Care UK consistently reports hand hygiene scores of above 85% across all its secondary care units.

Information governance data quality

We take our responsibilities very seriously to protect and maintain the confidentiality of patient information. The Caldicott Guardian, who is responsible for the security of patient information, leads this work and is committed to the highest standards. However, we have had a total of 174 Internal information incidents within the year and we have had 3 SIRI Level 2 reportable incidents which the ICO has concluded with no actions taken. We have continued to implement double checking of patients information with the patient before giving them the discharge letter and take home medicines, only printing patient information as you need it and redefined basic administration processes so there is a focus on completing one task before starting another one and reducing the risks of error.

We have a range of policies to guide employees and we train all staff at their induction and then on an annual basis in managing information and confidentiality. This is an externally assessed demonstration of our commitment to high standards in the management of information and security. Any serious breaches are reported to the board, commissioners and information commissioner. Information governance is included in the annual audit schedule. Monitoring and managing data quality is key to providing a quality service. Our strategy is reviewed and refreshed each year to take into account new clinical and quality performance initiatives. As

174
Internal information incidents

3
SIRI Level 2 reportable incidents
ICO has concluded with no actions taken

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in previous years we use the data quality dashboards published on a monthly basis by the Health and Social Care Information Centre (HSCIC) to monitor the ongoing data quality of the full range of commissioning dataset items for admitted patients and outpatients. Our board receives a quarterly data quality statement detailing any issues and the actions taken to correct them.

Information governance toolkit attainment

We have achieved the quality standard of Level 3 100% on the IG toolkit, which is underpinned by our ISO 27001:2013-information security management system and accreditation.

Clinical coding

During 2015-16 we submitted records to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES). These are included in the latest published data:

- Within Care UK there is a programme of clinical coding audits focused on data quality, in accordance with Information
- Governance Toolkit 13-505 and conducted in line with the Clinical Classification Service's clinical coding methodology: version 9. The 2015-2016 audit results demonstrated that all Care UK Treatment Centres were achieving the satisfactory percentage accuracy for either Level 2 or the higher Level 3, as recommended
- Care UK clinical coders receive ongoing training in line with the Information Governance Toolkit 13-510 attainment Level 2

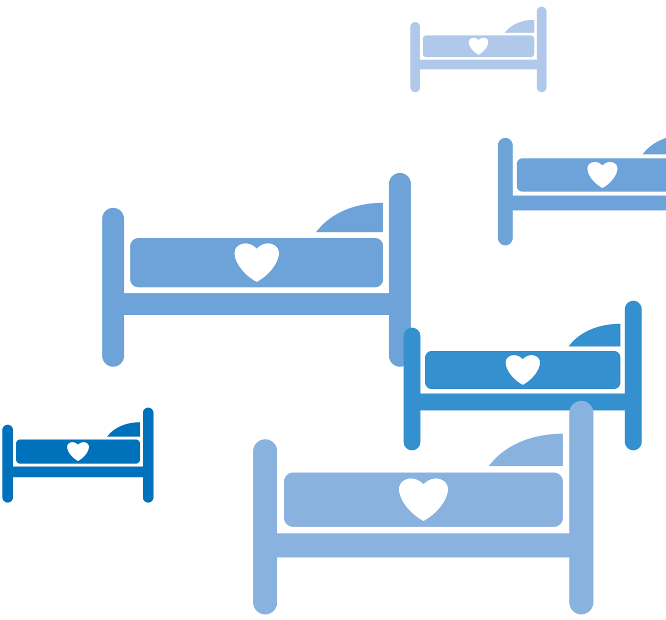
Same sex accommodation

In line with Department of Health guidance on mixed sex accommodation, it is standard practice in

Care UK facilities to provide separate accommodation for men and women throughout the process of admission, treatment and discharge. Treating men and women separately enables us to maintain the appropriate standards of privacy and dignity.

Care UK can confirm that there have been no breaches of the Department of Health guidance during the past year and this has been reported to the Health and Social Care Information Centre (HSCIC) every month. We are proud of this achievement and intend to maintain this standard in the future.

> " Treating men and women separately enables us to maintain the appropriate standards of privacy and dignity"



Local clinical audit

In total, 845 clinical audits of Care UK services were completed locally, between April 2015 and March 2016. Of these, 89% achieved 'compliance' status, 8% 'partial-compliance' and 3% 'non-compliance'.

Each audit forms part of Care UK's published Clinical Audit Schedule. This is reviewed and updated annually by our Clinical Audit and Effectiveness Group, which sets specific clinical audits for each service stream within our Health Care Division. The group prioritises audits that are mandatory and ensures that all scheduled audits are meaningful and will provide a positive contribution to quality improvement and clinical excellence.

We use a range of audit tools, and provide resource and expertise, to facilitate high quality clinical audit practices. Those involved in local clinical audit practices are also encouraged to complete Care UK's CPD accredited clinical audit training session (mandatory for at least one member of staff per service), which has been highly successful in driving a culture of clinical audit by highlighting the positives that can be achieved in terms of quality improvement.

Core audits in the Clinical Audit Schedule (undertaken within all areas) include: safeguarding; medicines management; documentation; CAS alert and NICE guidance; information governance and security; quality audit and emergency scenarios.

These are supplemented by focused, service stream-specific audits. For our NHS Treatment Centres, these include audits of: venous thromboembolism (VTE) risk assessment; peri-operative hypothermia; implementation of National Early Warning Score (NEWS) assessments; WHO Surgical Safety Checklist usage; and observational audits - falls and fluid balance.

Service stream-specific audits within our diagnostic imaging services, include: reject analysis; clinical practice and documentation; and, dose reference level (Radiation dose audit).

Our musculoskeletal (MSK) services also conduct local clinically focused audits to evaluate clinical practice outcomes, including: acupuncture; joint injection and patient triage.

The results, compliance status and details of any actions arising from clinical audits are submitted monthly to the Health Care Division's Clinical Audit Manager.

Results are then logged and key findings are reported by exception i.e. partial and non-compliant audits are reported to Care UK's Health Care Board as part of the monthly reporting cycle and governance processes.

Services are responsible for conducting clinical audits and progressing any actions arising. All actions are assigned to specific individuals for completion within defined timescales. Re-audit is completed where indicated, in order to close the audit loop.

Our operational services are clearly focused on conducting high quality clinical audit and ensuring that outcomes support

teams to either demonstrate their delivery of high quality, latest evidence-based clinical practice or highlight areas for quality improvement.

The following examples provide clear evidence of how clinical audit practice across Care UK has generated demonstrable improvements in the quality, safety and clinical effectiveness, our services - with shared learning mechanisms used to maximise the benefits across whole service streams.

Fluid Balance audit - The North East London NHS Treatment Centre has improved their compliance against NICE guidelines CG174 (IV fluids) from 82% (Non-Compliant) in May 2015 to 100% (Compliance) by November 2015. This was achieved by improving the documentation related to fluid management and ensuring all key factors were recorded appropriately on fluid charts.

The Barlborough NHS Treatment Centre has improved their compliance with VTE audit criteria, a key patient safety issue and a clinical priority for the NHS. Compliance rose from 80% (Non-Compliant) in February 2015 to 100% (Compliance) in April 2015, following targeted improvements in 24-hour VTE reviews.

The Devizes NHS Treatment Centre achieved significant improvements in WHO Surgical Safety Checklist implementation within operating theatres. This checklist is designed to enhance patient safety by encouraging theatre teams to consistently apply evidence-based practices and safety checks for all patients, and by improving teamwork and communication. The Treatment Centre demonstrated significant improvements from 86% (Non-Compliant) in April 2015 to 100% (Compliant) in July 2015.

This improvement was achieved by strongly focusing on the completion of all elements of the checklist by the key members of staff responsible.

In summary, our Clinical Audit Schedule ensures that practices are consistently assessed and benchmarked across a range of guidelines and standards issued by NHS and professional bodies.

Shared learning forms an integral part of the clinical audit cycle and specifically underpins our approach to using clinical audit as an effective quality improvement tool.

In this context, clinical audit outcomes, the key lessons learned and the specific changes and improvements that have been made, are formally discussed and shared amongst colleagues both locally and across Care UK, to ensure we maintain high quality standards for all our patients.

National Joint Registry (NJR)

All of the NHS Treatment Centres operated by Care UK that undertake hip and knee replacement surgery have submitted data to the National Joint Registry since their opening. The NJR has, since 2002, monitored joint replacement surgery in terms of both its clinical effectiveness and the effectiveness of the surgical implants used. Nationally, more than 1.6 million procedures are reported annually (11th Annual NJR Report September 2014).

Care UK's current selection of hip and knee replacement implants takes into account: the top performing outcomes demonstrated by the NJR; Orthopaedic Data Evaluation Panel (ODEP) ratings; and, the most commonly utilised implants in England and Wales.

Implants have been selected for their: proven long term performance; low revision rates; the accessibility of manufacturers' support and inventory; ease of application; and, the integration of continual learning into our intelligent pathways, which is integral to success of complex healthcare organisations.

Our protocols for choosing the right implants take into account individual patient needs, activities, health profile, age and bone stock in order to provide them with the best possible outcome and a quick return to normal life and function. These protocols are regularly reviewed to take account of the latest high impact scientific evidence and our own internal analysis of best outcomes data. This supports our strategic goal of maintaining/improving upon our excellent results year-on-year.

Enhanced Recovery Programme

Care UK was an early adopter of the Department of Health's Enhanced Recovery Programme for hip and knee replacement surgery. Patients' recovery is enhanced through careful pre-operative assessment, the use of modern techniques for anesthesia, surgery and post-operative pain relief, and support for early mobilisation.

As a result, patients have shorter hospital stays and good outcomes. The current average lengths of stay at our NHS Treatment Centres are: 2.6 days for hip replacement and 2.3 days for knee replacement.

Hospital	No. of procedures 2013	No. of consultants 2013	NJR consent rate	Average patient age at operation 2013	Outliers – mortality rate	Outliers – hip revision rate	Outliers –knee revision rate
Barlborough NHS Treatment Centre	1,834	14	100%	69.6			
Emersons Green NHS Treatment Centre	1,101	9	98%	70.2			
North East London NHS Treatment Centre	692	11	100%	70			
Peninsula NHS Treatment Centre	627	8	100%	70			
Shepton Mallet NHS Treatment Centre	616	7	100%	70.4			
Southampton NHS Treatment Centre	442	6	96%	69.1			2

Please note:

Compliance, consent and linkability are:

- Red if lower than 80%
- Amber if equal to or greater than 80% and lower than 95%
- Green if 95% or more

- Compliance figures may be low due to delayed data entry
- Linkability for some hospitals will be lower than expected if they have private patients from outside England and Wales
- Part Four data covers procedures carried out between 1 January 2013 and 31 December 2013

Outlier analyses are:

1 Light red if units are outside 99.8% control limits (approx. 3 standard deviations (SDs))

2 Dark red if units are outside 99.99% control limits

Management of near miss and incident reports

It is a mandatory requirement for all providers of healthcare services to have a procedure for reporting incidents. Care UK's procedure is based on National Patient Safety Agency (NPSA) published work , and related policies are regularly revised to reflect latest best practice in this area.

We promote the open reporting of all incidents and accidents, including no harm/ prevented harm and near miss incidents. If incidents do occur, we take immediate steps to minimise risk factors and prevent recurrence.

Our aim is to maintain a working culture that creates and maintains a safe, low risk environment for our patients and all those visiting or working within Care UK premises.

We also work with local commissioners, partners and external organisations to ensure any learning we derive from incidents is shared and overall risk is reduced. For example, all of our Treatment Centres have a nominated senior staff member who participates in the Local Information Network (LIN) to monitor and review any incidents involving controlled drugs.

Prevention of Never Events

Never events are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented'. Reviews of the circumstances surrounding never events typically exposes process failures that could be addressed through modern Human Factor (HF) training. To this end, Care UK has engaged a specialist company of HF trainers to work   alongside our own training department to help embed HF awareness throughout the organisation. In addition,   we have commissioned an external review by a medico-legal training company, to assess the adequacy of our post hoc analysis of never events, should they occur, and our process for learning from events.

There is a broader piece of work being undertaken to raise awareness of HF in our clinical settings, with formal training being given to clinicians and support staff to further reduce the possibility of never events occurring in the future.

There were 6 never events reported in 2015-16 across secondary care services. 2 related to wrong tooth removal, 1 related to wrong size prosthesis, 1 related to retained foreign object (Tourniquet),1 relating to wrong site procedure and 1 relating to incorrect spinal medication administered.

Site	Category
North East London NHS Treatment Centre	Wrong tooth removed
Barlborough NHS Treatment Centre	Incorrect spinal medication administered
Barlborough NHS Treatment Centre	Wrong size prosthesis
North East London NHS Treatment Centre	Retained foreign object
Barlborough NHS Treatment Centre	Wrong site procedure
Southampton NHS Treatment Centre	Wrong tooth removed

Root Cause Analysis

Once an incident has been investigated, we identify root causes, make recommendations and communicate those recommendations across the organisation to ensure any necessary changes are put into action. We then monitor the implementation of changes to practices, pathways and management, across all sites. Where indicated, we also review our policies and procedures to reflect these changes.

Risks identified through the reporting and investigation of incidents are also recorded in our Datix system alongside any action plans. These are frequently reviewed as part of our proactive approach to reducing the likelihood of future incidents occurring.

Patient deaths within 30 days

Patient deaths within 30 days of discharge were reported over this period although none were the result of treatment or incidents occurring while patients were under the care of Care UK.

Learning from Incidents

At a local level, shared learning from incidents and complaints is a standard agenda item at Quality Governance meetings - with additional, individual feedback being given to any staff members who were involved.

At a national level, we not only monitor the action plans resulting from incident investigations but ensure lessons learned are shared across all services. Our Professional Leads meetings, which are attended by all of our Heads of Nursing and Clinical Services, are a particularly useful forum for this.

Working in partnership with our commissioners and external stakeholders is another essential means of sharing our learning and promoting transparency in our services. To promote this in Southampton, representatives from our Treatment Centre team attend Panel Review Meetings convened by commissioners. These meetings enable teams of experts, including both senior managers and clinical staff, to get together to discuss and share learning derived from the root cause analysis of incidents. Meetings are quarterly or as required. Inspectors from the Dental Deanery and NHS England have commented positively on the results of these meetings.

Table 1

This table provides the number of patient safety incidents as a percentage per Treatment Centre

	% of patient safety incidents as a percentage of patient attendances		
	All incidents including near misses	Severe Harm	Death
Barlborough NHS Treatment Centre	7.6949%	0.0000%	0.0000%
Devizes NHS Treatment Centre	2.6778%	0.0000%	0.0000%
Emersons Green NHS Treatment Centre	3.2513%	0.0000%	0.0000%
North East London NHS Treatment Centre	1.2232%	0.0000%	0.0159%
Peninsula NHS Treatment Centre	2.9490%	0.0000%	0.0000%
Shepton Mallet NHS Treatment Centre	1.5068%	0.0000%	0.0000%
Southampton NHS Treatment Centre	0.9186%	0.0000%	0.0000%
St Mary's NHS Treatment Centre	2.6128%	0.0000%	0.0000%
Will Adams NHS Treatment Centre	0.5963%	0.0000%	0.0000%

Table 2

This table provides actual numbers of incidents per Treatment Centre

	Severe Harm	Death	No Harm	Total
Barlborough NHS Treatment Centre	0	0	176	225
Devizes NHS Treatment Centre	0	0	88	105
Emersons Green NHS Treatment Centre	0	0	264	312
North East London NHS Treatment Centre	0	1	52	77
Peninsula NHS Treatment Centre	0	0	81	100
Shepton Mallet NHS Treatment Centre	0	0	72	88
Southampton NHS Treatment Centre	0	0	85	111
St Mary's NHS Treatment Centre	0	0	141	165
Will Adams NHS Treatment Centre	0	0	14	21

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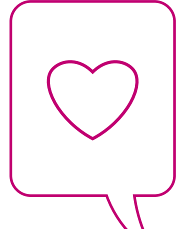
Part 5
Feedback from Key Stakeholders



We would like to thank all of the staff, patients, commissioning groups, healthwatch and other key stakeholders for reviewing and commenting on this Quality Account. Each year we learn something new and want to improve on how we present this account year on year.

Insert feedback here

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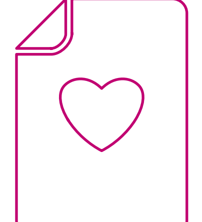
Appendix



Appendix 1 – Examples of patient's stories

Barlborough NHS Treatment Centre

"Having never been to hospital before I was naturally quite nervous but I need not have worried because everyone is so caring and professional that all my fears were allayed. I had a hip replacement on the 16th July and the operation was carried out by Thorwald Springer and his team all of who were amazing. I am now three weeks down the line and feeling fantastic it is wonderful to be pain free!

You are made to feel special by everyone there and all the staff are just lovely, so if ever I need any other orthopaedic work I would not hesitate in going back there - in fact I wouldn't go anywhere else!"

A patient's story

Devizes NHS Treatment Centre (AGW)

Dental patient sees the wisdom of Devizes NHS Treatment Centre

When Jonathan* , 48, from Swindon went to his dentist for a regular check-up he was initially told he would need a filling in a wisdom tooth. However, an X-ray showed decay under the tooth and his dentist suggested that his tooth would need to be extracted. John was offered a choice of where to receive his treatment. He chose Devizes NHS Treatment Centre.

John booked an appointment for a check-up and X-ray at Devizes, where he spoke to clinical staff about his treatment options. Having chosen, he was able to go to reception to book his treatment at a time to suit him.

Within 12 weeks of visiting his dentist, John came for his treatment. He said: "I met with the nurse, completed the paperwork and spoke to Michael Hahn who described my treatment to me. I had three injections and my tooth was extracted in 10 minutes. Afterwards, the hospital let me rest for a while before going home, and the bleeding stopped on the first day."

John was delighted with his treatment and wrote to the hospital saying: "I would like to say a huge thank you to Michael Hahn and the team that worked on me, I received the upmost of care and professional treatment. I feel in our times now we only get to hear when things may not go the way we want them to go, I would like to point out the great work you do here and say a massive thank you to the Devizes NHS Treatment Centre for making my treatment so stress free and enjoyable, I can't thank you all enough."

Speaking later, John said: "The Devizes NHS Treatment Centre is perfect, a lovely clean environment where you are treated well. I would recommend it to anyone – it's great, choose it for your treatment!"

* Patient name has been changed

A patient's story

Emersons Green NHS Treatment Centre (AGW)

Care pathway adapted to suit changes needs of a patient

Staff at Emersons Green NHS Treatment Centre showed great professionalism and flexibility in their treatment of a patient with dementia who needed a total knee replacement.

The patient was confused. His memory impairment meant he was at increased risk of a fall. Memory loss also contributed to his agitation, sense of frustration and to his unpredictable, often challenging, behavior. Communication was difficult not only because of his dementia, but also because English was not his first language.

To ensure that his needs were met, the staff at Emerson Green worked in consultation with his family, to put into place a series of actions.

He was moved to the hospital's dedicated dementia care room and was given one-to-one supervision throughout his stay – to help him feel safe and secure and to also ensure that his bandages and brace stayed in place to promote his recovery.

The patient expressed a strong wish to be discharged earlier than the clinical team would have recommended and the team respected this, liaising closely with his family and GP to ensure that he had all he needed to maintain his wellbeing and recovery at home.

During the week after his discharge, the team also continued to see the patient at the hospital for assessment and to check his dressing.

The following week the patient's GP called the operating consultant to say that there were issues with the wound. After discussion with the GP, the Emersons Green clinical team agreed that an urgent referral to the main local NHS hospital was the right course of action – for review and treatment of the wound, and geriatric and psychological assessment of the patient.

The Emersons Green consultant liaised with the patient's GP and the local NHS hospital throughout the transfer of care and assessment.

Mona Van Wyk, Head of Nursing and Clinical Services at Emersons Green, commented: "This patient had significant physical and psychological challenges. By adopting a flexible approach throughout his care pathway, both for the period he was with us and after he was discharged, the care he received was tailored to his needs. This demonstrates not only how we accommodate our patients' requirements, but also how well we work with our NHS colleagues in the region."

A patient's story

North East London NHS Treatment Centre

New techniques helped a Wanstead woman get back on her feet in double quick time

An active life coupled with an accident whilst walking her dog, left Sheila* in considerable pain from a complex knee injury. Thanks to the pioneering surgical techniques used at North East London NHS Treatment Centre, she is now active again – after spending only two nights in hospital.

The national average for hospital stays for people recovering from complete knee replacements is 6.4 days. At the Care UK-operated NHS Treatment Centre in Ilford, this average has been reduced to 2.8 days.

This achievement has resulted from our implementation of an Enhanced Recovery Programme that incorporates the use of spinal block anaesthetics, rather than the conventional general anaesthetic.

Sheila said: "I am a bit of an anxious patient and when I heard that I would not be under a general anaesthetic during the operation I was relieved.

The team in the ward and the operating theatre were very friendly and professional. The anaesthetist was very reassuring. I had the block and I was sedated and I felt comfortable and relaxed throughout the whole procedure.

When I got back on the ward the team were excellent and came to chat to me regularly during my stay, which I appreciated. I also enjoyed the food and the whole Centre was spotlessly clean."

The morning after the operation, Sheila worked alongside the team to get out of bed and become mobile. They helped her to walk with crutches and, as her confidence grew, Sheila began to practice walking up the Physiotherapy Department's stairs.

Sheila said: "They explained to me that getting moving helped recovery. Amazingly I was able to leave on the Monday in time to sleep in my own bed, which was a comfort. No matter how good a hospital is, I think we all feel more comfortable in our own home."

Sheila was also pleased with her follow-up care. As well as providing physiotherapy, the team were on hand to help her with a new compression stocking to increase her comfort and help prevent deep vein thrombosis (DVT).

When she noticed a slight area of redness six weeks after the operation, her surgeon saw her the next day.

She said: "My surgeon, Mr Nurul Islam Ahad, has been exceptional throughout my treatment, including the aftercare.

I have a very fine, faint scar from his operation, unlike the ligament surgery I had in the 1980s.

Four weeks after the operation I was able to go on holiday to the Norfolk Broads,

whereas previous surgery had seen me in a heavy cast for 10 weeks.

My knee problems stem back to my teenage years when I was a keen athlete. I was a fast runner and in one game of rounders I fell as I ran a corner and felt my knee just give way. I tore my cartilage and had to have an operation. It was operated on again 35 years later, when I fell down the stairs and tore the ligament. The surgeon said it was on the verge of collapse. That held for a number of years until my foot accidently went into a rabbit hole as I was walking my dog. It just got worse from there.

It wasn't until I had the operation that I realised how much pain I had been in and how much my movement and walking had been affected. People have commented on how that has changed already and I am really looking forward to being back to my active self.

I would recommend the Treatment Centre and the technique to any of my friends that need to have a knee replacement."

Mr Ahad said: "Sheila's story is really quite amazing in that her leg had a severe deformity and unlike simple jointreplacement she required complex surgery to improve her condition and enable her to walk straight. I am delighted she is so happy with her treatment."

Hospital Director Ashley Livesey said: "The new techniques we use at the Treatment Centre have been well received by our patients, who tell us they prefer to complete their recuperation at home.

Satisfaction levels are very high amongst our patients, and the short stays also allow us to carry out more surgeries - cutting the waiting times of people needing joint replacement in North East London."

* Patient name has been changed

A patient's story

Peninsula NHS Treatment Centre

Atlantic storm the impetus for knee replacement

When retired senior fire office Ray*, 75 from Dousland on Dartmoor in Devon, started having problems with his knee, he endured seven years of pain before he opted for a knee replacement – and it was a storm in the Atlantic that moved him to action.

Said Ray: "My wife and I were on a 33-day cruise across the North Atlantic and down to Barbados and other islands in the Caribbean. The weather was appalling and the journey was awful – the dining room windows blew in and two people had to be taken off the ship by helicopter. It was agony for me coping with the pitch and roll of the ship, and after a few days I said to my wife; 'When we get home I'm going to get this knee fixed!'"

Ray, who is now a self-employed fire risk assessor, chose to have his treatment at the Peninsula NHS Treatment Centre in Plymouth. It was not his first visit as he had carried out the final fire safety check at the Centre before it opened its doors in April 2005.

He said: "My knee was rubbing bone on bone and my leg was becoming out of alignment. I had my operation within two months of my referral for treatment and the whole experience was amazing – I have often said it was the first time I had ever enjoyed being in hospital."

He added: "It's fair to say that I was dreading the operation, which is why I put it off for so long. But I needn't have worried, everyone at Peninsula was marvellous and great at putting me at ease, and my advice to anyone else in my position would be 'go for it!'"

As a result of his operation Roy is now back to full fitness, enjoying mountain biking and trout fishing, as well as running his business.

Patricia Warwick, Hospital Director at the Peninsula NHS Treatment Centre, commented: "We are delighted to hear that Roy had such a good outcome and that his experience was excellent. We are also really pleased that, as a result of his good experience, Roy has joined our Patient Forum, becoming part of a group of wonderful people who help us to develop the hospital and our services."

* Patient name has been changed

A patient's story

Shepton Mallet NHS Treatment Centre

"Having had several years of pain from my knee I was referred to Mr Schindler at Shepton Mallet.

After the initial test to make sure I could undergo this operation I was admitted to his care.

He explained the procedure in full to enable me to understand what was involved and what to expect.

Everyone was kind and understanding and the operation was a great success.

Within two days I was taking my first steps and was discharged from hospital on the fourth day.

Now just three months later I am able to walk almost perfectly without aid and the scar is only just visible.

Mr Schindler's aftercare has been excellent and if asked by anyone in need of a knee replacement, I would not hesitate to recommend Mr Schindler to them.

I would like to thank Mr Schindler for giving me a new life."

A patient's story

Southampton NHS Treatment Centre

Children's author urges patients to consider travelling for treatment

An Isle of Wight author who travelled to Southampton to undergo a complete hip replacement is urging patients not to fear the journey, as the results and coordinated care are exceptional.

Martha*, was in constant pain and using pain killers to manage her condition.

She said: "For nearly a year bending was very painful, if not impossible. I had to give up Nordic walking and the pain was on my mind most of the time. I think the years sitting as I wrote and drew had taken its toll on my hip."

Martha's GP thought that she would need a hip replacement and mentioned that she could opt to have surgery in Southampton, including at the NHS Treatment Centre run by Care UK.

Martha, who lives in East Cowes and writes and illustrates children's Bible stories, said: "I was amazed, within four weeks of the GP appointment I was having the operation. A taxi was organised to take me to the terminal and tickets for the ferry were posted to me. On the day of the operation they also sent an extra set of tickets so that I could take a friend with me. I thought that was kind. The way it was organised took the stress out of the situation and increased my confidence in the process.

When I arrived at the Treatment Centre, at Royal South Hants Hospital, I was struck by how clean and bright the Centre is. I was seen immediately and everyone was very friendly and reassuring."

The operation was carried out by Consultant Orthopaedic Surgeon, Andrew Flood, using an epidural anaesthetic technique that not only prevents the need for a general anaesthetic but also reduces the time patients have to stay in hospital.

"It was incredible I was having tea soon after the operation. The physiotherapists were exceptional. They had me up on my feet shortly after, and I went home four days later. It could have been sooner but for the need to get an ambulance back to the Isle of Wight, and that day's one had already left."

Martha was so impressed she wrote to the Chief Executive of NHS England, Simon Stevens, to praise the Centre's theatre and physiotherapy teams as well as its cleanliness and food, which she described as superb. From the hospital Ms Goldsworthy moved to a rehabilitation care home on the Isle of Wight for two weeks of rest and physiotherapy.

She said: "I have recently had my one year review and the X-rays show how well the

hip has sealed. It never enters my mind now, which is very different from a year ago."

Hospital Director Paula Friend said: "I was delighted to read Martha's letter. I am very proud of my team and I am delighted that we can offer patients from the Isle of Wight this service. Our team were able to significantly improve Martha's wellbeing: at her one year review her Oxford score, which the NHS uses to measure patients before and after treatment, showed that she had moved from the lowest group for mobility and comfort on arrival, to the highest level on recovery."

* Patient name has been changed

A patient's story

St Mary's NHS Treatment Centre

Portsmouth woman thanks NHS teams for their life-saving diagnosis

A Waterlooville woman is thanking the city's NHS teams after a suspected back strain was correctly diagnosed as a life threatening condition.

Helen*, a support worker at a Portsmouth service for adults with learning disabilities, was suffering from backache: "My job is very active and I really thought it was no more than a strain. But the pain increased and by the end of my four-night shift pattern, my manager said she was worried and encouraged me to go to the doctors.

"I couldn't get a GP's appointment so I went along to the Minor Injury and Illness Unit at St Mary's NHS Treatment Centre and that decision saved my life. I was seen quickly and my details were taken and then I saw nurse, Jayne Fairbrother.

"I had worked as a practice nurse in Germany, when my husband was stationed there, and I can say she did an exceptional job. Jayne's diagnostic skills were excellent, as I know I didn't present with the usual symptoms associated with my eventual diagnosis.

"She carried out tests and told me that I had to go to the Queen Alexandra Hospital (QA) immediately. I said I would drive but she politely but firmly told me I would be going by ambulance. As I began to realise that things were significantly more serious than I had imagined, she kept me calm and well-informed as we waited for the ambulance and when they arrived she joked with the driver that I might try taking myself!"

At the QA Helen was diagnosed with pneumonia, a pleural effusion and empyema - whereby areas of pus develop on the lungs. As well as badly affecting the right lung, the infection had begun to affect Helen's liver.

She said: "Jayne's decision to send me to the QA saved my life; the consultant at Southampton General Hospital told me that I was on the verge of septicaemia and I could have died."

Helen spent 12 nights in the Respiratory Unit at QA followed by four nights in Southampton's Cardiothoracic Unit after video-assisted thoracic surgery. She is now back to full health and very grateful to the teams at all three hospitals. "I am usually a very fit and healthy person and although I had back pain, I did not feel as ill as I was. I am very grateful to Jayne for her exceptional skills and to the other teams whose dedication nursed me back to health," she said.

Hospital director Penny Daniels said: "I am very proud of the team. The Minor Injury and Illness Unit provides an invaluable service to Portsmouth people and helps to ease the strain on Accident and Emergency Departments locally.

We have an exceptional nursing team and Jayne's skills and years of experience averted what could have been a very different outcome. I am delighted that Mrs Rice was pleased with the service provided by the three hospitals, and I am glad to hear she has made a full recovery."

* Patient name has been changed

A patient's story

Will Adams NHS Treatment Centre

A patient who was referred by his GP to the Will Adams NHS Treatment Centre with symptoms of Carpal Tunnel Syndrome, was seen by Orthopaedic Consultant, Mr Nurul Ahad in Outpatients towards the end of November 2015. During the consultation the patient discussed his symptoms and mentioned that he was also experiencing dizziness, visual impairment and had a slight weakness on his right side. Mr Ahad immediately recognized that the patient could have a carotid stenosis (a narrowing of the carotid artery which supplies blood to the brain, neck and face), which could lead to a TIA (a mini-stroke). The patient was referred to the local hospital immediately and underwent surgery.

During the next consultation the patient was immensely grateful for Mr Ahad's prompt action, which meant he had undergone surgery that in his opinion had: "Saved my life."

Appendix 2 – National clinical audits

Name of National Clinical audit	Care UK eligible to participate in	Care UK participation (Yes / No)	Comments
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	No	No	Care UK does not provide treatment for cardiovascular illness at its Treatment Centres
Adult Asthma	No	No	Care UK chose not to participate in these audits
Adult Cardiac Surgery	No	No	Care UK does not provide treatment for cardiovascular illness at its Treatment Centres
Bowel Cancer (NBOCAP)	No	No	Care UK does not provide cancer services at its Treatment Centres
Cardiac Rhythm Management (CRM)	No	No	Care UK does not provide treatment for cardiovascular illness at its Treatment Centres
Case Mix Programme (CMP)	No	No	N/A
Child Health Clinical Outcome Review Programme	No	No	Care UK does not treat children at its Treatment Centres
Chronic Kidney Disease in primary care	No	No	Care UK does not manage long term conditions at its Treatment Centres
Congenital Heart Disease (CHD) - Adult	No	No	Care UK does not provide treatment for cardiovascular illness at its Treatment Centres
Congenital Heart Disease (CHD) - Paediatric	No	No	Care UK does not provide treatment for cardiovascular illness at its Treatment Centres
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	No	No	Care UK does not provide treatment for cardiovascular illness at its Treatment Centres
Diabetes (Paediatric) (NPDA)	No	No	Care UK does not treat children/manage long term conditions at its Treatment Centres
Elective Surgery (National PROMs Programme)	Yes	Yes	None
Emergency Use of Oxygen	Yes	No	Care UK chose not to participate in this audit
Falls and Fragility Fractures Audit Programme (FFFAP) - Fracture Liaison Service Database	Yes	No	Care UK chose not to participate in this audit
Falls and Fragility Fractures Audit Programme (FFFAP) - Falls	Yes	No	Care UK chose not to participate in this audit
Falls and Fragility Fractures Audit Programme (FFFAP) - National Hip Fracture Database	Yes	No	Care UK chose not to participate in this audit

Name of National Clinical audit	Care UK eligible to participate in	Care UK participation (Yes / No)	Comments
Inflammatory Bowel Disease (IBD) programme	No	No	Care UK does not manage long term conditions at its Treatment Centres
Major Trauma Audit	No	No	Care UK does not provide major trauma services at its Treatment Centres
Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal Mortality Surveillance	No	No	Care UK does not provide maternity or children's services at its Treatment Centres
Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths)	No	No	Care UK does not provide maternity or children's services at its Treatment Centres
Maternal, Newborn and Infant Clinical Outcome Review Programme - Maternal morbidity and mortality confidential enquiries (cardiac (plus cardiac morbidity) early pregnancy deaths and pre-eclampsia, plus psychiatric morbidity)	No	No	Care UK does not provide maternity or children's services at its Treatment Centres
Maternal, Newborn and Infant Clinical Outcome Review Programme - Maternal mortality surveillance	No	No	Care UK does not provide maternity or children's services at its T reatment Centres
Medical and Surgical Clinical Outcome Review Programme - Acute Pancreatitis	No	No	Care UK does not manage long term conditions at its Treatment Centres
Medical and Surgical Clinical Outcome Review Programme - Physical and mental health care of mental health patients in acute hospitals	No	No	Care UK does not manage long term conditions at its Treatment Centres
Medical and Surgical Clinical Outcome Review Programme - Non-invasive ventilation	Yes	No	Care UK chose not to participate in this audit
Mental Health Clinical Outcome Review Programme - Suicide in children and young people (CYP)	No	No	Care UK does not treat children at its Treatment Centres
Mental Health Clinical Outcome Review Programme - Suicide, Homicide & Sudden Unexplained Death	No	No	Care UK does not provide Mental Health services at its Treatment Centres
Mental Health Clinical Outcome Review Programme - The management and risk of patients with personality disorder prior to suicide and homicide	No	No	Care UK does not provide Mental Health services at its Treatment Centres

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Name of National Clinical audit	Care UK eligible to participate in	Care UK participation (Yes / No)	Comments
National Audit of Intermediate Care	Yes	No	Care UK chose not to participate in this audit
National Cardiac Arrest Audit (NCAA)	Yes	No	Care UK did consider participating in this audit but numbers within our facilities were too low for inclusion
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme - Pulmonary rehabilitation	No	No	Care UK does not manage long term conditions at its Treatment Centres
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme - Secondary Care	No	No	Care UK does not manage long term conditions at its Treatment Centres
National Comparative Audit of Blood Transfusion programme - Use of blood in Haematology	Yes	Yes	Care UK Treatment Centres participate in this audit
National Comparative Audit of Blood Transfusion programme - Audit of Patient Blood Management in Scheduled Surgery	Yes	Yes	Care UK Treatment Centres participate in this audit
National Complicated Diverticulitis Audit (CAD)	No	No	Care UK does not manage long term conditions at its Treatment Centres
National Diabetes Audit – Adults - National Footcare Audit	No	No	Care UK does not manage long term conditions at its Treatment Centres
National Diabetes Audit – Adults - National Inpatient Audit	No	No	Care UK does not manage long term conditions at its Treatment Centres
National Diabetes Audit – Adults - National Pregnancy in Diabetes Audit	No	No	Care UK does not manage long term conditions at its Treatment Centres
National Diabetes Audit – Adults - National Diabetes Transition	No	No	Care UK does not manage long term conditions at its Treatment Centres
National Diabetes Transition – Adults - National Core	No	No	Care UK does not manage long term conditions at its Treatment Centres
National Emergency Laparotomy Audit (NELA)	No	No	Care UK only provides elective surgery services at its Treatment Centres
National Heart Failure Audit	No	No	Care UK does not provide treatment for cardiovascular illness at its Treatment Centres

Appendix 3 – Table of CQC Inspections (Secondary Care) December 2014-December 2015

Site	Inspection Date	Compliant /Non-compliant	Notes
Barlborough NHS Treatment Centre	16/03/2015	Good	Adhering to the new format for inspections, based on 5 key lines of enquiry, the CQC advised that at this service we were: 'Good' in Safe, Effective, Responsive and Well Led and Outstanding in Caring
Southampton NHS Treatment Centre	18/05/2015	Good	Adhering to the new format for inspections, based on 5 key lines of enquiry, the CQC advised that at this service we were: 'Good' in Safe, Effective, Responsive and Well Led and Outstanding in Caring
Shepton Mallet NHS Treatment Centre	01/12/2014	Fully Compliant	This site was inspected using the older format for inspections. The CQC advised that we were: 'Compliant' regarding their 5 key lines of enquiry: Safe, Effective, Caring, Responsive and Well Led
St Mary's NHS Treatment Centre	02/10/2015	Good	Adhering to the new format for inspections, based on the 5 key lines of enquiry, the CQC advised that at this service we were: 'Good' in safe, Effective, Responsive, Well Led and Caring domains

Name of National Clinical audit	Care UK eligible to participate in	Care UK participation (Yes / No)	Comments
National Joint Registry (NJR) – knee replacement	Yes	Yes	Care UK Treatment Centres participate in this audit
National Joint Registry (NJR) – hip replacement	Yes	Yes	Care UK Treatment Centres participate in this audit
National Lung Cancer Audit (NLCA)	No	No	Care UK does not provide cancer services at its Treatment Centres
National Ophthalmology Audit	Yes	No	Care UK chose not to participate in this audit
National Prostate Cancer Audit	No	No	Care UK does not provide cancer services at its Treatment Centres
National Vascular Registry	No	No	Care UK does not provide treatment for cardiovascular illness at its Treatment Centres
Neonatal Intensive and Special Care (NNAP)	No	No	Care UK does not treat children at its Treatment Centres
Non-Invasive Ventilation - Adults	Yes	No	Care UK chose not to participate in this audit
Oesophago-gastric Cancer (NAOGC)	No	No	Care UK does not provide cancer services at its Treatment Centres
Paediatric Asthma	No	No	Care UK does not manage long term conditions at its Treatment Centres
Paediatric Intensive Care (PICANet)	No	No	Care UK does not treat children at its Treatment Centres
Paediatric Pneumonia	No	No	Care UK does not treat children at its Treatment Centres
Renal Replacement Therapy (Renal Registry)	No	No	Care UK does not manage long term conditions at its Treatment Centres
Rheumatoid and Early Inflammatory Arthritis - Clinician/ Patient Follow-up	No	No	Care UK does not manage long term conditions at its Treatment Centres
Rheumatoid and Early Inflammatory Arthritis - Clinician/ Patient Baseline	No	No	Care UK does not manage long term conditions at its Treatment Centres
Sentinel Stroke National Audit programme (SSNAP)	No	No	Care UK does not manage long term conditions or acute stroke at its Treatment Centres
UK Cystic Fibrosis Registry - Paediatric	No	No	Care UK does not manage long term conditions at its Treatment Centres
UK Cystic Fibrosis Registry - Adult	No	No	Care UK does not manage long term conditions at its Treatment Centres

Name of National Clinical audit	Care UK eligible to participate in	Care UK participation (Yes / No)	Comments
UK Parkinson's Audit - Occupational Therapy	No	No	Care UK does not manage long term conditions at its Treatment Centres
UK Parkinson's Audit - Speech and Language Therapy	No	No	Care UK does not manage long term conditions at its Treatment Centres
UK Parkinson's Audit - Physiotherapy	No	No	Care UK does not manage long term conditions at its Treatment Centres
UK Parkinson's Audit - Patient Management, elderly care and neurology	No	No	Care UK does not manage long term conditions at its Treatment Centres

Audit title	Purpose of audit	Frequency	ISTC	CATS
Documentation (Clinical)	Support best practice/guidance from professional bodies in patient documentation	Quarterly	✔	✔
Patient falls	Patient safety and compliance	Patient safety and compliance assessment tool	✔	
Prevention of VTE (venous thromboembolism)	Assess compliance with NICE guidance and best practice clinical protocols (assessment and provision of prophylaxis)	Monthly	✔	
Peri-operative hypothermia audit	Assess compliance with NICE guidelines – CG65	Monthly	✔	
Pain audit	Assess effectiveness of pain management protocols	Quarterly	✔	
WHO surgical site safety checklist audit	Assess compliance with WHO surgical site safety checklist	Monthly	✔	
WHO observational audit	Assess compliance with WHO checklist (Sign in, Time In & Sign out)	Monthly	✔	
NEWS (National Early Warning Score) audit	Use of NEWS audit to identify early signs of deterioration of a patient's condition	Monthly	✔	
Fluid balance audit	Assess fluid management in patients	Bi-Monthly	✔	
Blood transfusion audit	Compliance with blood safety and national transfusion guidance	6 monthly	✔	
Traceability audit - endoscopy	Compliance to JAG standards and re-accreditation	Monthly	✔	✔
Endoscopy environmental audit	Compliance to JAG standards and re-accreditation	Monthly	✔	✔
Medicines Management – Controlled drugs, Stock control, Responsibilities and prescribing and administration	Monitor all aspects of medicines management across clinical services	Annually (Self-audit) & Annually (External audit)	✔	✔
Controlled Drugs Documentation audit	Assess Pharmacists/Medicines Management Leads (focuses on the documentation element of controlled drugs usage)	Quarterly	✔	✔
Anaesthetic Observation audit	Assess compliance and quality of anaesthetic practice	Quarterly	✔	
Ward round (MDT) audit	Assess ward round practice and key team member involvement	Quarterly	✔	
Quality audit	Assess services against the CQC's Essential Standards	Bi-annually	✔	✔

Audit title	Purpose of audit	Frequency	ISTC	CATS
Safeguarding children audit	Ensure safeguarding procedures and appointed leads are effective in all services	Quarterly	✔	✔
Safeguarding adults audit	Ensure safeguarding procedures and appointed leads are effective in all services	Quarterly	✔	✔
CAS alert & NICE guidance audit	Ensure that all alerts (CAS & MHRA) are reviewed, documented and circulated and that all published NICE guidance is reviewed and implemented	6 monthly	✔	✔
Agency/Locum/Temporary staff audit	Ensure that appropriate checks and local inductions are undertaken for all agency, locum and temporary members of staff	Bi-annually	✔	✔
Information Governance & Security audit	Monitor compliance against IG Toolkit requirements and ISO 27001 accreditation	Bi-annually	✔	✔
Emergency scenario audit	Ensure all staff are prepared/fully aware of their responsibilities in the event of an emergency incident	Quarterly	✔	✔

Appendix 4 – List of Services and Locations

Services	Facilities	Specialties
Barlborough NHS Treatment Centre	Inpatients, Day patients, Diagnostics	Minor and major orthopaedic procedures, ophthalmology
Cirencester NHS Treatment Centre (AGW) CLOSED NOV 2015	Day patients, Diagnostics,	Dental, ENT, general surgery, gynaecology, minor orthopaedic procedures and urology
Devizes NHS Treatment Centre (AGW)	Day patients, Diagnostics,	General surgery, endoscopy, gastroenterology, gynaecology, urology, knee procedures, foot and ankle procedures, hand procedures, diagnostic imaging, ENT, ophthalmology, oral surgery
Emersons Green NHS Treatment Centre (AGW)	Inpatients, Day patients, Diagnostics	General surgery, endoscopy, gastroenterology, gynaecology, urology, hip procedures, knee procedures, foot and ankle procedures, hand procedures, diagnostic imaging, ENT, ophthalmology, oral surgery
North East London NHS Treatment Centre	Inpatients, Day patients, Diagnostics	Orthopaedics, general surgery, endoscopy, gastroenterology, ENT, ophthalmology, oral surgery
Peninsula NHS Treatment Centre	Inpatients, Day patients, Diagnostics	General surgery, hip procedures, knee procedures, shoulder and elbow procedures, foot and ankle procedures, hand procedures, ophthalmology
Shepton Mallet NHS Treatment Centre	Inpatients, Day patients, Diagnostics	Orthopaedics, general surgery, endoscopy, gastroenterology, gynaecology, urology, diagnostic imaging, ENT, ophthalmology, pain management
Southampton NHS Treatment Centre	Inpatients, Day patients, Diagnostics	Orthopaedics, general surgery, endoscopy, gastroenterology, gynaecology, urology, diagnostic imaging, ENT, ophthalmology, oral Surgery, pain management
St Mary's NHS Treatment Centre	Day patients, Diagnostics	Orthopaedics, general surgery, endoscopy, ophthalmology, diagnostic imaging
Will Adams NHS Treatment Centre	Day patients, Diagnostics	Orthopaedics, general surgery, endoscopy, urology, ophthalmology
Diagnostic services	**Facilities**	**Specialties**
Mid and South Buckinghamshire NHS Diagnostic Centre	Outpatients, Diagnostics	Musculoskeletal services
Community Diagnostics	Outpatients, Diagnostics	Musculoskeletal services
Havant Diagnostics	Diagnostics	Diagnostic imaging
Rotherham NHS Diagnostic Centre	Diagnostics	X-ray, ultrasound, bone density (DXA), echocardiogram

Additional services	Facilities	Specialties
Buckinghamshire Musculoskeletal Integrated Care Service	Diagnostics, physiotherapy	Musculoskeletal services – orthopaedic, pain, rheumatology
East and West Lincolnshire Musculoskeletal Clinical Assessment and Treatment Service	Diagnostics, day patients , physiotherapy	Musculoskeletal services - extended scope physiotherapy (enhanced), lifestyle advice and management, soft tissue and joint injections, ultrasound guided injections, MRI scans, ultrasound, X-ray, EMG nerve conduction studies (non-complex), pathology, back pain management service.
Greater Manchester Clinical Assessment and Treatment Service **TO BECOME NORTH WEST NHS CATS**	Diagnostics, day patients	Musculoskeletal services (lower limb, upper limb and spinal), physiotherapy, ENT, gastroenterology, endoscopy, minor procedures, gynaecology and urology
Rochdale Ophthalmology Clinical Assessment and Treatment Service	Day patients	Ophthalmology
Cirencester Community Hospital Outreach Clinic (AGW)	Outpatient appointments	ENT, general surgery, joint replacements, gynaecology and minor orthopaedic surgery.
Lincolnshire Musculoskeletal Pain Assessment and Treatment Service	Diagnostics, musculoskeletal, physiotherapy	Neck pain, thoracic pain, low back pain with or without sciatica, sacroiliac joint pain (SIJ), upper/lower limb pain of musculoskeletal origin, exacerbation of osteoarthritis or other chronic joint condition that will benefit from time limited therapy, acute soft tissue injury, pregnancy with symphysis pubis pain. pain (SIJ), upper/lower limb pain of musculoskeletal origin, exacerbation of osteoarthritis or other chronic joint condition that will benefit from time limited therapy, acute soft tissue injury,
Royal South Hands Minor Injuries Unit	Walk-in service	Minor injuries
St Mary’s Minor Injuries Unit	Walk-in service	Minor injuries and illnesses

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Solent NHS Trust – Quality Account 2015/16

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PART 1: Our Commitment to Quality

1.1 Chief Executive's Welcome

Welcome to our Quality Account for 2015/16. Each year all providers of NHS healthcare services are required to produce an annual Quality Account for publication. I am pleased to have this opportunity to share information on the quality of the services we deliver, the improvements and progress we have made over the past year, and some of our key strategic plans for next year.

Insert full Exec intro

Our focus in 2016/17 will remain on delivering high quality and timely care that improves outcomes. The 'Statement of Directors Responsibilities' at Annex X summarises the steps we have taken to develop this Quality Account and external assurance is provided in the form of statements from our commissioners, local Healthwatch organisations and Joint Scrutiny Committee. The content of this report has been reviewed by the Board of Solent NHS Trust therefore on behalf of the Board and to the best of my knowledge; I confirm the information contained in it is accurate.

Sue Harriman
Chief Executive Officer

1.2 Quality Assurance

DRAFT

As an organisation that seeks to continually improve, we have taken and will continue to take steps to quality assure our current activities in order to maximise the service user experience. Our Trust Board hold ultimate accountability for the quality of services provided by the Trust. In order to ensure that there is a robust quality assurance operating, the Board has established a sub-committee (the Assurance Committee). The Assurance Committee is chaired by a Non-Executive Director and includes other Trust Board members, lead clinicians from all clinical services and corporate leads with responsibility for risk and quality management.
Trust Board members have continued to participate in visits to clinical services which are known as 'Board to Floor' visits. This provides board members with opportunities to triangulate evidence, speak to service users and staff about their experience and to ensure that there is an open and transparent culture within the Trust.

Visits have taken place to the following areas in 2015/16:

Insert visit list

And improvement actions taken following visits (Kathy Providing)

We have also developed a programme of Mock CQC Visits to determine how we rank against the Key Lines of Enquiry and act on information from CQC Intelligent Monitoring.

The Executive team have considered intelligence gathered from a variety of sources including:

- Quality Account Priorities
- Contractual performance indicators from Quality contract
- Commissioning for Quality and Innovation (CQUIN)
- Trust Development Authority (TDA) targets
- CQC intelligent monitoring
- Patient Surveys and feedback
- Staff surveys and feedback
- Quality and Risk reports (Clinical Governance) including incidents, complements and complaints
- Quality Impact Assessment (QIA)monitoring
- Corporate Governance reports -Board Governance Assurance Framework (BGAF) and Quality Governance Assurance Framework (QGAF)

Need comment to finish this off e.g. How we performed and what we have done. Suggest this is where we discuss safe staffing?

DRAFT

1.3 Equality

Underpinning the delivery of the commitments set out in this Quality Account – in particular, the five quality improvement priorities identified in Part 4 – will be an on-going focus on promoting equality. We will aim to improve the quality of service, access and outcomes for service users of all protected equality characteristics. This is a fundamental operating principle for our organisation and examples of how we will continue to achieve this in 2015/16 include:

- Strengthening the data collection of protected characteristics of our patients and people who use our services
- Benchmarking our equality performance against key priority areas within the NHS Equality Delivery System 2
- Undertaking equality impact assessments on all business cases, plans and policies to ensure that the meet the needs of, and do not disadvantage service users or staff of any protected characteristics

To ensure that we have considered the implications of this Quality Account on specific groups, and acted on all opportunities to promote equality, we have undertaken an Equality Impact Assessment. The outcomes of this assessment are attached as Annex ?. Annex ? highlights those quality improvement measures that address specific needs relating to protected characteristics and confirms that no discrimination has been identified.

1.4 A Year of Achievements

1.5 TBC

PART 2: Statements of Assurance from the Board for 2015/16

This section of our Quality Account includes mandated information that is common across all organisations' Quality Accounts. This information demonstrates that we are

performing to essential standards; measuring clinical processes and performance; and are involved in national projects and initiatives aimed at improving quality.

2.1 Review of Services

We are a specialist provider of community and mental health services with an annual revenue of £xxxm for 2015/ 16, with a workforce in excess of XXXX staff and delivering over X.x 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, 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.

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 services are grouped into three clinical care groups: Portsmouth Care Group, Southampton Care group and County Wide Care Group.

During 2015/15 Solent NHS Trust provided and/or sub-contracted a wide range of relevant health services. More detail on the services provided by us can be found on our website http://www.solent.nhs.uk

We have reviewed all the data available on the quality of care in all of these services. The data reviewed has covered the three dimensions of quality (clinical effectiveness, safety and patient experience), ensuring that this Quality Account presents a rounded view of the quality of services provided. We hope that this will enable readers to gain a clear and balanced understanding of what quality means to us.

Insert examples of Services (for example- needs editing by service)

1. *Integrated Community Teams* *The Trust's Integrated Community Teams bring together occupational therapists, social workers, physiotherapists, community nurses and support workers into single teams, who work closely with local GPs and provide care to service users at home or close to home. As such, these Integrated Community Teams help people to be in control of their choices, and to maintain their independence safely and appropriately. Teams are focused on:*

- *Reducing unnecessary hospital admissions;*
- *Caring for people where they recover best- at home, wherever possible;*

A number of the Integrated Community Teams also provide access to a rapid response service, which operates 24 hours a day, 7 days a week, in order to provide assessment in the home for people who require urgent care within an hour and therefore avoid the need for hospitalisation;
Insert case study

2.2 Participation in Clinical Audits and National, Confidential Enquiries

Clinical Audit

During 2015 – 2016, 21 national clinical audits and 2 national confidential enquiries covered health services that Solent NHS Trust provides. During that period Solent NHS Trust participated in 100% of the national confidential enquiries and 100% of the national clinical audits which we were eligible to participate in.

The national clinical audits and national confidential inquiries that we were eligible to participate in during 2015 – 2016 are as follows:

Eligible National Clinical Audits /National Confidential Inquiries	Participated
National Confidential Inquiry into Suicide and Homicide	Yes
Mental Health CQUIN audit: Improving physical healthcare to reduce premature mortality in people with severe mental illness (Indicator 4a)	Yes
National Chronic Obstructive Pulmonary Disease (COPD) Pulmonary Rehabilitation Organisational Audit	Yes
National Chronic Obstructive Pulmonary Disease (COPD) Pulmonary Rehabilitation Clinical Audit	Yes
Prescribing Observatory for Mental Health Quality Improvement Programme audit: Prescribing Valproate for bipolar disorder	Yes
Prescribing Observatory for Mental Health Quality Improvement Programme audit: Prescribing for ADHD in children, adolescents and adults	Yes
Prescribing Observatory for Mental Health Quality Improvement Programme audit: Prescribing for people with learning Disabilities	Yes
End of Life Care: Dying in Hospital	Yes

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National Confidential Enquiry into Patient Outcomes and Deaths Sepsis Study	Yes
National Audit of Intermediate Care	Yes
National Audit of Cardiac Rehabilitation	Yes
National Paediatric Diabetes Audit	t.b.c.
National UK Parkinson's Audit	t.b.c.
National Diabetes Footcare Audit	t.b.c.
Sentinel Stroke National Audit	Yes
Management of under 16's in sexual health clinics	Yes
Partner notification for HIV infection	Yes
Routine monitoring of adults with HIV infection	Yes
Management of Gonorrhoea	Yes
NCEPOD Chronic Neurodisability study	Registered
NCEPOD Young People's Mental Health	Registered

The national clinical audits and national confidential inquiries in which we participated, and for which the data collection was completed in 2015 – 2016, 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.

Eligible National Clinical Audits /National Confidential Inquiries	**Percentage Number of Cases Submitted**
National Confidential Inquiry into Suicide and Homicide	100%
Mental Health CQUIN audit: Improving physical healthcare to reduce premature mortality in people with severe mental illness (Indicator 4a)	100%
National Chronic Obstructive Pulmonary Disease (COPD) Pulmonary Rehabilitation Organisational Audit	n/a
National Chronic Obstructive Pulmonary Disease (COPD) Pulmonary Rehabilitation Clinical Audit	100%
Prescribing Observatory for Mental Health Quality	100%

Improvement Programme audit: Prescribing Valproate for bipolar disorder	
Prescribing Observatory for Mental Health Quality Improvement Programme audit: Prescribing for ADHD in children, adolescents and adults	100%
End of Life Care: Dying in Hospital	100%
National Audit of Intermediate Care	100%
National Audit of Cardiac Rehabilitation	t.b.c.
National Paediatric Diabetes Audit	t.b.c.
National UK Parkinson's Audit	t.b.c.
National Diabetes Footcare Audit	t.b.c.
Sentinel Stroke National Audit	t.b.c.
Management of under 16's in sexual health clinics	t.b.c.
Partner notification for HIV infection	t.b.c.
Routine monitoring of adults with HIV infection	t.b.c.
Management of Gonorrhoea	t.b.c.

The reports of xx national clinical audits were reviewed by Solent NHS Trust in 2015 – 2016, via our service line governance structure.

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The reports of xx clinical audits were reviewed during 2015 – 2016. Examples of these and some of the actions we intend to take to improve the quality of healthcare are shown below:

Service Line	Audit Title	Actions taken to improve the quality of healthcare
Child and Family	Usage and monitoring of antipsychotic medication prescribed in children and adolescents in the Orchard Centre 2015	• Better documentation of substance misuse. • To improve monitoring and documentation of pre-treatment screening parameters. • To improve monitoring and documentation of movement disorders. • To ensure all patients on antipsychotic medication are reviewed every 6 months. • To improve monitoring and documentation of physical and biochemical parameters every 6 months. • To maintain the good work in all areas where 100 % target was achieved
	Safer Sleep	• To feedback audit results at citywide forum and at monthly team brief. • To amend 6-8 week contact template to include a prompt to record discussed.
Adult Services Portsmouth	Re-audit of NICE guidance relating to Documentation at Memory Clinics	• GP letter will be sent within 14 days of first patient contact • Letters will include lead professional/ care coordinator • Letter proformas will be used • Records entry will be made within 1 day of contact
	The Learning Disability POMH audit	To follow
Adult Services Southampton	Falls Audit	• Staff training on issues and sharing audit results with them via the governance groups and staff forums • Further improvements in the falls assessment process • More consistent screening for patients admitted to our caseloads
	National Audit Chronic Pulmonary Obstructive Disease (COPD)	• Offer a comprehensive variety of exercise facilities and other activities to engage the patient in a more active, social and quality-filled life • Ensure a more efficient seamless transfer from in-patient to out-patient service. • Achieving 2 practice tests therefore falling

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		in line with best practice • To clarify to the patient more succinctly what exercise regime they have agreed to undertake post PR
Primary Care	StartBack Audit	• Education around the management of patients psychosocial factors • Engagement/ education of GP's • Physiotherapists departments only accept patient referrals with completed STarT Back scores • Reception continue to hand out any necessary patient questionnaires • Devise a questionnaire for patients that drop out/DNA to assess whether their symptoms improved or treatment wasn't what they expected/ wanted
Adult Mental Health Services	Improving physical healthcare to reduce premature mortality in people with severe mental illness	To follow
Specialist Dental Services	Recording Parental Consent	• Parental Consent paperwork to be included in new patient paperwork at first clinic appointment • All child patients should have a record made of who can give parental consent in the Parental consent field on R4 • Reminder to staff included in monthly dental newsletter. • Receptionists will include parental consent paperwork with new patient paperwork at first appointment and to follow up the recording of details
Sexual Health Services	Partner Notification for adults newly diagnosed with HIV infection British HIV Association National Audit 2014	National Recommendations • All clinical services should review their results carefully and strive to improve PN completion for HIV. • PN efforts should focus on ex -regular and casual known as well as regular contacts. • Clinical services should not apply a fixed time limit after which to stop addressing unresolved PN. Local Recommendations: • Recommend PN is followed up at each appointment for the first year at diagnosis, and again each time sexual history is reviewed (at least annually).

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2.3 Participation in Clinical Research

Research & Development:

The number of patients receiving NHS services provided or sub-contracted by us in 2015/16 that were recruited during that period to participate in research approved by a research ethics committee was 1645. We have recruited to 40 studies on the National Institute of Health Research portfolio across a range of services. Solent NHS Trust continues to be at the top of the National League tables for research activity in Care Trusts.

Clinical impact from research:

Research is about improving patient care, treatment and clinical outcomes. Often, participating in research gives those that use our services access to novel treatment that they would not have had as part of normal care. Patients and staff also benefit from being involved in treatment based on the latest evidence and from contributing to improving what we know about conditions. Our aim is to give as many of our patients and staff as possible, the opportunity to participate in research. We also work in partnership with local Universities and Health Education England (Wessex) to offer a clinical academic training programme and career pathway for our clinicians, and strive to ensure that those that use our services are involved in all of our research activity and priority setting.

Suggest the following is done in boxes/ case studies?

Solent Care Home Research Partnership (CHRP)

We have developed a research partnership with care homes to open up access to clinical trials to residents, their family and staff. The benefits of conducting research in care homes have been numerous; improved knowledge, improved training for staff and bringing local care homes together to improve the quality of life for their residents. One key study has been investigating ways to deal with agitation amongst those with dementia in care home settings. Irene, one of the care home managers, has said:

> *"We are passionate about improving the quality of life of our residents but also about improving the lives of all those living with dementia. We feel by taking part in research that we are learning at the same time as contributing to all those people."*

Christopher's Research Story:

Christopher is a retired computer programmer from Southampton. Over the years he has enjoyed travelling the world for both work and for pleasure. In February 2013 Christopher was diagnosed with Parkinsons Disease.

Christopher has a constant thirst for new knowledge, and since his diagnosis he has signed up take part in a number of research projects. Recently he has been involved in the PDSafe trial. This project is investigating whether a tailored home based exercise programme,

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carried out with the support of a physiotherapist, can help improve balance and strength and reduce falls in people with this condition.

Since being involved in the trial Christopher has started walking confident enough to travel again and has recently been on holiday to Iceland and walked up a glacier – in his words: "Parkinson's or not I am going up that glacier!". Christopher thoroughly enjoyed his experience of being involved in PD Safe, stating that "being involved in the research was good for me" and is aware that he would not have ordinarily received the same therapy.

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Mary's Research Story:
Mary is one of our patient research ambassadors – and she tells her story:
"Roger, my husband, a retired airline pilot was diagnosed with vascular dementia in March 2014. Between October 2010 and September 2015 I had met him, married him, cared for him and I am now his widow. I made up my mind from the onset of the diagnosis that our life was going to be normal; dementia would live with us not rule our lives. The more his caring needs increased the more I was determined to fight it. But slowly it etched away at our lives; he became a different person, unable to live a normal life relying entirely on my support. This however, gave me the drive to support research teams into finding a cure.

As a carer, my belief was that numerous campaigns highlighting the illness never showed the real picture, I wanted to be able to have an involvement in getting the "raw" message out into the public domain so it could be fought and research was top on the agenda. I started by participating in research – the first was a genetic study on Systemic Inflammation in Dementia. I was proud to be helping in some small way.

When Roger passed away I became even more passionate to support research and generate interest in its studies. I want to be able to encourage people to understand that unless a cure for this illness is found it will destroy future generations. As my story portrays it does not discriminate, it can suddenly strike and life changes for ever for the sufferer and their family. By talking of my experience I hope I can encourage others to realise research into the cause, diagnosis and treatment can and is happening but only with ongoing support and resources.

Clinical Academic Career Pathway:
We have a clinical academic career pathway in which our clinicians can work in joint roles, seeing patients in clinics, working with Universities to carry out research and supporting the development of other staff to deliver care based on the best evidence. We have a variety of roles, from short internships, to clinical academic doctorates, and senior post-doctoral specialists.

Lindsay Cherry is a specialist podiatrist who splits her time between her clinical work and academic work. Her academic role is based at the University of Southampton, and involves research and teaching. Her clinical role is based in the our community clinics and a specialist multi-disciplinary team who care for patients with complex foot health problems. Her clinical role aims to prevent deterioration in foot health, hospital admissions, amputations or loss of life. Being based in a clinical team means that Lindsay can understand patient needs, where gaps are in care and what questions the research needs to address. She says it helps her 'understand the real world possibility of the solution that the research suggests' and also keeps her up to date on the best diagnostic and treatment options.

Lindsay supports a number of improvement projects across her service, and is supporting more junior staff to get involved in research. She also has a patient and public partnership group who work with her on service development, and sits on national advisory groups for foot health guidelines and research. The specialist service is currently being considered for Centre of National Excellence Status.

2.4 Commissioning for Quality and Innovation (CQUIN)

A proportion of Solent NHS Trusts income in 2015/16 was conditional upon achieving quality improvement and innovation goals agreed between GMW 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 (CQUIN) payment framework.

- For 2014/15 the value of the CQUIN payment was £XXXXX
- For 2015/16 the value of the CQUIN payment was £XXXXX

We are pleased to report that we have achieved XXX% of our agreed CQUIN schemes for 2015/16 which is a reflection of the hard work of staff across the organisation. We would like to take this opportunity to say 'thank you and well done' to everyone involved.
The CQUIN scheme agreed with our CCG commissioners for 2015/16 is detailed below:

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CQUIN Status Summary - 15.02.16

CQUIN Status Summary - East Contract	CQUIN Value		Status Summary											
			Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Local														
Heart Failure	£150,700	ECQ1	80%	80%	57%	80%	80%	86%	100%	80%	71%	100%		
In-Reach	£301,396	ECQ2	100%	33%	100%	100%	100%	100%	100%	100%	100%	0%		
Respiratory	£150,700	ECQ3	84%	84%	80%	89%	89%	100%	84%	89%	95%	74%		
Adult Mental Health	£242,320	ECQ4			50%			50%			50%			
Mental Health Safety Thermometer (MHST) - AMH	£50,000	ECQ5A			80%			60%			100%			
Mental Health Safety Thermometer (MHST) - OPMH	£71,959	ECQ5B			90%			100%			100%			
Funding Without Measures	£112,655													
National														
Cardio Metabolic Assessment and Treatment for Patients with Psychoses	£55,680	ECQ6			100%						100%			
Funding Without Measures	£407,068													
Total:	**£1,542,478**													

CQUIN Status Summary - West Contract	CQUIN Value		Status Summary											
			Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Local														
Stroke Six Month Reviews	£50,025	WCQ1						88%	0%	100%	100%	100%		
Falls and Bone Health	£268,673	WCQ3			100%			100%			100%			
Person Centered Planning (PCP)	£268,673	WCQ4			100%			50%			100%			
National														
Urgent Care	£115,146	WCQ5	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
Dementia	£115,146	WCQ6	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
Total:	**£817,661**													

CQUIN Status Summary - NHS England Contract	CQUIN Value		Status Summary											
			Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Local														
Embedding quality systems in HIV Networks	£32,693	NH1			100%			50%						
HIV: reducing unnecessary CD4 monitoring	£32,693	NH2												
Health Visiting Solent East	£48,600	NH3			100%			88%			100%			
Health Visiting Solent West	£51,325	NH4			100%			88%			100%			
Child Health Information Services	£17,884	NH5	100%	100%	100%			100%			75%			
Total:	**£183,195**													

2.5 Registration with the Care Quality Commission (CQC)

Solent NHS Trust is required to register with the Care Quality Commission (CQC) and its current registration status is 'registered without conditions'.

The Care Quality Commission has not taken enforcement action against Solent NHS Trust during 2015/16.

Solent NHS Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2015/16.

- Insert Solent NHS Trust has participated in thematic reviews in XXXX

The following or no compliance actions or requirements were identified by the CQC as an outcome of these reviews.

- Insert all MHA compliance visits

The reports from these Mental Health Act monitoring visits found that xxxx of areas for improvement identified on previous visits had been addressed. Any further identified areas for improvement have been addressed through action plans within the provider action statements submitted by the Trust to CQC after each visit. A system for monitoring progress on these action plans is in place. Further information about the visits can be found at www.cqc.org.uk/provider/R1G

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In March 2014 Solent NHS trust was selected as one of a range of trusts to be inspected under CQC's revised inspection approach to mental health and community services. Although as a pilot site we did not receive a formal rating for this inspection the inspectors reported that our services were Safe, Caring, Effective, Responsive and Well led. A copy of the full report can be accessed at;
www.cqc.org.uk/sites/default/files/new_reports/AAAA0657.pdf
We have been notified by The care Quality Commission that they will be visiting again to inspect the Trust at the End of June this year (2016) we are looking forward to this visit and to receiving our first formal rating under the new inspection process.

2.6 Data Quality

We recognise that high quality patient information promotes the speedy and effective delivery of patient care and that accurate and timely management information, derived from patient data, is essential to the planning and delivery of service improvements.

Check mandated statements and request info

2.7 Information Governance

Solent NHS Trust has completed the Information Governance Toolkit Assessment as a Mental Health Trust for the period April 2015 - March 2016 and is compliant with all 45 requirements, having attained 73% compliance, which has been graded as Green - Satisfactory.

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.

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

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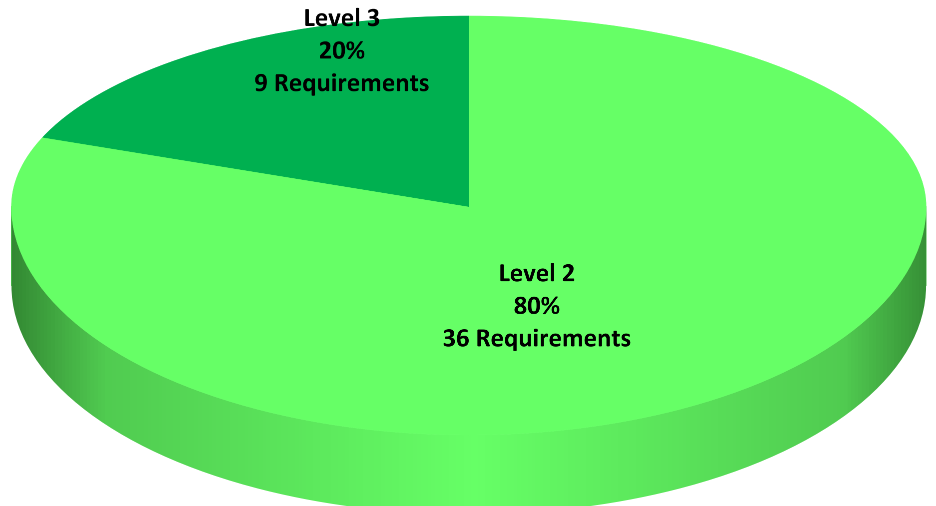
- the international information security standard: ISO/IEC 27002: 2005
- the Information Security NHS Code of Practice
- the Records Management NHS Code of Practice
- the Freedom of Information Act 2000

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.

Information Governance Toolkit V10 Summary Report for 2015/16
As of the 31st March 2016 Solent NHS Trust had achieved a Level 2 or above in all requirement areas, as mandated by the IG Toolkit.

A breakdown of the Trust's compliance is provided below;



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).
- Confidentiality and data protection.
- Information security.

IG Toolkit Category	Compliance Level
Information Governance Management	80%
Confidentiality and Data Protection Assurance	81%
Information Security Assurance	66%
Clinical Information Assurance	80%
Secondary Use Assurance	66%
Corporate Information Assurance	77%
Total	73%

Freedom of Information
(FOI) requests 2015/16
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 2014/15 in:

- Ensuring all requests relating to Solent NHS Trust 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 two 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 2015/16 for the period 1 April 2015 – 31 March 2016 Solent NHS Trust received a total of 215 FOI requests. The time frame for responding to FOI requests is 20 working days. As of the 8th April 2016, eight requests are currently not due. Solent NHS Trust's current compliance level is 92.3% compliance in 2015/16, with a total of 16 requests breaching.

Subject access requests / Access to records requests 2015/16
Responding to Data Protection Act 1998 Requests
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.

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- Department of Work and Pensions.
- Other Health Care Provides.
- Mental Health Tribunals.

In 2015/16 for the period 1 April 2015 – 31 March 2016 Solent NHS Trust received and complied with 871 requests to access information from the categories above. As of the 8th April 2016 84 requests are currently not due. Solent NHS Trust's current compliance level 84% compliance (to date) with the mandatory timeframe in 2015/16. Solent NHS Trust will continue to provide awareness of this requirement and the importance of time frames throughout the Trust and will review processes and practices to ensure an increased level of compliance.

2.8 Clinical Coding

Check mandated statements and request info

2.9 Department of Health Mandatory Quality Indicators

We have reviewed the required core set of quality indicators which Trusts are required to report against in their Quality Accounts and are pleased to provide you with our position against all indicators relevant to our services for the last two reporting periods (years).

2.9.1 Preventing People from Dying Prematurely - 7 Day Follow-Up

The data made available with regard to the percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care.

Insert Table

CPA 7 day follow up last two years,

2.9.2 Enhancing Quality of Life for People with Long-term Conditions – Gatekeeping

The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period

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Insert Table

2.9.3 Ensuring that People have a Positive Experience of Care – Readmissions:

The percentage of patients aged (i) 0 to 15 and (ii) 16 or over readmitted to a hospital which forms part of the trust during the reporting period 2015/16.

Insert data

2.9.4 Ensuring that People have a Positive Experience of Care – Staff Survey

Insert Table

'If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation' two years data

2.9.5 Ensuring that People have a Positive Experience of Care – Community Mental Health Patient Survey

The Trust's 'patient experience of community mental health services' indicator score with regard to a patient's experience of contact with a health or social care worker
To determine our performance against this indicator, we have calculated the mean score achieved against the following four questions in both the 2014 and 2015 NHS Survey of people who use community mental health services:
Insert data

2.9.6 Ensuring that People have a Positive Experience of Care – Friends and Family Test (FFT)

FFT report from Ann

2.9.7 Treating and Caring for People in a Safe Environment and Protecting them from Avoidable Harm – Patient Safety Incidents

The number and, where available, rate of patient safety incidents reported within the Trust, and the number and percentage of such patient safety incidents that resulted in severe harm or death

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Insert Table
Then

- External Reporting
- Review and Lessons Learned
- Board to Floor
- Duty of Candour
- Continually improving incident reporting and maintaining our culture of learning

2.10 Duty of Candour

Duty of Candour is a contractual duty under the Health and Social Care Act 2014 which requires Trusts to ensure that patients/families are informed of incidents causing moderate, severe harm or death and then provided with support. This includes receiving an apology, as appropriate, the investigation findings and actions to prevent recurrence are shared

Duty of Candour requires support of patient safety and quality improvement process through clinical governance frameworks to ensure lessons are learned. Accountability through the Chief Executive to the Trust Board ensures implementation of changes and effectiveness reviews. Findings should be disseminated to staff to facilitate learning. Establish practice-based systems, continuous learning programmes and audits to monitor implementation and effects of change.

Solent NHS Trust encourages all groups of independent contractors to adopt the policy of duty of candour with patients following adverse events, particularly when patients are harmed.

The Trust is committed to fulfil its obligation around 'Duty of Candour' by communicating with patients, their relatives and carers about any failure in care or treatment, whether they be the results via a

- Patient Safety Incident (PSI)
- Complaint
- Claim

There is a policy in place to support staff to meet this requirement and training has been provided. Compliance and effectiveness is monitored by the Claims and Legal Services manager additionally there is a planned audit using an appropriately sampled population.

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PART 3: Review of Quality Performance in 2015/16

3.1 Delivery of Quality Account Priorities for Improvement in 2015/16

We have made significant progress against all 8 of our 2015/16 Priorities for Improvement. Summaries of our key achievements are detailed in this section. Each achievement reflects the commitment of our staff, service users and carers to continually improving quality.

	Priority	Measures for Success	What we achieved
	This describes the aim of the Priority we set for 2015/16	This details the goals we set to measure how well we delivered against this priority	This is what we delivered
1	Implementation of a Quality Improvement Programme which enables delivery of the Trust Quality Improvement Plan through development of quality improvement skills within Service Lines. Particular focus will be given during 2015/2016 on improving handover and transfer of care working through the Wessex Patient Safety Collaborative	• A reduction against baseline from 2014/2015 in complaints associated with discharge and transfer of care. • A reduction against the end position reported for 2014/2015 overall the number of pressure damage incidents whilst in Solent care. • An increase in the number of joint investigations/reviews undertaken when things go wrong or issues are raised (SIRI/HRI investigations). • An increase in the numbers of patients/service users providing positive feedback about their experience of care as measured against the 2014/2015 baseline. • An increase in staff reported confidence in quality improvement skills and knowledge. The baseline position will be captured during Q1 of	• Teams from both Southampton and Portsmouth participated in the Wessex Patient Safety collaborative Programme focussing on improving handover and transfer of care. (see the example on table XXX) • Significant work has been undertaken to improve the management of Pressure Ulcers within the Trust. • The Pressure Ulcer Steering group has been reviewed and the Terms of reference refreshed. • The historical back-log of pressure ulcers has been cleared with xx% closed to the satisfaction of our commissioners. • Processes now enable identification of who the main care provider is, therefore enabling joint investigations and reporting to take place. • Staffing shortages have prevented us from

	Priority	Measures for Success	What we achieved
		2015/2016 to enable measurement for improvement by end of 2015/2016.	achieving as much progress as desired in relation to staff confidence in improvement skills and knowledge, therefore this priority will be reviewed to continue in part for the new financial year.
2	Development and implementation of agreed acuity and dependency tools for use by the Trust District Nursing Teams and in-patient teams as appropriate to the speciality to support Safe Staffing in line with national requirements.	• An agreed tool for use in District Nursing teams will be available and piloted in all relevant teams across the Trust. • A mechanism to enable monthly reporting on safe staffing (nursing) within District Nursing teams will be established and teams will report monthly. • Acuity and dependency in District Nursing teams will be articulated in discussions with Commissioners. • Nurse staffing related incident reports will reduce. • Acuity and dependency tools will be used in all in-patient wards and outcomes reported through service-line governance arrangements.	• Much work has been undertaken to research what is being used within other NHS organisations, which included reviewing NHS England –Community Nursing Workforce Planning – Scoping Exercise March 2015, which had reviewed 5 organisations who had implemented acuity and dependency tools. This work was being undertaken across both Portsmouth and Southampton Community Nursing teams. • Benchmarking of how service delivery is undertaken in Portsmouth and Southampton. • A team of senior community nurses also visited the Isle of Wight to review their acuity and capacity tool. • In May 2015 - working group formed in response to the need for the "the right staff, with the right skills in the right place" (NHS England 2012). The work of this group continues.
3	Implementation of the Trust Patient Experience Framework with the aim of improving levels of patient/service user feedback ensuring the 'You Said- We Did' approach is visible in all clinical areas where Solent NHS Trust	• FFT uptake rates will improve and be sustained in line with the agreed Quality Schedule. • Formal complaints about poor patient experience of care will reduce when measured against the 2015/2015 baseline. • Instances of local resolution of concerns will increase and the requirement for 2nd responses	• The FFT is available across all service areas and feedback is reviewed at trust overall level and service level. The majority of feedback is positive and complimentary but where indicated improvement plans implemented. • You said we did posters are provided for services for display where appropriate. There are some

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	Priority	Measures for Success	What we achieved
Page 194	provides care.	to complaints will reduce. • Plaudits received by services will increase local target will be agreed with service lines.	examples of good practice but this is an area we want to build upon next year.The number of complaints received by the PALs and Complaints Service has seen a reduction over the last year (3.5% down). • Services are being actively encouraged to resolve complaints locally, and this has meant an increase in the overall figure for the corresponding period (11% up) • The number of second responses has remained low, however it has not been possible to demonstrate a reduction. • Unfortunately there has been a reduction in the number of plaudits received (4.5%) however, this may possibly be because other forms have feedback, such as FFT are being actively promoted.
4	Embedding of the Accessible Information Standards due to be issued in June 2015 through the provision of the infrastructure required to comply with the standards. This work will bring focus to inclusion and shared decision-making.	• An improvement in the number of patients/service users and carers who confirm that our information is in an acceptable format for them. (A feedback questionnaire will be used). • Accessible Information champions in all Service Lines identified. • Complaints relating to poor communication will be reduced.	**Please refer to section XX for a full review of the years progress** • Sharing local evidence and knowledge relating to AI practice • Facilitating inclusive patient feedback on the draft standards, as summarised in a national publication XXXXXX • Contributing to NHS England's national implementation event. • Within the Trust, developments relating to AI have been achieved through the Health Education England (Wessex) funded project, led

	Priority	Measures for Success	What we achieved
Page 195			by Dr Clare Mander. This project aims to develop and pilot a tiered model of AI training. The project milestones are summarised below; • The development of a co-produced/co-designed 'Accessible Information Awareness DVD' with patients living with AI needs (Tier 1). The DVD is currently available on the Trust website see www.solent.nhs.uk/AI. It has been recognised nationally as best practice and is already in use within other Trusts across the UK. • Hosted a regional AI support event in December 2015 aimed at launching the awareness DVD and exploring a joined-up approach to supporting individuals with AI needs across organisations in the local area; in line with the new national standards. • Exploratory work with two services in Solent NHS Trust (one integrated community rehab team and one in-patient unit) to develop a self-directed learning and resource packs relating to embedding AI into practice (Tier 2).
5	Implementation of the Carers Framework so that the Trust can demonstrate compliance with the requirements of the Care Act.	• Positive feedback on carer experience of interaction with the Trust/Trust services will be captured (through FFT mechanisms). • Carers will report feeling appropriately engaged in the development and delivery of care.	• We have worked in partnership with Portsmouth City Council and Portsmouth CCG to develop Portsmouth Carers Strategy 2015-2020 and have identified specific priorities for Solent in relation to identification of carers, awareness training of our staff and signposting carers for support. • We continue to work in partnership with Carers in Southampton on the development of their strategy.

	Priority	Measures for Success	What we achieved
			• Carers are offered the opportunity to respond to the Friends and Family Test (I will get some data to add). • We gave the public including carers the opportunity to give feedback on out Patient Experience Strategy which includes priorities for carers.
6	Promotion of National Standards for End of Life Care, ensuring that patients and carers choice is recognised and facilitated to ensure that a positive outcome is achieved as measured by those directly involved.	• No complaints about the carer experience of End of Life care provided by the Trust. • Increased plaudits acknowledging the care provided by the Trust. • Confirmation of achievement against recognised best practice. • Audit of performance against the 5 priorities of care will evidence progress.	• There has been 1complaint about the carer experience of End of Life care provided by the Trust which is an improvement on the previous year. • The number of plaudits receive is xxxxxxxxxxxx • A group was established to lead this work within the trust. • New end of life care prescription charts have been developed are now available for use in Southampton and Portsmouth. Training can be accessed by staff that need to use these charts. • An audit tool has been developed and has been in use in Quarter 4 (Jan-Feb 2016), the findings of this audit will be reviewed and shared in due course.
7	Enhance governance arrangements from Ward to Board through refreshed Clinical leadership development and the launch of both nursing and AHP strategic frameworks focused on professional standards and practice.	• The Nursing Strategic Framework will be developed and launched. • The AHP Strategic Framework will be developed and launched. • All staff will be able to confirm their professional lead and be clear about the reporting arrangements within their Service Line and beyond as appropriate to role. This will be measured through staff reported experience,	• The Nursing Strategic Framework has been written by nurses in the Trust and is ready for launching. • The AHP Framework has been written by AHPs in the Trust and is ready for launching. • Work has taken place within services to clearly identify professional reporting lines. There is still more improvement needed. Need to add re the staff survey here

	Priority	Measures for Success	What we achieved
		questionnaires and the staff survey. • Nursing and AHP job descriptions will be reviewed, updated and consistent across the Trust. • Single competency frameworks will be developed for Nurses and AHPs.	• Job descriptions have been reviewed and a standard format has been piloted within the Children and Families Service for roles which were being advertised for recruitment. • Work has progressed on the competency frameworks, this work will continue into the new financial year.
8	Deliver an audit programme linked to care improvements, quality standards and NICE guidelines whilst working with Commissioners on the development of outcome focused service specifications aligned to national community indicators.	• Examples of improvements to clinical care as demonstrated via the audit process. • Dashboards for community indicators which highlight the quality and safety of our care in a quantifiable way will be in place. • An audit plan will be in place and compliance against the plan monitored and reported.	• Every service line develops their own audit plan in response to areas of concern, NICE guidelines requiring review, improvement priorities etc. Reports on completion are generated centrally for local teams to review progress against the plan each month at service line audit groups and care group governance groups. Progress is reported to the Trust Assurance Committee quarterly and the Audit and Risk Committee every six months. • Audits are also monitored for areas where learning or good practice can be applied to other areas within the Trust and shared via the Trust Clinical Audit and Service Evaluation Group. Examples of improvements as a result of the clinical audit process can be found in table xx • Dashboards that include community indicators are operational in some clinical areas. The project has been delayed by the phased implementation of a new Electronic Patient Record – the dashboards will now include quality indicators, clinical outcomes and patient reported outcome measures.

3.2 Spotlight on Accessible Information (Priority 4)

Accessible Information (AI)

2015 saw the launch of the new NHS England Accessible Information Standard, which Solent NHS Trust contributed to. Our contribution consisted of;

- Sharing local evidence and knowledge relating to AI practice
- Facilitating inclusive patient feedback on the draft standards, a summary of this work was published in the national journal XXXXXXXXXXX
- Contributing to NHS England's national implementation event.
-

Within the Trust, developments relating to AI have been achieved through the Health Education England (Wessex) funded project, led by Dr Clare Mander. This project aims to develop and pilot a tiered model of AI training. The project milestones are summarised below;

- The development of a co-produced/co-designed 'Accessible Information Awareness DVD' with patients living with AI needs (Tier 1). The DVD is currently available on the Trust website see www.solent.nhs.uk/AI. It has been recognised nationally as best practice and is already in use within other Trusts across the UK.
- We hosted a regional AI support event in December 2015 aimed at launching the awareness DVD and exploring a joined-up approach to supporting individuals with AI needs across organisations in the local area; in line with the new national standards.
- We have undertaken exploratory work with two services in Solent NHS Trust (one integrated community rehab team and one in-patient unit) to develop a self-directed learning and resource packs relating to embedding AI into practice (Tier 2).
-

Additional developments outside of the AI project;

- Embedding AI as a regular topic on the Patient Experience Forum
- Exploration of AI reporting requirements on the Clinical record system used within the Trust.
- National publication of local developments – two peer-reviewed publications relating to AI research in the field of adult learning disability, a conference presentation relating to medic's revalidation and our inclusive patient feedback approach.

It doesn't stop here! Below are a number of sequential objectives that need to be achieved in order to meet the national standards and to continue to consolidate previous best practice;

- Recruit a Thematic Lead for AI
- Ensure that all staff has basic AI awareness training – achieved by making the 'Accessible Information Awareness DVD' mandatory training on e-learning

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- Ensure that a new AI template is added to System 1 with an alert to prompt staff to complete. The template will be informed by an AI screen that is been developed and piloted through the AI Training Project. Once embedded into practice, a 6 month follow-up audit and AI needs analysis to be completed using data from the templates
- Complete the Health Education England (Wessex) funded project which will provide an opportunity to train staff to a champion level
- Set-up an AI forum to include AI champions and patients living with AI needs to act as an advisory group
- Ensure that all corporate events are inclusive to people with AI needs i.e. AGM and public facing publications
- Subject to funding – explore the feasibility of setting-up an AI resource centre to be managed by a new 'Accessible Information Officer' (Band 4). This resource centre will provide staff with the necessary equipment and expertise to produce accessible resources in-house
- Research – again subject to funding, conduct an economic impact assessment to analysis the implementation of AI practice.
- Continue to work in partnership with neighbouring organisations to ensure a patient-centred approach to the implementation of the national standards.

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3.3 Quality Performance

During this year we have introduced a new style of quality reporting to enable teams to see this information in a dashboard format. Below is an example of these dash boards.

3.4 Performance against Key National Priorities

Performance team to provide mandated reporting

PART 4 – Priorities for Quality Improvement in 2016/17

This part of the Quality Account looks forward to 2016/17, and the specific priorities that we will be working on throughout the next twelve months in order to deliver continuous quality improvement to the people who use our services. In deciding these priorities, we have reflected upon:

- Our understanding of the health and social care needs of the local population, as evidenced by health profiles and other statistical analysis, as well as by direct feedback provided to us by service users, families and carers;
- Guidance and directives issued nationally by the Department of Health and NHS England;
- The five questions used by the Care quality Commission in their inspections of services:
  - Are they safe?
  - Are they effective?
  - Are they caring?
  - Are they responsive to people's needs?
  - Are they well led?
- The requirements of our local commissioners
- Our own vision for our direction of travel

These priorities cover the three domains of quality (experience, effectiveness and safety).

We have also validated that these priorities are achievable in line with our current and future resources, and that they firmly put the focus on quality first and foremost - for this reason, we have aligned our priorities to the five domains of quality referenced throughout this document. Thus, our priorities for 2016-17 are:

Priority		Quality Domain
One	Quality Improvement	Safe
Two	Parity of Esteem	Effective
Three	Service User experience (Patients and carers)	Responsive
Four	Acuity and Dependency	Responsive
Five	Professional Standards	Well-led

4.1 Priorities

Priority No 1	
Quality Domain	Safety
Priority for Improvement	**To reduce avoidable harm by 50% with 3 years (Jan 2018).**
Aim	Through participation in the **Sign Up to Safety Initiative**, we will use quality Improvement methodology to reduce avoidable harm by 50% with 3 years (Jan 2018).
Improvement Measures	• *The number of teams who have identified Quality Improvement projects.* • *The number of teams who have completed Quality Improvement Projects.* • *We will reduce the number of avoidable grade 3 and 4 pressure ulcers in our care by at least 50% within 3 years (Jan 2018).* • *We will reduce avoidable harm by early recognition of the deteriorating patient in our care by at least 50% within 3 years (Jan 2018).* • *We will reduce avoidable harm from inappropriate/poor communication at critical transfer points in the patient's journey within 3 years (Jan 2018).*

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Priority No 2	
Quality Domain	Effectiveness
Priority for Improvement	**Parity of Esteem**
Aim	Agree care delivery standards for holistic assessment, care planning and onward referral. Describe range of health indicators to be monitored for each patient group (to include mental health screening that will be undertaken with key physical conditions AND physical health screening and care for MH patients)
Improvement Measures	• *Audit of MH physical screening and care planning standards and remedial action plan as required.* • *Implementation of Lester Tool as standard for cardio-metabolic screening across working age and older adults Mental Health Services* • *Establish agreement between specialist Mental Health services and Primary Care about roles and responsibilities – so that no service users' needs are overlooked* • *Audit of dementia screening standards and action plan as required.* • *Agreed Mental Health screening tools implemented*

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Priority No 3	
Quality Domain	Service User Experience
Priority for Improvement	**Service User experience (Patients and carers)**
Aim	We aim to listen and learn from patient experience and continually improve experiences of our care. We recognise that whilst we gather a range of data from patients and carers, a greater challenge is to act effectively on what people are telling us and this is a key area of focus for the coming year. We recognise and value the support carers provide and a further aim in the coming year is to deliver on our pledge to carers to: *'Promote a culture where the value, contribution and rights of carers are recognised and respected by our staff'*. As a provider of health care we are in a unique position to be able to identify carers and signpost them for support. To achieve this aim we must ensure increased carer awareness for our staff and we will continue to strengthen our working practices with our partner organisations to ensure we identify and signpost carers to the support that is available to them using joint resources. To ensure inclusivity we will monitor the protected characteristics of those who give feedback by a range of methods including the Friends and Family Test, surveys, concerns and complaints to ensure our processes for engaging are accessible to all including those who may find it difficult to do so. We recognise the important lessons we can learn from concerns and complaints and we aim to improve our responsiveness seeking to resolve at the local level wherever possible and where agreed with those making the complaint. We also want to ensure that those who have reason to complain find that they can do so easily, feel listened to and feel that their complaint has made a difference.

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Improvement Measures	- We will carry out an integrated review all sources of patient experience intelligence including complaints, feedback from the friends and family test, surveys social media and focus groups to improve insight into those aspects of the care experience that matter most to our patients. - We will provide greater transparency for patients, carers and staff regarding the feedback given and actions taken as a consequence by the development of a range of methods to publicise and communicate outcomes from feedback and associated service improvement. - We will set high standards for patient experience aiming for a consistently high level of reported patient satisfaction and at least a 95% satisfaction score on the Friends and Family Test. - We will implement carer awareness training for all staff. - We will increase our identification of carers and signposting for support with a specific focus on identifying carers in community settings and primary care services. - We will work jointly with our partner organisations on campaigns for Carers Week and Carers Rights day. - We will work in partnership with carer representatives to design and implement a carer's survey to gain insight on whether we have delivered on what is important to carers. - We will review the information on protected characteristics from the Friends and Family Test and the questionnaire given to people who complain. - We will redesign our complaints survey so that it is user led using 'I' statement questions.

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Priority No 4	
Quality Domain	Patient Safety and Effectiveness
Priority for Improvement	**Acuity and Dependency**
Aim	**What is the Aim?** To continue to develop the tools and weighting system for caseload management and to measure acuity and dependency in order to continue to deliver safe services where staff feel supported to work within safe parameters
Improvement Measures	**What are the improvement measures?** • Staff will report that they are clear about the trigger points which identify staffing levels are getting to a point where some alteration to delivery is required • Risk assessment will be evident in the decision making process • Very few, if any, reported safety incidents which are linked to staffing levels • Staff will report that they are clear about expectations when staffing levels are reducing and when to escalate concerns • Staff will report that they feel supported • All teams will have real time knowledge and understanding of their current caseload dependency and hot spots

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Priority No 5	
Quality Domain	Experience
Priority for Improvement	**Professional Standards**
Aim	**What is the Aim?** To continue the work from last year's priority enhancing governance arrangements from Ward to Board through further development of Clinical leadership and embedding both Nursing and AHP strategic frameworks focused on professional standards and practice.
Improvement Measures	**What are the improvement measures?** • The Nursing Strategic Framework will be launched and embedded. • The AHP Strategic Framework will be launched and embedded. • All staff will be able to confirm their professional lead and be clear about the reporting arrangements within their Service Line and beyond as appropriate to role. This will be measured through staff reported experience, questionnaires and the staff survey. • The review and standardisation of Nursing and AHP job descriptions will be completed, updated and consistent across the Trust. • The development of Single competency frameworks will be completed for Nurses and AHPs.

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ANNEX 1: Feedback from Key Stakeholders

ANNEX 2: Statement of Directors'Responsibilities in Respect of the QualityAccount

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

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust boards should put in place to support 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 2015/16 and supporting guidance
- 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 2015 to [the date of this statement]
- Papers relating to Quality reported to the board over the period April 2015 to [the date of this statement]
- Feedback from commissioners dated XX/XX/20XX
- Feedback from governors dated XX/XX/20XX
- Feedback from local Healthwatch organisations dated XX/XX/20XX
- Feedback from Overview and Scrutiny Committee dated XX/XX/20XX
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated XX/XX/20XX
- The [latest] national patient survey XX/XX/20XX
- The [latest] national staff survey XX/XX/20XX
- The Head of Internal Audit's annual opinion over the Trust's control environment dated XX/XX/20XX
- CQC Intelligent Monitoring Report dated XX/XX/20XX

- The Quality Report presents a balanced picture of the 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.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.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 ink except black

- ....Date..Chairman
- ....Date..Chief Executive

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ANNEX 3: Equality Impact Assessment

Equality Impact Assessment

Step 1 – Scoping; identify the policies aims	**Answer**
1. What are the main aims and objectives of the document?	
2. Who will be affected by it?	
3. What are the existing performance indicators/measures for this? What are the outcomes you want to achieve?	
4. What information do you already have on the equality impact of this document?	
5. Are there demographic changes or trends locally to be considered?	
6. What other information do you need?	

Step 2 - Assessing the Impact; consider the data and research	**Yes**	**No**	**Answer** (Evidence)
1. Could the document unlawfully against any group?			
2. Can any group benefit or be excluded?			

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3. Can any group be denied fair & equal access to or treatment as a result of this document?			
4. Can this actively promote good relations with and between different groups?			
5. Have you carried out any consultation internally/externally with relevant individual groups?			
6. Have you used a variety of different methods of consultation/involvement			
Mental Capacity Act implications			
7. Will this document require a decision to be made by or about a service user? (Refer to the Mental Capacity Act document for further information)			

If there is no negative impact – end the Impact Assessment here.

Step 3 - Recommendations and Action Plans	**Answer**
1. Is the impact low, medium or high?	
2. What action/modification needs to be taken to minimise or eliminate the negative impact?	
3. Are there likely to be different outcomes with any modifications? Explain these?	

Step 4- Implementation, Monitoring and Review	**Answer**
1. What are the implementation and monitoring arrangements, including timescales?	
2. Who within the Department/Team will be responsible for monitoring and regular review of the document?	

Step 5 - Publishing the Results	Answer
How will the results of this assessment be published and where? (It is essential that there is documented evidence of why decisions were made).	

Retain a copy and also include as an appendix to the document

ANNEX 4: Glossary of Terms

Needs to be checked/updated

Glossary

AI - Accessible information

Accessible information (AI) is all about making information easier to understand for people living with communication and information needs. AI is a supportive process that involves the identification of individual's needs, production of information in a way that meets their needs; and, for many, communication support in the delivery of the information.

Clinical Audit.

Clinical audit is a process that has been defined as "a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change

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.

Commissioners

Clinical commissioning groups (CCGs) are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.

To a certain extent they replace primary care trusts (PCTs), though some of the staff and responsibilities moved to the local authorities' Public Health teams when PCTs ceased to exist in April 2013).

CRHTT – Community Resolution Home Treatment Team

The Crisis Resolution Home Treatment Team (CRHTT) is a team of mental health professionals working within Solent NHS Trust.

CROS – Consumer Related Outcome Scale

Tool available to support recovery. Questionnaire that asks questions around five themes. Self assessment rating scale.

CSAC College Specialty Advisory Committee

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 which determine whether we achieve quality goals or an element of the quality goal. These achievements are on the basis of which CQUIN payments are made.

Duty of Candour

The duty of candour is a statutory duty which requires all health and adult social care providers registered with CQC to be open with people when things go wrong and to inform them about the outcome of investigation into why something went wrong.

FRIENDS AND FAMILY TEST

The Friends and Family Test (FFT) is a feedback tool that enables people who use our services to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses and opportunity to give free text comments. The FFT provides a mechanism to highlight both good patient experience and identify where improvements are needed based on patient feedback.

HRI

High Risk Incident

I.G. Information Governance

Information Governance ensures necessary safeguards for, and appropriate use of, patient and personal information.

Information Commissioners Office

The Information Commissioner's Office (ICO) upholds information rights in the public interest, promoting openness by public bodies and data privacy for individuals.

Information Asset Owner

Information Asset Owners (IAO) are senior individuals whose role is to understand what information is held, what is added and what is removed, how information is moved, and who has access and why.

KPI - Key Performance Indicator

A set of quantifiable measures that the Trust adopts to gauge or compare performance in terms of meeting its strategic and operational goals. KPIs vary, depending on the priorities or performance criteria.

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.

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Monitor - Monitor

Independent Regulator of NHS Foundation Trusts.

www.monitor-nhsft.gov.uk

NICE - The National Institute of Health and Clinical Excellence

Provide 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

The NPSA is an arm's length body of the Department of Health. It was established in 2001 with a mandate to identify patient safety issues and find appropriate solutions.

PADR - Performance Appraisal Development Review

The aim of this is to confirm what is required of an individual within their role, feedback on how they are progressing, to identify any learning and development needs and to agree a personal development plan.

PCT - Primary Care

Primary care is the care provided by people you normally see when you first have a health problem. It might be a visit to a doctor or a dentist, an optician for an eye test or a trip to a pharmacist to buy cough mixture. NHS walk-in centres and the NHS Direct telephone service are also part of primary care.

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.

Pressure Ulcer

Pressure ulcers are an injury that breaks down the skin and underlying tissue. They are caused when an area of skin is placed under pressure. They are sometimes known as "bedsores" or "pressure sores". Pressure ulcers can range in severity from patches of discoloured skin to open wounds that expose the underlying bone or muscle.

RAG rating

RAG (Red, amber, green) is the name given to a simple colour coding of the status of an action or step in a process.

Safety Thermometer

The NHS Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care, including falls and pressure ulcers.

TDA - Trust Development Authority

The NHS Trust Development Authority (TDA) is responsible for providing leadership and support to the non-Foundation Trust sector of NHS providers.

SBAR – situation, background, assessment, recommendation.

SBAR is a structured method for communicating critical information that requires

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immediate attention and action contributing to effective escalation and increased patient safety.

SIRI

Serious incident requiring investigation.

UTI - Urinary Tract Infection

A urinary tract infection is an infection that can happen anywhere along the urinary tract, ie bladder, kidneys, ureters and urethra.

VTE - Venous Thromboembolism

A venous thrombosis is a blood clot that forms within a vein. Thrombosis is a medical term for a blood clot occurring inside a blood vessel. A classical 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.

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CONTACT US:

For more information about anything contained in this Quality Account, please contact:

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Job Title?

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QUALITY REPORT & QUALITY ACCOUNT 2015/16

Version 1.6 (14.04.16)

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Part 1: Statement on quality from Katrina Percy, Chief Executive Officer of Southern Health NHS Foundation Trust

Southern Health's key priority is to provide patient centred care to people who use our services which is safe, effective and provides a positive patient experience. We can only do this through continuous quality improvement achieved through a collaborative effort from staff, who are in everyday contact with patients, supported by the Trust Board focused on getting it right for every patient, every time.

2015/2016 has seen us deliver challenging quality improvement plans across the Trust. In the first quarter our improvement schedule focussed on the undertakings agreed in 2014 with Monitor, the health service regulator, to improve the quality aspect of our services. This included a targeted improvement of our Quality and Board governance to strengthen the culture of reporting and oversight from 'Ward to Board'.

We also carried out a large amount of work on our quality improvement plans for the whole of our Learning Disability services. This work is now being overseen by Dr Chris Gordon, Chief Operating Officer who extended his portfolio in August 2015 to encompass the responsibility for quality performance and patient safety under the new title of Director of Performance, Quality and Patient Safety. Dr Lesley Stevens moved into the position of Medical Director to support this important work with a focus on patient, service user and family engagement.

In early 2015 an investigation, commissioned by NHS England, was undertaken into patient and service user deaths over a four year period to March 2015. An independent report was published in December 2015 which raised concerns regarding the quality of our serious incident investigations. We accept that the quality of processes for investigating and reporting death needed to be better. In the past, investigations have not always been up to the high standards that our patients and their families deserve. We have looked at this in great detail and made substantial changes and improvements to the way we work in addition to the improvements already made over the previous year and will continue to do so as we work hard to learn from all incidents.

Some of these improvements include;

- Researching, developing and launching a new mortality reporting system
- Forming a centralised investigation team to improve the quality, timeliness and learning from all investigations;
- Developing a culture where families are consistently welcomed to be involved in incident investigations and will receive open and honest information about mistakes that have been made;
- A commitment to working with other health care partners to investigate serious incidents and deaths where care has been given by more than one healthcare or social care provider; and
- Ensuring Board oversight of all deaths in a timely and focused manner.

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Monitor are working alongside the Trust to ensure that all of the recommendations provided in the report are adopted and a robust system of monitoring is in place whilst they embed into the culture of the organisation.

As a result of the report, the Care Quality Commission visited targeted areas of Mental Health and Learning Disabilities services in January 2016 and spent time reviewing our mortality governance processes in February 2016.

Add wording re warning notice/CQC reports. Below is replicated from AGS.
Whilst the Care Quality Commission found a number of improvements had been made, this was not consistent across all areas and they issued a warning notice to the Trust on 16 March 2016. They found that at some sites the Trust had not made all the necessary changes in respect of ligature points and other environmental remedial works and they were concerned about the governance arrangements for identifying and rectifying these. They also found that the Trust needed to strengthen its governance arrangements around investigating and learning from incidents. The Trust took immediate action in relation to specific matters raised in the warning notice and has also planned a number of improvements to its governance processes. This will ensure a more responsive, proactive identification of environmental risk, better support for teams who need it and more empowerment of frontline staff to monitor their performance and embed learning.

During this challenging time, I am proud to report that our staff have embraced the changes we have implemented and have shown their wholehearted commitment to improvement and development. This inspiring dedication was celebrated at our Annual Star Awards event in December 2015. We also launched the People's Choice Award which allowed our patients, services users and their families to nominate individual staff or teams who really made a difference to the way they live their lives. I would like to thank all our staff for their hard work in ensuring our patients and service users are experiencing better care. We will continue to support them to ensure each person who works in the Trust knows the role they play in providing high quality safe services.

Our vision for 2016 / 2017 is one of continued quality improvement. We have already made significant changes that have made impact and some that will take time to embed. It is our commitment to always strive to provide the best care and experience to our patients, services users and their families and I look forward to continuing making these improvements.

The content of the report has been reviewed by the Board of Southern Health NHS Foundation Trust. On behalf of the Board and to the best of my knowledge; I confirm the information contained in it is accurate.

Signature

Katrina Percy
Chief Executive Officer, Southern Health NHS Foundation Trust
XX May 2016

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Part 2: Priorities for improvement and statements of assurance from the Board

2.1 Priorities for improvement

Priorities for improvement in 2015/16
Every Quality Report must contain priorities for improvement, to be achieved in the following year, in the three dimensions of quality identified by Lord Darzi:

- Improving patient safety;
- Improving clinical outcomes; and
- Improving patient experience .

These priorities are selected based on feedback from our patients, stakeholders and staff and are approved by the Trust Board.

The 2014/15 Quality Report identified the priorities to be achieved in 2015/16. Overall performance to meet these priorities is given below with further details provided in Part 3.

Table: Performance to meet Priorities for Improvement 2015/16

Priorities for Improvement 2015/16		
Improving Patient Safety	1.1 To reduce avoidable grade 3 and 4 pressure ulcers	progress made
	1.2 Inpatients in our physical health wards will have a venous thromboembolism assessment on admission	progress made
	1.3 Inpatients will receive their critical medicines	achieved
Improving Clinical Outcomes	2.1 All our clinical services have a care planning framework in place that is patient led	progress made
	2.2 Physical health of our patients is monitored and any deterioration is acted upon	progress made
	2.3 To improve clinical outcomes and post-operative care for day surgery patients	achieved
Improving Patient Experience	3.1 Our complaints process provides satisfaction to the complainant	progress made
	3.2 Involve patients in the design of services	progress made
	3.3 Involve patients and carers in the co-design of our restrictive practice framework	progress made

Priorities for improvement in 2016/17
This year's Quality Report includes priorities for improvement to be achieved in 2016/17 which have been selected in consultation with our stakeholders and approved by the Trust Board.

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We have used a range of information to identify the priorities for quality improvement in 2016/17 including:

- What patients have told us about our services and how we can improve;
- What our commissioners have told us is important to provide to their patients;
- What our staff have said is important to them;
- What external organisations such as the Care Quality Commission have highlighted about our services;
- What the local Healthwatch organisations have said is important to them; and
- A review of the performance and quality of our services and where improvements could be made.

The new 5 year Quality Improvement Strategy, which is due to be launched in May/June 2016, supports the Trust's overall aim of providing high quality and safe care, and sets out a number of patient-centred quality improvement goals for the Trust including the priorities for improvement set out here. These are integrated into the Trust Quality Programme work streams which will oversee delivery and review progress with performance monitoring by the Quality Improvement and Development Forum, Quality and Safety Committee and Board throughout the year.

Priority 1: Improving Patient Safety

Priority 1.1 To develop a framework to share learning from serious incidents leading to a reduction in recurrent themes.	
Aim	To improve patient care through sharing learning from investigations into serious incidents and deaths across the Trust.
Why is this important?	It is important we learn from investigating serious incidents and share that learning so that similar incidents are not repeated. In 2015/16 recurrent themes in serious incident investigations were identified. The independent review of deaths of people with a learning disability or mental health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015 recommended improvements to the review and investigation of deaths process which were accepted by the Trust. Similar indicators focusing on learning from serious incidents have been included in previous Quality Reports but not in 2015/16.
Ambitions and actions	The development and use of a framework to share learning across the organisation leading to a reduction in recurrent themes. Actions include improving the quality of investigations into serious incidents; the central investigators team to continue to support clinical services in the analysis of incidents and identification of themes and learning; the embedding of mortality review meetings at both Trust and divisional level to ensure learning is identified and shared across the organisation.

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How we will measure and monitor progress	Themes from serious incident investigations will be discussed at divisional level and shared with the wider clinical services. Improvements to care delivery and patient pathways can be linked to thematic evidence. There is a reduction in recurrent themes from serious incidents. Progress to meet the indicator will be reviewed by the Quality Programme: Patient Safety workstream, the Quality Improvement and Development Forum and the Trust Mortality Working Group, with ongoing performance reviewed at Divisional Performance Review.

Priority 1.2 Inpatients will have a venous thromboembolism (VTE) assessment on admission	
Aim	To complete a risk assessment for venous thromboembolism (VTE) in inpatients on admission.
Why is this important?	VTE is a serious, potentially fatal medical condition. A person is more at risk of developing a blood clot if they can't move around very much or are very unwell. Therefore anyone in hospital is more susceptible to VTE and should have this risk assessed with appropriate treatment given. We are repeating this indicator from 2015/16 with a focus on the completion of the risk assessment as clinical audits showed this was not always fully completed although patients received appropriate treatment.
Ambitions and actions	90% of inpatients have a risk assessment for VTE completed on admission. A new process to capture VTE risk assessment data in Community Hospitals to be developed and put in place. VTE risk assessment performance to be reviewed with action taken to address any shortfalls. Continued training in use of VTE risk assessment and treatment to junior doctors.
How we will measure and monitor progress	We will audit the numbers of patients on admission who have a VTE risk assessment completed. Progress to meet the indicator will be reviewed by the Quality Improvement Programme: Patient Safety workstream/Quality Improvement and Development Forum with ongoing performance reviewed at Divisional Performance Review.

Priority 1.3 To reduce the number of pressure ulcers	
Aim	To share and implement learning across the Trust to reduce pressure ulcers.
Why is this important?	Pressure ulcers can be painful, increase the risk of associated infection and seriously affect the quality of life for an affected patient. In 2015/16 focused actions led to the successful reduction in the numbers of avoidable grade 3 and 4 pressure ulcers by over 30%. However these continue to be the most commonly reported patient safety incident in our community services. We are therefore prioritising this indicator again in

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	2016/17.
Ambitions and actions	As there is new national guidance in the reporting of pressure ulcers based on the actual harm caused to the patient rather than grade or whether avoidable, there is no baseline figure for comparison this year. Our ambition therefore is to see a reduction in numbers based on the new reporting guidance month by month over the course of the year. Actions will include the continued intensive support from the tissue viability team to clinical teams with the highest number of pressure ulcers, review of themes and learning shared across the Trust with changes made to clinical practice and embedded into everyday care.
How we will measure and monitor progress	We will compare the number of pressure ulcers reported in April 2016 (using the new guidance) with the number reported in March 2017 aiming for a reduction over the year. We will also review monthly figures to measure performance within the year. Progress to meet the indicator will be reviewed by the Quality Improvement Programme: Patient Safety workstream/Quality Improvement and Development Forum with ongoing performance reviewed at Divisional Performance Review.

Priority 2: Improving Clinical Outcomes

Priority 2.1 To embed care planning frameworks in our clinical services	
Aim	To embed effective care planning frameworks in our clinical services.
Why is this important?	A first step in our care for patients is to complete an assessment of their needs and then to work in partnership to develop a care plan that is centred on their needs and has goals that are important to them. Evidence demonstrates effective care planning ensures better continuity of care, clinical outcomes, patient safety and experience. Clinical audit results in 2015/16 showed improvements in care planning are not yet fully established. This indicator therefore builds on the work started in 2015/16 and looks to embed good practice across the Trust.
Ambitions and actions	Clinical services implement care planning frameworks using care plans developed with patients that are relevant to their needs and reflect their goals. Actions include completion of a gap analysis in care planning training with development of a training pathway; monitoring of the quality of care plans, identification of themes and changes required via quarterly triangulation of information on care plans from range of sources; review of progress made in required changes to practice.
How we will measure and	Quarterly audit of holistic assessment, care planning and progress notes will be carried out. Audit results will be used to triangulate information

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monitor progress	and identify themes and required changes to practice. Progress to meet the indicator will be reviewed by the Quality Improvement Programme: Record keeping and care planning workstream/Quality Improvement and Development Forum with ongoing performance reviewed at Divisional Performance Review.

Priority 2.2 The physical health needs of inpatients in Learning Disability and Mental Health services are appropriately assessed, monitored and treated with action taken if there is any deterioration in physical health	
Aim	The physical health needs of inpatients in Learning Disability and Mental Health services are appropriately assessed, monitored and treated with action taken if there is any deterioration in physical health.
Why is this important?	Patients with mental health needs or learning disabilities may also have physical health needs. If these are not appropriately assessed and treated with action taken to address any deterioration in physical health, it may lead to premature death. Clinical audit results in 2015/16 and the independent review into deaths published in December 2015 (see 1.1) found improvements could be made in the physical health assessment and care planning for these groups of patients. This indicator builds on the 2015/16 priority to monitor the physical health of patients and act on any deterioration but is specifically focused on patients seen by our mental health and learning disability services.
Ambitions and actions	All inpatients in mental health or learning disability units will have a physical health assessment completed and a corresponding care plan. Their physical health will be appropriately monitored and immediate action taken if there is any deterioration. Actions include developing action plan to address areas for improvement based on clinical audit results in January 2016 with re-audit in late 2016; review the content and learning outcomes of the five day physical health training course and ensure training compliance rates meet those stipulated for each area.
How we will measure and monitor progress	Clinical audit will measure standards for physical health assessment completion; training attendance records will provide information for training compliance. Progress to meet the indicator will be reviewed by the Quality Improvement Programme: Patient Safety workstream/Quality Improvement and Development Forum with ongoing performance reviewed at Divisional Performance Review.

Priority 2.3 Risk assessments and appropriate risk management plans are in place for all community and inpatients in Mental Health, Specialised, Older People's Mental Health and Learning Disabilities services	
Aim	Risk assessments and appropriate risk management plans are in place for all community and inpatients in Mental Health, Specialised, Older People's Mental Health and Learning Disabilities services.
Why is this important?	Effective and updated risk assessments and corresponding risk management plans are key to ensuring that patients do not come to

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	harm and are able to benefit maximally from the support offered by clinical services. Investigations into serious incidents during 2015/16 found that risk assessments and risk management plans were not always fully documented. This is a new indicator for 2016/17 which aims to ensure risk assessments and risk management plans are in place for patients in Mental Health, Specialised, Older People's Mental Health and Learning Disabilities services.
Ambitions and actions	All patients in these services will have an updated risk assessment and appropriate risk management plan in their health records. A baseline audit will be completed with an action plan to address required improvements developed and implemented. Root cause analysis will support identification of the reasons for standards not being met. Progress against the plan will be monitored by re-audit of identified areas and may include 'deep dives' or spot check audits.
How we will measure and monitor progress	The audits and subsequent action plans will measure compliance to meet the standards for risk assessment and risk management plans; progress to meet the indicator will be reviewed by the Quality Improvement Programme: Record Keeping and Care Planning workstream/Quality Improvement and Development Forum with ongoing performance reviewed at Divisional Performance Review.

Priority 3: Improving Patient Experience

Priority 3.1 Our complaints process provides satisfaction to the complainant	
Aim	Our complaints process provides satisfaction to the complainant.
Why is this important?	Patient experience is extremely important to the Trust; receiving complaints shows we haven't got something right for the patient or their carers. We have made improvements in 2015/16 in meeting the agreed timeframes to send final response letters to complainants with overall 88% successfully sent during the year. However, this target is not yet consistently met in all services and therefore we are repeating the same indicator for 2016/17. We are also working towards achieving standards in good complaints handling which are included in a toolkit for commissioners launched in November 2015.
Ambitions and actions	90% of final response letters are sent within the mutually agreed timeframes. 90% of standards met in 'Assurance of good complaints handling for acute and community care – a toolkit for commissioners' (November 2015).

	Actions will include a review of the complaints process framework and timelines as part of the review of the Complaints Policy and Procedures; quarterly training sessions for investigating officers; performance in meeting final response timeframes shared with clinical services; gap analysis of the good complaints handling standards and action plan implemented to address identified gaps.
How we will measure and monitor progress	Quarterly reports on work plan progress reviewed by the Quality Improvement Programme: Patient Experience and Engagement workstream/Quality Improvement and Development Forum with ongoing performance reviewed at Divisional Performance Review.

Priority 3.2 To involve patients and carers in the development of services	
Aim	Clinical services develop and implement work plans to involve patients and carers in the development of services.
Why is this important?	We put patients at the heart of everything we do and want to involve them and their carers in the development of services so that these best meet their needs. In 2015/16 we focused on the involvement of patients in the design of specific services following feedback from the Care Quality Commission inspection in October 2014. In 2016/17 we want to build on this work and make sure that patients and their carers are involved in the development of services across the whole Trust.
Ambitions and actions	Targets and outcomes in divisional work plans are met within agreed timeframes. Each division to develop and implement a work plan to involve patients in the development of services based on their business plans with regular review of progress being made. Each work plan to be agreed with the Trust Head of Patient Involvement and Engagement.
How we will measure and monitor progress	Quarterly reports on work plan progress reviewed by the Quality Improvement Programme: Patient Experience and Engagement workstream/Quality Improvement and Development Forum with ongoing performance reviewed at Divisional Performance Review.

Priority 3.3 To have a strategy to reduce restrictive practices in adult mental health services	
Aim	To develop and implement a reducing restrictive practice strategy in our adult mental health services.
Why is this important?	We want to provide environments for patients and staff where they feel safe and supported and where use of restrictive practices such as restraint are minimised. One of the highest categories in patient safety incident reporting on Ulysses Safeguard, our electronic incident reporting

	system, is assault, abuse and threat to staff. We want to build on existing actions and continue to work collaboratively with patients to reduce restrictive practices and improve patient experience and so are repeating a similar indicator this year. We are undertaking a specific restrictive practices project with the national Implementing Recovery through Organisational Change (IMROC) team and a national leading Trust in 2016/17.
Ambitions and actions	A restrictive practice strategy will be developed and be implemented. Actions include reviewing the numbers of incidents of restraint and seclusion aiming for a reduction; clinical audit of restrictive practices including qualitative analysis of patient experience of restraint and seclusion; quality improvement plan implemented based on audit findings; review involvement of agency and bank staff in incidents; participate in IMROC project.
How we will measure and monitor progress	Clinical audit results and quarterly reporting to commissioners on maximising de-escalation practice. Progress to meet the indicator will be reviewed by the Quality Improvement Programme: Patient Experience and Engagement workstream/Quality Improvement and Development Forum with ongoing performance reviewed at Divisional Performance Review.

2.2 Statements of assurance from the Board

These are nationally mandated statements which provide information to the public which is common across all quality reports. They help demonstrate that we are actively measuring and monitoring the quality and performance of our services, are involved in national initiatives aimed at improving quality and are performing to quality standards.

Review of services

During 2015/16 the Southern Health NHS Foundation Trust provided and/or sub-contracted 47 relevant health services. The Southern Health NHS Foundation Trust has reviewed all the data available to them on the quality of care in 47 of these relevant health services.

The income generated by the relevant health services reviewed in 2015/16 represents 100% of the total income generated from the provision of relevant health services by the Southern Health NHS Foundation Trust for 2015/16.

Clinical audits and national confidential enquiries

During 2015/16 5 national clinical audits and 1 national confidential enquiry covered relevant health services that Southern Health NHS Foundation Trust provides.

During that period Southern Health NHS Foundation Trust participated in 80% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

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The national clinical audits and national confidential enquiries that Southern Health NHS Foundation Trust was eligible to participate in during 2015/16 are as follows:

National Clinical Audit /Confidential Enquiry	Eligible
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	✓
Sentinel Stroke National Audit Programme	✓
UK Parkinson's Audit	✓
Prescribing Observatory for Mental Health (POMH)	✓
National Audit of Intermediate Care	✓
National Confidential Inquiry into Suicide and Homicide for People with Mental Illness	✓

The national clinical audits and national confidential enquiries that Southern Health NHS Foundation Trust participated in during 2015/16 are as follows:

National Clinical Audit /Confidential Enquiry	Participated in
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	✓
Sentinel Stroke National Audit Programme	✓
UK Parkinson's Audit	✓
Prescribing Observatory for Mental Health (POMH)	✓
National Audit of Intermediate Care	x
National Confidential Inquiry into Suicide and Homicide for People with Mental Illness	✓

The national clinical audits and national confidential enquiries that Southern Health NHS Foundation Trust participated in, and for which data collection was completed during 2015/16, 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 Clinical Audit /Confidential Enquiry	% of required cases submitted
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	53%
Sentinel Stroke National Audit Programme	100%
UK Parkinson's Audit	tbc
Prescribing Observatory for Mental Health (POMH)	100%
National Confidential Inquiry into Suicide and Homicide for People with Mental Illness	100%

The report of 1 national clinical audit was reviewed by the provider in 2015/16 and Southern Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

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- The report recommendations are currently being reviewed and a programme of work developed with a particular focus on improving waiting times to treatment and ensuring standardised measurement of exercise performance is completed.

The reports of 53 local clinical audits were reviewed by the provider in 2015/16 and Southern Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Audit title	Actions
GP Liaison	• To increase GP understanding of school nurse service • To act on feedback from GPs to improve service
Personal Child Health Record	• To develop staff guidance on correct completion of record • To update breast feeding section in liaison with partner Trusts • To explore focus group with parents to discuss completion of the record
Discharge Summaries	• Document all medications stopped or started during admission • Include statement of risk to self or others in summary • For patients with dementia, ensure appropriate professionals attend the discharge planning meeting
Maternal Mood Assessment	• To train staff in use of evidence based tools to identify and assess low mood in post natal mothers • To develop role and scope of perinatal mental health champions • To develop outcome measures including patient reported feedback
Physical Health Assessment (Learning Disabilities)	• To record assessment of all health needs and ensure associated care plans are in place if required • To review health status of patient, for example, smoking, and document associated care plans
Record keeping (physio-therapy)	• To amend physiotherapy assessment template so that all information is captured • To educate staff on correct process to follow when amending documentation if error made

Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by Southern Health NHS Foundation Trust in 2015/16 that were recruited during that period to participate in research approved by a research ethics committee was 1097.

Commissioning for Quality and Innovation Framework (CQUIN)

A proportion of Southern Health NHS Foundation Trust income in 2015/16 was conditional on achieving quality improvement and innovation goals

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agreed between Southern Health NHS Foundation Trust 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 2015/16 and for the following 12 month period are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-16-17/

In 2015/16 income totalling £4,546,184 was conditional upon Southern Health NHS Foundation Trust achieving quality improvement and innovation goals. In 2014/15 income totalling £5,800,635 was conditional upon Southern Health NHS Foundation Trust achieving quality improvement and innovation goals, of which payment of £5,722,950 was received.

Our CQUIN schemes for 2015/16 are shown below. CQUINs are negotiated and agreed with clinical commissioning groups (CCGs) and reflect both national and local quality improvement ambitions.

Commissioner	Service Area	Scheme
North East Hampshire & Farnham CCG	Integrated Community Services	Continuing Health Care Trusted Assessors in the community – safe and timely transfers of care
		Promoting co-ordinated patient and carer led care records
South East Hampshire and Fareham & Gosport CCGs	Integrated Community Services	Wound Care / Leg Ulcer
		In reach
		Respiratory
		Falls and fracture reduction service
		Heart failure
Hampshire & Southampton CCGs	Mental Health & Learning Disabilities	Improving physical healthcare for patients with severe mental illness (All)
		Reduction in A & E mental health re-attendances (All)
		Developing interface between primary care and secondary care (Hampshire Only)
		Older People's Mental Health – residential dementia screening/challenging behaviour (Hampshire only)
		Smoking cessation (Southampton only)
		Physical health screening (Southampton only)
		Borderline personality disorder pathway (Hampshire only)
		Safe approaches to suicide reduction (Southampton only)
		Person centered care planning (Southampton only)
		System management – rehabilitation

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		(Hampshire only)
Buckinghamshire CCGs	Learning Disabilities	Access to mainstream services
		Challenging behaviour – decreasing inpatient admissions
Oxfordshire Specialised Commissioning	Learning Disabilities	Support for annual health checks
		Anti-psychotic prescribing
Specialised Commissioning	Mental Health, Learning Disabilities, Children and Dental	Secure service users active engagement programme
		Supporting service users in secure services to stop smoking
		Mental health carer involvement strategies
		Improving physical healthcare to reduce premature mortality in people with severe mental illness
		Ensuring appropriateness of unplanned CAHMS admissions
		Improving CAHMS care pathway journeys
		Perinatal – specific involvement and support for partners
		Child Health Information System interoperability
		Local Dental Network
Hampshire County Council	Health Visiting	Two year old reviews and support to be ready for school

Care Quality Commission registration and actions

Southern Health NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is registered in full with no conditions. Southern Health NHS Foundation Trust has 41 locations registered with CQC under the Health and Social Care Act (2008).

The Care Quality Commission has taken enforcement action against Southern Health NHS Foundation Trust during 2015/16.

Southern Health NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2015/16: mortality reporting and serious incident investigations. Southern Health NHS Foundation Trust intends to take the following action to address the conclusions or requirements reported by the CQC: Southern Health NHS Foundation Trust has not yet received the report for this special review and will develop an action plan to address any recommendations once received.need to update

Southern Health NHS Foundation Trust has made the following progress by 31st March 2016 in taking such action: the Trust has not yet received the report for this special review. Need to update

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Quality of data
Southern Health NHS Foundation Trust submitted records during 2015/16 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:

- which included the patient's valid NHS number was:
  xx% for admitted patient care (data available May)
  xx% for out patient care and
  xx% for accident and emergency care.

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

Southern Health NHS Foundation Trust Information Governance Assessment Report overall score for 2015/16 was 82% and was graded green 'satisfactory'.

Southern Health NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2015/16 by the Audit Commission.

Southern Health NHS Foundation Trust will be taking the following actions to improve data quality:

- Data quality has continued to have a significant focus over the last 12 months and will continue to be prioritised within the Trust to ensure our reported performance is of a sufficiently high standard;
- A dedicated data quality programme has supported clinicians to ensure the data held within our Electronic Patient Record is robust and updated in a timely manner. Members of the Trust Executive Board have been closely involved in ensuring this work programme continues to be delivered;
- The Trust ensures that data collected within the Electronic Patient Record is used to report performance, avoiding the need for manual collection of performance information. This has been further supported by the move to Open RiO, which has allowed a more flexible approach to redesigning areas of the Electronic Patient Record that helps promote better recording practices across the Trust; and
- The Trust has invested in a new business intelligence tool (Tableau) which has made data quality reporting more accessible and easier to understand for colleagues throughout the Trust. This has led to improvement in the data quality of some key areas and will continue to support the Trust in further improving the level of data quality.

2.3 Reporting against core indicators
Since 2012/13 NHS foundation trusts have been required to report performance against a core set of indicators using data made available to the trust by the Health and Social Care Information Centre (HSCIC).

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Southern Health NHS Foundation Trust is reported and compared as a Mental Health/Learning Disabilities Trust.

PwC have considered two mandated indicators against Monitor's requirements with their opinion detailed on page xxxx:

- Percentage of patients on Care Programme Approach (CPA) who were followed up within 7 days after discharge from psychiatric in-patient care; and
- Admissions to inpatient services had access to crisis resolution home treatment teams.

PwC have also reviewed a locally chosen indicator:

- Number of patient safety incidents reported to the National Reporting and Learning Service and i) number and ii) percentage of such patient safety incidents that resulted in severe harm or death.

Definitions for these indicators are included in Annex 4.

Our patients on a Care Programme Approach who were followed up within 7 days of discharge

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 percentages of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period.

The Southern Health NHS Foundation Trust considers that this data is as described for the following reasons; taken from national dataset using the data provided.

The Southern Health NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by:

- Providing guidance on Monitor criteria to clinical services to ensure accurate recording in the patient electronic record; and
- Performance information is easily available to clinical services and is refreshed daily on the new business intelligence tool, Tableau.

Indicator	Percentage of patients on Care Programme Approach (CPA) who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period.	
	Apr 2014- Mar 15	Apr 2015- Mar 16
Southern Health	97.5	tbc
Average Trust Score	97.2	tbc
Highest Scoring Trust	100	tbc
Lowest Scoring Trust	93.3	tbc

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Our crisis resolution teams
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 percentages of admissions to acute wards for the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period.

The Southern Health NHS Foundation Trust considers that this data is as described for the following reasons; taken from national dataset using the data provided.

The Southern Health NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by:

- Providing performance information at division, service and team level showing areas where improvements may be made; and
- These are further detailed in our performance reports to board.

Indicator	The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper.	
	Apr 2014- Mar 15	Apr 2015- Mar 16
Southern Health	96.1%	tbc
Average Trust Score	98.5	tbc
Highest Scoring Trust	100.0	tbc
Lowest Scoring Trust	92.7	tbc

Our readmission rate for children and adults
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients aged –

(i) 0 to 15; and
(ii) 16 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 Southern Health NHS Foundation Trust considers that this data is as described for the following reasons; taken from national dataset using the data provided.

The Southern Health NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by:

- Providing performance information at division, service and team level showing areas where improvements may be made; and
- These are further detailed in our performance reports to board.

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Indicator	The percentage of patients aged 0-15 years 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.
Southern Health	Not applicable as Southern Health NHS Foundation Trust does not have any 0-15 year readmissions
Average Trust Score	
Highest Scoring Trust	
Lowest Scoring Trust	

Indicator	The percentage of patients aged 16 or over years 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.	
	Apr 2014 – Mar 2015	Apr 2015 – Mar 2016
Southern Health	7.6%	tbc
Average Trust Score		tbc
Highest Scoring Trust		tbc
Lowest Scoring Trust		tbc

Patient experience of community mental health services
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 experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.

The Southern Health NHS Foundation Trust considers that this data is as described for the following reasons; taken from national dataset using the data provided.

The Southern Health NHS Foundation Trust has taken the following actions to improve this indicator, and so the quality of its services, by:

- Hope, Agency and Opportunity care plan template developed in adult mental health services which includes contact details and arrangements for out of hours and crisis response;
- Older People's Mental Health services are developing a leaflet to be used at first contact which has contact details and service details; and
- New Care Programme Approach training package piloted and delivered in co-production.

Indicator	Patient experience of contact with a health or social worker*	
	2014-2015	2015-2016
Southern Health	6.8	6.7
Average Trust Score	Not available	
Highest Scoring Trust	7.5	7.4
Lowest Scoring Trust	6.5	6.2

*Data is based on responses on a 0-10 scale where 0 is ‘I had a very poor experience’ to 10 ‘I had a very good experience’.

Our rate of patient safety incident reporting
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 Southern Health NHS Foundation Trust considers that this data is as described for the following reasons; taken from national dataset using the data provided.

The Southern Health NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by:

- Providing weekly flash report of incidents due for review by manager.
- Data quality audits to check accuracy of reporting.
- Training and information to staff on accurate reporting of incidents, including correct categorisation.

Indicator	Number of patient safety incidents reported to the National Reporting and Learning Service (NRLS)*		
	Oct 2014 – Mar 2015	Apr 2015 – Sept 2015	Oct 2015 – Mar 2016
Southern Health	5,784	4,134	9,724
Average Trust Score	4,761	Available 19.04.16 n/a	n/a
Highest Scoring Trust	12,784	Available 19.04.16 n/a	n/a
Lowest Scoring Trust	382	Available 19.04.16 n/a	n/a

Indicator	i) Number and ii) percentage of such patient safety incidents that resulted in severe harm or death		
	Oct 2014 – Mar 2015	Apr 2015 – Sept 2015	Oct 2015 – Mar 2016
Southern Health	i) 122 ii) 2.1%	i) 33 ii) 0.8%	i) 239 ii) 2.5%
Average Trust Score	i) 26 ii) 1.2%	Available 19.04.16 n/a	n/a
Highest Scoring	i) 122 ii) 5.1%	Available 19.04.16	n/a

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Trust		n/a	
Lowest Scoring Trust	i) 0 ii) 0.0%	Available 19.04.16 n/a	n/a

The percentage of staff who would recommend the trust as a provider of care to their family and friends

In 2013/14 NHS England asked NHS providers to consider reporting on the staff element of the friends and family test, although did not make this a mandatory requirement for community trusts.

Indicator	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.	
	Apr 2014 – Mar 2015	Apr 2015– Mar 2016
Southern Health	64%	tbc
Average Trust Score	60%	tbc
Highest Scoring Trust	tbc	tbc
Lowest Scoring Trust	tbc	tbc

In 2013/14 NHS England asked NHS providers to consider reporting on the patient element of the friends and family test, although did not make this a mandatory requirement for community trusts.

Indicator	The percentage of patients during the reporting period who would recommend the Trust as a provider of care to their family or friends.	
	Apr 2014- Mar 15	Apr 2015- Mar 16
Southern Health	96.5%	tbc
Average Trust Score	tbc	tbc
Highest Scoring Trust	tbc	tbc
Lowest Scoring Trust	tbc	tbc

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Part 3. Other Information

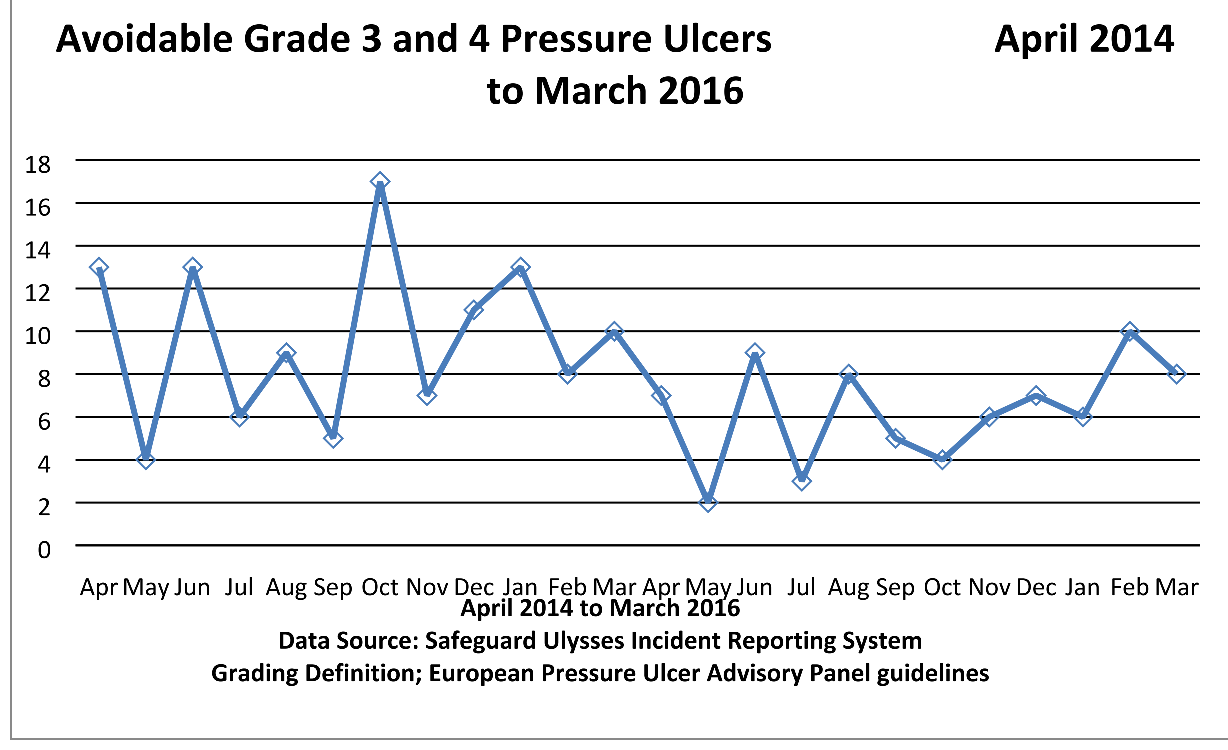
Progress made in meeting our priorities for improvement in 2015/16
Details in progress made to meet our priorities for improvement in 2015/16 are given below.

Priority 1: Improving Patient Safety

1.1 To reduce the number of pressure ulcers

Aim
Pressure ulcers are wounds that develop when constant pressure, friction or shear damages the skin. They can be painful and lead to an increased risk of infection and decreased quality of life for a patient. In 2014/15 many teams were successful in reducing the number of pressure ulcers developed whilst the patient was in our care, however this success was not consistent across the Trust and grade 3 and 4 pressure ulcers remained the highest category of patient safety incidents reported as serious incidents within our physical health services. We therefore repeated a similar indicator for 2015/16 with the aim of sharing best practice and learning across the organisation to reduce pressure ulcers following national guidelines.

Achievements
Graph: numbers of avoidable grade 3 and 4 pressure ulcers reported on StEIS as at 04.04.16



- We have achieved a significant reduction of over 30% in the numbers of avoidable grade 3 and 4 pressure ulcers reported as serious incidents compared to a baseline of 116 in 2014/15, but did not meet our 50%

reduction target. Some of this reduction reflects a change in reporting criteria agreed with our commissioners where we no longer include pressure ulcers where we are not the primary care giver, for example, patients in residential homes. However 'deep dives' into pressure ulcer numbers by the specialist tissue viability team suggest there is a genuine reduction.

- The tissue viability team has continued to provide intensive support to clinical teams with the highest number of pressure ulcers. The use of individualised tracker action plans which are monitored weekly by the tissue viability team have successfully focused the teams on prevention measures. Teams originally identified as having high numbers of pressure ulcers have successfully maintained a reduction in numbers over time following this intensive support.

- A 'Good Practice Pressure Ulcer Toolkit' which has guidance on all aspects of assessment and care of pressure ulcers was launched at the end of 2015 with training to relevant staff rolled out. The toolkit has been very well received and the tissue viability team won second prize for it in the national awards held by the Journal of Wound Care in March 2016.

- Further guidance to staff has included the launch of a moisture pathway to identify the difference between pressure ulcers and moisture damage with bespoke training provided by the tissue viability team. This will support the correct identification and treatment of moisture damage.

- 10,000 pocket sized pressure ulcer prevention cards with clear reminders of key good practice are being distributed to all clinical staff.

- Focused activities in 'Stop the Pressure' week in November included a conference day raising awareness and sharing best practice with over 110 attendees including commissioners and care home staff. Good practice and learning is shared across the Trust in newsletters and flyers at least monthly.

- A representative from the tissue viability team attends the NHS England Pressure Ulcer Strategy group which reviews national strategy and best practice, supports collaborative working and gives direction on new initiatives.

Future Plans

- We want to build on current successes and will repeat a similar indicator for 2016/17, taking into account new national guidance due in April 2016.

1.2 Inpatients in our physical health wards will have a venous thromboembolism (VTE) assessment on admission

Aim

Venous thromboembolism (VTE) is a serious, potentially fatal, medical condition. Patients who are unable to move around very much are more at

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risk of developing blood clots and so it is important to complete a risk assessment and take preventative measures to reduce this risk on admission to hospital. Lymington New Forest Hospital submits data to Unify on the percentage of patients who have a VTE risk assessment completed on admission and consistently meets the 95% target set nationally (for acute trusts). Other Community Hospital sites showed less consistent performance when reviewing data submitted to the Patient Safety Thermometer. This was a new indicator in 2015/16 which aimed to ensure consistent good practice across the Trust.

Achievements

- We have made progress towards meeting this target. A clinical audit in October 2015 found that although the VTE risk assessment form was completed for the majority of patients on our physical health wards in the community hospitals, there were some challenges with the form being completed. Some of our hospitals have medical cover provided by GPs who may not have been familiar with form. The audit found that over 97% of patients audited received the appropriate VTE treatment.

- The Consultant who is the Trust lead for VTE has been visiting inpatient sites to review clinical practice first hand and has found high compliance with both the VTE risk assessment being completed and the appropriate treatment given in sites visited to date. Some areas for improvement have been identified including completion of documentation and the provision of information on VTE to patients.

- The VTE Policy was reviewed and amended with final approval given by the Medicines Management Committee.

- New VTE risk assessment and treatment forms were developed and included in the policy and added to the staff website.

- The junior doctor training programme includes the use of the new risk assessment and treatment forms alongside guidance on 'what to do if you diagnose VTE' which describes the standard treatment to be followed.

Future Plans

We are repeating a similar indicator for 2016/17 focused on the completion of the VTE risk assessment on admission.

1.3 Inpatients will receive their critical medicines

Aim

Medicine doses may be omitted or delayed in hospital for a variety of reasons. Whilst only a small percentage of these occurrences may have the potential to cause harm, it is important to recognise that serious harm may result if a patient does not receive their critical medicines. We want to minimise any potential harm to patients by ensuring they receive their critical medicines when they should and that any inappropriate omissions are reviewed with actions put in place to prevent a similar omission in the future.

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The CQC inspection in October 2014 found improvements in the management and administration of medicines could be made. We focused on improving medicine reviews for inpatients in 2014/15 and then in 2015/16 focused on the administration of critical medicines. The list of critical medicines used within the Trust is developed and updated regularly by the Medicines Management team and is based on national guidance. The list is available to all staff on the Trust intranet.

Achievements

- The Medicines Management team undertake a range of clinical audits throughout the year to gain assurance that good practice is being followed and to identify any areas where improvements may be made. Two medicine omission audits have been completed in the year with inpatient drug charts reviewed on identified days. The results of the clinical audits showed that we achieved the administration target with over 95% of patients receiving their critical medicines or having an approved code for omission written on the drug chart.

- The clinical audits showed that a very small number of drug charts (single figures) had 'blank' boxes where no information on the administration of the critical medicine was given. These inappropriate omissions had not been reported as incidents as identified in the priority target and so were not reviewed by the manager to support best practice and share learning. The Medicines Management team are working with ward managers to address this action.

- There has been increased training and awareness raising for staff on the administration of critical medicines with this being included in the twice yearly junior doctor training, the Medicines Control, Administration and Prescribing Policy (MCAPP) training and online training developed for nurses. The MCAPP is being reviewed with guidance on the administration of critical medicines included which all staff can access.

- Learning from clinical audits, patient safety incidents involving medicines, safety alerts and new medicines guidance is shared in 'Breaking News' newsletters, presentations to teams and discussions at medicine management committee meetings.

Future Plans

We will continue to monitor that patients receive their critical medicines but will not include this as a specific priority in 2016/17.

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Priority 2: Improving Clinical Outcomes

2.1 All of our clinical services have a care planning framework in place that is patient led

Aim

A first step when providing care to patients is to complete a holistic assessment of their needs and to work in partnership with the patient and their carer/family to develop care plans that are centred on their needs and include goals important to them. Evidence demonstrates that effective care planning ensures better continuity of care, clinical outcomes, safety and experience for the patient. We have focused on care planning frameworks within Mental Health, Physical Health and Children's services this year.

Information from serious incident investigations and clinical audits show there is improvement to be made in care planning hence this indicator included in 2015/16.

Achievements

- We have partially achieved this target with care planning frameworks in development across the Trust.

- The Trust wide Record Keeping and Care Planning workstream has overseen a programme of work to develop care planning frameworks across clinical services. The workstream is reviewing the various care plan policies, guidance and competencies currently in use in order to bring together a comprehensive set of principles underpinning care planning frameworks. A training programme which will include a set of competencies is being developed in 2016.

- The care planning working group in Mental Health services has led a number of initiatives including a review of the various care plans currently used in inpatient settings with the aim to produce a set of common standards to be used by staff. The group has also led on developing a 'Hope, Agency and Opportunity' care planning framework which includes a care plan letter to patients and a checklist for staff to use in community services to ensure that everyone is working to the same standards. There is a pilot on an inpatient site in the use of the Hope, Agency and Opportunity care plan with an initial recovery focused conversation with the patient guiding the type of care plan developed and delivered.

- In Mental Health services there are a range of courses involving care planning which are delivered monthly at the Recovery College. These include developing crisis plans, Wellness Recovery plans, self-management, working in partnership and collaborative care planning. Both staff and patients attend these courses together so there is powerful learning from each other. Patients have been involved in developing guidance for others on care plans as well as developing their own care plans.

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- Within physical health services there has been a focus on developing standard care plans to be added to Open RiO, our revised electronic patient record system, so that staff are using the same care planning framework. 'My Wellbeing care plan' has been developed and is being piloted. Good practice in the use of editable care plan letters in Mental Health services is being shared across services.

- There are specific levels of support provided to children and families by Children's services with anyone receiving more than the universal level of care having a care plan. Health visitors and parents go through the care plans and jointly agree actions.

- Within Children's services proposed care plans for infant mental health and perinatal support were circulated to parents for comment and amended following feedback.

- A maternal mood assessment clinical audit found that 100% of mothers identified as having low mood received a health visiting intervention. The audit highlighted good practice in partnership working with parents and increased use of care plans with an action to continue the development of care plans with training to staff in use of care plans completed.

- The results of clinical audits into the development and use of care plans which are patient led have shown that practice is not consistent across the Trust and that improvements can still be made.

Future Plans
We recognise that good progress has been made in developing care planning frameworks and want to ensure that these are embedded into clinical practice and so are including a similar indicator for 2016/17.

2.2 Physical health of our patients is monitored and any deterioration is acted upon.

Aim
Increasingly patients with more complex physical health needs are being cared for in our inpatient hospitals and units. The Physical Assessment and Monitoring Policy highlights the importance of recognising clinical deterioration with physiological observation charts ('track and trigger' tools) developed as an early warning system to be used with patients. This enables quick action to be taken in response to any deterioration leading to improved outcomes for patients. A similar indicator was included previously.

Achievements
- We have made progress towards meeting this target with evidence that the physical health of patients is being monitored and deterioration acted upon.

- Clinical audit showed the early warning 'track and trigger' tool was used with over 90% of patients audited. Over 95% of the patients where the

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recorded observations fell into the ‘red’ category which required immediate action had these actions completed, for example, emergency help was summoned, nurse in charge alerted.

- A separate project piloted the National Early Warning System (NEWS) at Lymington New Forest Hospital as it was considered to be a more appropriate system to use in that setting. A pilot on one ward found over 90% of patients had the NEWS completed fully but that episodes which should have triggered a response were not always actioned. Recommendations to address this include use of stickers on notes to identify patients with high scores, completion of online training by staff and ongoing audit results to be shared with all staff via whiteboards so easy to see audit results and progress made.

- The Resuscitation Committee has reviewed the appropriateness of the specific early warning systems used in different services within the Trust and has recommended that NEWS continues to be used at LNFH and ‘Track and Trigger’ tools used across the rest of the Trust. The Resuscitation Committee will review key themes and learning from the Trust wide mortality groups and will include any recommended actions and learning into the training programme.

- Training in Basic Life Support and Immediate Life Support is available to all clinical staff and includes guidance on the use of both of the early warning systems currently in use: ‘track and trigger’ and the National Early Warning System (NEWS). The training stresses the importance of recognising the deteriorating patient.

Future Plans
We want to continue a focus on meeting the physical health needs of our patients and are including an indicator in 2016/17 which will focus specifically on Mental Health and Learning Disability services.

2.3 To improve clinical outcomes and post-operative care for day surgery patients.

Aim
We want to ensure that patients undergoing day surgery are safe and have the best possible outcomes. We can help achieve this by using the World Health Organisation (WHO) checklist at Lymington New Forest Hospital (LNFH) Day Surgery Unit to ensure all appropriate procedures are followed and that any potential risk of harm to the patient is minimised.

NICE Quality Standard 49 has requirements to review post-operative infection rates for certain types of surgery. The latter types are not carried out at LNFH but this action anticipates that the guidance will be extended to other surgery.

The CQC inspection in late 2014 found improvements could be made in the management of day surgery and therefore this indicator was included in 2015/16.

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Achievements

- We have achieved both targets in this priority to improve clinical outcomes and post-operative care for day surgery patients.

- Observational clinical audits based on the standards recommended by the World Health Organisation and National Patient Safety Agency took place for all patients undergoing day surgery at LNFH in one week in June and one week in November. The audits are designed to measure that all the safety steps in the checklist are completed. The audits found high compliance in all phases of the use of the checklist. Some actions were identified and subsequently completed to ensure there are no distractions and that the unit is completely silent during the checklist.

- Although the new NICE Quality Standard to review post-operative infection rates relates to types of surgery not carried out at LNFH, it was anticipated that the guidance may be extended to other surgery. A new process therefore to gather baseline information on post –operative infection rates for patients with open hernia surgery has been trialled with the Clinical Director reviewing any post-operative infections to identify any themes, learning and improvements to practice required. Patients were asked to return in 30 days a brief questionnaire relating to post-operative infection. The notes of two patients who reported post-operative infections were reviewed with no specific issues or learning identified. The patients were treated by their GPs and no further treatment was required. The process is being rolled out to other types of surgery with questionnaires now sent to patients who have had laparoscopic cholecystectomy.

Future Plans

We will continue to regularly audit use of the WHO surgery checklist but will not repeat this indicator in 2016/17.

Priority 3: Improving Patient Experience

3.1 Our complaints process provides satisfaction to the complainant

Aim

Patient experience is extremely important to us; receiving complaints shows we haven't got things right for the patient or their families. We want to improve the timeliness of our responses and the overall satisfaction with how we are handling complaints to give reassurance that we are committed to putting things right.

Achievements

- As part of the process when someone makes a complaint, the customer experience advisor discusses with the complainant a timeframe for the complaint to be investigated and a response letter to be sent. We were close to meeting our 90% target with 88% of response letters sent within the mutually agreed timeframes. This compares favourably to 58% of response letters being sent within agreed timeframes in 2014/15.

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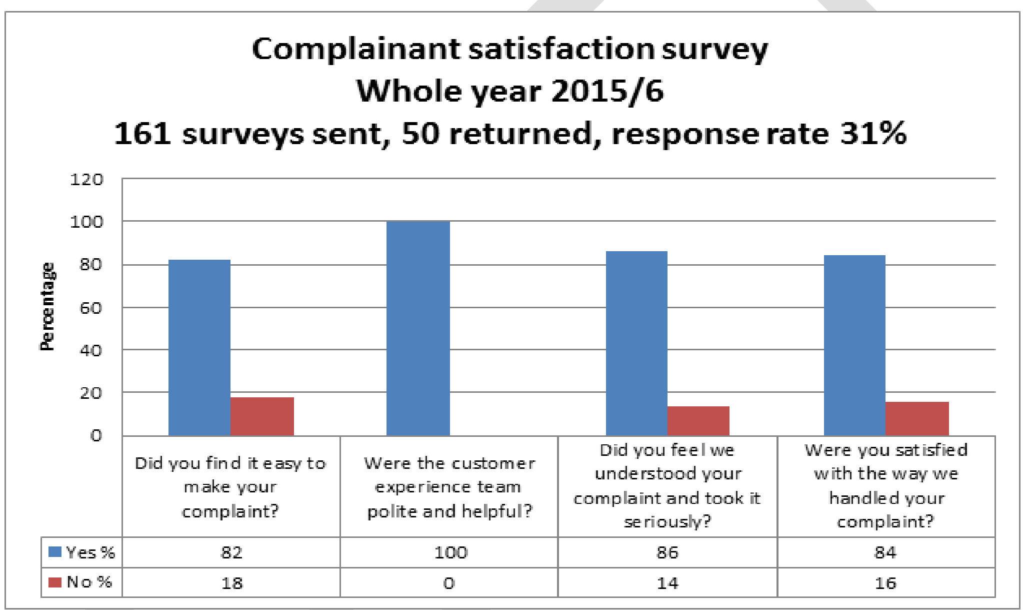
- The Trust launched a revised electronic reporting system for complaints, concerns and compliments in December 2015. The updated system gives greater visibility of the complaints process to clinical teams and enables services to track progress with resolving complaints, identify themes and share learning more easily. It is anticipated that the new system will have a positive impact on the time taken to complete investigations and the final response letters.

- We are keen to receive feedback on our complaints process and send a brief satisfaction survey to complainants to ask for comments and suggestions for improvements. We did not quite meet our target of 90% of complainants being satisfied with how we handled their complaint with 84% over the year expressing satisfaction as shown below. This shows a slight increase in satisfaction from 82% in 2014/15.



	Did you find it easy to make your complaint?	Were the customer experience team polite and helpful?	Did you feel we understood your complaint and took it seriously?	Were you satisfied with the way we handled your complaint?
Yes %	82	100	86	84
No %	18	0	14	16

- Many positive comments are made:
  'I am very happy that my complaint was taken seriously and a very thorough investigation was carried out. I hope future patients will benefit '

  'I was very pleased to see that at my recent appointment the receptionist did indeed have a list of appointments/patients so the problem I experienced should not re-occur. Thank you.'

  'The response to the complaint was very detailed and very professional'

- Some comments are less positive and indicate we can still make improvements:
  'I have not seen any difference in the service since making the complaint.'

'…do feel the investigation inconclusive'

- We have taken part in the initial development of a national complainant survey which is based on 'My expectations for raising concerns and complaints' (Healthwatch; Local Government Ombudsman; Parliamentary and Health Service Ombudsman November 2014) and have volunteered to be part of a pilot starting later this year to test the new survey.

Future Plans
We will be repeating a similar indicator in 2016/17 as further improvements in the timeliness and way we address complaints and concerns can be made.

3.2 Involve patients in the design of our services

Aim
We put patients at the heart of everything we do. We want to listen and involve them in the design of services so that we can best meet their needs and provide a good patient experience.

The CQC report based on their inspection in October 2014 found improvements in our Minor Injury Units and End of Life care could be made. We therefore included this indicator in 2015/16 focusing on those services.

Achievements

- We have made progress towards achieving this target with patients involved in the design of some new services particularly with the new Multi-speciality Community Provider (MCP) implementation for the Minor Injury Units (MIU) at LNFH and at Petersfield Hospital. The MCP Boards have patient representatives who are involved in the planning and design of new services. At other times patients and carers are consulted on changes to practice once proposals have been drafted rather than at an earlier design phase.

- The patient focus group at LNFH meet bi-monthly and have discussed and given feedback on new services, for example, the new GP Practice which opened at LNFH in September 2015 and have been engaged in the project focusing on closer working between MIU and the new GP Practice. The patient focus group has patient representatives as well as representation from Healthwatch Hampshire, the League of Friends and The British Red Cross.

- The MIU at LNFH are developing a new 'See and Treat' clinical process. The proposals have been shared and patients and carers asked for their feedback on the new process.

- End of Life Care services have consulted with patients and carers in the development of an individualised care plan to be used in the last few days of life with the initial pilot care plan radically amended following their feedback. Patients and carers have been consulted on the revised End of

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Life Strategy with their views forming the basis of the objectives for End of Life services within the Trust.

- A carer has been invited to sit on the End of Life Steering Group which has strategic overview and planning role for services. Patient stories and patient feedback is used to improve the quality of care provided at end of life.

- Within Children's services quarterly joint parent/health visitor groups have been piloted in each locality which provide an opportunity for parents to feedback on how services could be designed to better meet their needs.

Future Plans
The indicator this year focused on specific services. We are going to repeat a similar indicator in 2016/17 but will involve all services across the Trust.

3.3 Involve patients and carers in the co-design of our restrictive practice

Aim
We aim to support patients with mental health problems to recover in safe, calm and therapeutic environments, and to engage patients to work in collaboration with us. We know that patients experiencing mental health distress can sometimes express this through violent or aggressive behaviour. We want to work with patients to manage their distress and avoid violence and aggression wherever possible. If it occurs we want to address it in a way that is safe for all concerned, and maintains the dignity and respect for the individual, and minimises the use of coercion.

Following the CQC report based on their inspection in October 2014 which recommended that improvements could be made in the management of restrictive practices, we included an indicator in the 2014/15 Quality Report on improving the management of violence and aggression. We want to build on progress made with a new focus on the involvement of patients in the co-design of our restrictive practice framework.

Achievements
- We have made progress towards meeting this target and have involved patients in the early development of our restrictive practice framework although recognise that further work and improvements are still required. Via a request on social media, two people who have experienced restraint have offered to share their experiences and to be involved in the development of the restrictive practice framework.

- We are excited to take part in a project led by a national initiative 'Implementing Recovery through Organisational Change' and Merseycare, a leading Trust in reducing restrictive practices. Planning for the project took place in late 2015 with several workshops planned between April to October 2016. These will involve both staff and patients in the review and design of the

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restrictive practice framework and will explore how to involve patients meaningfully in the co-production of services.

- Peer support workers who have lived experience of mental health problems are trained and employed by the Trust in a variety of roles. Peer support workers are sharing their reflections on their experience of being restrained and are recommending improvements to practice, for example, they discuss with a patient the importance and use of medication prior to restraint being used. Peer support workers have supported the development of future mental health services in Southampton by conducting focus groups and interviews with service users to gain feedback. A workshop has taken place with both patients and carers to develop a charter for the Crisis Care Concordat. This will outline what individuals can expect from services no matter why or where in the pathway they present in crisis.

- A member of the Consultancy, Advice and Support Team (CAST) is using her recent experience of crisis and the use of her crisis care plan to co –facilitate training to staff on effective crisis planning with people who have a diagnosis of borderline personality disorder. The use of effective collaborative crisis planning will impact on the need to use restriction with a person with an anticipated reduction in restrictive practices used.

- Advance statements are an important way of ensuring that the use of restrictive practice is least restrictive and is guided by how the patient would like to be cared for in circumstances where restrictive practice may be necessary. Bluebird House, a secure unit for adolescents, has developed in collaboration with the patients individualised advance statements which are written in the first person and use their own words. A project to develop the routine use of individualised advance statements in Mental Health services will build on this work. The results of the project will inform further development of the restrictive practice framework.

- The seclusion working group has collated patient narratives about their experience of the use of restraint and seclusion which are being used in training programmes with staff to raise awareness. The training will also include a video of a patient describing their experiences of seclusion with recommendations made on how current practice could be improved.

- A new restrictive practices policy has been consulted on and developed to support the use of restrictive practices with an overall aim to minimise their use.

- The Trust wide Safer Forum oversees the initiatives in place to create an appropriate restrictive practice framework across the organisation and monitors progress made in this area.

Future Plans

We want to build on the achievements in 2015/16, recognising that further developments are required and will include a similar indicator in 2016/17.

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Performance against key national priorities

To insert end of year Trust performance dashboard : achieving Monitor access to care and outcome standards – should be available by end of week.
The dashboard shows performance to meet the access to care and outcome standards set by Monitor in 2015/16. It shows the Trust was compliant with xxx of the Monitor non-financial indicators by year end.

Further Information

Please refer to the Annual Report and the Annual Governance Statement for further details on the quality of services and the quality governance frameworks in place within the Trust.
To insert topics and page reference numbers

Quality Governance Strategy

Southern Health first devised a Quality Governance Strategy in 2013 entitled "Getting it right the first time" which was published in 2014. This document supports the Trust's overall aim of providing high quality and safe care, and sets out a number of patient-centred quality improvement goals for the Trust. At its centre is the promotion of a culture of continuous improvement where every member of staff has the pride, compassion, confidence and skills to champion the delivery of safe and effective care. The Quality Governance Strategy delivery objectives are based on the continuous improvement principles described in the organisational learning strategy. They are integrated into the Trust Quality Programme work streams, and overseen monthly by the quality improvement and development forum

To make sure that we can provide high quality care and meet our objectives we have a wide range of projects taking place throughout the Trust:

A review of our Quality Strategy by Deloittes in June 2015 as part of their assessment of Quality and Board Governance process showed that the document required revision. A new 5 year Quality Improvement Strategy has been developed to link the quality activities to the Trust strategic and business planning methodology to ensure that it becomes business as usual for the service managers and senior clinicians rather than an additional standalone piece activity. It has been developed taking into consideration the quality improvement work which is already established in the Trust such as the Quality Programme and use of the national recognised Plan, Do, Study, Act cycle (PDSA) and has been enhanced with new quality improvement initiatives such as the development of Quality Ambassadors to ensure that quality leads exists at each level of the organisation and the improvement results are owned by those providing the care and closest to the patients and service users.

The new Quality Improvement Strategy is due for approval by Trust Board in April 2016 with launch across the organisation in May/June 2016.

Quality Programme
During 2014/15 we established a Quality Programme to discharge some of the operational elements of our Quality Governance Strategy and provide a framework to enable focus to be given to achieving delivery of quality improvement priorities. Eight workstreams were established at this time: Governance; Patient Safety, Reporting & Learning; Peer Review & CQC Compliance; Estates & Infrastructures; Recordkeeping & Care Planning; Workforce; Patient Experience & Engagement; and Medicines Management.

During 2015/16 the role of the workstreams was reviewed to align with the 2015/16 Trust quality improvement priorities and to refocus on the areas which required further work. It was agreed that the Workforce Workstream would be disbanded as identifying and implementing quality improvements had been embedded into their existing processes. Two new workstreams were established at the end of 2015/16: Organisational Learning – separated out of the Patient Safety, Reporting & Learning Workstream to allow more focussed work in each areas; and Safeguarding – to deliver the quality improvements required following an internal thematic review.

Work has progressed through these nine workstreams and the Quality Programme will continue to be the vehicle through which quality improvement priorities continue to be driven and monitored in 2015/16.

The Peer Review programme is instrumental in validating the completion and embedding of the Care Quality Commission inspection action plans and in assessing ongoing compliance against the CQC standards. 82 peer reviews were carried out during 2015/16 and a full programme of peer reviews across all clinical divisions has been developed for 2016/17.

How we are implementing Duty of Candour
(LF needs to complete wording relating to DoC information as advised by PwC)

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Within Southern Health we are continuing to educate all staff to be open and honest with our service users. When there something wrong with the care provided we want them to be honest about what went wrong and why. It is extremely important that we say sorry and explain how we will work to prevent it happening again.

Within the past year there have been several developments to support this process;

- We have developed a training video for staff to explain the importance of this open and honest communication and provide guidance on how to say sorry straight away;
- Provided 'face-to-face' training within our bespoke investigators training course which concentrates on how to involve service users and families within serious incident investigations;
- Executive led review of serious incidents always asks how and whether the family have been involved in the investigation, whether we have said sorry and whether they have received a copy of the report;
- Our incident management system, Ulysses Safeguard, now has the ability to record 'duty of candour' communications of incidents of moderate harm and above;
- We ensure that the process has been followed correctly by monthly audit of our incident information which is shared with our service commissioners; and
- The use of 'hotspot' and 'could it happen here' communication posters throughout the organisation to ensure that we learn when things have gone wrong.

Continuing improvements which are underway;

- Development of a service user leaflet explaining the 'duty of candour' process;
- Rewrite of the Trust-wide Duty of Candour policy and procedure to make it easier for staff to interpret and undertake the role; and
- Involvement of our chaplaincy service and service user groups in educating staff in the art of writing apology letters.

We consider the implementation of 'Duty of Candour' to be extremely important and our progress is carefully monitored by the Patient Engagement working group of our quality improvement program.

Reporting and investigation of deaths and incidents

Significant work has been undertaken over the past year to improve the quality of investigations and to ensure that relatives/carers are afforded the opportunity to be fully involved in these.

In October 2015 we recruited a team of central lead investigators to lead the improvements and provide support to our frontline clinical staff. The team comprises of six senior specialist nurses who have an interest in, and the skills to support, complex investigations.

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They are specifically tasked to ensure that investigations are carried out:

- In a timely manner as required by the NHS Framework document;
- Efficiently, with the involvement of family members and loved ones in an open and transparent manner with a full explanation and apology provided when things have gone wrong; and
- In a way that ascertains root causes and contributory factors to aid the development of effective action plans.

The central team also:

- Assist with sharing of learning across the organisation using established learning networks and 'HotSpot' publications; and
- Support Trust staff at Coroners inquests ensuring that the detail of the Coroners deliberations and conclusion is understood so we can focus improvement activities and learning as a direct result of this process.

The training of frontline staff who are supported by this central team to undertake investigations has been completely revised and a new two day course created. A register of investigators has been established to ensure that only those who can evidence the training they have received will undertake the investigations. This is monitored by the Quality Governance team.

Improving our decision making process as to whether a death requires investigation

In December 2015 we launched a new mortality review process. When a death is reported, a decision is made by a panel of people chaired by a senior clinician as to whether the death requires an investigation to be undertaken and what level of investigation this should be. This process determines whether a death meets the criteria for external reporting and also whether an internal investigation should be undertaken. The process also reviews how much involvement the Trust, as a community service provider, has had in the care of the service user who died in the community and whether a commissioner-led, multi-agency investigation would be more appropriate.

We have stopped using the terms 'expected' and 'unexpected' to differentiate between deaths that require investigation and those that do not. We feel that this case by case review by a panel is a more robust way of determining whether an investigation is necessary.

It is extremely important that we involve families and loved ones from the outset of an investigation therefore it is the responsible of this panel of people to decide who is going to investigate the death and who will be the point of contact for the family members.

The information from the panel is recorded on our Ulysses risk management system which now also holds our electronic investigation documents. This allows the information to be audited to ensure that trust policy has been followed. This information is used as part of our assurance process.

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Each Division holds a Mortality Review meeting on a regular basis to review the themes and specific learning arising from investigations which have taken place for the division. The focus of these meetings is ensuring learning and service improvement.

These are new processes which came into effect in quarter three of 2015 / 2016 and as such we will be monitoring how well they are being embedded throughout 2016 / 2017. A newly establish Mortality and Serious Incident Board with executive and non-executive director membership holds the responsibility for monitoring progress, with regular reporting to Board sub-committees.

Sign up to Safety

Southern Health is pleased to be taking part in the national 'Sign up to Safety: Listen Learn Act' programme designed to help realise the ambition of making the NHS the safest healthcare system in the world by creating a system devoted to continuous learning and improvement. We are implementing our three year plan which is built around five core pledges and describes what the Trust will do to reduce harm and save lives by working to reduce the causes of harm and take a preventative approach. The action plan to meet these pledges draws together existing work programmes that support the safety improvement theme with progress monitored by the Quality Improvement Programme: Patient Safety workstream.

The five core pledges are:

- ✓ We will put safety first (reduce pressure ulcers, assess and treat venous thromboembolism, make sure patients receive all their medicines, monitor physical health);
- ✓ We will continually learn (improve action plans and learning, quarterly quality conferences, involve patients in developing services);
- ✓ We will be transparent (say sorry when things have gone wrong, involve patients and families in investigations of serious incidents);
- ✓ We will collaborate (listen to our patients and their carers and change practice, involve patients in co-designing clinical pathways); and
- ✓ We will support (support teams to understand and learn from quality information, 'speak out' service to highlight safety issues).

Care Quality Commission

The Care Quality Commission undertook a comprehensive inspection of the Mental Health, Learning Disability and Community Health services of the Trust between 6 – 10th October 2014 with their final report published in February 2015. The Trust was rated as follows:

Overall rating for mental health and community health services	Requires Improvement
Are mental health and community health services safe?	Requires Improvement
Are mental health and community health services effective?	Requires Improvement
Are mental health and community health services caring?	Good
Are mental health and community health services responsive?	Good
Are mental health and community health services well-led?	Requires Improvement

The Trust developed a 129 point action plan to address the areas identified for improvement by CQC.

Among the areas identified for improvement were the following:

- Management of ligatures, restraint and seclusion;
- Suitability of Ravenswood House as a medium secure forensic unit ;
- Community staffing levels;
- Medicines management;
- Mental health crisis care and use of out of area beds;
- Information systems; and
- Timeliness of equipment provision.

Delivery of improvements has been through the existing Quality Programme which is led by the Chief Operating Officer and Director of Performance, Quality and Safety on behalf of the Executive Team and reports into the Quality & Safety Committee. All action plans have been agreed with commissioners and the peer review programme (which includes external stakeholders), is used as one of the methods of validation.

The CQC have carried out five inspections during 2015/16. Each of these was a follow-up inspection to review progress against the actions from the 2014/15 inspections. Two inspections were within the Trust's social care services and these services received individual ratings of Good and Requires Improvement. Action plans have been developed to address any areas for improvement identified. Two inspections of specialised services found progress had been made against the original action plan following the October 2014 inspections with some areas of improvement still to be completed. The report from the latest inspection of Mental Health and Learning Disabilities services has not yet been received, however the Trust was issued with a warning notice in late March. Further details are included in the Annual Governance Statement on page xxxxxxxxx.

Staff Survey

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The NHS Staff Survey is one way that the Trust can hear directly from staff about their experience at work across a variety of factors. The responses received help to ensure that their views inform decisions that influence what it is like to work here or receive treatment from our services. Further information is included in the Annual Report.

The most recent NHS Staff Survey results for indicators KF26 (percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months) and KF21 (percentage believing that trust provides equal opportunities for career progression or promotion) are shown in the following table.

KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	21%
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	88%

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Annex 1: Statements from commissioners, local Healthwatch organisations and Overview and Scrutiny Committees

To insert

Annex 2: Statement of directors' responsibilities for the quality report

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

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support 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 2015/16 and supporting guidance;
- 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 2015 to date of statement
- papers relating to quality reported to the board over the period April 2015 to date of statement
- feedback from commissioners dated XX/XX/2016
- feedback from governors dated XX/XX/2016
- feedback from local Healthwatch organisations dated XX/XX/2016
- feedback from Overview and Scrutiny Committee dated XX/XX/2016
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated XX/XX/2016
- the national patient survey 2015
- the national staff survey 2015
- the Head of Internal Audit's annual opinion over the trust's control environment dated XX/XX/20XX
- CQC Intelligent Monitoring Report dated February 2016

- 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 Account

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regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

NB: sign and date in any colour ink except black

………………Date…………………………………Chairman

………………Date…………………………………Chief Executive

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Annex 3: External Auditor’s Limited Assurance Report

To insert

Annex 4: Data definitions

PwC tested the following indicators

100% enhanced Care Programme Approach (CPA) patients receive follow up contact within seven days of discharge from hospital

Detailed descriptor
The percentage of patients on Care Programme Approach (CPA) who were followed up within seven days after discharge from psychiatric inpatient care during the reporting period.

Data definition
Numerator
The number of people under adult mental health illness specialities on CPA who were followed up (either by face to face contact or by phone discussion) within seven days of discharge from psychiatric in-patient care during the reporting period.

Denominator
The total number of people under adult mental illness specialities on CPA who were discharged from psychiatric in-patient care. All patients discharged from psychiatric in-patient wards are regarded as being on CPA during the reporting period.

Details of the indicator
All patients discharged to their usual place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within seven days of discharge. Where a patient has been transferred to prison, contact should be made via the prison in-reach team. The seven-day period should be measured in days not hours and should start on the day after the discharge.

Exemptions include patients who are re-admitted within seven days of discharge; patients who die within seven days of discharge; patients where legal precedence has forced the removal of the patient from the country; and patients transferred to an NHS psychiatric inpatient ward.

All CAMHS (child and adolescent mental health services) patients are also excluded.

Accountability
Achieving at least a 95% rate of patients followed up after discharge each quarter.

Detailed Guidance
More detail about this indicator and the data can be found within the Mental Health Community teams Activity section of the NHS England website.

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Admissions to inpatient services had access to crisis resolution home treatment teams

Detailed descriptor
The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team (CRHT) acted as a gatekeeper during the reporting period.

Data definition
In order to prevent hospital admission and give support to informal carers, CRHT are required to gatekeep all admission to psychiatric inpatient wards and facilitate early discharge of service users.

Numerator
The number of admissions to the trust's acute wards that were gatekept by the CRHT during the reporting period.

Denominator
The total number of admissions to the trust's acute wards.

Details of the indicator
An admission has been gatekept by a crisis resolution team if it has assessed the service user before admission and was involved in the decision-making process which resulted in an admission. An assessment should be recorded if there is direct contact between a member of the CRHT team and the referred patient, irrespective of the setting, and an assessment is made. The assessment may be via a phone conversation or by any face-to-face contact with the patient.

Exemptions include patients recalled on Community Treatment Order; patients transferred from another NHS hospital for psychiatric treatment; internal transfers of service users between wards in the trust for psychiatry treatment; patients on leave under Section 17 of the Mental Health Act; and planned admissions for psychiatric care from specialist units such as eating disorder units.

Partial exemption is available for admissions from out of the trust area where the patient was seen by the local crisis team (out of area) and only admitted to this trust because they had no available beds in the local area. Crisis resolution team should assure themselves that gatekeeping was carried out. This can be recorded as gatekept by crisis resolution teams.

This indicator applies to patients in the age bracket 16-65 years and only applies to CAHMS patients where they have been admitted to an adult ward.

Accountability
Achieving at least 95% of patients in the quarter.

Detailed Guidance

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More detail about this indicator and the data can be found within the Mental Health Community teams Activity section of the NHS England website.

Local Indicator

Safety incidents involving severe harm or death

Indicator description
Patient safety incidents (PSI) reported to the National Reporting and Learning Service (NRLS) where degree of harm is recorded as ‘severe harm’ or ‘death’, as a percentage of all patient safety incidents reported.

Indicator construction
Numerator: the number of patient safety incidents recorded as causing severe harm/death as described above.

The ’degree of harm’ for patient safety incidents is defined as:
‘severe’ – the patient has been permanently harmed as a result of the PSI
‘death’ – the PSI has resulted in the death of the patient

Denominator: the number of patient safety incidents reported to the National Reporting and Learning Service (NRLS).

Indicator format: standard percentage.

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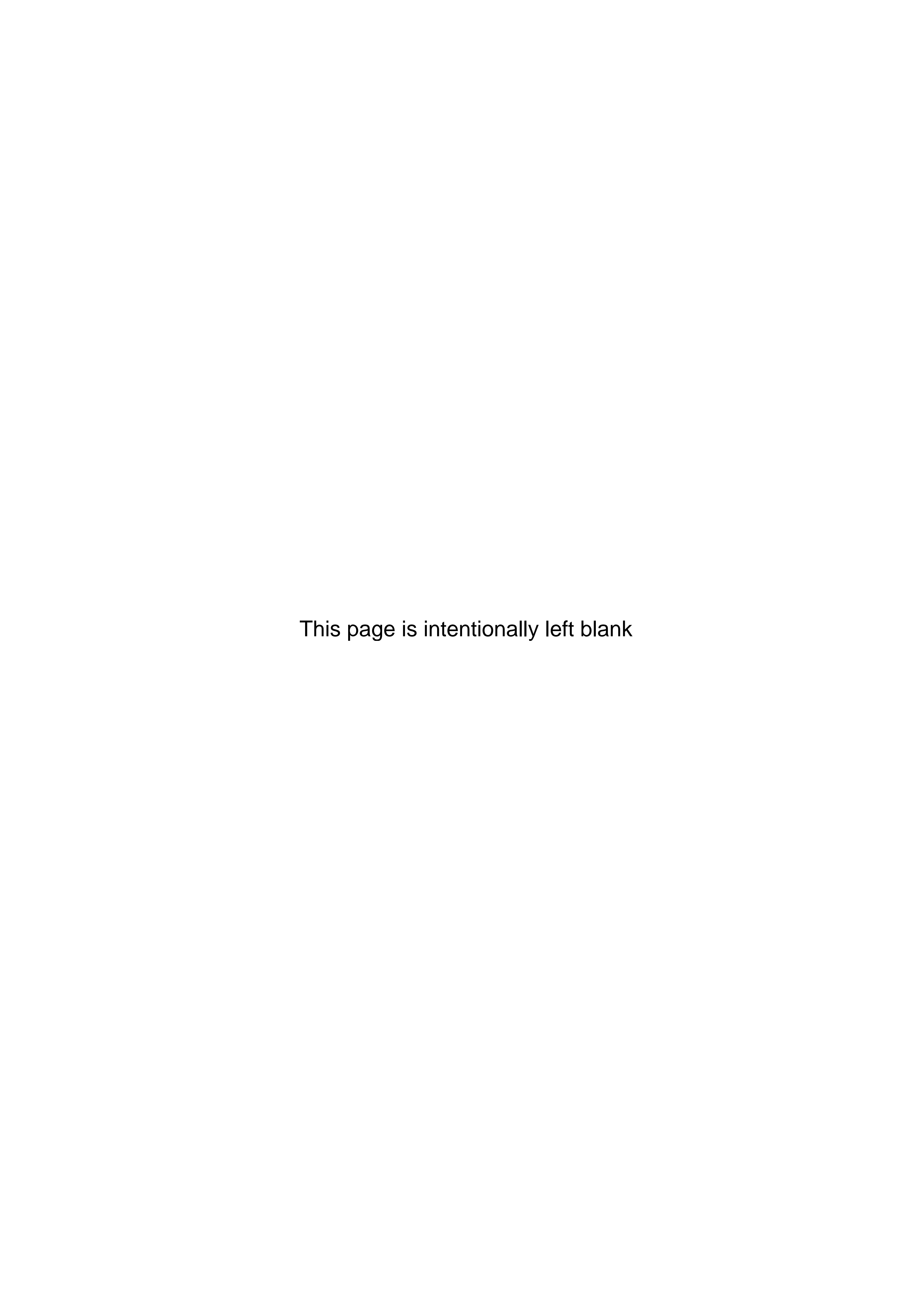

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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		UPDATE ON PROGRESS - INDEPENDENT REVIEW OF DEATHS OF PEOPLE WITH A LEARNING DISABILITY OR MENTAL HEALTH PROBLEM IN CONTACT WITH SOUTHERN HEALTH NHS FOUNDATION TRUST APRIL 2011 TO MARCH 2015		
DATE OF DECISION:		28 APRIL 2016		
REPORT OF:		SERVICE DIRECTOR - LEGAL AND GOVERNANCE		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Mark Pirnie**	**Tel:**	**023 8083 3886**
	E-mail:	**Mark.pirnie@southampton.gov.uk**		
Director	**Name:**	**Richard Ivory**	**Tel:**	**023 8083 2794**
	E-mail:	**Richard.ivory@southampton.gov.uk**		
STATEMENT OF CONFIDENTIALITY				
None				

BRIEF SUMMARY

NHS England commissioned Mazars to conduct an investigation of the deaths of all patients of Southern Health who had been in receipt of mental health or learning disability services since 2011 following the avoidable death of Connor Sparrowhawk in Oxfordshire. Connor was a patient in the care of Southern Health NHS Foundation Trust.

The Mazars report was published on NHS England's website on 17 December 2015 and highlights a number of actions for the Trust, commissioners and regulators.

At the 1 February 2016 meeting of the Health Overview and Scrutiny Panel (HOSP) the Panel considered the Mazars report with invited representatives and recommended that Southern Health, at an appropriate meeting, updates the Panel on progress implementing the improvement plan and feedback from regulators.

Appended to this report is a briefing paper and updated action plan informing the Panel of the progress made following publication of the Mazars report, and the recent developments with regards to NHS Improvement and the Care Quality Commission.

The Panel are requested to consider the appendices and discuss the key issues with the invited representatives from Southern Health NHS Foundation Trust.

RECOMMENDATIONS:

	(i)	That the Panel considers the attached briefing paper and updated action plan and discusses the issues with the invited representatives from Southern Health NHS Foundation Trust.

REASONS FOR REPORT RECOMMENDATIONS

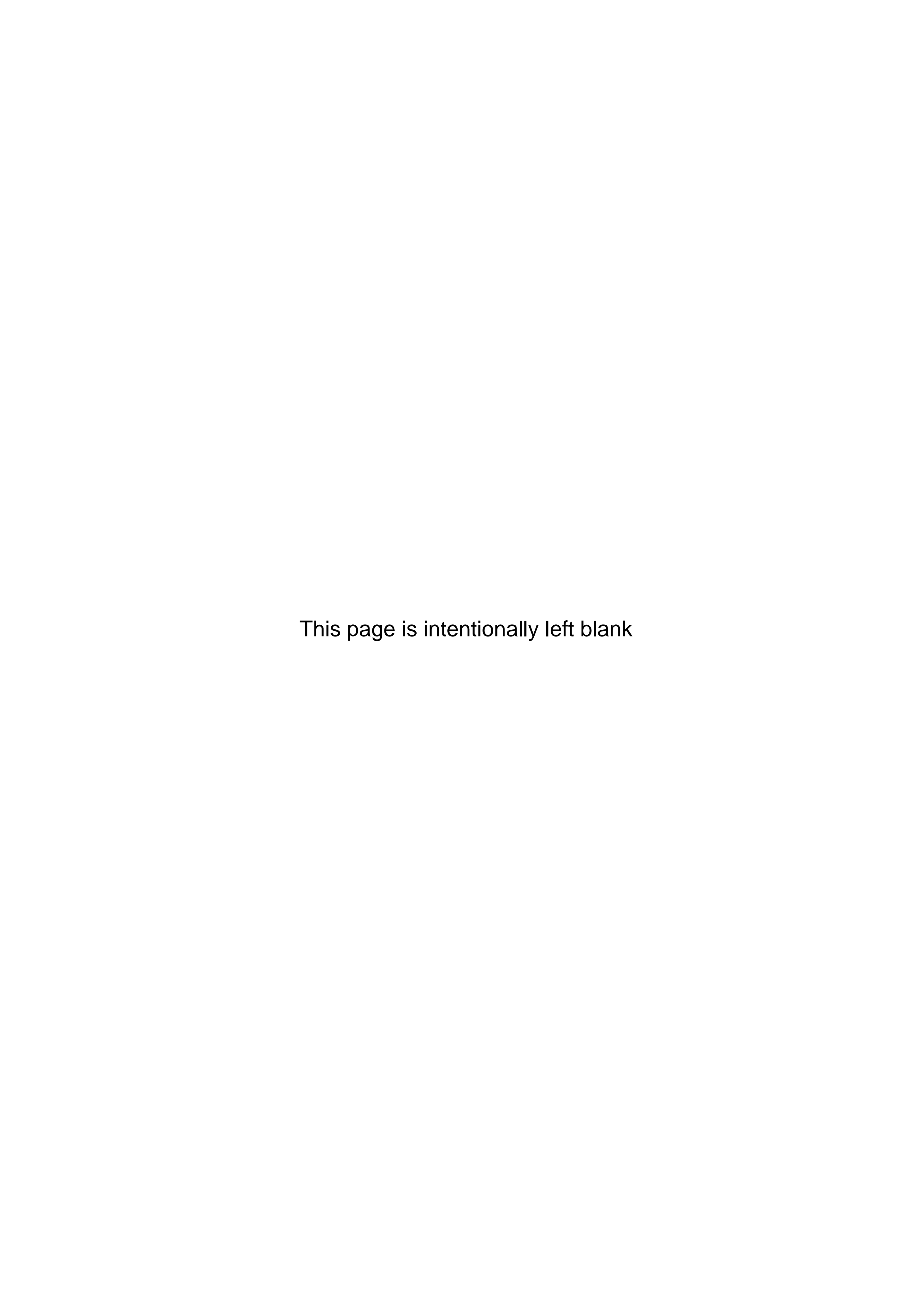
1.	To enable the Panel to effectively scrutinise the issues impacting on health services in Southampton raised by the Mazars report.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2.	None.

<table>
<tr><td colspan="3">DETAIL (Including consultation carried out)</td></tr>
<tr><td>3.</td><td colspan="2">Following consideration of the Mazars report at the 1 February 2016 meeting of the HOSP the Panel made a number of recommendations for Southern Health and commissioners.</td></tr>
<tr><td>4.</td><td colspan="2">The Panel recognised the need to regularly review the issues raised in this report until the Panel are assured that progress is being made. The Panel therefore made the following recommendation:
‘That, following discussion with the Chair, Southern Health NHS Foundation Trust updates the Panel on progress implementing the improvement plan and feedback from regulators, at an appropriate meeting of the HOSP.’</td></tr>
<tr><td>5.</td><td colspan="2">Attached as Appendix 1 is a briefing paper from Southern Health NHS Foundation Trust. Attached as Appendix 2 is the updated Mortality and SIRI Improvement Plan. The Panel are requested to consider the briefing paper and improvement plan and discuss the key issues with the invited representatives.</td></tr>
<tr><td colspan="3">RESOURCE IMPLICATIONS</td></tr>
<tr><td colspan="3"><u>Capital/Revenue</u></td></tr>
<tr><td>6.</td><td colspan="2">None.</td></tr>
<tr><td colspan="3"><u>Property/Other</u></td></tr>
<tr><td>7.</td><td colspan="2">None.</td></tr>
<tr><td colspan="3">LEGAL IMPLICATIONS</td></tr>
<tr><td colspan="3"><u>Statutory power to undertake proposals in the report</u>:</td></tr>
<tr><td>8.</td><td colspan="2">The duty for local authorities to undertake health scrutiny is set out in National Health Service Act 2006. The duty to undertake overview and scrutiny is set out in Part 1A Section 9 of the Local Government Act 2000.</td></tr>
<tr><td colspan="3"><u>Other Legal Implications</u>:</td></tr>
<tr><td>9.</td><td colspan="2">None.</td></tr>
<tr><td colspan="3">POLICY FRAMEWORK IMPLICATIONS</td></tr>
<tr><td>10.</td><td colspan="2">None.</td></tr>
<tr><td colspan="2">KEY DECISION</td><td>No</td></tr>
<tr><td colspan="2">WARDS/COMMUNITIES AFFECTED:</td><td>None</td></tr>
</table>

SUPPORTING DOCUMENTATION		
Appendices		
1.	Briefing Paper - Update on progress made since publication of the independent review of deaths of People with Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015	
2.	Southern Health - Updated Mortality and SIRI Improvement Plan	
Documents In Members' Rooms		
1.	None.	
Equality Impact Assessment		
Do the implications/subject of the report require an Equality and Safety Impact Assessments (ESIA) to be carried out.		No
Privacy Impact Assessment		
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.		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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Southern Health NHS
NHS Foundation Trust

Appendix 1

Update on progress made since publication of the independent review of deaths of People with Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015

1.1 This report aims to update Southampton Health Overview and Scrutiny Panel members regarding progress made against Southern Health's improvement plans following publication of the Mazars report in December 2015.

1.2 The independent review found that the Trust's processes for reporting and investigating deaths of people with learning disabilities and mental health needs could have been better. We fully accept this and apologise unreservedly that families were not always involved as much as they could have been. We accept the report's recommendations.

1.3 The report looked at the way the Trust recorded and investigated deaths of people with mental health needs and learning disabilities who had been on contact with Southern Health at least once in the previous year, over a four-year period from April 2011 to March 2015. The report did not consider the quality of care provided by the Trust to the people we serve.

1.4 Since the independent report was published four months ago we have made extensive changes to the way we record and investigate deaths of any patient who uses services provided by Southern Health. On 1 December 2015, a new Trust-wide system for reporting and investigating deaths came into force to increase monitoring and scrutiny, share learning with staff and improve the quality of reports and investigations. This system is continuously being reviewed by the Board and significant progress has been made in a number of areas:

- The Mazars report highlighted concerns over the quality of investigations and reports into patient's deaths. Reports made by Southern Health are now reviewed by a clinically-led panel, including an Executive member, to ensure full oversight by the Board of all deaths. This new process is monitored daily by the Trust's Quality and Governance Team and the panel specifically considers the quality of reports to make sure they are thorough, clearly written and understandable.
- Since December 2015 we no longer define deaths as "expected" or "unexpected" as this is not helpful in determining whether an investigation is required. Instead all deaths of patients outlined in the new procedure must be recorded, this includes all deaths of people known to the learning disability service within 12 months of their last contact with the service. This is to ensure that every death is scrutinised by the clinically-led panel and investigated further if required.

- Under this new system, 100 per cent of the 316 deaths reported under the new system between 1 December 2015 and 4 April 2016 have bene reviewed by the clinically-led panel. Panel members have carefully considered on a case-by-case basis, whether a further investigation into a patient's death is needed. Where required, a full investigation into a patient's death has been launched.
- Every family has been offered the opportunity to be involved in an investigation into the death of their loved one wherever possible.
- All clinical staff have been informed of the requirement for them to adhere to the new system for reporting patient deaths. Compliance with the new system is closely monitored and scrutinised by a member of the Executive team.

1.5 This is in addition to steps already taken, which include:

- Significantly strengthening Executive oversight of the quality of investigations and ensuring appropriate measures are in place to address any issues identified, and that all learning is shared and implemented across the Trust. New Executive level doctors and nurses joined the Trust Board from July 2014.
- Setting up a central investigation team which is improving the quality and consistency of investigations and learning.
- Capturing conclusions of inquests more effectively to identify and act swiftly on areas for improvement.

1.6 The health sector regulator NHS Improvement announced in January 2016 that it had decided to take action against Southern Health, utilising its powers under section 106 of the Health and Social Care Act 2012. Monitor is providing expert support to improve the way the Trust reports and investigates deaths. Southern Health has agreed with Monitor to take a number of steps to show how the Trust is improving. These are:

- Implement the recommendations of the Mazars report through a comprehensive action plan
- Get assurance from independent experts on the action plan
- Work with an Improvement Director appointed Monitor

1.7 Earlier this month, independent experts were appointed to provide assurance on improvements being made by Southern Health following publication of the Mazars report. Specialist health and social care consulting firm Niche has now been appointed to provide expert external assurance on the Trust's action plan. A thorough and detailed procurement process was undertaken in partnership with NHS Improvement prior to Niche being appointed.

1.8 The appointment of Niche comes after NHS Improvement announced last month that Alan Yates would work with Southern Health as Improvement Director. Alan started his role on 30 March 2016. He is providing expert

support and challenging the Trust as we continue to build on improvements already made. Alan's experience as a Chief Executive is extremely valuable in supporting us as we continue to learn, and make improvements to the way we deliver care to everyone who relies on the services we provide. We are committed to working with Alan to ensure we make all necessary changes required as quickly as possible.

1.9 The Care Quality Commission (CQC) undertook a follow-up inspection of Southern Health services in January, focusing on improvements within mental health and learning disability services, in particular acute mental health inpatient wards, units for people with learning disabilities, crisis/community mental health teams and child and adolescent inpatient and secure services. The inspection also focused on how the Trust is progressing with our action plan in place following the Mazars review, and progress on improving how we investigate and respond to patient deaths. At the time of submitting this update, the inspection report is yet to be published, but is expected to be published near the end of April.

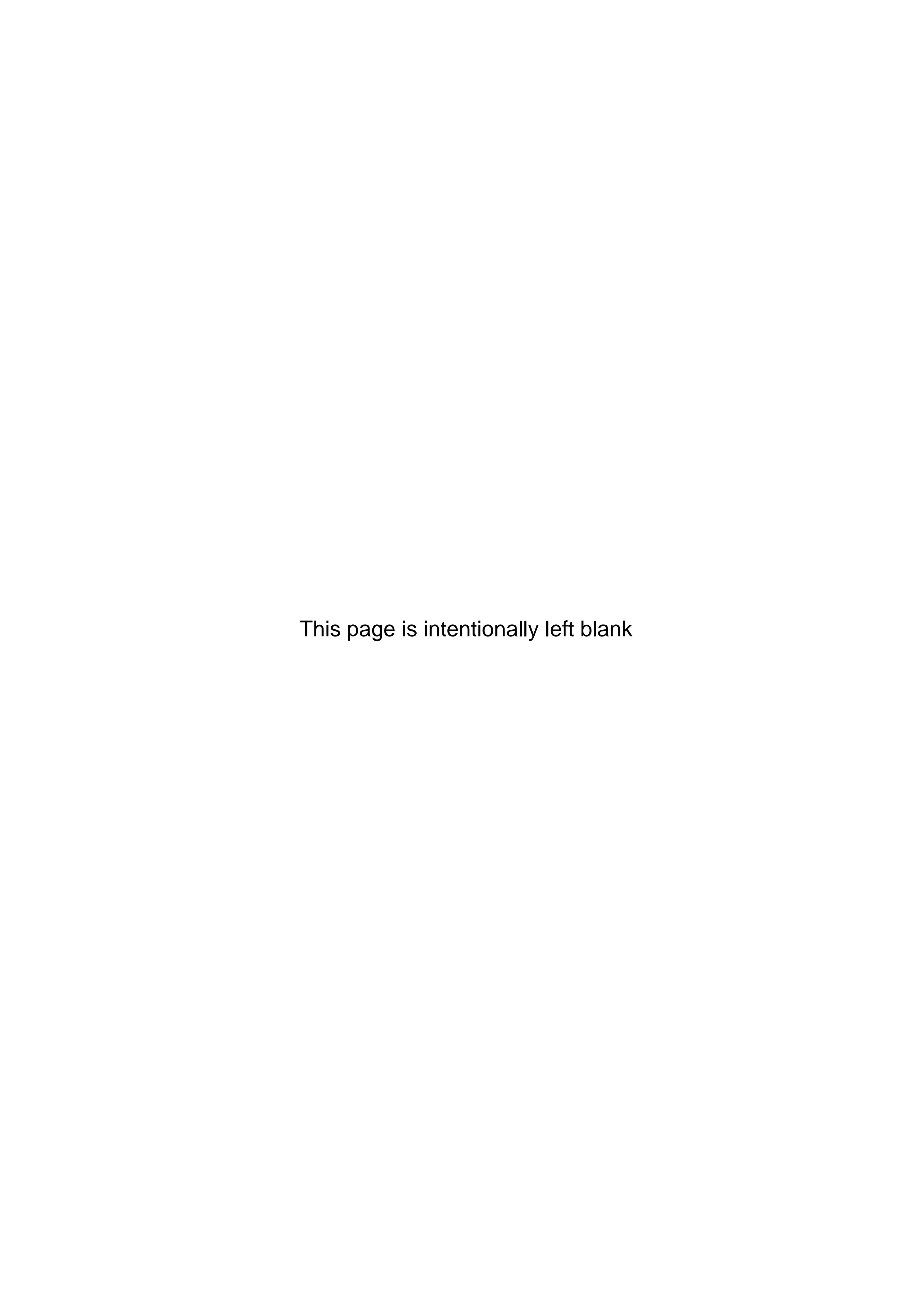
1.10 However the CQC published a warning notice on 6 April 2016 which highlights further improvements that need to be made to our governance arrangements in respect of findings from the 2014 inspection. We have been very clear and open that we have a lot of work to do to fully address recent concerns raised about the Trust.

1.11 Good progress has been made, however we accept that the CQC feels that in some areas we have not acted swiftly enough. We take the CQC's concerns very seriously and have taken a number of further actions. The full CQC inspection report will allow us to consider their findings in full.

1.12 In addition, NHS Improvement has announced that it intends to take action to allow it to make management changes if progress isn't made on fixing the concerns raised.

1.13 Southern Health fully accepts the need to continue to make changes. We will continue to work closely with the Improvement Director, our regulators and commissioners to make the improvements required. The Trust's focus continues to be on ensuring that everyone who relies on the services we provide receives the best possible care.

ENDS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Action Plan for: Mortality and SIRI Improvement

Version No: 10 ***Date:*** 31/03/2016

Issue No.	What is the issue to be addressed?	Current Risk/ Priority Low, Med, High	Action/s to be taken	Evidence of the completion of each action	Action Timescale	Action Progress Blue=Complete Green=Begun & On Track Amber= Risk of slippage Red=Overdue	Evidence of the achievement of the required improvement	Progress with achieving required improvement It should be noted that whilst individual actions may be completed, a number of these will need a few months 'bedding in time' before the required improvement is seen. This column provides progress updates on achieving the actual improvements rather than completion of individual actions Red = improvement overdue or at risk of being overdue Amber = improvement partially achieved or not yet achieved but on track Green = improvement achieved Blue = improved position maintained consistently over 3 month period	Who is responsible for completing the action Name & Job Title	Who is accountable for ensuring the action is completed? Name & Job Title
			Number							
1	Ensure that Serious Incident investigation reports adhere to national timescales.	high	1.1 Weekly 'flash' report to be developed to describe the status and timelines for every SIRI investigation - this will be embedded into the Trust BI System. The Flash report will be circulated to the Executive team and all Divisional leads accountable for ensuring that investigations are completed to timescales. The detail in the report will contain the stage the investigation is at and whether it has been rejected by the quality assurance panel at corporate level.	1.1 Weekly Flash produced in new format.	1.1 Completed	1.1 Completed	60% of all Serious Incident Investigation reports to adhere to national timescales by 31.03.16. 90% of all Serious Incident Investigation reports to adhere to national timescales by 30.06.16	31.03.16 37% of Serious Incident Investigation reports adhere to national timescales due to the backlog of historical incident which are more than 100 days overdue. Technical issues aligning Ulysses and Tableau has created a delay on combined reports	Helen Ludford, Associate Director of Quality Governance Fiona Richey, Head of Business Continuity and Risk (for BI and Ulysses system developments) Sarah Pearson, Head of Legal & Insurance Services (for SIRI management team), Communications Team, Mayura Deshpande, Associate Medical Director (Quality), Patient Safety and Divisional Clinical Directors	Dr Chris Gordon, Director of Performance, Quality and Patient Safety, Chief Operating Officer
			1.2 Executive team to review the governance 'flash' report every week.	1.2 TEG minutes	1.2 Completed	1.2 Completed				
			1.3 Serious Incident Investigation Training to include the National timescale requirement.	1.3 Investigators in post and in date for training and competency requirements to undertake their role	1.3 Completed	1.3 Completed				
			1.4 Lead Investigators to be appointed for each Division who will track compliance to timescales and support investigators to achieve this. Job Description to be standardised with a 20% Corporate and 80% Divisional governance focus and an initial priority objective to deliver clearance of any SIRI backlogs which will be evidenced in the Flash report.	1.4 Centralised lead investigation team workforce metrics to include- 'in post' and 'vacancy' position (register of names / divisions to be supplied) and role specification.	1.4 Completed	1.4 Completed				
			1.5 Executive support to be sought and agreed to ensure that investigators are given sufficient time to investigate serious incidents as part of their job plans. If improvement trajectories are not being met a divisional review of capacity will take place.	1.5 Monitoring of the percentage improvements in the ability to complete quality investigations within 60 days.	1.5 30.03.16	1.5 Slippage - trajectories not being met, predicted backlog closure 30.04.16				
			1.6 All incident trackers to form part of the Ulysses Safeguard system rather than stand-alone spreadsheets.	1.6 All investigations will be on the Ulysses system as of the 1st January 2016, a dual process will be in place until 1st April 2016 when the trackers will be closed down. This will be monitored by the Ulysses System Analyst. Evidence - ERCA report.	1.6 31.03.16	1.4 Completed				
			1.7 Implement the new death reporting process.	1.7 Compliance monitoring of Divisions at each stage of the new reporting process evidenced within the Flash report.	1.7 31.01.16	1.7 Overdue Combined Tableau reports with Spine and Ulysses data not available until 04.16 due to technical issue with N3 security agreements and data extractions from the Ulysses system				
			1.8 Increase compliance to 48hr panel process.	1.8 Monitor compliance to 48 hr panels through the TEG Flash Report aiming to achieve set improvement criteria of 75% by January 2016 and to 95% by February 2016.	1.8 30.06.16	Overdue 21.03.16 87% compliance achieved - monitored on a rolling 4 week basis				
			1.9 All deaths of patients detained under the Mental Health Act to be reported via the Death reporting process and have system 'flag' to ensure that all are investigated as Serious Incidents.	1.9 System generated mortality report and Serious Incident tracking report.	1.9 completed	1.9 Completed in Ulysses				

Agenda Item 8
Appendix 2

No.	Objective	Priority	Action	Evidence	Timescale	Status	Success measure	Progress	Lead	Executive lead
			1.10 All Trust staff must be informed of changes to policy and the new procedures linked to improved incident investigation and the oversight of mortality. All new policies to be published on the intranet and highlighted in the staff bulletin. Executive level announcements to the made about the changes to process and why incident investigation is so important.	1.10 Policy publication, staff bulletin features and team level meeting minutes.	1.10 30.04.16	1.10 On track				
2	Ensure that Serious Incident investigation reports are of the required quality, identify a clear root cause and investigations have been undertaken by a trained professional.	high	2.1 All corporate panels to be chaired by an Executive director.	2.1 Corporate panel minutes and Terms of Reference	2.1 Completed	2.1 Completed	60% of all Serious Incident Investigation reports will achieve panel approval on first submission by 31.03.16 (some minor amendments acceptable). 80% of all Serious Incident Investigation reports will achieve panel approval on first submission by 30.06.16 (some minor amendments acceptable). 95% of Serious Incident Investigations to include a root cause.	31.03.16 67% Serious Incidents achieving panel approval on first submission and progressing to minor amendments panel. 87% Serious Incident reports now contain a root cause.	Helen Ludford, Associate Director of Quality Governance Fiona Richey, Head of Business Continuity and Risk (for BI and Ulysses system developments) Sarah Pearson, Head of Legal & Insurance Services (for SIRI management team)	Dr Chris Gordon, Director of Performance, Quality and Patient Safety, Chief Operating Officer
			2.2 Recruit centralised Serious Incident Investigator team to be known as the Divisional Lead Investigation Officers.	2.2 Demonstration that these individuals are in post, competent and are working to a defined job description	2.2 Completed	2.2 Completed				
			2.3 Provide Investigator Training to Divisional Lead Investigation Officers and those staff who undertake Investigating Officer roles. The course will be advertised and booked through the LEaD training system. This training will include: All related SHFT policies NPSA guidance tools on report writing in training Root cause analysis tools and how to use these to extract a root cause National Serious Incident Framework guidance inclusive of timescales Requirement for reporting deaths in detention Duty of Candour (cross reference to section 4 DoC) Human Factors Complaints management Ulysses system training Legal and inquest overview	2.3 Course schedule and attendance logs	2.3 Completed	2.3 Completed				
			2.4 Create an investigation template for the Ulysses Safeguard system to guide investigators with the process of report writing and ensure that additional tools / supplementary documents can be stored with the investigation.	2.4 Template for electronic RCA developed in the Ulysses system and an example of an SI produced in the electronic format.	2.4 Completed . Electronic template went live on 1st January 2016	2.4 Completed				
			2.5 Senior clinician in a senior leadership role to lead Divisional Serious Incident report reviews prior to presentation at corporate panel.	2.5 Standardised Terms of reference for the Divisional Panels - which include a scheme of delegation	2.5 Review of Terms of Reference to include a scheme of delegation	2.5 In review but on track				
			2.6 Create a register of Trust-wide Investigating Officers to ensure all have been trained and competency assessed by undertaking a minimum requirement of one investigation per annum	2.6 Register of Investigating Officers to include annual number of investigations undertaken and supported by each individual	2.6 30.04.16	2.6 On track				
			2.7 Develop a Divisional Lead Investigating Officers supervision session for case study learning from IMAs and Corporate Panels and updates to National guidance.	2.7 Minutes of the Divisional Lead Investigating Officers supervision session	2.7 Completed	2.7 Completed				
			2.8 To ensure improvement is demonstrable through the monitoring of first time sign off of SI Investigation reports at commissioner sign off panels and by the coroner	2.8 Monitoring evidence of % achievement against aim of 100% first time sign off at both corporate panel and by commissioner panel and coroner	2.8 30.04.16	2.8 On track				
3	Ensure that Corporate review panels are effective in the sign off of high quality investigation reports and that they are used to capture organisational learning.	high	3.1 Corporate panels to be held every other week with Executive Director Chair and all Serious Incident Investigation Reports to be presented and signed off through this panel (excluding pressure ulcers).	3.1. The corporate panels schedule and the minutes and Terms of Reference of the panel	3.1. Completed	3.1. Completed	60% of reports signed off by external CCG panel on first submission by 31.03.16. 90% of reports signed off by external CCG panel on first submission by 30.06.16.	31.03.16 This target cannot yet be accurately monitored due to the backlog of historical incidents 2013, 2014 and 2015 which have not been closed. There is an exercise taking place with commissioners to clear this backlog.	Helen Ludford, Associate Director of Quality Governance Sarah Pearson, Head of Legal & Insurance Services (for SIRI processes)	Dr Chris Gordon, Director of Performance, Quality and Patient Safety, Chief Operating Officer
			3.2 Minor amendment review panels to be held every other week with Associate Director Chair to ensure timely final version reports uploaded onto STEIS.	3.2 The minor amendment review panel schedule and the minutes and Terms of Reference of the panel	3.2 Completed	3.2 Completed				
			3.3 Serious Incident panel process to be clearly and simply described in the SHFT policy.	3.3 Up to date policy.	3.3 Completed	3.3 Completed				
			3.4 Minutes of corporate panels to be recorded and held by the Serious Incident and Incident Team.	3.4 Process in place for the taking of, storage and Chair sign off of serious incident panel minutes. This can be evidenced by SOP.	3.4 Completed	3.4 Completed				
			3.5 The learning from Serious Incident investigations to be extracted and shared within 'Hot-Spots'.	3.5 'Hot-Spots' organisational learning tools to be disseminated on a monthly basis with Corporate Panel learning points.	3.5 Completed	3.5 Completed				
			3.6 A scoring mechanism to be added to the corporate panel minutes, scoring the quality of the reports submitted to track improvement.	3.6 Evidence of the scoring mechanism and ability to track improvement. Improved quality scores in all Divisions	3.6 Completed	3.6 Completed				
4	Ensure that Duty of Candour requirements	medium	4.1 Duty of Candour training to be delivered as part of the investigators course.	4.1 Investigators course programme supported by evidence in SIRI reports.	4.1 Completed	4.1 Completed				

	are always met.		4.2 Leaflet to be created which explains the Duty of Candour requirements to service users / patients / staff / next of kin.	4.2 Leaflet created approved by the Patient Engagement workstream prior to launch, evidence provided in minutes.	4.2 31.03.16	4.2 Slippage - not approved by the work stream requires direction within the policy	100% compliance to the commissioned requirements for Duty of Candour compliance. 100% compliance that families or next of kin, where possible, have been involved in Serious Incident Investigations by 31.03.16 100% compliance with new procedure for writing to families where death was not a SIRI by 30.06.15.	31.03.16 100% compliance to DoC but manual process to validate at the present time.	Briony Cooper, Head of Quality Contracts and Quality Performance	Dr Lesley Stevens, Medical Director - Executive sponsor of the Patient Engagement workstream
			4.3 Ulysses Safeguard screens to be further developed to map the Duty of Candour requirement and to record full compliance with each stage. Audit of data capture will be used as an evidence base for assuring family involvement or reviewing cases where it has not been appropriate to facilitate involvement.	4.3 Ulysses capture screens - screen shots - audit	4.3 30.04.16 - for audit tool and first audit	4.3 On Track				
			4.4 Data from Ulysses Safeguard to be used to report the Duty of Candour compliance to Commissioners via CQRM process.	4.4 Informatics report and validation process. Serious Incident panel minutes will capture that the Duty of Candour has been met for all Serious Incidents.	4.4 Completed	4.4 Completed				
			4.5 Role description for the Lead Investigator (centralised team) to include the specific role of oversight of communication and involvement of families.	4.5 Role description.	4.5 Completed	4.5 Completed				
			4.6 Duty of Candour policy to be reviewed and rewritten to be specific about the involvement of families in investigations.	4.6 Up to date policy.	4.6 31.03.16	4.6 Slippage - document in ratification process				
			4.7 Process to be developed (and included in first revision of new Death reporting procedure) which formally invites any concerns from families to be raised following a death that meets the criteria set out in the new procedure and advises families as to whether an investigation will take place. (this will be over and above the actions already required by Trust policy when it is clear from the outset that the death constitutes a SIRI and Duty of Candour is engaged as well as the requirement to invite families to participate in the investigation)	4.7 Evidence of family involvement in investigations to be shown by; SIRI report Family feedback to be capture in commissioned report Corporate panel review templates	4.7 31.01.16	4.7 Overdue - report has been commissioned to seek information regarding family involvement				
			4.8 Root Cause Analysis investigation template to be amended in order that the section which outlines what involvement/contact there has been with the families is more structured and requires specific details (currently a free text box).	4.8 Copy of the investigation template extracted from Ulysses	4.8 31.03.16	4.8 Completed				
			4.9 The Trust will seek to engage lay people, families and service users to oversee the development of documents in relation to Duty of Candour and the investigation processes	4.9 Evidence of oversight and input from lay people, families and service users to be found in mortality related minutes and within the ratification groups for new policies or procedures or patient facing literature	4.9 30.04.16	4.9 On Track				
5	Ensure that there is evidence of the rationale of the decision making process of whether to conduct an investigation into a death and that it is clearly recorded.	high	5.1 Provide a clear definition of the decision making process surrounding what constitutes a serious incident. Incorporate this process in Serious Incident training and document it within the new Procedure for the Reporting and Investigation of Deaths.	5.1 Copy of the Procedure for the Reporting and Investigation of Deaths and evidence of sign off by the Mortality Working Group.	5.1 Completed	5.1 Completed	There will be a robust audit trial of the decisions to investigate a death which is 60% correct without need for central moderation by 31.03.16 and 95% correct by 30.06.16.	31.01.16 Audit tool developed and piloted, 1st result 82%	Helen Ludford, Associate Director of Quality Governance Fiona Richey, Head of Business Continuity and Risk (for BI and Ulysses system developments)	Dr Chris Gordon, Director of Performance, Quality and Patient Safety, Chief Operating Officer
			5.2 Develop and launch a Ulysses death reporting form. This will commence a process with a senior clinical sign off as to whether a death should be investigated and what level of investigation would be required. This will all be tracked and monitored within the system.	5.2 Screen shot of death reporting form and audit evidence that these have been completed correctly.	5.2 Completed	5.2 Completed				
			5.3 Provide Trust wide communication of the new process ahead of 'go live' using bulletin and intranet communications.	5.3 Evidence of Trust communication team circulating the new process ahead of the 'go-live' date.	5.3 Completed	5.3 Completed				
			5.4 Monitoring of compliance with this process to be undertaken by the Mortality Working Group under Executive leadership.	5.4 Minutes of the Mortality Working Group and Ulysses extraction to provide assurance of reporting.	5.4 Completed	5.4 Completed				
6	Ensure a systematic approach to cross organisational learning from deaths through formal Mortality review processes at Divisional and Trust level through Mortality Meetings and themes and trends are clearly identified and acted on.	high	6.1 Divisions to introduce regular Mortality Meetings (minimum of once a quarter).	6.1 Schedule of Mortality Meetings.	6.1 31.03.16	6.1 Completed	That themes from Serious Incident Investigations will be discussed at Division level and shared with the wider clinical group. Improvements to care delivery / patient pathways can be linked to thematic evidence.	31.03.16 Evidence base within SharePoint site not 100% complete	Helen Ludford, Associate Director of Quality Governance Tracey McKenzie, Head of Compliance Mayura Deshpande, Associate Medical Director (Quality), Patient Safety and Divisional Clinical Directors	Dr Chris Gordon, Director of Performance, Quality and Patient Safety, Chief Operating Officer
			6.2 Terms of Reference and standardised agenda inclusive of case study review to be drawn up by the Governance Workstream of the Quality Programme and implemented within each group.	6.2 Terms of Reference and standardised agenda documents.	6.2 Completed	6.2 Completed				
			6.3 Divisional Mortality Meetings to report into the Trust Mortality Review Group under Executive leadership (quarterly).	6.3 Minutes of the Mortality Review Group.	6.3 31.03.16	6.3 On Track				
			6.4 Divisional Mortality Meetings to be chaired by the senior clinician in a senior leadership role and the data presented by the Lead Investigator for the Division.	6.4 Minutes of the Mortality Meetings.	6.4 31.03.16	6.4 Slippage - evidence within SharePoint site not complete being chased				
			6.5 All Divisions to use 'Hot Spots' and 'Could it happen here?' templates to share thematic review findings and enhance organisational, divisional and team learning. This should include learning from family involvement.	6.5 Evidence of the use of 'Hot-Spots' in the Division which contain Serious Incident learning.	6.5 31.03.16	6.5 Slippage - evidence not yet provided from all Divisions				

			6.6 Data for Mortality Meetings to be produced by the Ulysses systems analyst (monthly).	6.6 Examples of the standardised reports provided.	6.6 Completed only for Spine reports in Tableau	6.6 Overdue. Combined Tableau reports with Spine and Ulysses data not available until 04.16 due to technical difficulties				
			6.7 Organise and deliver bi-annual Serious Incident workshop / conference to discuss improvement progress and changes to national frameworks.	6.7 Programmes for the workshops and attendance lists	6.7 Completed	6.7 Completed				
			6.8 Provide improvement report to the SOG on a quarterly basis.	6.8 Report to be provided.	6.8 Completed	6.8 Completed - standard agenda item				
7	Ensure robust systematic Mortality Reporting to Trust Board and Board Sub-Committees which review mortality.	med	7.1 Develop standardised Board report templates through Mortality Task and Finish Group to include numbers, national benchmarks, case studies, themes and organisational learning.	7.1 Standardised Board and sub-committee reporting of mortality and the associated themes. Evidence will be the papers.	7.1 31.03.16	7.1 Slippage - standardised mortality report not yet created due to delay of integration of Ulysses and Tableau. Manual based reporting is in place.	Complete and effective Board oversight and assurance. External confidence in the annual report.	31.03.16 Report not yet standardised	Sarah Pearson, Head of Legal & Insurance Services (for SIRI data) Amanda Owen, Corporate Governance Manager Briony Cooper, Head of Quality Performance and Quality Contracts	Dr Chris Gordon, Director of Performance, Quality and Patient Safety, Chief Operating Officer
			7.2 The Mortality Review Groups and Mortality Meetings must identify any Mortality themes and link themes to clear risks on the risk register.	7.2 Mortality Review Group and Mortality Meeting minutes.	7.2 31.03.16	7.2 Completed				
			7.3 2015/16 Annual Report to include detail of new mortality reporting process and any early identification of themes from specialities. This will not be a complete data set which will be in place for the 2016/17 Annual Report. First draft to be shared in February 2016.	7.3 Content of the Annual Report.	7.3 31.03.16	7.3 Completed - section submitted				
8	Improve thematic review across the Trust and share this process externally with the stakeholders (CCGs) for assurance.	low	8.1 Produce a thematic review template in line with best practice guidance to include lessons learnt.	8.1 Standardised template	8.1 29.02.16	8.1 Overdue but in development - pilot template used in OPMH	Improved oversight and assurance of thematic review process.	31.03.16 template in development, thematic review paper to be discussed at SOG 11.04.16	Tracey McKenzie, Head of Compliance Briony Cooper, Head of Quality Performance and Quality Contracts	Dr Chris Gordon, Director of Performance, Quality and Patient Safety, Chief Operating Officer, Dr Lesley Stevens, Medical Director
			8.2 Share thematic review approach, template and schedule with CCGs.	8.2 Minutes of SOG.	8.2 31.03.16	8.2 Agenda item for SOG on Monday 11 April				
			8.3 Review the themes which the Mortality Report suggests require further investigation such as, the role of the care coordinator. Undertake review and report to Quality and Safety Committee.	8.3 Evidence of thematic reviews.	8.3 30.06.16	8.3 On Track				
			8.4 Provide evidence of thematic review to the CCG commissioners through CQRM's and SOG.	8.4 Supply thematic review papers for discussion.	8.4 30.06.16	8.4 On Track				
9	Ensure that SHFT incident reporting and management policy is aligned to the national framework and submission of data to the National Reporting and Learning Service is evidenced as correct to guidance.	med	9.1 Re-write SHFT incident policy to ensure alignment to the national framework to acknowledge process developments made during the last year.	9.1 Up to date policy.	9.1 Completed	9.1 Completed	Accurate national reporting aligned to the published national frameworks. Evidence that the NRLS criteria are being applied correctly.	31.03.16 Completed	Fiona Richey, Head of Risk and Business Continuity Sarah Pearson, Head of Legal & Insurance Services	Dr Chris Gordon, Director of Performance, Quality and Patient Safety, Chief Operating Officer
			9.2 Governance team to meet with the NRLS centralised team to ensure that the Southern Health impact grading and uplift processes are occurring within the required criteria.	9.2 Minutes of a meeting and SHFT process for uplift to NRLS	9.2 31.03.16	9.2 Completed				
10	Ensure that the requirement for multi-agency retrospective and forward planned thematic reviews and Serious Incident investigations are discussed with partner organisations, CCG's and the Local Authorities to agree process.	med	10.1 Engage all stakeholders in a workshop to discuss the appropriateness, the capacity for and ownership of the terms of reference for retrospective and forward planned thematic review.	10.1 Programme for the Serious Incident workshop scheduled for 01.02.16 in which these issues will be debated.	10.1 Completed	10.1 Completed	SHFT to be fully engaged in multi-agency Serious Incident investigations and thematic review.	31.03.16 - Commissioners are taking responsibility for action 10.3, there a further meeting organised and SHFT will receive feedback	Helen Ludford, Associate Director of Quality Governance	Dr Chris Gordon, Director of Performance, Quality and Patient Safety, Chief Operating Officer
			10.2 Engage all stakeholders in a workshop to discuss the process of commissioning and managing multi-agency Serious Incident investigations.	10.2 Content of the agenda for the Serious Incident workshop scheduled for 01.02.16 in which these issues will be debated.	10.2 Completed	10.2 Completed				
			10.3 As part of a wider stakeholder group create a process framework for undertaking multi-agency Serious Incident investigations.	10.3 Process framework for undertaking multi-agency investigations agreed by all stakeholders.	10.3 31.03.16	10.3 This piece of work is being led by WHCCG DoN&Q, there is a multi-commissioner organised for April with no provider input. Consider extending the deadline for this action as not SHFT led. Interim processes are in place for discussions with CCGs on a case by case basis if multi-agencies are involved in the care and treatment.				

11	Ensure that the physical health needs of patients in mental health and learning disability services are met.	med	11.1 Review the content of the five day physical health course which LEaD provide and ensure that there is the correct percentages of staff attending from each service.	11.1 Course content and learning outcomes which will be reviewed. Attendance data per service.	11.1 31.03.16	11.1 Slippage - evidence being obtained	Compliance rates for the 5 day course will meet those stipulated for each area. Audit results of physical health care plans in MH/LD services will show 95% or above as having appropriate physical health care plans in place.	31.03.16 Physical health audit planned fro June 2016	Sara Courtney, Acting Director of Nursing and Allied Health Professionals and all Associate Directors of Nursing Mayura Deshpande, Associate Medical Director, Patient Safety and all Clinical Service Directors	Dr Lesley Stevens, Medical Director Sara Courtney, Acting Director of Nursing and AHP's
			11.2 As part of service redesign, ensure that integrated teams contain physical expertise as part of the staffing component.	11.2 Staffing models following service redesign.	11.2 31.03.16	11.2 Slippage - evidence being obtained				
			11.3 A clinical audit to be undertaken within Q1 of 2016/17 to evidence that physical health needs of mental health and learning disability patients are being met.	11.3 Clinical audit results achieve above 90% compliance to physical health care plans being in place and up to date.	11.3 30.06.16	11.3 On Track				

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DECISION-MAKER:	HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:	MONITORING SCRUTINY RECOMMENDATIONS TO THE EXECUTIVE		
DATE OF DECISION:	28 APRIL 2016		
REPORT OF:	SERVICE DIRECTOR - LEGAL AND GOVERNANCE		

CONTACT DETAILS

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STATEMENT OF CONFIDENTIALITY

None

BRIEF SUMMARY

This item enables the Health Overview and Scrutiny Panel to monitor and track progress on recommendations made at previous meetings.

RECOMMENDATIONS:

	(i)	That the Panel considers the responses to recommendations from previous meetings and provides feedback.

REASONS FOR REPORT RECOMMENDATIONS

1.	To assist the Panel in assessing the impact and consequence of recommendations made at previous meetings.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2.	None.

DETAIL (Including consultation carried out)

3.	Appendix 1 of the report sets out the recommendations made at previous meetings of the Health Overview and Scrutiny Panel. It also contains summaries of any action taken in response to the recommendations.
4.	The progress status for each recommendation is indicated and if the Health Overview and Scrutiny Panel confirms acceptance of the items marked as completed they will be removed from the list. In cases where action on the recommendation is outstanding or the Panel does not accept the matter has been adequately completed, it will be kept on the list and reported back to the next meeting. It will remain on the list until such time as the Panel accepts the recommendation as completed. Rejected recommendations will only be removed from the list after being reported to the Health Overview and Scrutiny Panel.

RESOURCE IMPLICATIONS

Capital/Revenue

5.	None.

Property/Other	
6.	None.
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
7.	The duty for local authorities to undertake health scrutiny is set out in National Health Service Act 2006. The duty to undertake overview and scrutiny is set out in Part 1A Section 9 of the Local Government Act 2000.
Other Legal Implications:	
8.	None.
POLICY FRAMEWORK IMPLICATIONS	
9.	None.
KEY DECISION	No
WARDS/COMMUNITIES AFFECTED:	None directly as a result of this report

SUPPORTING DOCUMENTATION

Appendices	
1.	Monitoring Scrutiny Recommendations – 28th April 2016
Documents In Members' Rooms	
1.	None
Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessments (ESIA) to be carried out.	No
Privacy Impact Assessment	
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.	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	

Health Overview and Scrutiny Panel: Monitoring Recommendations

Scrutiny Monitoring – 28th April 2016

Date	Title	Action proposed	Action Taken	Progress Status
24/03/16	Vascular Services	1) That UHS circulate to the Panel an outline project plan relating to the Vascular Services proposals, including timescales, finances and accountability.	Circulated to HOSP - 18/04/16	Completed
24/03/16	Mental Health Matters	1) That benchmarking data identifying how Southampton performs in comparison to other areas with regards to mental health outcomes is circulated to the Panel.	Circulated to HOSP – 19/04/16	Completed
		2) That this item returns to the HOSP when there is greater clarity on key outcomes and service specifications.	Agreed	
24/03/16	Health and Wellbeing Strategy - Update	1) That a workshop for elected members on the emerging Health and Wellbeing Strategy is scheduled following the elections in May 2016.	Agreed – Date to be confirmed shortly	

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