University Hospital Southampton NHS Foundation Trust

Quality Account & Quality Report 2016/2017 - DRAFT

Contents

1. Statement from the Chief Executive

DRAFT

Our mission is to be better every day and to work with our partners at the leading edge of healthcare for the benefit of patients. The highest quality patient care remains the top priority at University Hospitals Southampton (UHS). This is reflected every year in our annual objectives and in our core values of 'patient's first, working together and always improving', however we cannot do this without our staff and we are proud that in 2016 University Hospital Southampton NHS Foundation Trust was rated as one of the top performing organisations in the country for staff engagement.

The trust was rated among the top ten in the country for staff being happy with the standard of care provided (82% against a national average of 70%) and the top 20% for staff recommending the trust as a place to work or receive treatment (4.03 against a national average of 3.76), staff who feel they are able to contribute towards improvements at work (76% against 70%) and good communication between senior management and staff (43% against 33%).

The trust also ranked among the top 20% for staff agreeing their role makes a difference to patients (92% against 90%) and organisation and management interest in and action on health and wellbeing (3.79 against 3.61), as well as staff satisfied with opportunities for flexible working (57% against 51%), satisfaction with resourcing and support (3.40 against 3.33) and recognition and value of staff by managers and the organisation (3.62 against 3.45).

In addition, the trust was among the lowest (best) 20% of trusts for percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months (23% against 27%).

2015/16 has been a challenging but rewarding year and we are proud of our achievements. This quality account looks back at some of those achievements and sets out our priorities for the coming year 2017/18.

We have shown significant improvements in many areas of patient care such as end of life care (p.xxx), safe and timely discharge (p. xxx) and responding to and learning from complaints and incidents (p.xxx).

We have also been able to invest in improved and expanded facilities for patients and for research. Building work started on the new radiotherapy bunker, and the new Cancer Immunology Centre. The ongoing investment into diagnostics, in particularly radiology but also more specific schemes such as hysteroscopy, should help patients right across the hospital.

We have been successful in renewing our research funding, through both our Biomedical Research Centre and Clinical Research Facility. There was tough competition for this funding as we were competing against every other academic medical centre in the country, and the rules were clear that only "world class research" would be funded. We are proud of the Southampton research team and the knowledge that Southampton research, for instance into childhood obesity, osteoporosis and COPD, will continue to help patients receive better care across the world. Our extensive participation in research has a positive impact on patient outcome.

We also recently received national recognition as a "global digital exemplar"; an award which we anticipate will bring an additional £10 million of national money. This will not only be through some large-scale informatics projects, but importantly improving the day to day IT equipment staff have available.

Children's services are very important to us, and thanks to a combination of NHS funds and very generous donations, we have been able to refurbish and expand Piam Brown Ward and are currently expanding Paediatric Intensive Care. We also have been raising funds and sponsorship for the new children's emergency department which has been match funded by the treasury. Both these developments sees the further expansion of our children's hospital build.

The new main entrance has also been completed, and it is worth noting it was rebuilt without spending any NHS money.

2015/16 has seen us in financial surplus. This means we can continue to look to invest in capital investment (for example, buildings or equipment). Our current financial position is enabling us to plan continued investment in our estate, particularly for the most vulnerable patients - for instance expansion and refurbishment of high dependency and intensive care facilities for patients of all ages, and theatre and interventional radiology rooms. This means that we will continue to have the facilities to look after the sickest Patients in Wessex and beyond.
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Our financial position is a result of countless acts of imagination, commitment and innovation across the trust all of which has improved our efficiency and allowed us to treat more patients, with less waste and more added value.

I am proud of our achievements and the commitment and dedication of our staff who strive continuously to provide high quality, cost effective and compassionate care. I am constantly left inspired by staff across all areas of work within this Trust, with outstanding displays of commitment, dedication and desire to provide the best possible service even at the most difficult times.

We have also done well in our 2016 in-patient survey which has highlighted many positive aspects of the patient experience. Overall: 84% rated care 7+ out of 10, 83% felt they were treated with respect and dignity and 84 % always had confidence and trust in doctors. 97% of our patients rated our environment very/fairly clean and 91% felt they always had enough privacy when being examined or treated.

Most patients are highly appreciative of the care they receive. However, it is evident that there is also room for improving the patient experience and we continue to focus on the patients experience of discharge (p. xxx) and nutritional and hydration needs (p.xxx) a

This quality account contains information on our performance in relation to quality, which, by its nature is less precise than financial information and there are acceptable differences in the way this information is measured. In addition, it has less internal and external scrutiny than the financial information presented in our annual report and accounts.

With this in mind UHS has done its best to ensure that, to my knowledge, the information in the document is accurate.

Fiona Dalton

CEO

2. Introduction: our approach to Quality Assurance

'Always improving' is embedded at UHS as one of the values in our 'forward vision' along with 'patients first' and 'working together'. These are the Trust's underpinning values, and delivering on them in relation to quality is the responsibility of Trust Board. The named executive leads for quality are the Medical Director and the Director of Nursing and Organizational Development.

Quality Improvement is just one element of a coordinated and organisation -wide approach to quality. In previous years these priorities have been outlined in a Trust- wide Patient Improvement Framework (PIF) with priorities set against outcomes, safety, experience and performance. This year we have listened to feedback from our staff and changed our approach to focus on fewer key priorities in each domain. We recognize that the quality improvement framework should focus on priorities not already led and measured in other key operational strategies and that this will strengthen our message to staff about what the priorities are. The PIF can be found in Appendices 1.

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

To embed quality and provide assurance at ward and department level the Trust has introduced a Clinical Accreditation Scheme (CAS) a process where wards or departments are required to demonstrate adherence to standards of care to become accredited. The process for wards gaining this accreditation is through the submission of information on key quality performance indicators, patient complaints and compliments to a senior clinical panel with patient representatives who also undertake an unannounced visit of the ward or department. Successes are celebrated and areas to improve agreed where necessary.

The Trust also conducts Clinical Quality Reviews (CQR's) of nominated services in each Division based on the Care Quality Commission (CQC) inspections and identified key lines of enquiry. The objective of the CQR is to provide an internal assurance process which is proportionate, risk based, professionally informed and based on what matters to patients and staff. This information is also triangulated with feedback around areas of good practice from the division, direct observation during the review and other information collected during the CQR which provides evidence for the overall judgement framework. A formal report and action plan is generated following the review.

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

Our commitment to safety

Healthcare carries some risk and while everyone working in the NHS works hard every day to reduce this risk, harm can still happen. Whenever possible, we must do all we can to deliver harm free care for every patient, every time, everywhere.

We will:

1. Put safety first.

Commit to reduce avoidable harm in the NHS by at least half and make public our goals and plans developed locally.

In 2015 the Trust agreed a new ambitious strategy to reduce avoidable harm to all patients within our care and go further and faster to support all clinicians to provide a high level of safe care consistently to all our patients. We fully aligned our strategy to the NHS England sign up to safety campaign and to demonstrate our commitment we have made public our 5 key pledges.

2. 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.

As a Trust it is important that we learn when things go wrong, and as such we take reported incidents very seriously. Using a well-received e-reporting system for incidents (including “near misses”) facilitates real time reporting and escalation in order that appropriate action is taken. It has also improved the reporting of themes down to ward level and feedback to those who have reported the incident, and allowed meaningful thematic analysis at all levels.

In the national learning reporting system, we benchmark as a top reporting Trust due to the higher as a result of the higher number of incidents reported per 100 admissions, the timeliness of reporting, and the lower numbers of incidents graded as high and moderate harm.

We focus on a culture which allows staff to ‘speak up, speak out’ about practice which compromises patient safety as part of the Trust raising concerns (or whistle blowing) helpline. Our staff survey shows that our staff rate us as above average in:

- Organisation treats staff involved in errors fairly – 65% against a national average for acute trusts of 54%
- Organisation encourages the reporting of errors- 90% against a national average for acute trusts of 87%

- Organisation takes action to ensure errors are not repeated-75% against a national average for acute trusts of 69%
- Staff given feedback about changes made in response to errors-64% against a national average for acute trusts of 55%
- Staff know how to report unsafe clinical practice-96% against a national average for acute trusts of 95%
- Staff would feel secure raising concerns about unsafe clinical practice-76% against a national average for acute trusts of 69%
- Staff would feel confident that the organisation would address concerns about unsafe clinical practice-66% against a national average for acute trusts of 57%

The national safety thermometer is a prevalence audit tool that allows teams to measure harm and the proportion of patients that are “harm free” from four of the most common and preventable causes (pressure ulcers, patient falls, VTE [blood clot] and urinary infections due to catheters). The audit is undertaken by our staff on a monthly basis and submitted to a national database for benchmarking.

We have consistently achieved over 95% for no new harms/new harm free care with over 1,100 patients audited each month.

3. Be honest and transparent. Honesty and transparency 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.

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

We have worked hard to ensure that our staff are aware of their obligations under the duty of candour, and have provided education and support to enable them to do this.

We provide training to staff of all levels both as part of their induction, education days and through rolling local programmes and cascade training.

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

4. Collaborate. Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.

UHS are working in collaboration across Wessex to improve rapid assessment and treatment of Sepsis and Acute Kidney Injury (AKI) and improving standards of care and outcomes for patients undergoing emergency laparotomy, sharing our approach and learning across the Wessex Academic Health Science Network (WAHSN). UHS is a key member of the WAHSN Patient Safety Collaborative and staff participate in shared learning activities within this Collaborative.

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

Every year UHS holds a safety conference attended by over 100 delegates from our staff and partners. This is an opportunity to celebrate our successes and share our challenges. Our staff say: Comments from our staff were:

'I attended the safety study day last week what a fantastic day inspiring speakers, great organisation, one of the best days I have attended in a long time, a credit to our Trust'

'Excellent range of speakers, all very interesting and informative. Good to use individual cases for examples, very impressed with the patient's own story of surviving sepsis, very powerful messages. Glad she is using her experience to help others'

This was also demonstrated via the safety pledges each delegate was asked to write following the conference. Such as:

- To create and publish a safety magazine/newsletter for theatres to educate staff on all matters of safety and safe practice
- To ensure that I have the courage to speak up when I have something to contribute to a situation and not assume that the leader has considered all risk factors
- 'Patient First' – my pledge is to ensure my patients remain informed and involved in their care so they feel safe in my care

All pledges are emailed to delegates to offer support in implementing them and to follow up on their progress.

Our commitment to Staff: NHS Staff Survey

The NHS Staff Survey results predominantly aim to inform us about staff experience and well-being. Nationally, the NHS Staff Survey results provide an important measure of performance against the pledges set out in the NHS Constitution. The constitution outlines the principles and values of the

NHS in England, setting out a number of pledges that define what staff should expect from NHS employers.

In 2016 our top 5 results were:

1. KF7. Percentage of staff able to contribute towards improvements at work- 76% against a national average for acute trusts of 70%
2. KF6. Percentage of staff reporting good communication between senior management and staff- 43% against a national average for acute trusts of 33%
3. KF31. Staff confidence and security in reporting unsafe clinical practice- 3.81 against a national average for acute trusts of 3.65
4. KF5. Recognition and value of staff by managers and the organisation- 3.62 against a national average for acute trusts of 3.45
5. KF15. Percentage of staff satisfied with the opportunities for flexible working- 57% against a national average for acute trusts of 51%

We also continued to perform above average for KF21 -percentage believing that trusts provide equal opportunities for career progression or promotion – 88% against a national average for acute trusts of 87%.

Table 1 – KF 21 percentage believing that trust provides equal opportunities for career progression or promotion 2016 breakdown:

UHS	Average for acute Trusts	Disabilities	Hours	Gender	Age groups
White – 89%	White – 88%	Staff with disabilities – 81%	Part time staff – 88%	Men – 86%	16 – 30yrs – 90%
BME – 78%	BME – 76%	Staff with no disability – 89%	Full time staff – 88%	Women – 89%	31 – 40yrs – 86%
					41 – 50yrs – 88%
					51+yrs – 87%

In 2016 our performance for KF 26 - percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months was unchanged from 2015 – 43% against a national average for acute trusts of 45%.

To further improve supporting our staff in 2017 UHS are developing a framework of core behaviours to support each of our values and our wider quality strategy and organizational development. The behavioural framework 'living our values' will be used in recruitment, appraisal, performance management and talent management.

Our consultation for this included multidisciplinary focus groups which were held between September and November 2016 with trained internal facilitators, lunchtime sessions which were led by the CEO and Director of Nursing, one to one interviews with senior executives (Talent Works) and other staff at Fab NHS Change Day, and online input from Survey Monkey. Approximately 300 staff have been involved in the process so far.

In collaboration with our black and minority ethnic (BME) network, we have developed a workforce race, equality and action (RACE) place against the workforce race quality standard to address inequalities for our BME staff.

Our focus makes explicit behaviours expected in 3 areas – putting patients first, working together and always improving:

- Working with colleagues to agree a shared view of what good looks like and what we need to achieve
- Joining things together across professional and organisational boundaries to make them easier, better and safer for patients and staff
- Taking a genuine interest in our colleagues and patients as people
- Sticking to our word and doing what we say we will do
- Finding creative ways to bring people together in order to build long-term relationships based on trust and respect
- Offering constructive feedback to colleagues with intent to help them improve

- Valuing each other as the most precious resource in UHS.
- Being there for each other during the low points as well as the high.
- Supporting colleagues to develop their potential and enabling everyone to be part of shaping our services.
- Listening to each other and responding to the needs of others.
- Recognising and celebrating the achievements of others.
- Appreciating our diversity and making the most of the difference between us.
- Being proud to be part of UHS and of making a difference for patients.

Over the next 12 months we will continue to promote the NHS staff survey and encourage staff to participate. Any issues or concerns identified will be reported to the board and a suitable action plan developed and implemented. We will use the feedback from the survey to support staff to improve the services we deliver and will share our findings so that we can learn from our mistakes.

Our commitment to education and training

Training health professionals in quality improvement has the potential to impact positively on attitudes, knowledge and behaviours. The health care workforce needs to be adequately prepared to ensure it continually understands and measures quality of care in terms of structure, process, and outcomes. To deliver quality care, health professionals must be able to be clear about what they are trying to accomplish, how they will know that a change has led to improvement, and what change they can make that will result in an improvement

We promote educational experiences whereby health professionals define best practices by reviewing currently available information and literature, compare these with current practice to identify gaps in performance, develop policies, procedures and standards to organize care around the best practices, and then continuously monitor them.

We already have significant quality improvement activity in education at UHS, including a training programme to develop professional 'quality improvement' skills across the organization, and a formal four day training programme in quality improvement techniques.

We also support learner reviews as part of the quality assurance process for learning in clinical areas, and 3 Scientific Training Programme (STP) candidates have completed their training and have been retained in the organization in paediatric cardiology, radiation protection and radiotherapy physics and pharmacy.

Leadership development and human factors are now an integral part of patient safety's scrutiny of avoidable harm incidents and near misses. Delivering human factors education as part of our leadership development programme ensures staff involved in investigation of incidents focus on not just 'how did it happen?' but, importantly, also 'how can we prevent it from happening again?'.

We are also fully engaged in apprenticeships and public sector targets for apprenticeships. Our skills for practice leads are participating in national and regional apprenticeship working groups, and post graduate medical training has seen a year on year improvement in ratings via the GMC survey with 2016 seeing 32 areas of statistically significant positive outliers (compared to 13 the year before) and a fall from 41 to 24 of outliers. Scoring especially well were Paediatric Surgery, Respiratory Medicine, Medical Oncology, Obstetric and Gynecology Post Graduate Foundation Year doctor in their first year of training (FY1) and General Practitioner Emergency Medicine.

Training provides staff with a range of recognised tools and techniques they can apply in appropriate context. In our recent staff survey the Trust has scored in the upper quartile for staff reporting engagement in change and improvement.

Our commitment to the Care Quality Commission

In preparation for the unannounced Care Quality Commission (CQC) inspection of our core services in January 2017, UHS reconvened a CQC executive steering group .The group was chaired by the Director of Nursing and included a wide range of senior membership such as the Divisional Heads of Nursing, Divisional Clinical Directors, Divisional Directors of Operations, Medical Director and representatives from education, communications, facilities, and performance.

The CQC inspection assessed the Trust against 5 key questions and the Well Led domain:
The results were as follows :

Insert outcome grid here,

3. Progress against 2016/17 priorities

This section outlines how we have performed against the delivery of our 2015/16 quality priorities. Action plans and measures were developed for each of the priorities last year, and performance has been monitored throughout the year by clinical teams and UHS committees. The section describes progress against the following priorities:

Patient Experience:

1. End of life care
2. Safe and timely discharge of all patients
3. Responding to and learning from patient feedback (complaints)

Patient Safety:

4. Acute Kidney Failure
5. Reduction in high harm pressure ulcers and high harm falls
6. Reduction of never events

Clinical Effectiveness:

7. Clinical specialties having outcome measures

8. Improvements in mortality rates/way mortality is measured and evaluated

Patient Experience

Priority 1: End of Life Care

Our aims for 2015/16 were:

1. Education and Training programme: delivering sessions on each of the five priorities for care, difficult conversation skills and advance care planning

2. Continued participation in, and inform of, the National work stream around the Emergency Care & Treatment Plan, working alongside Wessex Collaboration for Leadership in Applied Health Research & Care (CLAHRC) into the use of Treatment Escalation Plans (TEP)

3. 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.

4. Development of information for relatives and carers for those individuals who's wish it is die at home supporting them in who to contact and who will be there for support in their bereavement

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

Our achievements for 2015/16 were:

1. Education and training on the five priorities for care within our Trust is incorporated into other existing programmes of teaching rather than stand-alone sessions. This recognises the difficulty of releasing clinical staff for non-mandated training. The key components of End of Life Care (Recognition, Communication, Involvement, Support Plan and Do) are broken down to ensure that each of these priorities are explored and explained. This is delivered in Trust induction, at ward level and within other formal development programmes such as Health Care Assistant (HCA) training and overseas nurses' sessions. All FY1 and FY2 (Post graduate Foundation Year doctor in their second year of training) doctors receive 2 sessions of teaching, one primarily about pharmacological and non-pharmacological symptom control and another about care of the dying patient including talking about bad news and the use of the Individualised End of Life Care Plan. Sage and Thyme, a level 1 communication skills training, continues to be delivered and is now accessed via the Virtual Learning Environment (VLE). Advanced communication Skills training will be run internally at UHS from March 2017 and will be free for suitable multi-disciplinary clinical staff.

2. The Trust remains engaged with the Treatment Escalation Plan (TEP) agenda and we continue to participate in and inform the national work stream together with the research conducted by the Wessex CLAHRC. The national launch of the ReSPECT initiative is on the 27th February 2017. The Trust will critically analyse this initiative with the potential to explore a unified Wessex adoption approach with partner organisations and establish the most effective implementation, communication, and training approach. Use of our local UHS Treatment Escalation Plan remains an option alongside the unified Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) form if widespread use across Wessex is unachievable.

3. The development of an End of Life Care competency framework has been superseded by the national End of Life Care Core Skills Education and Training Framework currently under consultation, which, when ratified, will form the basis of future training and education delivery within the Trust. The national framework is based on a tiered approach ensuring that each staff group receive the appropriate level of training and education in End of Life Care. Local competency documents for clinical band 5 nurses have been adapted to include awareness of key national initiatives and policy documents [One Chance to Get it Right (2014), Ambitions in Palliative and End of Life Care; A national framework for local action 2015 – 2020, Every Moment Counts (2015), What's Important to me: A Review of Choice in End of Life Care (2015)] together with the UHS document the Individualised End of Life Care Plan for the last days or hours of life. This approach has supported staff in developing the skills, knowledge and attitudes required in the delivery of excellence in end of life care.

4. Within the Acute Hospital, the Hospital Palliative Care Team give out a patient and carers leaflet with contact details and information about the service we provide. Patients who are referred to the Countess Mountbatten House Community services are given a comprehensive information leaflet detailing the services available. Those patients who do not reside within the Countess Mountbatten House catchment area receive information relevant to their locality from their Community Palliative Care providers directly. Families of those patients who die within UHS, are given written information directly by the UHS bereavement team and signposted as needed to bereavement services.

5. The Trust participated in the 2015 National Care of the Dying Audit which was hosted by the Royal College of Physicians. The results, which were disseminated in reports in March 2016, showed better than average results for :

    - The Trust's usage of syringe drivers at the end of life was in line with the national average at 24%.

    - For symptom management included agitation, pain, dyspnoea, noisy breathing and other symptoms UHS is closely in line with national symptom management, scoring above average by 2-3% in all areas except the management of pain. The national average is 57% and UHS scored 55%.

- UHS performed well in the provision of a holistic assessment in the last 24 hours of life at 76% compared the national average of 66%.
- for patients who died in hospital there were consistently high levels of documented evidence within the last episode of care that it was recognised that the patient would probably die in the coming hours or days. However for a significant proportion of patients this recognition was not made in a timely manner. Nationally this was 87%. When sudden or unexpected death was taken into account, UHS was recognising 90% of patients that would die in the coming hours or days in a timely manner.
- The Choice in End of Life Care Programme review found people identified the importance of thinking and planning for the end of life early, while people are still able to consider and express their wishes, but highlighted the difficulties of initiating these sensitive conversations. The difficulty of these conversions is reflected in the low numbers nationally at 20%. UHSFT's data showed this happened in 29% of cases reported, and this increased to 33% if adjusted for sudden and unexpected deaths. Based on the national data, it would appear that having the conversation with a relative or nominated person is far less challenging with good levels of engagement nationally and locally. Nationally this sits at 79% when adjusted to exclude sudden and unexpected deaths. UHSFT performed well in this at 95%.

It is acknowledged that in some areas in 2015/16 we did not perform so well:

- The national average for medication review in the last 24 hours of life was 65%; UHS data demonstrated 53% of patients had this review in the last 24 hours of life
- Discussion of DNACPR decision making in conjunction with the patient nationally sits at about 36%. UHS recorded 30% in the data they submitted to the National Care of the Dying audit. This data excludes sudden and unexpected deaths
- Currently UHS does not seek feedback from bereaved relatives. The national average for this is 80% demonstrating a clear need for improvement at UHS
- The perceived lack of hydration of dying patients was one of the most common complaints reported by the public to the Neuberger Review of the Liverpool Care Pathway. The new NICE Guideline NG31 on 'Clinical care of adults in the last days of life' is very clear on the importance of maintaining hydration, either by patients being allowed and supported to drink, or by clinically assisted forms of hydration. National assessment of hydration status in the last 24 hours of life was 67%. UHS recorded 60% compliance with this assessment process

The trust is currently repeating the national audit at a local level using the same methodology. The results will be compared against our previous performance and end of life care will be identified as a priority for 2017/18.

Priority 2: Promote safe and timely discharge of all patients

Planning for patient discharge is an essential element of any admission to an acute setting, but may often be left until the patient is almost ready to leave hospital. When patient discharge is effective, complications as a result of extended lengths of hospital stay are prevented, hospital beds are used efficiently and readmissions are reduced, and patient experience is improved.

Our aim in 2015/16 was to ensure discharge planning was prioritised by focusing on the essential principles that should be met to ensure that patients do not experience delays at discharge and leave feeling confident and safe to do so.

We already had an Integrated Discharge Bureau (IDB) in the Trust which aimed to provide a coordinated and seamless service to our patients to ensure a prompt and efficient discharge or transfer, whilst taking into consideration their personal preferences as much as possible.

The key elements of the IDB model are collaboration, commitment and enhanced communication throughout the discharge pathway. The IDB already has representation from five organisations working in partnership who aid the discharge process, considering choice and safety, and aiming for assessed needs to be met in a person-centred way and to empower colleagues, patients and families to work collaboratively to improve the patient experience of discharge planning

In 2016 the IDB focused on introducing new initiatives including a new managing complex discharge policy , the introduction of discharge officers , ward link competencies, Continued Healthcare Coordinators and front loading the discharge process to ensure planning begins on admission.

The UHS pharmacy department also led on a variety of projects in 2015/16 aimed at improving the quality of discharge with regards to discharge medication. This area had been highlighted as an area for improvement via incident reporting and patient feedback.

These projects included;

1. Developing a discharge checklist to ensure that patients received all the necessary medicines, ancillaries and information at the point of discharge. This includes in particular an assurance that nursing homes and rest homes will receive all the information they need at the point of discharge

2. Developing written advice about the use of taxis to transport medication to patient's home addresses post discharge. Most discharge medication is given to the patient before they leave hospital; however there are occasions when medication is sent on afterwards. We aim to reduce this practice, but to provide more governance and assurance of a safe process when it does need to occur.

3. Planning to develop the role of a discharge pharmacy officer who will be responsible for the reconciliation of the discharge medication, counselling the patient and providing a steer to patients regarding when their medicines/discharge will be ready. They will also support in the proactive management of the discharges

4. Referring patients who had been assessed as at risk from develop medicines related problems post discharge to their community pharmacy for advice. This is as a result of work published in Newcastle that highlighted improved outcomes in patients referred to their community pharmacy

5. Scoping the discharge process trying to identify alternative mechanisms of discharge for patients that perhaps have fewer care needs. This is in response to patient feedback highlighting their frustration regarding the lack of options with how their discharge medication is provided.

6. Planning working on a discharge information sheet to explain to patients what their discharge involves and the necessary steps that require completion before discharge

Whilst we have made progress, we acknowledge that there is still a great deal to do in both the quality and timeliness of patient discharge, and this is why we have chosen this as an ongoing priority for 2017/18.

Priority 3: Responding to and learning from patient feedback (complaints)

If a patient is unhappy with the care they are or have received we always seek to resolve this as early and effectively as possible to prevent the patient or family feeling the need to make a formal complaint. There are occasions when we can resolve issues by arranging a meeting with the clinicians involved to answer any questions and manage concerns. This can shorten the time taken to provide a response and resolution. We monitor the numbers and themes from these complex concerns.

If the patient or family wish to make a formal complaint, we will complete a formal investigation and provide a written response.

Complaints were identified as a key patient experience indicator in our quality account of 2015/16 , and a target set to reduce complaints (excluding complex concerns which do not require formal investigation) to below 550 for the year 2016/17.

A target to close > 93 % of complaints within a target time of 35 days was agreed. For cases where this timescale is not possible, complainants are updated and informed of the reasons, and a new closure date is negotiated and agreed. The target then converts to closure of > 93% for the newly negotiated time frame.

Table 2: % of complaints closed within agreed time frames

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	2016/17 Total
Complaints received for investigation	39	37	47	34	33	27	46	51	44	31	37	32	476
% of complai	7.69 %	31.82%	37.21%	46.67%	41.86%	41.94%	45.24%	56.60%	78.43%	76.74%	72.73%	72.5 %	50.78%

nts closed within original 35 days timefra me													
% complai nts closed followin g re-negotiat ed timefra me	100. 0	100. 0	100. 0	100. 0	100. 0	94.6	97.4	98.1	100. 0	100. 0	100	97. 1	98.9%

Table 3- Number of complaints and complex concerns received monthly April 2016 to January 2017

2016/17	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	Total
Complaints received for investigation	39	38	47	34	33	28	47	51	47	43	37	32	476
Total Number of Complex Concerns	20	24	22	33	26	32	17	27	13	25	24	31	294

Table 4- Percentage of Dissatisfied Complaints over Total Number of Complaints

By Received Date	Number of Dissatisfied Cases	Number of Complaints	Percentage Dissatisfied
2015/16	49	431	11.37%
2016/17	44	420	10.48%

The average time to respond for 2015/16 across the year was 38 days with variation month to month from 24 to 54 days.

Year to date 2016/17 the average remains the same but variation is from 24 to 47 days and consistently in last three months we have been below our 35 day target.

The complaints team also sit on each division's governance boards to advise, inform and support their complaints management, and to help ensure learning is embedded in practice.

Learning from our complaints:

A vital part of the complaints process is to look for any learning that we can identify and seek to change our practice accordingly.

If complainants are not satisfied by our investigation and response then they can refer themselves to the Parliamentary and Health Service Ombudsman (PHSO).

In 2015/16 there were 10 complaints referred to the PHSO concerning UHS and 20% of these were either partially or fully upheld. This compares favourably with the PHSO average of 46% across all NHS trusts.

For each upheld complaint by the PHSO an action plan is developed by the Trust to rectify any failures and an apology given. In some cases a financial settlement can also be requested.

Failings found in consent process and record keeping in relation to procedure to remove ear wax.

Action taken

Each patient is given an information sheet which includes advice on

Discharged too early following surgery. *We found that although discharge had been appropriate the written discharge information sheet was inadequate.*

Action taken

Information sheet reviewed and post operative follow-up phone call introduced a week following discharge.

This year we have introduced a follow up phone call to complainants after the receipt of their complaint response to get feedback on their satisfaction. We have also started to engage with our local population at community events to inform diverse groups about how to raise concerns or make complaints and as an example have attended the Southampton Pride event late last year. We hope to continue to expand upon this work over the next year. We also will continue to work with our local Health Watch representatives as they support our complainants through the complaints process.

We have published the first two editions of a tri annual newsletter for UHS staff to support them in ensuring they have a good understanding of the complaints process and how to support our patients and visitors when they raise a concern.

During this past year we have worked hard to reduce our complaint response time, aiming to get this down to a period of 35 working days. This has been achieved for December 2016 and January 2017 with the response time moving from 48 days in April 2016 to 31 days in January 2017.

Themes from issues raised through complaints and complex concerns are shared at the patient engagement and experience strategy group to ensure that this is part of the UHS strategy for improving patient experience.

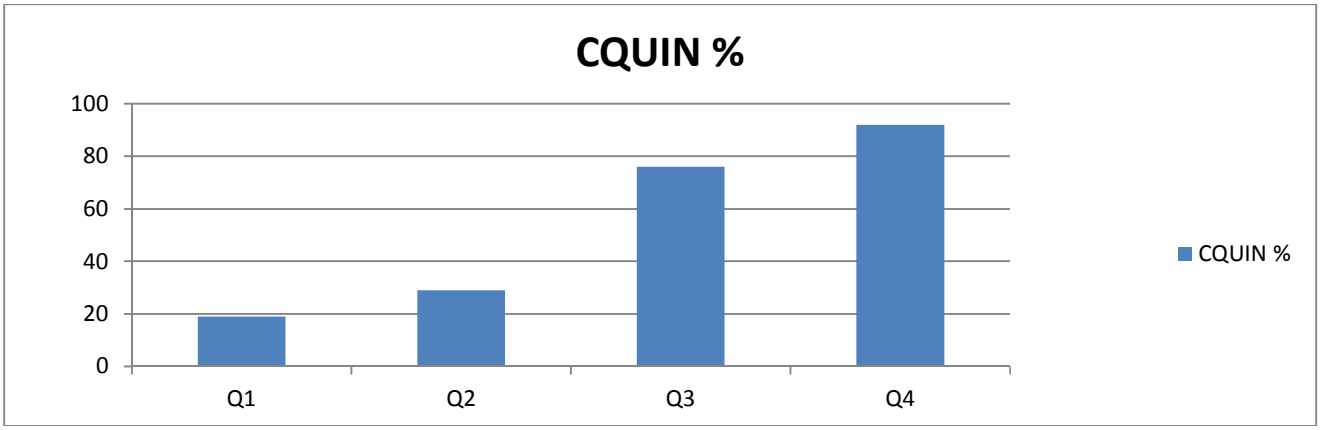
Patient Safety

Priority 1: Acute Kidney Injury (AKI)

Acute kidney injury (AKI) is common in hospitalized patients and has a poor prognosis with the mortality ranging from 10%-80%. We have been working over the last 2 years as part of our safety strategy to improve the detection, prevention and management of AKI within our trust by:

1. Ensuring information about their AKI is sent to primary care, so that these patients receive appropriate blood testing and medication following discharge from the hospital. The goal was that more than 90% of patients would have this discharge information sent to primary care by the end of 2015/2016. We measured this by auditing a random sample of 25 patients who had an AKI during their acute hospital stay every month. Four elements of information were required for the discharge information were needed for this information considered to be complete
2. Alongside the Commissioning for Quality and Innovation (CQUIN) goals we were aiming to improve the recognition and management of patients with AKIs within UHS

Table 5 - % of CQUIN achieved by Quarter 1-4



Successfully achieving the CQUIN meant we achieved a £1,240,000 cost saving to the trust.

3. An AKI working group was set up to deliver a multi professional approach to achieving this goal and an AKI Clinical Nurse Specialist (CNS) was appointed. Her role was to assist in the implementation of an electronic AKI alert that was added to the discharge summary, alongside reviewing all patients with an AKI stage 3 and being responsible for AKI education to the trust as well as to assist in reviewing all patients with an AKI stage 3 outside of critical care areas and advising on their care and management

4. Improving AKI education to the trust with a particular focus on improving the management of hydration for our inpatients and improving fluid balance documentation. We developed an e-learning AKI package which was the first of the kind in the country and likely to be taken up nationally: 400 staff members have completed this to date. Consultant-led education was given to medical students, junior doctors and on grand rounds and interdepartmental meetings including elderly care, Acute Medical Unit (AMU) , anesthetics, respiratory and cardiology

5. An AKI pharmacist was also appointed and completed cascade training with the pharmacist team. The automated section on the electronic discharge summary was launched in October 2015 and this led to a dramatic increase in completion. Clinical pharmacists took a lead role in alerting the prescribers to circumstances that might change the safe or effective dose for individual patients with an AKI alert. This includes changing doses of drugs such as the antibiotic Gentamicin to reduce renal toxicity and prevent new or worsening acute kidney injury

6. A number of pathways, guidelines and educational resources have been developed to raise awareness of AKI, improve patient management and hopefully reduce incidence of AKI including primary and secondary care pathways on map of medicine and an AKI Care Bundle for patients undergoing elective hip and knee surgery

In 2015/16 we achieved:

1. A mean reduction in length of stay for patients with an AKI 3 alert of 4 days following implementation of AKI alerts, focused AKI education and the appointment of an AKI CNS

2. A 16% reduction in number of patients with an AKI from January 2015 to September 2016 with significant and sustained falls in total numbers of alerts in medicine, orthopedics and surgery

3. A 39% reduction in number of AKI alerts (comparison of April 2015, n=2191 alerts to April 2016, n=1346 alerts)

Moving forward into 2016/17, AKI recognition and management will be a continued priority. We will focus on:

1. Trust wide rollout of hydration charts and development of an e-learning fluid balance chart package

2. Learning from AKI Mortality and Morbidity meetings and incident reports shared trust wide

3. More patients with AKI receive a urinalysis at the time of diagnosis

4. Maintaining the appropriate information sent to primary care for patients with AKI

5. Ongoing achievement of more than 90% of our patients with AKIs having information about the inpatient management of their AKI and what follow up is required sent to primary care

6. Ensuring more than 90% of patients with AKI have a urinalysis completed when their AKI is diagnosed. This is important for the correct diagnosis and management of their AKI

7. A 10% reduction in hospital acquired AKI bed days. We will achieve this through improving the management of hydration for our inpatients and improving fluid balance documentation

Priority 2: Reduce High Harm Pressure Ulcers and Falls

Our aim in 2015/16 was to continue to reduce the incidence of all pressure ulcers, with particular emphasis on high harm pressure ulcers Grade 3-4. (Definitions of grades of pressure ulcers are found in Appendices 2). We have made a clear commitment to reduce the numbers across the Trust and have achieved a year on year reduction.
We did this by:

1. The roll out and monitoring of a new UHS developed risk assessment tool to replace the risk assessment tool previously used (Braden). This tool was piloted and evaluated by staff on 2 ward areas in July 2016 and was found to be clear and simple to use, as well as increasing the accuracy of the assessment. The assessment leads ward staff to a care plan according to the level of risk to ensure that all steps in the process, appropriate to that individual are in place from admission. The new risk assessment tool, Pressure Risk Evaluation and Skin Screening tool (PRESS) and associated care plans were developed using the latest national guidelines and tailored to support staff in both the prevention and management of patient's risk of pressure damage. Learning from previous investigations had demonstrated that staff using the previous risk assessment were underestimating the risk and no care plans were consistently being

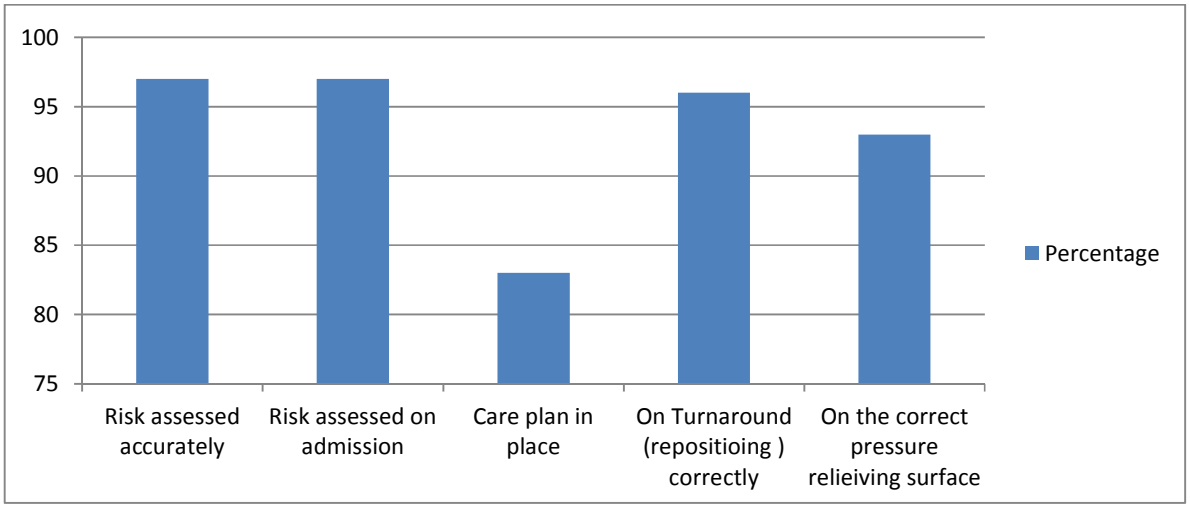
documented for individuals. The new tool and care plan process was piloted with excellent results and has now replaced the previous risk assessment in all adult in patient areas.

2. We have also focused on Grade 2 pressure ulcers and now investigate each grade 2 to identify the root causes of the damage development and to implement actions to change practice and provide support at this early stage to prevent the damage deteriorating.

3. We have focused on better measurement of the process of repositioning which is called Turnaround at UHS. A competency process was developed to ensure that after staff had attended education sessions they were also assessed as being competent with the process in their own ward areas. An audit of the process in each ward area has also been introduced to identify any areas of learning specific to that ward team and allow leaders to monitor areas progress and achievement in line with the process.

   The process is being closely monitored and an audit was undertaken at both 3 months and 6 months following implementation in late April. Results are shown in the chart below from the 3 month audit (6 month audit not currently available):

Table 6 - % compliance with key audit areas



97% of patients had an accurate risk assessment completed and completed on admission. The focus will continue over the next year to improve the use of the care plans, which was a new step in the process and so has taken longer to embed in practice.

All of the prevention initiatives available including the repositioning of patients has achieved a significant reduction in grade 2, 3 and 4 pressure ulcers so far in 2016/17:

Table 7 – All grade 2/3/4 pressure ulcers reported 2015-2017

Grade 3 and 4	2015/6		2016/17	
	Avoidable	Unavoidable	Avoidable	Unavoidable
April	2	3	1	5
May	3	3	2	3
June	4	2	1	3
July	4	5	0	7
August	5	6	1	4
September	5	3	1	3
October	4	5	1 (1 case to determine)	6
November	1	0	0	3
December	2	4	2	2
Totals	30	31	9	36
	65		45	

Grade 2 pressure ulcers	2014/15	2015/16	2016/17
April	20	12	13
May	14	19	15
June	24	19	16
July	21	11	11
August	14	21	8
September	24	20	8
October	14	10	16
November	13	15	12
December	19	18	8
Total	163	145	107

The focus on reduction will continue as a priority over the following year. There is still more work needed to ensure assessment of the risk of pressure ulcer development is completed as soon as possible on admission to enable timely intervention. The support and shared learning will continue to be cascaded to staff via the pressure ulcer strategy and working groups.

For 2016/2017 the Trust has set an internal target of a 10% reduction in all high harm falls and zero avoidable high harm. 'High harm' includes all falls that result in any fracture and/or severe head injury .An avoidable fall would be a fall where, following investigation, there is insufficient evidence that every reasonable effort was made to reduce the risk of a fall. This could include lack of initial assessment, review of risk on change of condition or following a fall and mitigation of any risk identified.

Year to date we have achieved a 14% reduction in the number of high harm falls, 56 compared to 65 in the same period the previous year. Unfortunately we have not achieved the target of zero avoidable high harm falls, and currently year to date we have reported 4. This is, however, a reduction on the previous year's total of 6.

It is a recognized risk that patients with dementia are at an increased risk of falls and harm from falls and there has been intensive support for these patient provided by the enhanced care support teams (ECST).The ECST currently support patients in Division B & D and can assess and plan care for patients with enhanced care needs (care that is assessed as being over and above the planned daily staffing levels for that area). The team consist of Band 5 registered mental health / learning disability nurses and health care support workers. They are able to assess and plan care individualised to the patient and work in close collaboration with the ward team. They can provide various levels of support to patients from care planning to providing therapeutic interventions and, if required 1:1 care.

Additional initiatives are also being developed. In 2016 medicine for older people introduced 'Bay Watch' which involves cohorting same sex patients identified as high risk for falls into one ward bay. A member of the multidisciplinary staff is present and visible in that bay all times. The staff members wear an armband to clearly show they are 'on duty' in that bay. The armband is then handed to the next staff member when care is taken over. There have been no avoidable high harm falls within medicine for older people since May 2016.

The emergency department has focused on increasing education and training for staff around the early identification of falls risk, and the coloured wrist bands highlighting risk of falls which they introduced in 2015 has started to roll out into other areas of the hospital including surgery.

Priority 3: Reduce 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.

As an organisation in 2015/2016 we carried out 125,615 procedures including surgeries. Most of the procedures that we carry out are uncomplicated, but we would like to work in an organisation that is successful in eradicating all avoidable harm to our patients.

If never events do occur we take them extremely seriously. The Trust has a never event oversight group which consists of members of the executive team, clinical teams and human factors with the aim of scrutinising any never events that occur as well as the safer invasive procedures work stream. Investigations are promptly instigated and action plans generated and completed to ensure learning occurs. Staff involved in never events are supported through the process and learning is widely shared in the organisation.

In 2015/16 UHS reported 6 never events. In 2016/17 we reported 3:

1. A wrong site brain biopsy .This resulted in no harm to the patient as the biopsy was diagnostic and could have been performed on either side.

2. A mismatch of hip components during a total hip replacement which resulted in a return to theatre for revision of the hip.

3. The insertion of an incorrect lens during cataract surgery as it had been calculated based on incorrect patients details.

These investigations are currently ongoing, but immediate actions taken include:

1. A review of the checking and documentation of hip components intraoperatively

2. A review of the checking process for lens calculations intraoperatively

These actions will link into the existing work stream within the Trust regarding safer invasive procedures.

Clinical Effectiveness

Priority 1: Every clinical specialty will identify an outcome measure

During 2016/17 all Divisions within UHS worked towards identifying clinical outcome measures for their services that can best be used to measure improvement in the care they provide. 36 specialities successfully identified outcome measures.

A considerable amount of progress has been made in identifying and reporting the number of areas in the Trust that contribute to national outcomes data collection to assess our performance against other specialist services and also areas who are collecting (or developing) local outcomes data.

We acknowledge we have not fully achieved this, and therefore this is a high priority for the coming year and will continue to be taken forward during the year 2017/2018.

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

The patient safety team is targeted and focused on ensuring we deliver the safest and most effective treatment we can. Measuring outcomes provides reassurance and allows us to focus our improvement efforts to deliver changes where most needed the NHS is appropriately focused on learning from events and in particular from reviewing mortality rates.

It is difficult to obtain representative rates given the different populations we all serve. Although we measure and review the crude death rate its value is limited as it does not consider the case mix, in other words take into account the severity of the underlying illness or complexity of the patient

group. To improve on this we calculate the hospital standardised mortality ratio which adds complexity into the calculation.

This is an imperfect science, however it is a useful tool as it allows a degree of benchmarking but most of all allows measurement of trends and highlights potential outliers or anomalies which require evaluation.

In order to improve assurance we do not rely on this alone but consider it along with other mortality indicators and outcome measures such as Summary Hospital-level Mortality Indicator (SHMI). The Internal medical examiners group (IMEG) is particularly important. This group examines the notes and discusses the care of every patient who dies at UHS looking for both good care practice but also any areas that could be improved escalating any issues for more detailed scrutiny.

The Hospital Standardised Mortality Ratio (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 case mix 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 UHS HSMR in 2015/16 was 102.6, while the current Year to Date (YTD) position for 2016/17 is 101.5.

The 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 the HSMR; however there are some differences in the case mix model. The two models 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.

The SHMI data shows a consistent quarterly performance below the benchmark (benchmark = 1). Over the last 3 reporting periods the SHMI for UHS was 0.95, 0.96 and 0.96.
The data used to derive HSMR and SHMI is taken from the Hospital Episodes Statistics (HES) data therefore our ability to capture the primary diagnosis (the main condition treated by the clinicians), secondary diagnoses and co morbidities has 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 Trust maintained its level 3 status (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 continued improvements including additional information systems access and continued clinical coding awareness programs for clinical staff.

An additional priority for 2016/17 involved working with specialities, care groups and divisions to improve knowledge and understanding on HSMR. HSMR and SHMI data are 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.

Priorities for improvement 2017/18

In order to determine our priorities for improvement we have consulted with a number of stakeholders including our Trust Quality Committee (QC), our Trust Board, our Trust Executive Committee, commissioners and patient representatives through our Health Watch Group, and our Governors. The QC on behalf of the board approved the priorities and there will be regular reports on progress to the QC throughout the year.

We have developed this years' Patient Improvement Framework (PIF: found in Appendices 1) to ensure that our quality priorities are aligned with feedback from patient surveys and complaints as well as incidents, and we have taken into account our progress throughout the year against last year's priorities to help decide which priorities need an ongoing focus within this year's quality account. Priorities are built around our ambitions and intention to deliver safe, reliable and compassionate care in a transparent and measurable manner.

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

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

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

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

This section outlines the following 2017/18 quality priorities.

Patient Experience:

1. Improving patients experience of and safety of discharge from hospital

2. Meeting patients nutritional and hydration needs
3. Improving care for vulnerable adults

Patient Safety:

1. Safer invasive procedures
2. Recognising and treating sepsis
3. Recognition and management of the deteriorating patient

Clinical Effectiveness:

1. Report outcome measures in every speciality across the hospital
2. Improve care for patients at end of life care
3. Reduce deconditioning and the impact of immobilisation on the frail elderly

Patient experience

Priority 1: Improving patients experience of and the safety of discharge from hospital

1.1 Why we have chosen this priority

The principles and benefits of safe discharge from the acute hospital setting have been discussed in section 'Progress against 2016/17 priorities Priority 2'.

We know from our in-patient surveys that we still have areas related to discharge which need improvement:

Table 7: Inpatient Survey Results 2016:

The Trust has worsened significantly on the following questions:

Lower scores are better

	2015	2016
Discharge: did not feel involved in decisions about discharge from hospital	45 %	51 %
Discharge: not given any written/printed information about what they should or should not do after leaving hospital	27 %	34 %
Discharge: not fully told side-effects of medications	55 %	64 %
Discharge: not told how to take medication clearly	23 %	30 %

1.2 What we are trying to achieve

We aim to build on the work completed in 2016/17 by setting clear patient and family expectations around discharge processes right from the beginning of the hospital admission in order to be clear about what people can expect from the start and to fully engage them with the process.

This will include:

1. Standard information to set expectations on admission

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

3. Clear process to be followed by the wards in conjunction with the IDB

4. Clear timelines between each stage of the process

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

The policy has been accepted by all the partners in the system.

1.3 What will success look like?

Metrics designed to monitor all discharges from the Trust will demonstrate improvement, and feedback via patient surveys/FFT/patient forums/Health Watch will corroborate these improvements.

Priority 2: Meeting patients nutritional and hydration needs

2.1 Why we have chosen this priority

Ensuring the nutrition and hydration needs of our patients are met has been a priority over previous years with changes and improvements identified and implemented. Patients continue to provide feedback on the meal service they receive and this area of patient care and experience remains a key focus for improvement.

Table 8: Inpatient survey results 2016

		2011	2012	2013	2014	2015	2016
22+	Hospital: food was fair or poor	54 %	53 %	50 %	49 %	44 %	49 %
23	Hospital: not offered a choice of food	19 %	19 %	17 %	16 %	15 %	19 %
24+	Hospital: did not always get enough help from staff to eat meals	47 %	44 %	46 %	35 %	34 %	43 %

(NB : the survey does not give the detail of which age groups responded to these question , however it is noted that 82.1 % of respondents were > 50 years of age , with 22.2 % being 60-19. 24% being 70-79 , 17.4 % being 80-89 and 4.3 % being over 90 years of age).

2.2 What we are trying to achieve

1. To review the process for nutrition screening, in adults and children, to ensure that patients at risk of malnutrition are identified and managed appropriately according to their individual needs

2. To review and establish compliance with Protected Meals guidelines

3. To implement a hydration assessment and chart to all adult inpatient areas

4. Work collaboratively with our new server provider to increase the percentage of patient satisfaction with food

2.3 What success will look like?

1. Patients are screened for malnutrition on admission to hospital or at pre-assessment and those at risk have an appropriate care plan implemented

2. Patients are adequately prepared for meals and receive the help they require in an environment conducive to mealtimes

3. Hydration assessments and charts are used appropriately in all adult inpatient areas

4. Progress against our performance will be reflected in the national inpatient survey 2017/18

Priority 3: Improving care for vulnerable adults

3.1 Why we have chosen this priority

'Living a life free of harm and abuse is a fundamental right of every person. When abuse or neglect does occur, it needs to be dealt with swiftly, effectively and in ways that are proportionate to the concerns raised. In addition, the person must be at the centre of any safeguarding response and must stay as much in control of decision making as possible. The right of the individual to be heard throughout the process is a critical element in the drive to ensure more personalised care and support'. The Care Act 2014.

Health services have a duty to safeguard all patients but also provide additional measures for patients who are vulnerable and less able to protect themselves from harm or abuse. The core definition of “vulnerable adult” from the 1997 Consultation “Who Decides?” issued by the Lord Chancellor’s Department, is a person:

“Who is or may be in need of community care services by reason of disability, age or illness; and is or may be unable to take care of unable to protect him or herself against significant harm or exploitation”. This definition of an Adult covers all people over 18 years of age.

Safeguarding adults covers a spectrum of activity, from prevention through to multi-agency responses where harm and abuse occurs. Multi-agency procedures apply where there is concern of neglect, harm or abuse to a patient defined under 'No Secrets' guidance as vulnerable.

Safeguarding adults is an integral part of patient care. Duties to safeguard patients are required by professional regulators, service regulators and supported in law.

The Department of Health (DoH) document 'Safeguarding Adults: The Role of Health Service Practitioners' reminds health service practitioners of their statutory duties to safeguard adults. It aims to assist practitioners in preventing and responding to neglect, harm and abuse to patients in the most vulnerable situations.

3.2 What we are trying to achieve

The Trust’s framework for safeguarding adults is based on national guidance and from a policy perspective is jointly shared through the local safeguarding adults’ boards. This includes the national guidance detailed within the Care Act 2014, which created a new legal framework for how local authorities and other parts of the system should work together to protect adults at risk of abuse or neglect. UHS and its partnership organizations have agreed how they should work together and the roles they will play to keep adults at risk safe. This approach promotes the development of inter-agency working to make safeguarding personal and individualize care to ensure it meets each persons’ needs.

The key principles of good safeguarding include empowerment, prevention, proportionality, protection, partnership and accountability. Other important governance frameworks are also in place and ensure good levels of safeguards to keep people safe, these include; continuous learning, quality improvements, team work, professional curiosity and challenge.

UHS continues to ensure that adult safeguarding remains a high priority. Key achievements in 2015/16 have included:

1. Development and partial implementation of the learning disability strategy & investment into more learning disability clinical nurse specialist posts

2. Continual partnership working between clinical and estates teams to refurbish ‘dementia friendly’ wards & departments, Medicine for Older People (MOP) being an exemplar site

3. Development and implementation of the Enhanced Care Support Team (ECST)

4. Support for carers' through regularly held 'carers' cafés' providing expert support and guidance to people caring for our patients

5. All patients admitted to our hospital as an emergency are screened for signs of cognitive impairment and referred to their GP

6. Improved senior leadership and multi agency/disciplinary working on the pathway and resources involved in improving the safety & experience for patients presenting in mental health crisis to ED

7. PWC internal audit of adult & children's safeguarding with an outcome risk rating of 'Low' with key assurances gained of how timely and effectively concerns relating to safeguarding are identified and investigated

8. Implementation of dragon fly approach in the ED. This is a visual prompt to staff (a picture representing a dragon fly) which alerts staff to the particular needs of the patient with dementia and is currently used throughout the rest of the trust

Our priorities for next year include:

1. Meet the rising demand of patients presenting in mental health crisis – grow service, gap analysis of current service delivery against the need to identify gaps & develop a plan to address this

2. Develop robust training programs for our staff so they feel well equipped with the clinical skills for example, support patients behavior to de- escalate, refer to other specialist professional teams

3. Development a UHS Mental Health Board to address the challenges and impact for mental health patients and for staff looking after them.

4. Evaluate responsiveness & effectiveness of ECST and potentially expand service.

5. Focus on autism agenda

6. Develop leadership approach and evaluate progress with dementia strategy

7. Consider proposal for joining adults & children's safeguarding teams

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

9. Introduce carers' passports

10. Introduce the vulnerable adult champion role
11. Development of a combined safeguarding team with associated joint governance & meeting structure
12. Provide training and awareness on mental health capacity assessment and deprivation of liberty

3.3 What will success look like?

1. Staff will be competent and confident in caring for vulnerable patients
2. Increased number of safeguarding referrals received by adult safeguarding teams and improved timeliness of response
3. Number of complaints from patients, relatives or carer's relating to safeguarding will reduce
4. Feedback from carer's / relatives will improve
5. Numbers of serious case reviews will have reduced.

How we will monitor progress for our patient experience priorities:

As national surveys are published yearly or less we measure our performance during the year using our real time patient feedback system. This provides monthly feedback which is shared with all the clinical teams. At UHS level this data is reviewed in detail at the patient experience and engagement steering group and the high level data is reported to Trust Board. We will report progress against our performance in the national survey next year.

Patient Safety

Priority 1: Recognition and management of the deteriorating patient

1.1 Why we have chosen this priority

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

UHS is committed to having standards in place for managing the risks associated with the deteriorating patient who has been identified as a recurring theme through incident reporting, serious incident investigations and complaints during 2016/17.

1.2 What we are trying to achieve

Our purpose is to prevent avoidable deterioration. Our priorities are establishing:

1. Where are we now, how are we performing?

2. Overview of current work streams, Serious Incident Requiring Investigations (SIRI), AKI, and sepsis

3. What and how are we measuring- the role of acuity audits, Modified Early Warning System (MEWS) activation data

4. Development of an annual plan for acuity improvement including roles and responsibilities, timescales and measures

5. Escalation on electronic systems (ePAMS) and paper based systems with timescales to move to all electronic systems

The existing acuity group responsible for monitoring the deteriorating patient has been reviewed and restructured to ensure that it is driven from executive level. This is to increase the trust wide profile and in acknowledgement that this affects all patients in every Division. As part of a re-launch of the group it has been renamed ROAR (recognise, observe, assess, rescue) to reflect its purpose.

The membership includes Matrons and/or Clinical Leads for each Care Group who are clearly responsible for cascading of actions and information after each meeting, the Patient Safety Team, Divisional Heads of, Nursing (DHN), Divisional Clinical Directors (DCD), AKI nurse, Sepsis nurse, Critical Care Outreach Team (CCOT), Out of Hours (OOH) team, education teams and consultants. The group's function is as a clinical reference group, providing leadership and guidance to UHS on management of the acutely unwell patients. Shared learning can be achieved through linking in directly with Quality Steering Group.

The group will meet monthly throughout 2017/18 with the above agenda, followed by a case presentation from each Division in rotation, i.e. each Division will present 3 patients per year who were unplanned Intensive Care admissions for learning.

1.3 What will success look like?

We will be able to measure and react to these metrics for improvement:

1. Measurement of baseline/ compliance/improvement.
2. Pulseless Electrical Activity (PEA) cardiac arrests

3. “False” cardiac arrest calls
4. Unplanned intensive care admissions
5. CCOT call data
6. MEWS/NEWS data
7. Development of an acuity review template
8. Development of unplanned admissions to intensive care template

These metrics may change depending on national and local priorities.

Priority 2: Safer invasive procedure

2.1 Why we have chosen this priority

A Patient Safety Alert was issued by NHS England to launch an NHS-wide programme of work based around the National Standards for Invasive Procedures (NatSSIPs) that were published on 7th September 2015.

The alert asked NHS providers to review current clinical practice and ensure the NatSSIPs are embedded into local processes by developing their own local safety standards for invasive procedures (LocSSIPs) in collaboration with staff, patients and the public.

The aim of the NatSSIPs is to reduce the number of patient safety incidents related to invasive procedures in which surgical Never Events could occur. They set out the minimum standards considered necessary for the delivery of safe care during invasive procedures as well as underpinning aspects of education and training.

The NatSSIPs have been set and endorsed by all relevant professional bodies, including the Royal Colleges, the Care Quality Commission, the Nursing and Midwifery Council, the General Medical Council, Monitor, the Trust Development Agency, and Health Education England.

2.2 What we are trying to achieve

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

2.3 What will success look like?

Our initial focus will be to build on work completed in the theatre environment in 2016/17. The World Health Organization (WHO) safer surgery checklist used within theatre has been reframed as

questions to frame practice and rebranded as ‘stop points for safety’ to allow safe, effective and consistent safety steps and move away from a tick box mentality.

In 2017/18 this will continue to roll out to all other interventional suits such as interventional radiology and interventional cardiology. There will also be the introduction of team based LocSSIPs for procedures such as central venous catheter and arterial line placement in other clinical areas such as ward areas and out- patient departments.

Compliance will be measured quarterly via number of ‘never events’, number of staff trained and percentage of each staff group trained, observational audit data and Safety culture survey. The results will be reported to the quality and governance committees, scrutinised by audit to identify missing actions or documentation with learning fed back to team meetings, and results will be disseminated throughout the Trust for wider learning.

Priority 3: Recognising and treating sepsis

3.1 Why we have chosen this priority

Sepsis occurs when the body has an abnormal response to infection. This can be life threatening and if not treated quickly sepsis can rapidly progress. Septic shock, the worst type of sepsis carries a mortality of 50%.

It is estimated that 44,000 people die in the UK from sepsis each year. For comparison approximately 18,500 patients die each year from myocardial infarction (heart attack). Sadly, diagnosing sepsis is far from straightforward and it can mimic a myriad of other conditions.

Key factors that may reduce this mortality rate are the timely recognition of the septic patient followed by rapid administration of antibiotics and other simple supportive therapies - the sepsis six care bundle.

With implementation of the basic elements of care it is believed that 12,000 lives a year could be saved. This equates to 20 lives saved per 100,000 population, 285 fewer hospital bed days and 168 fewer critical care bed days.

3.2 What we are trying to achieve

Our aim is to improve our recognition of patients at risk of sepsis and as a consequence allow the early management of septic patients. Not unsurprisingly if patients with sepsis are treated quickly mortality is reduced.

With this in mind, UHS is working towards a hospital wide, systematic approach for the identification and appropriate treatment of life-threatening infections. Whilst at the same time reduce the chance of the development of strains of bacteria that are resistant to antibiotics.

Through this we aim to reduce death and morbidity related to sepsis in all areas of the hospital. As a result, this will reduce patient length of stay, critical care length of stay and thus improve patient experience and outcome.

3.3 What success will look like?

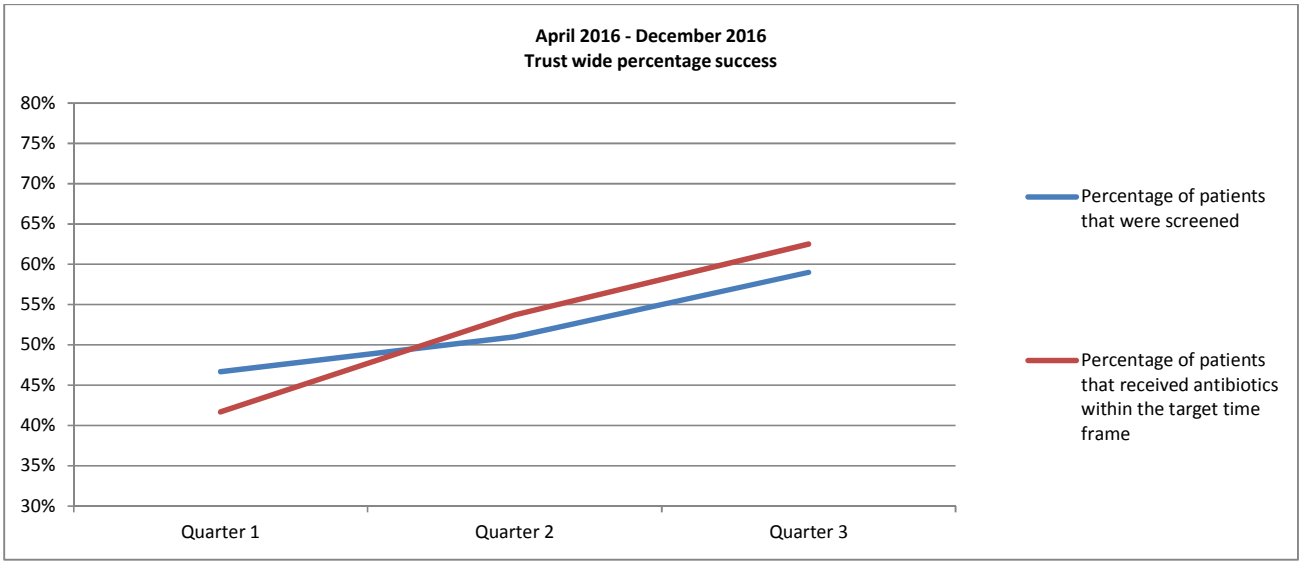
All patients deemed to be at high risk of sepsis will have appropriate screening. Following screening, if sepsis is likely they will receive timely treatment – namely the sepsis 6 care bundle of which rapid delivery of antibiotics is probably the most important element.

Our success in this hospital wide initiative will be monitored using data collected for the national sepsis CQUIN.

Current progress:

Programmes have initially rolled out to acute admitting areas and are being slowly rolled out to all acute inpatient settings. Ongoing for 2017 we aim to continue to roll out the sepsis screening programme to all adult and paediatric wards. Our progress over the last year can be seen below.

Table 8 – Roll out of the sepsis screening programme 2016-2017 (Q1-3)



(NB this data does not capture % of patients who went on to enter palliative care).

How we will monitor progress for our patient safety priorities:

Progress will be measured and monitored via clinical boards, the sepsis steering group and reported to the Quality Safety Committee.

Clinical outcomes

Priority 1: Report outcome measures in every specialty across the hospital

1.1 Why we have chosen this priority

During 2017/18 the plan is to continue developing this work stream across all clinical specialities and to establish an outcomes group to provide a greater level of scrutiny and assurance.

1.2 What we are trying to achieve

Our aims for 2017/18 are that every speciality will identify outcomes that are specific to their clinical service – these can be nationally reported or locally developed outcomes

1.3 What will success look like?

Each Care Group will be able to present their outcomes to a newly established Outcomes Scrutiny Group on an annual basis, demonstrating progress against the identified outcomes

Priority 2: Improve care for patients at End of Life

2.1 Why we have chosen this priority

We are committed to a standard whereby any person in our care at the end of their life will receive individual care based on their needs, delivered with compassion and sensitivity by our staff, and that there is regular and effective communication between staff and the dying person and those close to them. We believe these are priorities which must be embraced.

2.2 What we are trying to achieve

1. Education and training in care of the dying to be delivered for all staff caring for dying patients, to include communication skills training, and skills for supporting families and those close to dying patients

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

3. Aim to have an adequately staffed and accessible pastoral care team to ensure that the spiritual needs of dying patients and those close to them are met

4. Patients at the end of life will be discharged home or to an alternative place of their choice in a timely manner if that is their wish

5. To consider how the experience of relatives and carers could be incorporated in moving forwards

6. Continue to 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).

7. Repeat the National Care of the Dying Audit in 2017

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

2.3 What will success look like?

1. Staff will be competent and confidant in all aspects of end of life care

2. All end of life decisions will be made, and actions taken in accordance with the person's needs and wishes

3. The dying person, and those identified as important to them, will be involved in decisions about treatment and care in adherence with the dying persons wishes

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

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

6. An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, coordinated and delivered with compassion will always be in place

7. Audit results will have improved from 2016/17 results

Priority 3: Reduce the impact of deconditioning and immobilisation on the frail elderly

1.1 Why we have chosen this priority

Frail older adults have reduced functional and physiological reserves, rendering them more vulnerable to the effects of hospitalisation, which frequently results in failure to recover from the pre-hospitalisation functional loss, new disability or even continued functional decline. Alternative care models with an emphasis on multidisciplinary and continuing care units are currently being developed. Their main objective, other than the recovery of the condition that caused admission, is the prevention of functional decline. Despite the theoretical support for the idea that mobility improvement in the hospitalised patient carries multiple benefits, this idea has not been fully translated into clinical practice.

Being in bed, sedentary or just not moving leads of the impact of immobilisation of patients, this is known to increase length of stay and potentially the need for onward care.

2.2 What we are trying to achieve

At UHS we have three projects developing in 2017/18 to reduce the impact of immobilisation on the frail elderly:

1. Increasing ambulatory care at the front door: ambulatory emergency care (AEC) is an emerging, streamlined way of managing patients who would traditionally be admitted. Instead, they can be treated in an ambulatory care setting and discharged the same day – offering benefits to patients, carers, support workers and us as an organisation by releasing bed capacity within AMU and improving the delivery of the four hour ED target.

Since September 2016, the emergency medicine care group has been part of Cohort 10 of the Ambulatory Emergency Care Network, supported by NHS Elect. This is an exciting opportunity which has provided us with access to a network of sites and national experts who have developed their ambulatory care models. Resources are available to the project team to use to support the cycle of the project, including conferences, webinars, analytical tools as well templates for experience based design models.

During 2017/18 we will re-launch our present ambulatory pathways and rolling out AEC clinics seven days a week, reviewing the headache pathway with ED colleagues and looking at diabetes and superficial thrombophlebitis

2. Increasing the identification and better understanding of frailty: we are fully engaged with CEDT, Urgent Response (Solent), CAT and Social Services to begin to look at what we can develop to expedite the discharge of patients' home from CDU and in the future AMU (subject to resourcing)
3. Positively encouraging mobilisation on the wards including: Joined Ambulatory care network and frailty network led by UHS, Weekly stranded Patient reviews, creating a new care hub and walking track in elderly care and, working with the hospital therapy team.

In addition, other initiatives include:

1. Use of trained volunteers and relatives in hospital to encourage older people to be more active
2. Review the outcome of the So Move feasibility study and support continued use of the project
3. Implement the Eat Drink, Move and Pyjama Paralysis initiative in AMU and MOP wards. This is an initiative to encourage patients to dress in their own clothes to promote self-reliance in the frail elderly which has been shown to improve their independence, well-being, and reduce their length of stay.

1.3 What will success look like?

1. Reduced length of stay for patients in MOP and medicine
2. More patients being discharged back to original place of residence
3. A reduction in the number of patients needing onward care
4. Increase in the number of non-admitted cases from Acute Admissions Unit, AMU and ED
5. improvement in gait speed

How we will monitor progress for our clinical effectiveness priorities:

Performance will be measured and monitored via clinical boards, and reported to the Quality and Safety Committee. Using the Plan –Do- Study- Act (PDSA) cycle of improvement, we will continual review the potential for growth.

4.Review of quality performance

All NHS trusts are required to report their performance against a statutory set of core quality indicators in a predetermined format in their quality reports to enable readers to compare performance across organisations.

The tables in Appendices 3 provides information against a number of national priorities and measures that, in conjunction with our stakeholders, which form part of our key performance indicators which are reported monthly to trust board.

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

Research

Innovative thinking and research is at the heart of UHS's efforts to improve care and health. In 2016/17 we consolidated our strong R&D activity and infrastructure, with a top-5 national ranking in trial recruitment and the securing over £25 million of National Institute for Health Research (NIHR) facilities.

UHS patients have wide and rapid access to clinical trials, something underlined by the recruitment to national portfolio trials of 18583 patients, the fourth highest recruitment rate in England. Adding participants in our wider research partnerships to this takes our total recruitment to 19,984.

This performance helped secure £20M in research funding for further investment, and strengthening a key preferred partner deal that gives UHS priority on new trial contracts. Continuation of strategic partnership meetings with major pharmaceutical companies have ensured Southampton remains a key site for drug and vaccine studies.

With our partners at University of Southampton, we made successful funding submissions for a NIHR Biomedical Research Centre (BRC, £14.5 million), renewal of our NIHR Wellcome Trust Clinical Research Facility (CRF, £9.2 million) and for renewal of the Southampton Experimental Cancer Medicine Centre (ECMC). Combined, these awards secure our role in the first rank of UK clinical research sites. The BRC award consolidates our existing world-class nutrition and lifestyle BRC and respiratory NIHR Biomedical research Unit with three cross-cutting themes of microbial science, data science and behavioural science.

CQUINS

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

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

A proportion of UHS income in 2016/17 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 2016/17 are currently being determined between UHS and clinical commissioning groups.

The conditional income in 2016/17 upon achieving quality improvements and innovation goals was £13,366,000.

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 2016/17 can be found in Appendices 4

Data Quality

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

University Hospital Southampton submitted records between April 2016 and March 2017 to the NHS-wide Secondary Uses Service for inclusion in Hospital Episode Statistics. As at December 2016 (latest reporting month) the percentage of records in the published data:

Which included a valid NHS number was:

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

Which included a valid General Medical Practice Code was:

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

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 organization. The Trust met or exceeded the minimum required level of compliance assessment for all Information Quality and Records Management requirements of the Toolkit for the reporting year.

The Trust has maintained a level 3 accreditation against the NHS Litigation Authority risk management standards for Acute Trusts which contains two standards specific to records management and record keeping.

UHS recognizes that good quality health services depend on the provision of high quality information.

UHS took the following actions to improve data quality in 2016/17:

- 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.

Participation in national clinical audits and confidential enquiries

A clinical audit is a quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes.

During 2016/17 60 national clinical audits and 6 national confidential enquiries covered NHS services that UHS provides.
During 2016/17 UHS participated in 96% (57) of national clinical audits and 100% national confidential enquiries of which it was eligible to participate in.

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) studies that UHS participated in during 2016/17 were:

NCEPOD Mental Health Adults
NCEPOD Acute Pancreatitis
NCEPOD Acute Non Invasive Ventilation
NCEPOD Children and Young People Chronic Neurodisability
NCEPOD Children and Young People Mental Health
NCEPOD Cancer in Children, Teens and Young Adults

The national clinical audits that UHS participated in, and for which data collection was completed during 2016/17, are listed in Appendices 5 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.

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

(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. The results can be found in Appendices 6

6. 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 recognize that maintaining high quality services relies upon continual day-to-day improvements alongside longer term strategic developments. We are not complacent and know that we are still on a journey to achieve excellence in all areas.

This Quality Report enables us to qualify our progress comprehensively and demonstrate in 2015/16 we made good progress against our quality priorities.

We see this as an essential vehicle for us to work closely with our Council of Governors, our commissioners and the local and wider community on our future quality agenda as well as celebrating our successes and progress. Working with all our key stakeholders including patients we are determined to continue improving to achieve leading healthcare for the benefit of our patients.

We are confident that we have the necessary priorities, processes and plans in place to further improve our patients' care and hospital experience as we continue striving to deliver excellence throughout 2017/18.

Pending :

Annex 1: Statements from commissioners, Health watch and Board of Governors

Appendices 1

University Hospital Southampton NHS
NHS Foundation Trust

Patient Improvement Framework

2017 - 2018

The PIF is a tool to engage and communicate with staff and patients about transformation projects to improve care planned for 2017/18. The priorities have been chosen to reflect areas that are important to our patients and staff that need transformational change and enhanced focus to realise improvements by year end.

- The PIF is not designed to replicate the detail in the trust strategy and annual plan or cover all of the key performance indicators and work streams for quality.
- The safety strategy, patient experience strategy and the clinical strategy contain detail on the plans and processes to maintain and improve quality for patients at UHS.
- It forms part of the annual quality account where each year we report on progress against last year's priorities and set priorities for the following year

University Hospital Southampton NHS
NHS Foundation Trust

Patient Improvement Framework

2017 - 2018

"Our mission is to be better every day" - Fiona Dalton, Chief Executive

Patient Experience

- Improving patients experience of discharge from hospital
- Meeting patients nutritional and hydration needs
- Improving care for vulnerable adults

Patient Safety

- Recognition and management of the deteriorating patient
- Safer Invasive procedures
- Recognising and treating sepsis

Patient Outcomes

- Report outcome measures in every specialty across the hospital
- Improve clinical data recording to ensure that the HSMR accurately reflects our performance
- Reduce deconditioning and the impact of immobilisation on the frail elderly
- Improve care for patients at end of life.

Our values	**Patients first, Working together and Always improving**
Our strategies	**Clinical, Clinical effectiveness, Patient Safety, Patient Experience, Research, Education and Training, Equality and Diversity, Workforce**
Our Assurance	**Clinical accreditation, internal quality reviews, KPI monitoring, audit**

Appendices 2

International NPUAP / EPUAP Pressure Ulcer Classification System (2009)

GradeI: Non-blanchable erythema
Intact skin with non-blanchable redness of a localized area usually over a bony
prominence. . Darkly pigmented skin may not have visible blanching; its colour may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons.

Grade II: Partial thickness
Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or sero-sanginous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising*. This category should not be used to describe skin tears, tape burns, incontinence associated dermatitis, maceration or excoriation.
*Bruising indicates deep tissue injury.

Grade III: Full thickness skin loss
Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are *not* exposed. Slough may be present but does not obscure the depth of tissue loss. *May* include undermining and tunneling. The depth of a Category/Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and Category/Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage III pressure ulcers. Bone/tendon is not visible or directly palpable.

Grade IV: Full thickness tissue loss
Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling. The depth of a Category/Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and these ulcers can be shallow. Category/Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis or osteitis likely to occur. Exposed bone/muscle is visible or directly palpable.

We have chosen to measure our performance against the following metrics:	2013/14	2014/15	2015/16	2016/17	2016/17 benchmark
Patient Safety Indicators					
Serious Incidents Requiring Investigation (SIRI)	195	35	54	63	25 for whole year
Never Events	2	2	7	3	0
Healthcare Associated Infection MRSA bacteraemia reduction	5	5	3	1	0
Healthcare Associated Infection Census (as average of monthly %)	354%	357%	363%	361%	100%
Healthcare Associated Infection Clostridium difficile reduction	33	37	35	38	<=3 a month. 43 for whole year
Avoidable Hospital Acquired 33* Grade III and IV Pressure Ulcers	42	26	36	11	30 for whole year
Falls - Avoidable Falls	19	9	3	0	1 a month. 12 for whole year

Falls Assessment Tool (timeframe of completed within 6 hours commenced in 2016) Compliance (as average of monthly %)	95%	95.70%	71%	90.42%	>95%
Thromboprophylaxis (VTE) % Patients Assessed (CQUIN)	95.41%	95.35%	95.18%	94.87%	>=95%
Thromboprophylaxis (VTE) Pharmacological prophylaxis (as average of monthly %)	97.32%	99.46%	97.75%	95.19%	>=95%
Patient Experience Indicators					
Total Complaints	578	579	443	457	550
Percentage of complaints closed in target time (due this month) (As average of monthly %)	96.70%	93%	93%	99.08%	>=90%
National Friends & Family Test Response Rate					
UHS		27.90%			
Emergency Department		37.94%	10.76%	6.21%	>10%
Inpatients		25.15%	21.74%	20.28%	>20%
Maternity	21.70%		23.38%	29.07%	>20%

Percentage of patients recommending UHS to their friends & family					
UHS					
Emergency Department			92.26%	95.42%	>90%
Inpatients			96.16%	96.68%	>90%
Maternity			95.81%	97.66%	>90%
Monthly Real time Survey Have you ever shared a sleeping area with patients of the opposite sex during this stay in hospital? (Those who gave an answer, as average of monthly %)	13%	13.47%	13%	11.34%	<=15%
Same Sex Accommodation (Non clinically justified breaches)	16	10	5	3	0
Nutrition % of patients with Nutritional screening in 24hrs (as average of monthly %)	89.10%	89%	82%	80.47%	>=95%
Patient Outcome Indicators					
Emergency readmissions, within 28 days (as average of monthly %)	10.70%	10.40%	10.10%	10.59%	<=10%

Hospital Standardised Mortality Rate (HSMR) University Hospital Southampton NHS Foundation Trust	108.84	105.19	102.5	101.47 (Apr-Dec)	100
Hospital Standardised Mortality Rate (HSMR) Southampton General Hospital	102.53	97.64	93.63	93.14 (Apr-Dec)	<90.1
Hospital Mortality Rate (%)	1.83	1.76	1.63	1.63 (Apr-Dec)	1.61
Patient Reportedc outcome measures. PROMS hip replacement data contibuted	68.4%	74.1%	86.7%	74.0%	>=50%
Knee replacemnet data contributed	107.0%	105.9%	103.9%	104.4%	>=50%

Q.19 Readmission data from https://indicators.hscic.gov.uk/webview/ has not been updated since the last Quality Account
Q4 201617 is only Jan-Feb as March's data has yet to be submitted to DoH nationally.

Q21.1 FFT

RHM	**RESPONSE RATE**										
A&E		Q1 201516	Q2 201516	Q3 201516	Q4 201516	Q1 201617	Q2 201617	Q3 201617	Q4 201617	201516	201617
	UHS response rate	19.60%	14.30%	8.94%	4.81%	5.23%	9.52%	6.02%	4.39%	11.96%	6.53%
	National Average	21.15%	14.55%	13.05%	12.72%	12.99%	13.19%	12.18%	12.45%	14.90%	12.73%
	Highest Trust	100.00%	45.12%	44.57%	47.22%	44.43%	45.31%	45.03%	45.46%	100.00%	45.46%
	Lowest Trust	0.03%	0.18%	0.02%	0.19%	0.07%	0.00%	0.23%	0.46%	0.02%	0.00%
RHM											
Inpatient and daycase		Q1 201516	Q2 201516	Q3 201516	Q4 201516	Q1 201617	Q2 201617	Q3 201617	Q4 201617	201516	201617
	UHS response rate	22.66%	20.64%	21.22%	22.54%	20.79%	19.11%	19.87%	17.30%	21.74%	19.44%
	National Average	20.51%	26.08%	24.43%	24.43%	25.77%	25.12%	24.26%	24.32%	23.87%	24.92%
	Highest Trust	100.00%	100.00%	125.00%	100.00%	100.00%	100.00%	96.67%	100.00%	125.00%	100.00%
	Lowest Trust	0.06%	4.16%	4.66%	4.56%	4.75%	3.27%	1.70%	3.83%	0.06%	1.70%

RHM	**POSITIVE**										
A&E		Q1 201516	Q2 201516	Q3 201516	Q4 201516	Q1 201617	Q2 201617	Q3 201617	Q4 201617	201516	201617
	UHS response rate	94.53%	92.27%	94.04%	93.73%	93.79%	96.34%	94.82%	96.17%	93.74%	95.38%
	National Average	90.82%	88.14%	87.07%	84.91%	85.95%	86.01%	86.04%	87.02%	87.74%	86.16%
	Highest Trust	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Lowest Trust	58.25%	62.42%	33.33%	46.33%	42.75%	44.75%	48.16%	45.49%	33.33%	42.75%
RHM											

Inpatient and daycase	Q1 201516	Q2 201516	Q3 201516	Q4 201516	Q1 201617	Q2 201617	Q3 201617	Q4 201617	201516	201617
UHS response rate	95.81%	83.04%	96.10%	96.48%	96.35%	96.23%	97.19%	96.83%	92.92%	96.63%
National Average	92.61%	95.71%	95.61%	95.70%	95.79%	95.60%	95.54%	95.75%	95.11%	95.66%
Highest Trust	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Lowest Trust	61.40%	74.44%	71.68%	72.00%	67.97%	66.86%	75.34%	75.55%	61.40%	66.86%

RHM **NEGATIVE**

A&E	Q1 201516	Q2 201516	Q3 201516	Q4 201516	Q1 201617	Q2 201617	Q3 201617	Q4 201617	201516	201617
UHS response rate	2.10%	2.72%	3.12%	2.95%	3.03%	1.89%	2.49%	1.59%	2.54%	2.26%
National Average	4.15%	6.09%	6.89%	8.37%	7.62%	7.61%	7.63%	7.01%	6.37%	7.52%
Highest Trust	29.13%	26.11%	34.78%	37.23%	37.69%	33.31%	41.03%	32.28%	37.23%	41.03%
Lowest Trust	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

RHM

Inpatient and daycase	Q1 201516	Q2 201516	Q3 201516	Q4 201516	Q1 201617	Q2 201617	Q3 201617	Q4 201617	201516	201617
UHS response rate	1.33%	0.88%	1.41%	1.07%	1.08%	1.23%	0.75%	0.79%	1.18%	0.98%
National Average	3.30%	1.43%	1.48%	1.47%	1.44%	1.56%	1.53%	1.51%	1.80%	1.51%
Highest Trust	21.05%	9.34%	10.00%	11.11%	10.55%	13.01%	8.59%	9.54%	21.05%	13.01%
Lowest Trust	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Q24 Cdiff per 100,000 bed days

	2015/16	2014/15	2013/14	2012/13	2011/12	2010/11
UHS	9.74	11.82	9	11.3	18.9	25.8
National Ave	14.91	15.04	14.7	17.3	22.2	29.7
Highest Trust Score	66	62.57	37.1	30.8	58.2	71.2
Lowest Trust Score	0	0	0	0	0	0
Lowest Trust Score (non-zero)	1.1	2.8	1.2	1.2	1.2	2.6

Q 25 Patient Safety Incidents

	April-15 to Sept-15			Oct-14 to Mar-15			Apr-14 to Sep-14		
	Rates Per 1000 bed days	Severe and death	severe and death %	Rates Per 1000 bed days	Severe and death	severe and death %	Rates Per 1000 bed days	Severe and death	severe and death %
UHS	31.5	54	0.91%	35.41	61	0.90%	32.3	57	0.85%
National Ave (Acute Teaching Trusts)	39.3	20	0.43%	37.15	23	0.58%	33.29	20	0.52%
Highest Trust Score (Acute teaching trusts)	74.67	89	2.92%	82.21	128	5.19%	74.96	97	3.05%
Lowest Trust Score (Acute teaching trusts)	18.07	2	0.07%	3.57	2	0.05%	0.24	0	0.00%

Oct-13 to Mar-14		
Rates Per 100 Admissions	Severe and death	severe and death %
8.35	33	0.61%
7.94	29	0.51%
12.84	46	0.88%
4.87	1	0.03%

Q 23 VTE

	2014/15/Q1	2014/15/Q2	2014/15/Q3	2014/15/Q4	2015/16 Q1	2015/16 Q2	2015/16 Q3	2015/16 Q4	2016/17 Q1	2016/17 Q2	2016/17 Q3
UHS	95.60%	95.10%	95.23%	95.38%	95.10%	95.30%	95.14%	95.17%	95.04%	95.12%	94.61%
National Ave (Acute Providers)	96.40%	96.50%	96.34%	96.30%	96.30%	96.20%	95.51%	95.45%	95.64%	95.45%	95.57%
Highest Trust Score) (Acute Providers	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Lowest Trust Score (Acute Providers)	87.20%	90.50%	81.91%	79.23%	86.10%	75.00%	78.52%	78.06%	80.61%	72.14%	76.48%

Q 12a SHMI

	January 15 - December 15		April 15 - March 16		July 15 - June 16		October 15 - September 16	
	Value	OD Banding	Value	OD Banding	Value	OD Banding	Value	OD Banding
UHS	0.95	2	0.96	2	0.96	2	0.95	2
National Ave	1	2	1	2	1	2	1	2
Highest Trust Score	1.17	1	1.18	1	1.17	1	1.16	1
Lowest Trust Score	0.67	3	0.68	3	0.69	3	0.78	3

Q12b Palliative Care Indicator

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

	January 15 - December 15	April 15 - March 16	July 15 - June 16	October 15 - September 16
UHS	44.3	42.6	42.2	43.2
National Ave	27.6	28.5	29.2	29.8
Highest Trust Score	54.8	54.6	54.8	56.3
Lowest Trust Score	0.2	0.6	0.6	0.4

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

	January 15 - December 15	April 15 - March 16	July 15 - June 16	October 15 - September 16
UHS	2.35	2.15	2.19	2.29
National Ave	1.45	1.48	1.51	1.54
Highest Trust Score	3.46	3.28	3.61	3.67
Lowest Trust Score	0.49	0.01	0.01	0.01

18 Hip Replacement Surgery

	2016/17 Q2*
UHS	19.09
National Ave (Acute Providers)	22.02
Highest Trust Score) (Acute Providers	25.20
Lowest Trust Score (Acute Providers)	18.04

Knee Replacement Surgery

	2016/17 Q2*
UHS	Too few modelled records (<30) for NHSD to provide a health gain.
National Ave (Acute Providers)	16.88
Highest Trust Score) (Acute Providers	21.35
Lowest Trust Score (Acute Providers)	12.65

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* Data is only available for April through September 2016 and is not split by quarter, the data is entered under Q2 but the data is for Q1 and Q2 combined. WeI have used the latest available updated data (Feb 2017) and the metric used is average adjusted health gain for Primary hip and knee replacements

Q 25 MRSA screening

2016/17

	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	
Eligible patients	15493	14731	13948	17172	61344
Screened for MRSA	57541	49099	56023	58772	221435
% achieved	371.40%	333.30%	401.66%	342.25%	360.97%

2015/16

	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	
Eligible patients	14943	15594	15402	16270	62209
Screened for MRSA	55759	55507	56575	57688	225529
% achieved	373.14%	355.95%	367.32%	354.57%	362.53%

Appendices 4

Clinical	CQUIN Scheme	CQUIN Target	National or Local Scheme	Financial Reward for Achieving Scheme
CCGs	Sepsis 2a	Screening all patients for sepsis screening is appropriate who arrive through the Emergency Department/ or by direct admission to any other unit	National	£335,000
CCGs	Sepsis 2b	Initiate intravenous antibiotics within one hour of presentation, for those patients who have suspected severe sepsis, Red Flag or septic shock	National	£335,000
CCGs	Staff health & Wellbeing - staffing	Introduction of health and wellbeing initiatives covering physical activities, mental health and improving access to physio for people with MSK issues	National	£669,000
CCGs	Staff health & Wellbeing – healthy food	Achieve a step change in the health of food offered on the premises and submit national data based on existing contracts with food and drink suppliers	National	£669,000
CCGs	Staff health & Wellbeing – Flu Vaccine	Achieve a 75% uptake on the flu vaccine for frontline clinical staff	National	£669,000
CCGs	Antimicrobial Stewardship 4a	Reduction in antibiotic consumption per 1,000 admissions	National	£536,000
CCGs	Antimicrobial Stewardship 4b	Empiric review of antibiotic prescription	National	£134,000
CCG's	All National CQUINs	All other local CCG's collaborative CQUIN funding split across all National CQUINS	National	£412,000
SCCCG	Outpatient Follow Up	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	£373,000
SCCCG	Choose and Book	Deliver directly-bookable services to all patients referred from GP and community services	Local	£373,000
SCCCG	Frequent Attendees	Working with community partners, reduce the number of frequent attendances at ED and frequent admissions	Local	£373,000
SCCCG	Cancer 62 day pathway	In Depth review of all long waiters >104 days including an RCA and a clinical harm review	Local	£373,000

WHCCG	Non Elective Excess Bed days	A reduction in non elective excess bed days. Improved discharge planning, reduction in length of stay and improved quality care	Local	£720,000
WHCCG	Ambulatory Emergency Care	Focus on developing, implementation and strengthening of AEC protocols to deliver care outside traditional bed based hospital setting resulting in enhanced patient experience and outcomes	Local	£720,000
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	£535,000
NHSE	Intravenous Immunoglobulin Panel Database	Database of IVIG data	Local	£535,000
NHSE	CF Adherence	Randomised pilot trial providing services for Cystic Fibrosis patients	Local	£162,000
NHSE	Optimal Device	Maintenance and improvement in optimisation of device usage during the year of transition to a centralised national procurement and supply chain	Local	£351,000
NHSE	SACT	Dose banding principles using local and national dose banding tables	Local	£128,000
NHSE	Rheumatic MDT	Development of coordinated MDT clinics for patients with multisystem auto-immune rheumatic diseases and to ensure data collection and compliance with existing NHSE commissioning policies	Local	£166,000
NHSE	Audit of clinical intervention rates	Participate in required clinical interventions requested by NHSE	Local	£459,000
NHSE	Adult Critical Care	Baseline and thematic review of delayed discharges over 24 hours from GICU	Local	£351,000
NHSE	Dental	Data reporting standards – Identification of secondary dental activity within commissioning data sets	Local	£13,000
NHSE	Dental	To support local clinical commissioning for dental services	Local	£37,000
NHSE	Hep C Network	Infrastructure governance and partnership working across the healthcare providers	Local	£3,815,000
NHSE	Public Health	No specific CQUIN so funds spread across other NHSE CQUINs	Local	£125,000
			Total	£13,366,000

Appendices 5

	Total number of NCAs UHS were eligible to participate in (n=60)	Eligible (58)	Participated (55 = 98%)	% Actual cases submitted / expected submissions
1.	Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	✓	✓	Continuous
2.	Adult Asthma (BTS)	✓	×	N/A
3.	BAUS Nephrectomy Audit	✓	✓	In progress
4.	BAUS Percutaneous Nephrolithotomy	✓	✓	In progress
5.	BAUS Prostatectomy Audit	✓	✓	In progress
6.	BAUS Stress Urinary Incontinence Audit	✓	✓	In progress
7.	Bowel cancer (NBOCAP)	✓	✓	100%
8.	Cardiac Rhythm Management (CRM)	✓	✓	Continuous
9.	Case Mix Programme (CMP)	✓	✓	1212 Cases (every GICU admission)
10.	Child health clinical outcome review programme (NCEPOD) Neurodisability and Mental health in 0-25 years old	✓	✓	100%
11.	College of Emergency Medicine (CEM)- Asthma (paediatric and adult) care in emergency department	✓	✓	100%
12.	College of Emergency Medicine (CEM)- severe sepsis and septic shock	✓	✓	100%
13.	College of Emergency Medicine (CEM)- Consultant sign-off	✓	✓	100%
14.	Congenital Heart Disease (Paediatric cardiac surgery) (CHD)	✓	✓	In progress
15.	Coronary Angioplasty (NICOR)	✓	✓	100%
16.	Diabetes Footcare	✓	×	N/A
17.	Diabetes in pregancy (NPID)	✓	✓	62 cases
18.	Diabetes Diabetes Transition	✓	✓	100%
19.	Diabetes Inpatient Audit (NADIA)	✓	✓	100%
20.	Diabetes (Paediatric) RCPCH NPDA	✓	✓	100%
21.	Elective surgery (National PROMs Programme) hips and knees Hip participation rate: Knee participation rate:	✓	✓	Yes, continuous 86.7% 103.9%
22.	Endocrine and Thyroid National audit	✓	✓	TBC
23.	Falls and Fragility Fractures Audit Programme (FFFAP) national hip fracture database	✓	✓	Continuous

24.	Falls and Fragility Fractures Audit Programme (FFFAP) fracture liaison database	✓	✓	Continuous
25.	Falls and Fragility Fractures Audit Programme (FFFAP) national inpatient falls	✓	✓	In progress
26.	Head and Neck Cancer Audit	✓	✓	In progress
27.	Inflammatory Bowel Disease (IBD) programme - Biological therapies adult and paeds	✓	✓	In progress
28.	Learning Disability Mortality Review Programme (LeDeR)	✓	✓	15 cases
29.	Lung cancer (NLCA) (LUCADA)	✓	✓	Continuous
30.	Major Trauma: The Trauma Audit & Research Network (TARN)	✓	✓	100%
31.	Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) – Perinatal Mortality	✓	✓	100%
32.	Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) – Maternal Mortality	✓	✓	100%
33.	Medical and Surgical Clinical Outcome review programme NCEPOD – NIV	✓	✓	100%
34.	Medical and Surgical Clinical Outcome review programme NCEPOD –Acute pancreatitis	✓	✓	100%
35.	Medical and Surgical Clinical Outcome review programme NCEPOD – Mental health Adults	✓	✓	100%
36.	National Adult Cardiac Surgery Audit	✓	✓	In progress
37.	National Audit of Dementia	✓	✓	100%
38.	National Cardiac Arrest Audit (NCAA)	✓	✓	118 Team visits which met NCAA scope
39.	National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme - Secondary Workstream	✓	✓	In progress
40.	National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme - Pulmonary Rehabilitation Audit	✓	✓	In progress
41.	National Comparative Audit of blood Transfusion- 2015 Audit of Patient Blood Management in Scheduled Surgery (NCABT)	✓	✓	29 cases
42.	2016 Audit of Red Cell and Platelet Transfusion in Haematology (NCABT)	✓	✓	40 cases
43.	National Emergency Laparotomy Audit (NELA)	✓	✓	In progress
44.	National Heart Failure Audit	✓	✓	In progress
45.	National Joint Registry (NJR)	✓	✓	95%
46.	National Ophthalmology Audit	✓	✓	In progress
47.	National Prostate Cancer Audit (NPCA) (2nd year)	✓	✓	100%
48.	National Vascular Registry (NVR)	✓	✓	In progress
49.	Neonatal Intensive and Special Care (NNAP)	✓	✓	737
50.	Neurosurgical National Audit programme	✓	✓	6,617 admissions
51.	Oesophago-gastric cancer (NAOGC) (NOGGA)	✓	✓	In progress

52.	Paediatric Intensive Care Audit Network (PICANet)	✓	✓	In progress
53.	Paediatric Pneumonia	✓	✓	In progress
54.	Renal replacement therapy (Renal Registry)	✓	✓	100%
55.	Sentinel Stroke National Audit Programme (SSNAP) continuous SSNAP Clinical patient Audit	✓	✓	207 expected every quarter
56.	Sentinel Stroke National Audit Programme (SSNAP) SSNAP Post Acute Organisational Audit	✓	✓	100%
57.	UK Cystic Fibrosis Registry (Adults and Paeds)	✓	✓	100%

National Clinical Audit: actions to improve quality

National audit title	Actions
1. Diabetes Inpatient Audit (NADIA)	• Nursing staff to have twice annual link nurse meetings and diabetes study days. • Bespoke ward/department based teaching to be further arranged as necessary. • Doctors to have regular diabetes education slots and lunchtime departmental teaching as required • HCP's and undergraduates education sessions to be provided upon request • Update the diabetes guide and make available on StaffNet. • DiAppBetes (smartphone application to support HCPs for diabetes care) being updated. • Inpatient diabetes E-learning tool to be made available on VLE. • Divisional Education Leads to support areas that need diabetes updates. • Push for increased foot clinic support for patients from West Hampshire.
2. 2016 Audit of Red Cell and Platelet Transfusion in Adult Haematology Patients	• To reduce transfusion of platelets from two to one unit in out-patients. • Re-audit in Autumn 2017 looking at intervals between transfusions in Haematology out-patients
3. Rheumatoid and Early Inflammatory Arthritis	• Quality Standard (QS) 1 & 2 - Improvements to GP education to be made to increase awareness of early inflammatory arthritis (EIA) and to encourage rapid referral of patients suspected of having an EIA directly to the Consultant or via urgent referral through the Choose and Book service. • Looking to introduce an electronic referral form to support the current Choose and Book process. • QS3 - A Consultant-led service to be introduced. • QS4 & 5 – To introduce a formal personalised patient education portfolio with information about their condition, treatment, monitoring requirements and advice line information.

4. National Comparative Audit of Blood Transfusion (NCABT) 2015 Audit of Lower GI Bleeding and the use of blood	• Audit outcomes to be discussed at Surgery care group audit meeting and circulated to clinicians.
5. Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) – Perinatal mortality	• Active program is ongoing, which mirrors National initiatives to reduce stillbirth numbers. • Revise guidelines for monitoring fetal growth. • Planned revision of patient information on the importance of reduced fetal movements. • On-going internal review of all perinatal mortality with a view to learning lessons.
6. Elective surgery (National PROMs Programme) - Hips and knees	• An audit of patients reporting worse condition-specific health post-operatively is complete and a report will be circulated once it has been signed off by the lead clinician. • PROMs health gains have been used to produce a patient handout for hip replacements and to highlight areas where post-operative rehabilitation could be changed. This document is now live on the UHS website. • Work with the MSK physiotherapy department to develop targeted occupational therapy • Further analysis to be carried out.
7. UK Cystic Fibrosis Registry (Adults and Paeds)	• To increase social worker time. • Develop a strategy to address nutritional outcomes in our patients.
8. Coronary Angioplasty (NICOR)	• To continue to perform at same level of care
9. Sentinel Stroke National Audit Programme (SSNAP) SSNAP Post Acute Organisational Audit	• On-going work within the trust to work on CT time within 1 hour for all strokes admitted
10. National Joint Registry (NJR)	• A monthly report to ensure all relevant hip and knee replacements are entered onto the NJR. This was instituted in October 2015 and has decreased the number of missing records in the 15/16 data quality audit. • NJR consent forms are being sent with pre-assessment appointment letters which has help boost the percentage of patients consenting to their data being held on the NJR from 71% in 13/14 to 95% in 16/17 to date. • The Orthopaedic Department are engaged in an ongoing process of validation and implication of individual consultant level data • Other contributing factors are being identified and addressed
11. Bowel cancer (NBOCAP	• Improved completeness of submission data
12. National Vascular Registry (NVR)	• Vascular centralisation with Portsmouth Unit moving to Southampton.

13. College of Emergency Medicine (CEM) – procedural sedation	• Development of pre sedation checklist • Development of pre discharge checklist
14. Diabetes (Paediatric) PNDA	• Reviewed & amended team agreed blood glucose targets for patients at team away day on 7th June 2016 • Reviewed & amended team agreed HbA1c targets for patients at team away day on 7th June 2016
15. Medical and Surgical Clinical Outcome review programme NCEPOD – Acute pancreatitis	• To revise the Gall bladder surgery pathway. • To discuss complex pancreatitis cases in an MDT meeting.
16. National Prostate Cancer Audit (NPCA) (2nd year)	• Improvement of data completion for certain fields expected in future years following improved import processes from HICCS.

Local Clinical Audit: actions to improve quality

Audit Title	**Actions**
1. Assessment and prevention of delirium in people with Hip fracture	• Education and awareness about the 4AT poster which is to be placed on ward. • Education session for FY1 and SHO doctors working in T&O to include 4AT and audit findings.
2. 6 monthly completion of Real-Ear-to-Coupler Difference (RECD) measurements on all Permanent Childhood Hearing Impairment (PCHI) children <5 years	• Staff to continue to ensure RECD measurements are performed at each hearing aid review appointment. • To try to ensure appointments are booked no more than 6 months apart. • If RECD measurements cannot or are not performed the reason for this needs to be documented.
3. Diagnosis and management of clinically isolated syndromes that have a high risk of conversion to multiple sclerosis	• Patients presenting with asymptomatic T2 high signal lesions on imaging should be offered a referral to the multiple sclerosis disease-modifying drug clinic or MDT. • Patients presenting with asymptomatic T2 high signal lesions on imaging should be offered a follow-up MRI scan after 3-6 months. • Present the results at our regional neurology meeting. • Share results via a group email. • Ensure all MS specialists in the region are in agreement with these recommendations.
4. Drink thickening practices against the process agreed by the Nursing and Midwifery Group (NMG), and the Oropharyngeal Dysphagia Policy.	• Supply/replacement process for the new generic above bed sign to be circulated within the Trust • A crib sheet on how to use bed signs to be produced and circulated. • Bed signage to be covered in all relevant SLT/N&D training. • A rolling ward training programme on how to mix thickened drinks and to follow SLT recommendations will be rolled out.

	• Rigorous incident reporting of incorrect recommendations to be completed. • Training and process for diet grid sign off by Nurse in Charge to be revisited. • Matrons to support wards on the agreed drink round process. • Matrons to support wards on agreed process for water jug thickening. • Matrons to support wards on following the NPSA alert that tins of thickener must not be left on patient's tables without a risk assessment being carried out. • SLT to provide bespoke ward/staff training when needed.
5. Use of delirium diagnostic tool in elderly care	• To ensure the recommended tool for assessing patients with delirium is available to staff on the relevant wards.
6. Management of Diabetic Ketoacidosis in Adults at UHS	• Nursing and medical staff on AMU will be educated about the need for hourly observations on patients admitted with DKA. • To amend the DKA chart to carry a check box for foot examination. • All patients presenting with DKA and ph<6.9 on a blood gas will be referred to ITU. • Diabetes team will have a new checklist indicating ketone/sick day advice as well as post-discharge follow up.
7. Epilepsy Surgery: Outcomes and Complications	• To make alterations in surgical technique to reduce morbidity from temporal lobe resections. • To have less prolonged gaps between operations. • To send notification of adverse outcomes directly to neurosurgical management team. • To have a rapid review of post-operative outcomes to discuss complications more quickly. • A formal re-audit to be completed in 12-18 months.
8. Management of anaphylaxis in Paediatric patients presenting to PAU and ED	• To introduce a discharge proforma.
9. An audit of domperidone prescribing in children	• Educate prescribers on the importance of ECG monitoring with domperidone. • Speak to prescribers/consultants and try to come to a solution on length of time medication is taken for.
10. Emergency diabetic eye screening referrals to eye casualty	• New telephone answering service to be installed. • Protocol for referring patients to eye casualty has been redesigned to include faxing of why being referred. • Two-part referral to be amalgamated into one. • Staff to be trained on the new Optimise computer system to be able to view retinal screening images. • Access to the Optimise computer system to be given to staff once trained.
11. Ongoing pain management in the major trauma patient	• Teaching and education on pain scoring in ED to be performed in cooperation with the Acute Pain Team.

	• Teaching and education on at rest and movement pain scoring performed in cooperation with the Acute Pain Team. • Discussion with Metavision Team re: implementation of rest/movement pain score to be added in the electronic observation chart. • Introduction of regular analgesics and laxatives in the analgesia bundle; teaching and education of the ward staff including T&O doctors (at T&O induction). • Re-audit in 6 months time once above actions implemented
12. A re-audit of the prevalence of overweight and obesity amongst the local paediatric diabetes population	• Develop resources which are designed specifically to support overweight and obesity patients. • To include prescriptive kilocalorie counting diets and portion sizes in the resources. • Use alternative and more modern methods to communicate with diabetes patients, which better suit their needs. • To make appointments outside of school and parents working hours. • Increasing the use of e-mail to communicate with families about dietary intake. • To improve communication and awareness of local community run exercise and activity programmes that are accessible to the children and young people. • To look at an obesity strategy and resource that links UHS with community activities. • To be part of the Southampton City strategy board for the healthy weight campaign. • To ensure all the diabetes team continue to discuss growth charts and targets with patients and their families in clinic. • To describe in all written communication with parents their child's weight status and their target. • To consider adding nutritional requirements at the top or bottom of each dietetic report given to all patients as standard. Explaining recommended daily grams of carbohydrate and sugar. • To change the written information given to newly diagnosed diabetes patients to have more emphasis on healthy diets and bodyweight. • To keep a record of prevalence of diabulaemia on the database.
13. Perineal repair guideline – patient information leaflet audit	• To use 'Theme of the week' to remind staff to record in the case notes when they have given the perineal repair leaflet to a woman.
14. A re-audit to assess the use of a cough assessment framework in neuromuscular patients admitted with respiratory problems.	• To keep the cough assessment form in ward folders to allow quick and easy access. • Repeat teaching sessions to all teams. • Re-launch interest across all Divisions. • To complete a re-audit.

15. Children and young people diagnosed with Type I Diabetes who are Carbohydrate Counting at Level 3	• To aim for 100% carbohydrate counting at re-audit in 2018. • To review patients identified as not carbohydrate counting and aim to establish them carbohydrate counting with appropriate support. • To continue to introduce carbohydrate counting at diagnosis. • To carry out another audit in the 2017 audit cycle looking at carbohydrate counting at diagnosis and HbA1c six months on. • To work with the rest of the diabetes team to develop a strategy. • To consider and recognise at the time of diagnosis which patients and families may find carbohydrate counting challenging. • For patients and families who need additional support a home visit or school visit may be required.
16. Audit of GICU & CICU Metavision Recording of Enteral Feeds August 2016	• To document the times the feed is paused by pausing the infusion line on metavision.
17. A re-audit of patient experience of empathy in clinical encounters with therapy staff during admission to trauma & orthopaedic wards	• To ensure the feedback relates specifically to therapists the word 'Therapy' to be made clearer on the questionnaire. • An alternative version to be considered in order to include those with learning difficulties or cognitive impairments. Similarly, to enable those with communication difficulties to complete the questionnaire independently, a tablet/touch screen version could be used.
18. Is our hand trauma service hitting the British Society for Surgery of the Hand (BSSH) 2007 standards?	• To develop guideline criteria with the hand consultants for access to the hand clinic. • To develop and undertake an education programme to ED clinicians to ensure full implementation. • To discuss with consultants the development and implementation of a teaching programme for the trauma consultant teams. • To develop guideline criteria with the hand consultants for access to the hand clinic to ensure the most appropriate patients are seen by the right team. • To develop a specific pathway for priority patients from ED assessment to definitive surgery.
19. Audit of patient medical notes where the DNACPR audit form recorded that there was no discussion with the patient	• To educate the medical staff on the need to document in patient's medical notes the reasons DNACPR decisions are not communicated to patients. • To be added to the resuscitation training for medical staff.
20. Developmental Dysplasia of Hips (DDH) - Risk Factors - Timeliness of intervention	• Guideline to be reviewed and republished, ensuring the referral criteria is clear. • Risks register entry (2113) to be update to reflect the timeliness aspect of the PHE criteria. • Audit to be discussed with the DGM and CE lead for child health.

	• Trust Screening Lead to be made aware of the current non-compliance. • To inform the DCD of the current non-compliance. • Continue to audit to include Q1, Q2 and Q3.
21. Anticoagulation after Hip or Knee Surgery in Patients on Long-Term Anticoagulation	• Presentation of results at T&O Care Group, M&M & Audits Meeting. • Informing the T&O Consultants and Registrars who were not present at the meeting about the results of the audit and about the necessity to document Anticoagulation plans in the operation notes accurately.
22. Documentation Of post take ward round in trauma orthopaedics	• Suggest implementing a set format for post take ward round documentation.
23. Comparison of traditional Norwood procedure and its Sano modification: outcome and indication	• Results of our experience to be discussed between Paediatric Cardiac Surgeons, PICU and Cardiologist Consultants. • To agree whether to continue with Norwood and Sano modification during stage 1, moving the conduit shunt to the right pulmonary artery.
24. An audit on handover practice in Oncology	• To create a handover checklist poster. • To create signs on door during handover to minimise distraction during handover, remind other HCP not to interrupt. • To create a permanent bleep for the second twilight SHO on-call. • To create a clear structure for handover including a clear triage system for sick patients. • To put an up-to-date on-call rota in all handover rooms. • To standardise criteria for handing patients over on weekend. • To specify roles of job during on-calls. • To schedule allocated time for handover- normal days and pre-weekend. • To create a job folder for writing routine jobs done and ensure job book available on each ward for nurses to complete. • Identifying SpR/SHO on-call for the day and create a briefing for every morning. • Whatsapp group for easier communication if running late/unable to attend handover. • To ensure adequate training for new staff to manage common emergencies in the department..
25. Re-offer of virology screening (Antenatal Screening)	• Further communication with midwifery staff by newsletter.
26. Intermittent Auscultation (IA) Audit	• To feedback and educate through the education team regarding documentation of the presence of accelerations and absence of decelerations for both low risk women and women transferred to continuous fetal monitoring.

	• To feedback and educate through the education team regarding documentation of the reason for transfer to continuous fetal monitoring. • To feedback and educate through the education team regarding undertaking and documenting the maternal pulse as per the guidance. • To remove from the Care Group Risk Register entry (1624) as improved compliance. • Discuss with the consultant Midwives the options and benefits for a 'fresh ears' approach with intermittent auscultation.
27. MEOWS audit	• To add MEOWs activation hotline ext, bleeps for the Coordinator and SHO on handover sheet. • For the Theme of the week, to add education on MEOWs activation, scores.
28. Shoulder dystocia re-audit	• To encourage use and completion of shoulder dystocia proforma in paper notes by raising awareness among multidisciplinary team, via: presenting audit at MDT meeting, PROMPT course, and theme of the week. • To promote use of checklist for babies with suspected brachial plexus Injury at PROMPT course. • To raise awareness of entering babies with brachial plexus injury or upper limb fracture details on HICSS or SEND at PROMPT course.
29. High dependency care audit	• To promote documentation standards for admission and discharge on Theme of the Week. • To review guideline. • Ongoing education to be completed during HDU study days.
30. Complications from Botox in Squint	• To ensure patients having Botulinum Toxin follow-up within 6 weeks to ensure measurements are taken at time of maximum efficiency. • To make an improvement to EMG machine to enable greater accuracy with injection. • To continue to record the results of future injections to see if any alterations in practice reduce complication rate and improve success rate. • To maintain the recent increase in number of clinics to meet the demand of patients requiring treatment.
31. Retinal detachment audit	• Audit to be repeated every three months to ensure fellows are adequately monitored and to guide clinical supervision.
32. Outcomes of DCR surgery at UHS	• To discuss audit outcomes with managers to increase theatre capacity.
33. Audit to review DNACPR sheet within patients medical notes to review if signed by Consultant	• To reiteration the need for DNACPR forms to be verified by Consultants within 48 Hours. • To complete spot-checks of DNACPR forms on Matron walkabouts.

34. Re-audit of the documentation of critical care rehabilitation for those patients admitted to general intensive care	• Investigate the potential to fund a rehab coordinator post (Job description has been written, awaiting funding). • To develop current information pack (ICU Steps) given to patients on ICU admission to include details about rehab pathway. • To include information regarding potential discharges from the unit in the daily therapist handover meeting. • To include information to review patients prior to discharge will now be in the daily therapist handover meeting. • To develop information pack to give to patients on discharge from GICU in order to provide information to patients and with contact details for follow up clinics. • Reminders to complete CPAx and Barthel scores to be included in the daily therapist handover meeting. • Reminders to review goals to be included in the daily therapist handover meeting.
35. Broken down Perineum - The rate and causes of cases where women return to the Maternity Assessment Unit with complications with Perineal wound healing	• To raise awareness of the information to be given to patients about PR checking before and after suturing. • To be a Theme of the week.
36. MUST & Food Chart Audit in Trauma and Orthopaedics	• To arrange a meeting to discuss training needs that need to be implemented from the audit findings.
37. AMU handover/safety audit	• To discuss with CE lead to break down the work list to Elderly care and AMU patients. • To present audit report in AMU teaching and Governance meeting.
38. Completion of recommended onward referrals following diagnosis of a permanent childhood hearing impairment (PCHI)	• To report audit findings at the next paediatric meeting on 16th December 2016.
39. Documentation Reliability of Transthoracic Echocardiography in Diagnosing Morphology of Bicuspid Aortic Valve Disease	• To contact HICCS to assess possibility and request for mandatory data entry point for aortic morphology (with set criteria) for those undergoing aortic surgery. • To contact the department in charge of developing the echo reporting software to assess possibility and request for mandatory data entry point for aortic morphology (with set criteria) for all echo reports.
40. Management of low Hb on Neuro-intensive Care Unit (ICU)	• To increase awareness of new guidelines within the multidisciplinary teaching. • To update online Neuro ICU guidelines.
41. Giant cell arteritis audit	• To ensure that all patients that have CXR are treated with aspirin (where no contraindication).

42. An audit of Speech & Language Therapy (SLT) and ward compliance with the Oropharyngeal Dysphagia Policy on acute paediatric wards	• To feedback the audit results to the SLT team. • To circulate the report to ward leaders/matrons/division leads via email. • To meet with ward managers and matrons of the respective ward areas to share audit data and together create an action plan for improvement. • To feedback audit results to relevant trust forums/meetings i.e. NMG • To provide training to wards as appropriate. • To provide extra bed-signs to areas that requires them.
43. Completion of Peripheral Cannula Care Record	• To reiterate to all medical/nursing staff the need to record insertion date, VIPS scores and removal dates. • To ensure all medical/nursing staff to include reason if cannula has been insitu for more than 72 hours. • To reinforce the above actions to medical staff via email. • To reinforce the above actions to nursing staff via band 7 meeting. • To ensure all Nursing staffs (via band 7s) are asked to continue to submit AERS for forms not initiated/ completed.
44. Audit of completeness and accuracy of genotyping results in adult cystic fibrosis (CF)	• To add section to annual review to check whether genotype result has been seen. If not available to request result from genetics department or retest. • CF consultant to check all patients genotype at annual review and send extended genotyping where indicated. • The patient registry data to be updated with results available from extended Genotyping.
45. Developmental Dysplasia of Hips (DDH) - Risk Factors - Timeliness of intervention re-audit	• To communication with the PSC to reiterate appointments should be booked within 6 weeks of age.
46. Essence of Care - Promoting Health & Wellbeing audit	**Intensive Care actions** • To change the doctor's documentation on CIS to include health risk factors. • CAM score (to evaluate patients agitation) to be introduced through a focused education programme in CICU. • To use NICU Agitation - Sedation escalation tool using Richmond Agitation Sedation score (RASS) - continuous education and training to all staff. • Sleep assessment documentation to be placed on CIS. • To commence a sleep project to reduce noise at night. • To purchase an audiometer for the unit to assess noise at night.
47. Trustwide record keeping audit including ED	• To distribute audit results to all clinicians and governance teams at UHS. • To educate clinicians and new doctors on the importance of detail about timing and ability to identify clinicians involved with patients.

	• Consultants to ensure they educate all members of clinical team when reviewing notes, and also to ensure their trainees documentation is up to standard. • Top tips for doctor to ensure they document allergy status. • Awareness for consultant to check the junior doctors are documenting allergy status.
48. Essence of Care Bowel Bladder and Continence Audit	**Actions from Surgical Wards** • Share findings and results of audit with Senior Nursing Team on surgical ward areas. • To continue with education to new staff and current staff re: completion of patient elimination assessments for both bowel and bladder. • To meet with Ward Leader on ASU/ASA and F5 to educate nursing staff on completion of elimination assessments.. • To work with Nursing leads in bowel and bladder care to produce new Trust guidelines and to continue to scope compliance against care plans for both bowel and bladder assessments. • To work with nursing teams to educate them to complete care plans for catheter removal. • To confirm that all surgical wards have hand wipes available for patient use. **Actions from Critical Care** • To add a separate form to the nursing task for flexiseal observations to make it more accessible to document care actions. • Bedside flexiseal training sessions to be provided on GICU by the company representative. • CICU will get the flexiseal company representative to provide updates and training. • To produce new “Do Not Enter” signs. • Prompts to be made via email / Hawkeye and forums to increase compliance of the “Do Not Enter” signs use during patient care. • Staff nurse on GICU to liaise with Trust lead nurse specialist for infection prevention to investigate implementing a nurse–led protocol for Trial With-Out Cather (TWOC) specific for critical care. • To increase education on documentation of care plans for urinary care and the TWOC flow chart for the Trust. • To ensure nurses refer to Tissue Viability service (TVS) when skin damage is identified and ensure correct care plan is in place. • Educate staff on correct monitoring treatment and documentation of skin damage. **Actions from Elderly and Acute Medicine Wards** • Privacy signs to be attached to all curtains during toileting patients at bedside. • To ensure all curtains are well fitted.

	• Staff to leave patients alone whilst going to the toilet as long as it is clinically safe to do so. • All patients to be given a call bell when they are left alone whilst toileting. • All patients to be offered to be taken to the toilet rather than using the commode / bedpan as long it is clinically safe to do so. • All staff to be reminded of and educated in the importance of giving patients a choice. • To ensure patients are offered the facility to clean their hands before and after going to the toilet. • To ensure all patients are appropriately referred to community continence services prior to discharge and information to be made available to these patients. • To ensure nursing staff record an accurate plan of care for bowel, bladder and continence that should be discussed with the patient and evaluated and updated as necessary. • To ensure all patients with a catheter to receive appropriate catheter care and for this to be documented regularly and clearly.
49. Saving Lives HII 1 Central Venous Catheter Care	• All Care Group Managers / Care Group Clinical Leads to support the Clinical teams, follow up on actions and monitor those areas with sub optimal performance. • Care Group Managers / Care Group Clinical Leads to ensure that all areas submit audits as per the Infection Prevention annual audit programme.
50. Saving Lives HII 2 Peripheral Intravenous Cannula Care	• All Care Group Managers / Care Group Clinical Leads to support the Clinical teams, follow up on actions and monitor those areas with sub optimal performance. • Care Group Managers / Care Group Clinical Leads to ensure that all areas submit audits as per the Infection Prevention annual audit programme.
51. Saving Lives HII 3 Renal Dialysis Catheter Car	• Divisions and Care Groups to review and discuss this report with areas taking action in order to address those areas with sub optimal performance.
52. Saving Lives HII 5 Ventilated Patients	• Produce action plan to address non compliance (Emergency Medicine Respiratory High Dependency Unit) and provide evidence of implementation • To re-audit within 1 month ensuring compliance addressed through action plan.
53. Saving Lives HII 6 Urinary Catheter Care	• 13 Areas that scored below 85% to produce an action plan to address non compliance and provide evidence of implementation • To refer to training areas that scored low on compliance with Non Touch technique. • To re-audit within 1 month ensuring compliance addressed through action plan.

54. Saving Lives HII 8 Cleaning and decontamination	• CICU and D8 to produce an action plan to address issues and send to Infection Prevention for monitoring. • To re-audit within 1 month ensuring compliance is addressed through action plan.
55. Multi Professional Hand Hygiene Audit – IN Patient Areas	• Divisions and Care Groups to review and discuss this report with clinical teams. • Areas to take action in order to address those areas with sub optimal performance. • A review by all Care Group Managers / Care Group Clinical Leads is required to ensure that all teams required to submit audits do so as per the infection prevention annual audit programme. • Areas showing compliance with hand hygiene are to ensure work is ongoing in order to sustain compliance. • Action plans and notification of re-audit submissions should be emailed to Infection Prevention Team.
56. Hand washing facilities	• Areas to produce an action plan to address issues and send to Infection Prevention for monitoring. • To re-audit within 1 month ensuring compliance addressed through action plan.
57. Environmental audits kitchen	• CMH and Endoscopy to produce an action plan to address issues and send to Infection Prevention for monitoring. • To re-audit within 1 month ensuring compliance addressed through action plan.
58. Environmental audits linen	• Audiology to produce an action plan to address issues and send to Infection Prevention for monitoring. • To re-audit within 1 month ensuring compliance addressed through action plan
59. Isolation audit	• AMU and Paediatrics Medical Unit G2 to produce an action plan to address issues and send to Infection Prevention for monitoring. • To re-audit within 1 month ensuring compliance addressed through action plan • Care Group Managers / Care Group Clinical Leads are required to support the Clinical teams, follow up on actions and monitor those areas with sub optimal performance. • A review by Care Group Managers / Care Group Clinical Leads is required to ensure that all medical teams are required to submit audits do so as per the infection prevention annual audit programme. • Areas showing compliance with hand hygiene are to ensure work is ongoing in order to sustain compliance
60. Standard Precautions audit	• C7 Haematology day unit, Pulmonary function and complete Fertility to produce an action plan to address issues and send to Infection Prevention for monitoring. • To re-audit within 1 month ensuring compliance addressed through action plan
61. Auditing ward compliance with the UHS	• To feedback findings to Speech and Language Team.

Oropharyngeal Dysphagia policy on adult wards	• To circulate report to ward leads / matrons / divisional leads, etc, via email. • Areas to be encouraged to complete audit as it is difficult to feed back to specific wards due to small sample size. • Managers from areas of concern to be provided with verbal / written feedback. • Audit findings to be discussed at the Catering Operational meeting.

62. Use of Chaperones when examining or carrying out intimate cares on children or young people (aged 0-18yrs) in both inpatient and outpatient settings	• To review and update the Policy to ensure:
	  • There is clarity of terms 'formal' and 'informal' chaperone.
	  • What documentation is required to be completed and when.
	  • How to report the inappropriate use of a chaperone.

63. To look at the effectiveness of the new portable CT scanner	• To encourage use of the portable CT scanner. • To increase the number of staff who can use the portable scanner.
64. An audit of record keeping of strong potassium products in both designated Critical and non critical care areas.	• To discuss whether CCU needs a potassium record book for their own area or is it acceptable that they can use CHDU book. • Cardiac pharmacy team to investigate and discuss with ward manager about keeping appropriate records up to date. • Critical care pharmacist to investigate and discuss with ward manager about keeping appropriate complete records of pre-filled syringes. • Critical care pharmacist to investigate and discuss with ward manager about keeping records up to date on pre-filled syringes and 20% injection. • To consider blue and pink side having a record book each. • Ward pharmacist to investigate and discuss with the ward manager about the missing Piam Brown record book. • Ward pharmacist to investigate and discuss with ward manager about the missing Gynae Theatre record book. • To raise awareness and re-education of the supply and administration requirements of strong potassium products to non-designated critical care areas. • To address the pharmacy involvement around supply and record keeping. • To re-iterate the requirements of the policy that need to be adhered to with regards to administration records.
65. Pharmacy compliance with UHS Controlled Drugs Policy	• To review Pharmacy CD policy. • To review frequency of RSH CD stock checks. • To develop a more efficient way of ordering stock CDs at RSH. • Need to improve specific processes within the dispensary before the next audit.

66. Wessex N.I.C.E (Neuro-intensive Care Emergencies) Course simulation-based training	• To run course over 2 afternoons per month, instead of 1 whole day.
67. Noise levels in Neuro-intensive Care	• Source new noise monitors and re-audit. • To discuss results with GICU staff. • To re-audit more widely during both day and night time.
68. Audit to evaluate current practice on Ritaximals infusion by ensuring pre treatment screening is completed before infusion.	• To improve lg check by ensuring staff are aware of completing the check before rituximab is given, as below standard of 60%.

Appendices 6

Adjusted health gain

	Reporting Period

	Apr 2015 - Mar 2016 (Provisional, published Feb 17)		Apr 2014 - Mar 2015 (Final, published Aug 16)		Apr 2013 - Mar 2014 (Published Aug 15)		Apr 2012 - Mar 2013 (Published Aug 14)	
	UHS	Eng. Ave.	UHS	Eng. Ave.	UHS	Eng. Ave.	UHS	Eng. Ave.
Hips	20.829	21.617	21.199	21.443	21.671	21.380	20.707	21.299
Knees	15.037	16.368	15.721	16.116	14.975	16.273	15.448	15.996

Participation rates

	Reporting Period							
	Apr 2015 - Mar 2016 (Provisional, published Feb 17)		Apr 2014 - Mar 2015 (Final, published Aug 16)		Apr 2013 - Mar 2014 (Published Aug 15)		Apr 2012 - Mar 2013 (Published Aug 14)	
	UHS	Eng. Ave.	UHS	Eng. Ave.	UHS	Eng. Ave.	UHS	Eng. Ave.
Overall	89.5%	74.9%	86.4%	75.6%	82.4%	77.2%	70.1%	75.5%
Hips	86.7%	86.2%	74.1%	85.8%	68.4%	87.0%	55.6%	83.2%
Knees	103.9%	96.0%	105.9%*	95.0%	107.0%*	95.0%	104.0%*	90.4%

Appendices 7

Registration with the Care Quality Commission (CQC)

The Care Quality Commission (CQC) is the independent regulator of health and adult social

care in England. It ensures that health and social care services provide people with safe, effective, compassionate, high quality care and encourages care services to improve.

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

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

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

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

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

Regulated activity: Transport services, triage and medical advice provided remotely
Provider conditions: This regulated activity may only be carried on at the following locations:
• Princess Anne Hospital, Coxford Road, Southampton, SO16 5YA
• Southampton General Hospital, Tremona Road, Southampton, SO16 6YD

Regulated activity: Assessment or medical treatment for persons detained under the 1983 (Mental Health) Act
Provider conditions: This regulated activity may only be carried on at the following locations:
• Countess Mountbatten House, Moorgreen Hospital, Botley Road, West End, Southampton, SO23 3JB

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

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