University Hospital Southampton NHS Foundation Trust

Our Quality Account & Quality Report 2015/2016

DRAFT

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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.

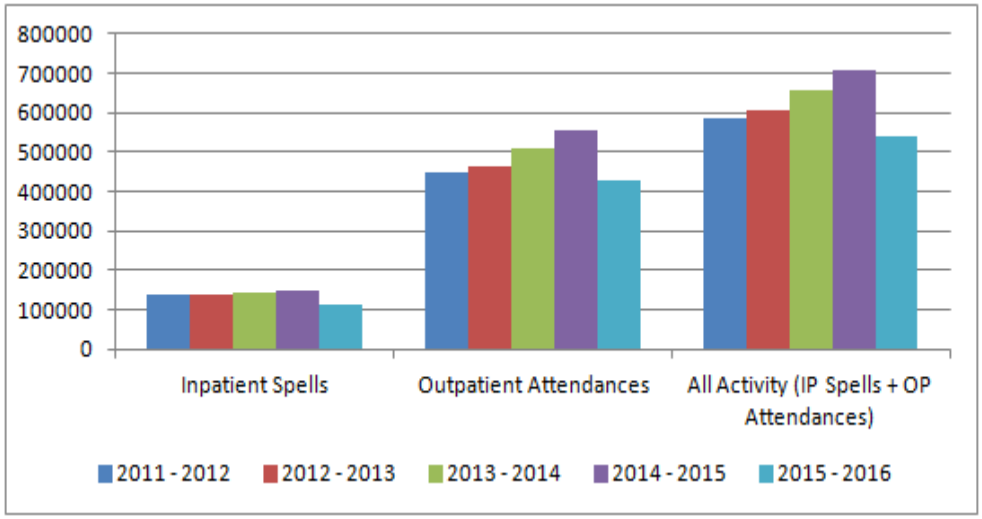
Fiona Dalton, Chief Executive

- **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



Nb. 2015/16 only part year effect

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

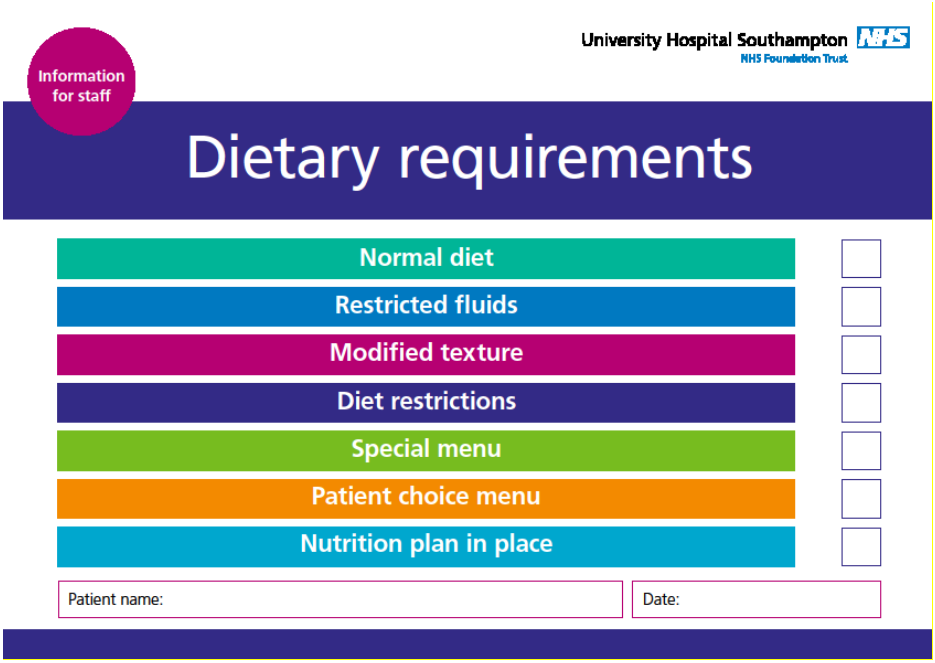
- Review the role of meal time coordinator
- Review of the nutrition screening policy and e learning
- Develop a UHS strategy to shift to protected meals rather than protected mealtimes, to allow patient attendance at scheduled investigations and treatment that may need to occur around a mealtime. This 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).

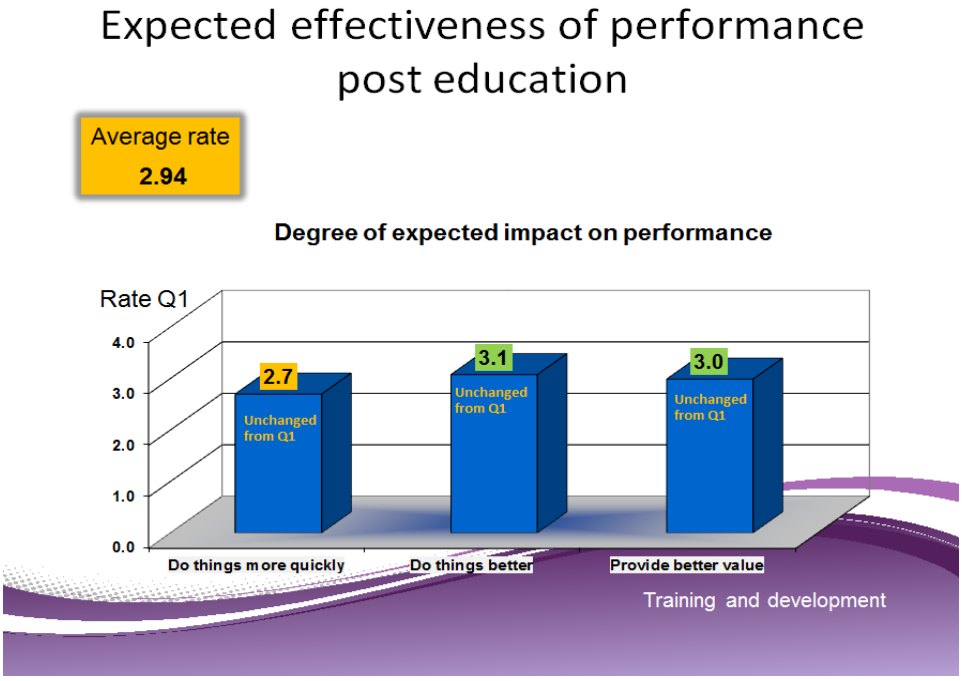
In response to this feedback, during 2015 we developed guidance to help patients rest and sleep whilst in hospital. A "Noise at night" pledge sets out standards of clinical practice, identifying measures that can be taken to reduce the amount of noise at night and promote relaxation, rest and recovery 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.

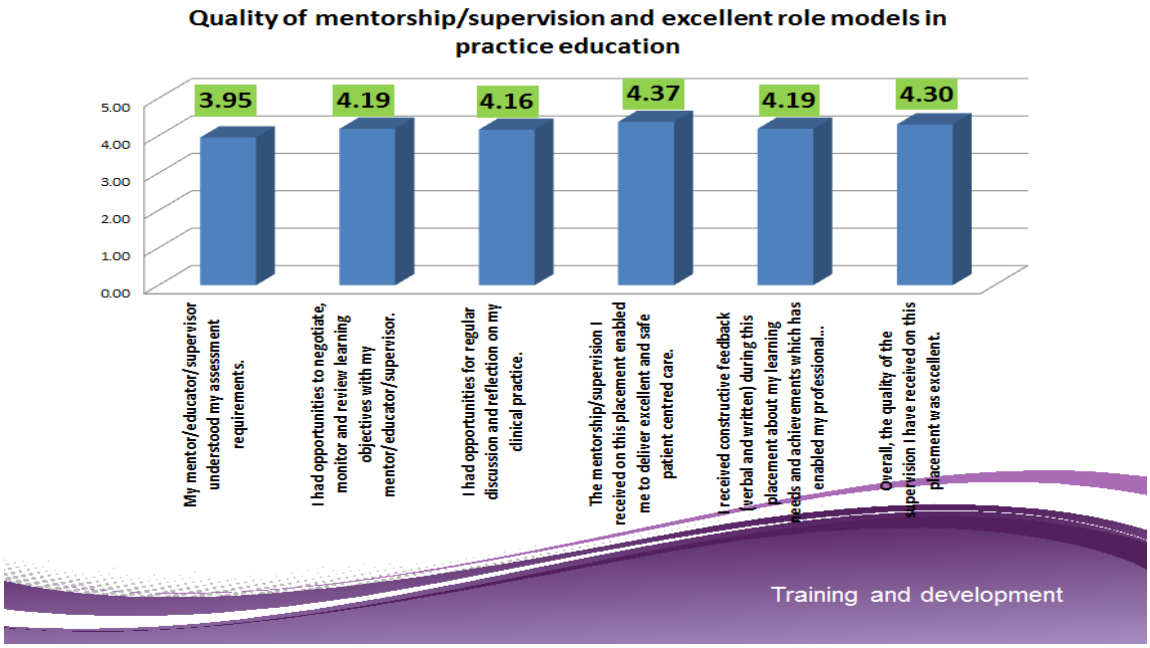
The courses that the training and development team provide are constantly evaluated by the course attendees and the results are below

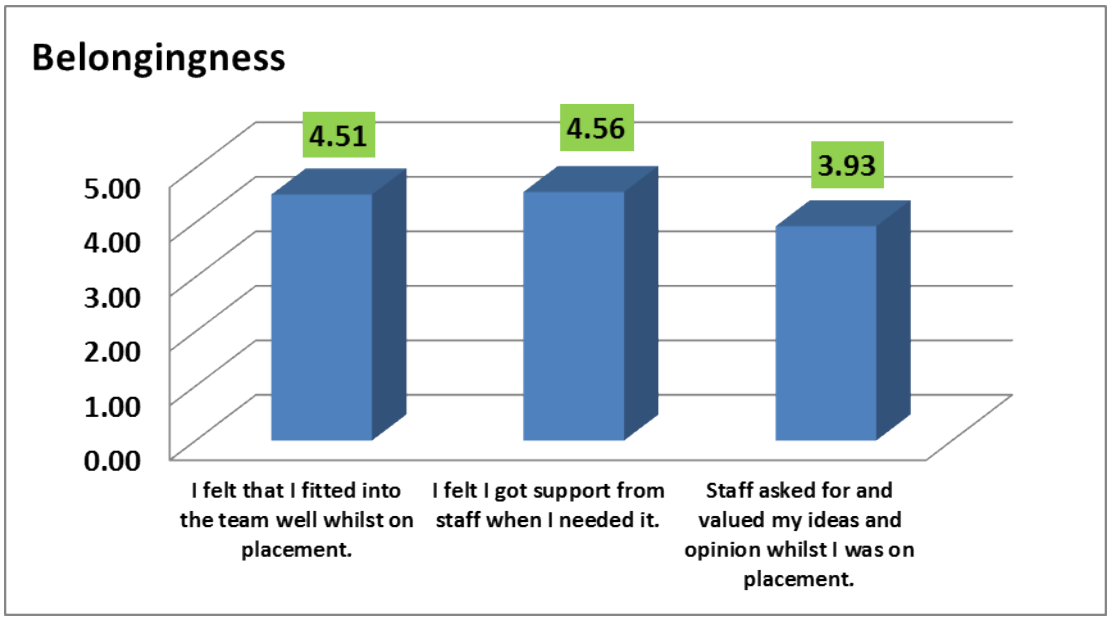


Student Placement Evaluation

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

APPENDIX C

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