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Chief executive’s welcome

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 our top priority and this is reflected in our core values of patient’s first, working together and always improving, as well as in our annual objectives. We could not do this without our staff and we are proud that in 2016 University Hospital Southampton NHS Foundation Trust (UHS) was rated one of the top performing organisations in the country for staff engagement.

The Trust was also 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%).

As well as this, the Trust 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 being 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).

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

Like every NHS hospital in the country, we don’t have as many permanent clinical staff as we would like, so it’s been a pleasure to recently welcome the new deanery junior doctors, the new group of UHS Fellows, overseas recruited staff, our newly qualified nurses and our first group of Foundation Degree Higher Apprentices. We very much hope that all our new colleagues enjoy working here and that they choose to stay or come back. It’s vital that we continue to recruit and retain the right staff with the right values from Southampton, the UK, and from all over the world.

Nationally and internationally, the political situation continues to be more unstable and unpredictable than I have ever experienced. Our biggest concern is the impact on staff from overseas. UHS are doing everything that we can, both directly and through groups such as NHS Providers and the Cavendish Coalition (a national body focussing on the impact of Brexit on employment), to lobby the government about the importance of providing certainty to EU colleagues working in the NHS, and the need for a sensible migration policy that enables people from around the world to continue to enter the UK and enrich our health and social care.

2016/17 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 establishes our priorities for 2017/18.

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

We have also been able to invest in improved facilities for both patients and 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 across the hospital.

We have been successful in renewing our research funding, through both our Biomedical Research Centre (BRC) 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 (our paediatric cancer ward) and are currently expanding the Paediatric Intensive Care Unit. We have also been raising funds and sponsorship for the new children’s emergency department which has been match-funded by the Treasury. Both these developments move us a step closer to the creation of our children’s hospital.

The new main entrance has also been completed without NHS money. The Trust is acutely aware that car parking and transport to the hospital is undoubtedly a major concern for both patients and visitors and impacts upon our patients’ experience. We have made efforts to reduce the difficulties and have long-term plans to further reduce the problem. This year we have seen good progress on the new multi-storey car park which will be six storeys high with a tiered design to set it back from surrounding properties, and will provide up to 778 spaces.

2016/17 has seen us in financial surplus. This means we can continue to invest in capital investment, such as buildings and equipment. Our current financial position is also 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 Hampshire and beyond.

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 our care seven plus out of ten, 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 but there is room for us to improve the patient experience, with particular focus on the patient’s experience of discharge and their nutritional and hydration needs.

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

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

Fiona Dalton,
Chief executive
23 May 2017
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 the Trust Board. The named executive leads for quality are the medical director and the director of nursing and organisational development.

Quality improvement is just one element of a coordinated and Trust-wide approach to quality. In previous years these priorities have been outlined in our 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 recognise 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 appendix one.

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 and departments are required to demonstrate adherence to standards of care to become accredited. The wards gain this accreditation by submitting information on key quality performance indicators and patient complaints and compliments to a senior clinical panel. Patient representatives also undertake unannounced visits to the ward or department. Successes are celebrated and areas for improvement are agreed where necessary.

The Trust also conducts Clinical Quality Reviews (CQRs) 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 linked to 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:

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 NHS England’s ‘Sign up to Safety’ campaign and, to demonstrate our commitment, we have made public our five key pledges.

Continually learn
Make our organisation more resilient to risks by acting on the feedback from patients and constantly measuring and monitoring how safe our services are.

As a Trust it is important that we learn and make appropriate changes when things go wrong, and so 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 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 considers UHS 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, blood clots 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.
**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). We involve patients and their families at each stage of our investigation into patient safety incidents and complaints. We contact them at the start of the process to make sure that their concerns are heard and this helps structure the investigation. We keep them updated on progress and share our findings with them at the end of the investigation. We do this in a variety of ways to suit the needs of the patient or family. This builds on our current policy of being open. We acknowledge we can still improve in this area.

**Table 1: Inpatient survey results January 2016**

<table>
<thead>
<tr>
<th>Care and Treatment</th>
<th>Trust</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care: wanted to be more involved in decisions</td>
<td>44%</td>
<td>44%</td>
</tr>
<tr>
<td>Care: could not always find staff member to discuss concerns with</td>
<td>60%</td>
<td>62%</td>
</tr>
<tr>
<td>Care not always enough privacy when discussing condition or treatment</td>
<td>25%</td>
<td>24%</td>
</tr>
</tbody>
</table>

NB: CQC patient survey not published at time of writing

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’ 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.

**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 Hampshire 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.

**Support**
Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate their progress.

In a large organisation 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. Feedback from our staff included:

“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 some of which are shown below:

“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”.

“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

The NHS staff survey results predominantly aim to inform us about staff experience and well-being. Nationally, the 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 five 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 Trust provides equal opportunities for career progression or promotion - 88% against a national average for acute trusts of 87%.

Table 2 KF 21 percentage believing that Trust provides equal opportunities for career progression or promotion 2016 breakdown:

<table>
<thead>
<tr>
<th>KF21 - Percentage of staff believing that UHS provides equal opportunities for career progression / promotion</th>
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</tr>
</thead>
<tbody>
<tr>
<td>UHS 2015</td>
<td>88%</td>
</tr>
<tr>
<td>UHS 2016</td>
<td>88%</td>
</tr>
<tr>
<td>National average 2016</td>
<td>87%</td>
</tr>
</tbody>
</table>

Breakdown of 2016 results

| White | 89% |
| BME | 78% |
| Disabled | 81% |
| Not Disabled | 89% |
| Full time staff | 88% |
| Part time staff | 88% |
| Age 16-30 years | 90% |
| Age 31-40 years | 86% |
| Age 41-50 years | 88% |
| Age 51+ years | 87% |
| Men | 86% |
| Women | 89% |
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 organisational 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 and were run by trained internal facilitators. There were lunch-time sessions which were led by the chief executive and director of nursing and one-to-one staff interviews with senior executives (Talent Works) and other staff at our Fab Change Day. There was also 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 three areas – always improving, patients first, and working together:

- 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 healthcare 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 organise care around the best practices which are intelligently implemented, and then continually 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 organisation, 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 three scientific training programme candidates have completed their training and been retained by the organisation in paediatric cardiology, radiation protection and radiotherapy physics and pharmacy. Good quality training for these candidates is important to us. It ensures that we get the best workforce for the future, highly skilled and prepared for professional practice and demonstrating the correct values and behaviours. It gives the trainee an effective and stimulating training experience and promotes quality at UHS by providing an opportunity to reflect on best practice, and pass on invaluable knowledge, experience and insight. The most important beneficiaries are patients, for whom high quality science is the bedrock of improved care.

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 is part of both our leadership development, simulation and clinical skills programmes, ensuring that staff involved in investigation of incidents focus on not just how it happened but, importantly, on how can we prevent it from happening again. These questions are shared within teams so that all who deliver healthcare can learn and change to be safer and better.

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, obstetrics and gynaecology post graduate foundation year doctors in their first year of training (FY1).

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 technology to support quality

The global digital exemplar (GDE) programme will run over three years and provide an additional £10m of funding alongside our existing planned investment to fast track the UHS digital strategy. A key aim of the GDE programme is to use digital innovation to deliver significant benefits in quality. The programme will do this in three different ways.

Firstly we will quantify the quality benefits from the projects that are planned as part of the GDE programme. This will include identifying baseline metrics and then measure them after implementation to validate quality improvements.

Secondly through our GDE communications strategy we will engage with staff, patients and other key stakeholders to identify areas where digital solutions can bring improvements to care and how we work.

Thirdly we will undertake a review of the 2017/18 priorities identified in the quality accounts and identify where planned digital projects and solutions may enhance or help deliver actions and improvement.
Our commitment to the Care Quality Commission

Our last CQC ratings were recorded in December 2014. Overall, we were rated as ‘requires improvement’. We were rated ‘good’ for caring, effective and well-led services, but ‘requires improvement’ for providing safe and responsive care.

Our A&E, medical care, maternity and gynaecology, and children and young people’s services were rated as ‘good’ and surgery, critical care, end of life care, and outpatient and diagnostic services, as ‘requires improvement’. Countess Mountbatten House was rated as ‘good’.

Following the inspection report in 2014 we set up a multidisciplinary group to develop, implement and monitor the action plan against the CQC recommendations. There has been excellent engagement at every level of the organisation and collaborative working with partner organisations to share progress. We publish our progress both internally via our staff intranet and externally on our public website.

In order to reduce delayed discharges we have taken on operational leadership for all teams within the integrated discharge bureau and have agreed new improved processes, we have also invested in new discharge roles and processes to support wards, as well as focusing on simple discharges via our ‘Home for Lunch’ initiative to increase the proportion of patients discharged by midday.

To improve our estate, particularly our general intensive care unit (GICU), we have installed an Uninterruptable Power Supply (UPS), ensured hoists are repositioned and appropriately maintained within the area and agreed a business case to design and build a new GICU which will improve the experience and care for patients and their relatives.

A comprehensive recruitment plan was put in place to continue to reduce nursing vacancies. We have used recruitment days, return to practice and increased undergraduate commissioning and placement, and overseas cohorts to improve recruitment. We have an established daily Trust-wide review of staffing levels and skill mix chaired by the senior nursing team using safe care electronic solutions and we continue to reduce dependency on agency staff.

The Care Quality Commission (CQC) has since carried out an inspection of our services in January 2017. They inspected the following services: surgery, end of life care, critical care, outpatients and diagnostic imaging. Overall they rated the Trust as ‘well-led’.

We have not received any formal feedback from the CQC as yet; however the informal feedback provided was that our staff are “amazing” and that they saw a drive for improvement in every area, and from every team that they met. We believe that the CQC will have seen an organisation which is working hard to provide the best possible care for patients, where we try to always support each other and where we are ambitious to improve. We are sure that they will have witnessed a culture of teamwork and patient-focused care.
Progress against 2016/17 priorities

This section outlines how we have performed against the delivery of our 2016/17 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.

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.

**Patient experience**

**Priority one: End of Life Care**

Our aims for 2016/17 were:

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

2. Continued participation in, and inform of, the national work stream around the Emergency Care and Treatment Plan, working alongside Wessex Collaboration for Leadership in Applied Health Research and 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 who are supporting an individual whose wish it is to die at home; providing information on 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 2016/17 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 two 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 one 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 was on the 27 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 five 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 provide a patient and carers leaflet with contact details and information about our service. Patients referred to the Countess Mountbatten House community services are given a comprehensive information leaflet detailing the services available. Those patients who do not live within the Countess Mountbatten House catchment area receive information relevant directly from their local community palliative care providers. Families of those patients who pass away while at UHS, are given written information directly by our 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:

- The Trust’s usage of syringe drivers at the end of life was in line with the national average at 24%.
- For symptom management including 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 for which 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 to the national average of 66%.
- For patients who died in hospital there were consistently high levels of documented evidence that within the last episode of care staff had 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%. UHS’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. UHS performed well in this at 95%.
It is acknowledged that in some areas in 2016/17 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 two: 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 2016/17 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 upon admission.

The UHS pharmacy department also led on a variety of projects in 2016/17 to help improve the discharge process 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 have been assessed as at risk from developing medicine 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 work 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 three: 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 them. This target would excluding complex concerns (which are investigated against different standards and do not require formal investigation) to below 550 for the year 2016/17.
Table 3 Percentage of complaints closed within agreed time frames 2016/17

<table>
<thead>
<tr>
<th>2016/17</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complaints received for investigation</td>
<td>39</td>
<td>37</td>
<td>47</td>
<td>34</td>
<td>33</td>
<td>27</td>
<td>46</td>
<td>51</td>
<td>44</td>
<td>31</td>
<td>37</td>
<td>32</td>
<td>458</td>
</tr>
<tr>
<td>% of complaints closed within original 35 days timeframe</td>
<td>7.6</td>
<td>31.82</td>
<td>37.21</td>
<td>46.67</td>
<td>41.86</td>
<td>41.94</td>
<td>45.24</td>
<td>56.60</td>
<td>78.43</td>
<td>76.74</td>
<td>72.73</td>
<td>72.5</td>
<td>50.78</td>
</tr>
</tbody>
</table>

Those cases not closed within the agreed timeline had new timelines negotiated and agreed with the complainants.

Table 4 Number of complaints and complex concerns received 2016/17

<table>
<thead>
<tr>
<th>2016/17</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complaints received for investigation</td>
<td>39</td>
<td>37</td>
<td>47</td>
<td>34</td>
<td>33</td>
<td>27</td>
<td>46</td>
<td>51</td>
<td>44</td>
<td>31</td>
<td>37</td>
<td>32</td>
<td>458</td>
</tr>
<tr>
<td>Total number of complex concerns</td>
<td>20</td>
<td>24</td>
<td>22</td>
<td>33</td>
<td>26</td>
<td>32</td>
<td>17</td>
<td>27</td>
<td>13</td>
<td>25</td>
<td>24</td>
<td>31</td>
<td>294</td>
</tr>
</tbody>
</table>

Table 5 Percentage of dissatisfied complaints over total number of complaints

<table>
<thead>
<tr>
<th>By Received Date</th>
<th>Number of Dissatisfied Cases</th>
<th>Number of Complaints</th>
<th>Percentage Dissatisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015/16</td>
<td>49</td>
<td>431</td>
<td>11.37%</td>
</tr>
<tr>
<td>2016/17</td>
<td>44</td>
<td>458</td>
<td>10.48%</td>
</tr>
</tbody>
</table>

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

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 potential complications.
Verbal consent is gained and documented before commencement of procedure.
Failings found in consent process and record keeping relating to procedure to remove ear wax.
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.

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 2016/17 there were ten 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.

This year we have introduced a follow up phone call to complainants after the receipt of their complaint response to obtain 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 HealthWatch 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 four: Acute kidney injury (AKI)**
Acute kidney injury (AKI) is common in hospitalised patients and has a poor prognosis with the mortality ranging from 10% to 80%. As part of our safety strategy we have been working over the last two years to improve the detection, prevention and management of AKI within the 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 2016/17. 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 six Percentage of CQUIN achieved by quarter one to four

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. This key leadership 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 three and being responsible for AKI education to the Trust as well as to assist in reviewing all patients with an AKI stage three outside of critical care areas and advising on their care and management so that local leadership becomes more skilled in this area.

4. Improving AKI education in the Trust with a particular focus on improving the management of hydration for our inpatients and improving fluid balance documentation. This documentation relies on individual staff understanding the fuller picture of hydration and fluid balance beyond the charting of measurements and their responsibilities therein. We developed an e-learning AKI package which was the first of the kind in the country and is likely to be adopted nationally: 400 staff members have completed this to date. Consultant-led education was given to medical students, junior doctors and on consultant led teaching rounds (known as grand rounds) and interdepartmental meetings including elderly care, acute medical unit (AMU), anaesthetics, 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 2016/17 we achieved:

1. A mean reduction in length of stay for patients with an AKI three alert of four 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, orthopaedics 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 2017/18, AKI recognition and management will be a continued priority for effective local leadership which 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 five: Reduce high harm pressure ulcers and falls
Our aim in 2016/17 was to continue to reduce the incidence of all pressure ulcers, with particular emphasis on high harm pressure ulcers grade three to four. (Definitions of grades of pressure ulcers are found in appendix two). We have made a clear commitment to reduce the numbers across the Trust and have achieved a year on year reduction 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 two 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 two pressure ulcers and now investigate each grade two 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 three months and six months following implementation in late April. Results are shown in the chart below from the three month audit (six month audit data not currently available):

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 two, three and four pressure ulcers so far in 2016/17:

**Table 7 Percentage compliance with key audit areas**

<table>
<thead>
<tr>
<th>Percentage compliance</th>
<th>Risk assessed accurately</th>
<th>Risk assessed on admission</th>
<th>Care plan in place</th>
<th>On Turnaround (repositioning correctly)</th>
<th>On the correct relieving surface</th>
</tr>
</thead>
<tbody>
<tr>
<td>97%</td>
<td>97%</td>
<td>95%</td>
<td>80%</td>
<td>90%</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Table 8 All grade two, three and four pressure ulcers reported 2015-2017**

<table>
<thead>
<tr>
<th>Grade three and four</th>
<th>2015/6</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Avoidable</td>
<td>Unavoidable</td>
</tr>
<tr>
<td>April</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>May</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>June</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>July</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>August</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>September</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>October</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>November</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>December</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Totals</td>
<td>30</td>
<td>31</td>
</tr>
<tr>
<td></td>
<td>65</td>
<td>45</td>
</tr>
</tbody>
</table>
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.

In reference to high harm falls, the Trust had an internal target of a 10% reduction in all high harm falls and zero avoidable high harm for 2016/17. 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 four. This is, however, a reduction on the previous year’s total of six.

It is a recognised risk that patients with dementia are at an increased risk of falls and harm from falls and there has been intensive support for these patients provided by the enhanced care support teams (ECST). The ECST currently support patients in division B and 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 five registered mental health / learning disability nurses and healthcare support workers. They are able to assess and plan care specific 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, one to one care.

Additional initiatives were also being developed. In 2016 medicine for older people introduced ‘Bay Watch’ which involves placing 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.

<table>
<thead>
<tr>
<th>Grade two pressure ulcers</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>20</td>
<td>12</td>
<td>13</td>
</tr>
<tr>
<td>May</td>
<td>14</td>
<td>19</td>
<td>15</td>
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<tr>
<td>June</td>
<td>24</td>
<td>19</td>
<td>16</td>
</tr>
<tr>
<td>July</td>
<td>21</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>August</td>
<td>14</td>
<td>21</td>
<td>8</td>
</tr>
<tr>
<td>September</td>
<td>24</td>
<td>20</td>
<td>8</td>
</tr>
<tr>
<td>October</td>
<td>14</td>
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<td>16</td>
</tr>
<tr>
<td>November</td>
<td>13</td>
<td>15</td>
<td>12</td>
</tr>
<tr>
<td>December</td>
<td>19</td>
<td>18</td>
<td>8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>163</strong></td>
<td><strong>145</strong></td>
<td><strong>107</strong></td>
</tr>
</tbody>
</table>
**Priority six: 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 2016/17 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 expertise 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 six never events. In 2016/17 we reported three:

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 patient details.

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

1. A comprehensive review of the processes involved in checking and documentation of hip components intra-operatively.

2. A comprehensive review of the checking process for lens calculations intra-operatively.

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

**Clinical effectiveness**

**Priority seven: 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 2017/18.
Priority eight: 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 serve. Although we measure and review the crude death rate, its value is limited as it does not take into account the severity of the underlying illness or complexity of the patient group. To improve 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, it allows the 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. They look for both good care practice as well as 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 = one). Over the last three 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 three status (highest level of attainment possible) based on the targets set by the Clinical Classification Service (CCS) regarding coding accuracy. This has been achieved due to 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 of 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, our Trust Board, our Trust executive committee, commissioners and patient representatives (through our HealthWatch group), and our governors. The quality committee on behalf of the board approved the priorities and there will be regular reports on progress to the committee throughout the year.

We have developed this year’s patient improvement framework (PIF: appendix one) 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 in 2017/18. Priorities are built around our ambitions and intention to deliver well led, 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

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

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 two’.

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

Table 9 Inpatient Survey Results January 2016:

<table>
<thead>
<tr>
<th>The Trust has worsened significantly on the following questions:</th>
<th>lower scores are better</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge: did not feel involved in decisions about discharge from hospital</td>
<td>Trust: 51% Average: 45%</td>
</tr>
<tr>
<td>Discharge: not given any written/printed information about what they should or should not do after leaving hospital</td>
<td>Trust: 34% Average: 36%</td>
</tr>
<tr>
<td>Discharge: not fully told side-effects of medications</td>
<td>Trust: 64% Average: 61%</td>
</tr>
<tr>
<td>Discharge: not told how to take medication clearly</td>
<td>Trust: 30% Average: 24%</td>
</tr>
<tr>
<td>Discharge: not told who to contact if worried</td>
<td>Trust: 10% Average: 20%</td>
</tr>
</tbody>
</table>
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.

What will success look like?
Metrics designed to monitor all discharges from the Trust will demonstrate improvement, and feedback via patient surveys, Friends and Family Test, patient forums and HealthWatch will corroborate these improvements.

Priority two: Meeting patients’ nutritional and hydration needs

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 10 Inpatient survey results 2016

<table>
<thead>
<tr>
<th>22+</th>
<th>Hospital: food was fair or poor</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>23</td>
<td>Hospital: not offered a choice of food</td>
<td>19 %</td>
<td>19 %</td>
<td>17 %</td>
<td>16 %</td>
<td>15 %</td>
<td>19 %</td>
</tr>
<tr>
<td>24+</td>
<td>Hospital: did not always get enough help from staff to eat meals</td>
<td>47 %</td>
<td>44 %</td>
<td>46 %</td>
<td>35 %</td>
<td>34 %</td>
<td>43 %</td>
</tr>
</tbody>
</table>

NB: the survey does not provide a detailed breakdown 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 60-69, 24% being 70-79, 17.4 % being 80-89 and 4.3 % being over 90 years of age.

NB: CQC Patient Survey not yet published at time of writing.

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 service provider to increase the percentage of patient satisfaction with food.
What will success 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

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 to provide additional measures for patients who are vulnerable and less able to protect themselves from harm or abuse. The core definition of a vulnerable adult as defined by 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.

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 organisations 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 individualise care to ensure it meets each person’s 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 and investment into more learning disability clinical nurse specialist posts.

2. Continual partnership working between clinical and estates teams to refurbish wards and departments so that they are dementia friendly - 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 and experience for patients presenting in mental health crisis to ED.

7. PWC internal audit of adult and 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 dragonfly approach in the ED. This is a visual prompt to staff (a picture representing a dragonfly) 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 and develop a plan to address this.

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

3. Develop a UHS mental health board to address the challenges and impact for mental health patients and for staff looking after them.

4. Evaluate responsiveness and 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 and children’s safeguarding teams.

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

9. Introduce carers’ passports.

10. Introduce the vulnerable adult champion role.

11. Develop a combined safeguarding team with associated joint governance and meeting structure.

12. Provide training and awareness on mental health capacity assessment and deprivation of liberty.
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 four: Recognition and management of the deteriorating patient

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 deteriorating 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.

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, and 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 three patients per year who were unplanned intensive care admissions for learning.

**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 five: Safer invasive procedure**

**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 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, NHS Improvement, and Health Education England.

**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.
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 Organisation (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. We will also introduce team based LocSSiPs for procedures such as central venous catheter and arterial line placement in other clinical areas such as ward areas and outpatient departments.

Compliance will be measured quarterly by monitoring the 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. The results will be disseminated throughout the Trust for wider learning.

Priority six: Recognising and treating sepsis

Why we have chosen this priority?
Sepsis occurs when the body has an abnormal response to infection. This can be life threatening and if it’s not treated quickly sepsis can rapidly progress. Septic shock, the most severe 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). 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.

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.

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 six care bundle of which rapid delivery of antibiotics is probably the most important element.

Our success in this trust-wide initiative will be monitored using data collected for the national sepsis CQUIN.
Current progress:
Programmes have been introduced to acute admitting areas and are slowly being 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 11 Roll out of the sepsis screening programme 2016-2017 (Q1-3)

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 committee.

Clinical outcomes

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

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

What we are trying to achieve
Our aims for 2017/18 are that every specialty will identify outcomes that are specific to their clinical service – these can be nationally reported or locally developed outcomes.

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 eight: Improve care for patients at end of life

Why we have chosen this priority
We are committed to a standard whereby any person in our care thought to be approaching their last days of 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.
What we are trying to achieve
The NICE Quality Standard 144, ‘Care of dying adults in the last days of life’ was published on 2 March 2017 and we wish to align our patient improvement framework for end of life care to this quality standard.

There are four quality statements:
1. Adults who have signs and symptoms that suggest that they may be in the last days of life are monitored for further changes to help determine if they are nearing death, stabilising or recovering
2. Adults in the last days of life, and the people important to them, are given opportunities to discuss, develop and review an individualised care plan
3. Adults in the last days of life who are likely to need symptom control are prescribed anticipatory medicines with individualised indications for use, dosage and route of administration
4. Adults in the last days of life have their hydration status assessed daily and have a discussion about the risks and benefits of hydration options

We will achieve this through:
1. Delivering our new five year UHS End of Life Care Strategy so that education and training in care of the dying are delivered for clinical and front-line non-clinical staff caring for dying patients. The scope and level will vary according to staff group and the frequency that they are involved with care of dying patients and their families.
2. The decision that the patient is probably in the last hours or days of life will be made by the multidisciplinary team and documented by the senior doctor responsible for the patient’s care. This will be discussed with the patient, if well enough and appropriate, and with family, carers or other advocates.
3. Enhancing our pastoral care team to ensure that the spiritual needs of dying patients and those close to them are met.
4. Facilitating discussions with patients and families about their wishes relating to their preferred place of care whilst dying. This will include discussion about what is safe and feasible. This will enable increased numbers of dying patients to be discharged home or be transferred to an alternative place of their choice in a timely manner.
5. Working with relatives and carers to hear their voice about their experiences of end of life care and their ideas for improvement.
6. Continue to participate in and inform the national work stream around the emergency care and treatment plan, working alongside Wessex CLAHRC into the use of treatment escalation plans (TEP).
7. Replicating the National Care of the Dying Audit locally in 2017 ahead the anticipated next national audit round.
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.
What will success look like?
1. Staff will be competent and confident in all aspects of end of life care.

2. Adults in the last days of life, and the people important to them, are given opportunities to discuss, develop and review an individualised care plan which will include:
   • personal goals and wishes
   • preferred care setting
   • current and anticipated needs including preferences for symptom management and maintaining hydration
   • needs for care after death
   • resource needs.

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

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

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

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

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

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 has a measurable impact of immobilisation of patients. This is known to increase length of stay and potentially the need for onward care.

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 from CDU and in the future AMU (subject to resourcing).

3. Initiatives to encourage mobilisation on the wards. These will include using the joined ambulatory care network and frailty network led by UHS. There will be a weekly ‘stranded patient’ reviews to ensure progress is not delayed, and a new care hub will be created in elderly care with a walking track. The hospital therapy team will be included in all these initiatives.

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, wellbeing, and reduce their length of stay.

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 committee. Using the Plan-Do-Study Act (PDSA) cycle of improvement, we will continual review the potential for growth.
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 appendix three provide information against a number of national priorities and measures that, in conjunction with our stakeholders, 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.

Clinical coding have not had a payment by results (PbR) audit during 2016/17.

The last PbR audit was in 2013/14 and no further audits were recommended for the Trust as we were found to be fully compliant.

(NB Clinical coding were also audited externally in 2016 by KPMG audit for the Trust’s annual Quality Account and PWC as part of the Reference Costs audit)

Clinical research

Research is at the heart of UHS’s efforts to improve care and health. Over the last year alone we have seen the results better protect patients from severe flu, improve surgical patients’ recovery, restore sight to those with ‘incurable’ eye conditions and use standard NHS 999 software to accurately identify heart attacks before the ambulance reaches the scene.

In outright performance measures we have delivered strongly too. Over 2016/17 we were again in the top five Trusts for trial recruitment and secured over £25m of National Institute for Health Research (NIHR) facilities funding.

UHS patients benefit through this performance, with 18,583 patients gaining access to clinical trials, the fourth highest recruitment rate in England. Including participants in our wider research partnerships takes our total recruitment to 19,984.

That access to trials has given those with respiratory conditions arriving in ED diagnosis of severe flu strains in under an hour, rather than days – with demonstrably better care, isolation and reductions in antibiotic use. For cancer patients it’s given access to groundbreaking exercise ‘prehabilitation’ and care, improving tumour reduction ahead of surgery, physical condition and wellbeing before and after surgery, and cutting their time in critical care after surgery.

Similarly, trials using an inexpensive cancer drug have saved the sight of patients with Sorsby’s Fundus Dystrophy (SFD), a rare and previously incurable disease causing sight loss in patients as early as their thirties.

Our work also goes beyond the hospital walls, with one study demonstrating that call data from the software used to handle 999 calls, NHS Pathways, accurately predicts heart attacks in 75% of cases – opening the door for better care before and on ambulance arrival.

Our trial recruitment performance also underpins our ability to invest in research and improve services with over £20m of funding secured over the year. It’s central to a preferred partner deal that gives UHS priority on new trial contracts, and our strategic partnerships with major pharmaceutical companies, ensuring Southampton remains a key site for drug and vaccine studies.
To support the progress of scientific discoveries into new treatments we have made successful funding submissions, with our partners at University of Southampton, 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 and consolidates our existing world-class researching nutrition and lifestyle BRC, respiratory NIHR Biomedical research and microbial science, data science and behavioural science.

**Review of services**

During 2016/17 the UHS provided and/or sub-contracted 107 relevant health services (from Total Trust activity by specialty cumulative 2016/17 contractual report). UHS has reviewed all the data available to them on the quality of care in all of these relevant health services.

The income generated by the relevant health services reviewed in 2016/17 represents 100% of the total income generated from the provision of relevant health services by University Hospital Southampton NHS Foundation Trust for 2016/17.

**CQUINS payment framework**

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. This compares to the 2015/16 figure of £11,309,000.

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

Our CQUIN priorities for 2016/17 can be found in appendix four.

**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 care
- 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 organisation. University Hospital Southampton Information Governance Assessment Report overall score for V14 (2016/17) was 73% and was graded Satisfactory meaning 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 recognises 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 six national confidential enquiries covered NHS services that UHS provides.

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 confidential enquiry for the Trust’s maternity and neonatal service MBRRACE Stillbirths and Neonatal Deaths

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

**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 recognise 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 report enables us to qualify our progress comprehensively and demonstrate in 2016/17 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, HealthWatch, 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.
Response to the Quality Account from Southampton City and West Hampshire Commissioning Groups

Southampton City and West Hampshire Clinical Commissioning Groups (CCGs) are pleased to comment on University Hospital Southampton NHS Foundation Trust’s (UHS) Quality Account and Quality Report for 2016/17; for the services that they commission.

The CCGs have over the past year continued to work with the Trust in monitoring the quality of care provided to the local population of Southampton and West Hampshire and in identifying areas for improvement.

The Quality Account and Quality Report 2016/17, reflects the Trust’s values of always improving, patient first and working together to provide patient centred care through a continued focus on quality improvement and has highlighted some of the positive progress made during 2016/17. It is encouraging to see these include; progress with their end of life care programme, the improved detection, prevention and management of acute kidney injury, reduction in high harm pressure ulcers and falls, as well as responding to and learning from patient feedback.

It is disappointing to note the limited progress with the management of pain and discussions around do not attempt cardiopulmonary resuscitation (DNACPR) at the end of life. Many of the priorities listed in the Quality Account will continue to be a focus for UHS during 2017/18 and have been captured within the Trust’s Patient Improvement Framework (PIF).

Whilst the Trust’s efforts to reduce preventable harm are recognised with a continued reduction in high harm falls and incidents of pressure ulcers over 2016/17, it is of note that three Never Events were reported and the CCGs will be keen to see the progress and outcomes of the planned initiatives to implement Local Safety Standards for Invasive Procedures (LocSSIPs) and other initiatives to prevent such events occurring in the future.

Commissioners will expect UHS to make further progress in 2017/18 against the ongoing priority the Trust has set itself in improving the quality and timely discharge of all patients recognising that some of this is dependent on system partners, as well the other priorities outlined to meet the rising demand of patients presenting in mental health crisis. This includes the development of a UHS Mental Health Board to address the challenges and impact for patients and the staff looking after them. Commissioners are expecting UHSFT to continue working to improve on key performance standards for Accident and Emergency, 18 week and cancer pathways of care as well as the implementation of sustainable seven day working.

It is positive to see a summary of the Trust’s identified learning and actions from both the national and locally initiated clinical audits. However the embedding and success of these identified actions may not be evident until the results of a repeat audit are published.

There is positive feedback reported from staff in the 2016 National Staff Survey which the Trust has pledged to build upon with the development of a behaviours framework and workforce plan to address recognised inequalities for black and ethnic minority staff.

Overall the Quality Account reflects both the challenges experienced by UHS over the last 12 months and highlights some of the work undertaken through their continued ambition to improve the quality of services.

The Quality Account on the whole meets the minimum national expected reporting requirements, but as suggested in 2015/16 could have been strengthened through the inclusion of patient stories.
UHS should be proud of all the initiatives undertaken during 2016/17 and its success in research, successful funding and partnerships with other local partners such as the University of Southampton.

Both Southampton City and West Hampshire CCGs support the quality priorities for 2017/18 which reflect patient and carer feedback and continue to build upon the key priorities from 2016/17 including pain management, recognising and treating sepsis and improving care for patients at the end of life.

Southampton City and West Hampshire CCGs are satisfied with the Quality Account for 2016/17 and look forward to continue working closely with the Trust over the coming year to further improve the quality of services.

Yours sincerely

John Richards
Chief officer
Southampton CCG West Hampshire CCG

Heather Hauschild
Chief officer
Southampton CCG West Hampshire CCG
Response to the Quality Account from our lead governor on behalf of the Council of Governors

During this past year, our Trust has been under increasing pressure due to the lack of finance available from Government and also political pressures, new ‘rules’ which are difficult to achieve. It is my belief that those who dictate from the ‘Centre’ fail to consider that the NHS is run not by machines, but by human beings. Our staff have responded to the challenges that they have been given, both clinically and professionally, with outstanding success.

In a recent staff survey, the responses showed that our staff are happy and proud to be working for a Trust that has achieved so much during the past year. Our staff survey also put us in the top ten trusts in the country.

It was noted in the Governor’s Quality Account from last year that, in company with members of the Trust Board, governors may visit wards within the hospital, unannounced, so that they may talk to staff and, if appropriate, patients, to gain a view of the daily pressures that are apparent in running a ward. In all cases the staff were very forthcoming in giving their views and were happy to receive us, with no feeling of being asked questions in an impromptu manner, or being ‘put on the spot’. This visit to the wards is now an ongoing arrangement for all governors who attend Trust Board meetings.

Each year the University, through its research and development departments, have extended an invitation to the governors, a visit to these areas and have explained, by the researchers, the projects that they are involved in at the time. This visit has become a most popular event and I am pleased that it will now be formally made an annual event.

The pressures being experienced by trusts to perform within their budgets and produce new ways to improve on savings to their costs, has been yet again a huge challenge to our Trust Board and staff. Great credit should be given to the staff in the way they have risen to the challenge and also to the Trust as a whole.

Our Trust has recorded a credible surplus for each month during 2015/16, a situation which, I believe most trusts in the country would not be able to claim. Your governors are appointed to ‘hold the Trust Board to account, through the non-executive directors’.

It must be pointed out that we, at UHS, have an exceptional group of executive and non-executive directors, steered by an excellent chair and led by a chief executive officer, who rules with her heart not just her head, coupled with our staff, which is the reason for the great achievements within the hospital. The Council of Governors would also like to be associated with the priorities of care and effectiveness, outlined in the Quality Report.

From the results of a members’ survey last year, it was evident to us that feelings were high with regard to the problems of parking within the hospital. The Board have taken this to heart as they realise that this is a serious problem concerning our patients and visitors. It should be noted that plans to build a multi-storey car park are underway coupled with amendments to existing parking areas which hopefully will come to fruition within the near future.

Last October gave us a new intake of governors, five representing Southampton City, one representing New Forest, Eastleigh and Test Valley and one representing the Rest of England and Wales. The Council of Governors had realised that we were not representing the members as well as we should have done. With this in mind we have strengthened our Membership and Engagement Working Party and, with a new chair and help and advice from the Trust’s newly appointed membership manager are actively engaged in making arrangements to meet the existing members and members of the public to enrol them and seek their comments.
We also have other active working groups for instance Staff Engagement, Strategy and Finance and Patient Experience. All of these groups are able to call upon members of the Board to arrange presentations applicable to the respective subjects. We also in turn may pose questions to the Board on points arising from those working groups.

Over the past year, your governors have been invited to join several hospital committees, which has added another dimension of expertise within those areas. We also are involved in discussions with NHS Properties to obtain the replacement of many parking spaces at our Countess Mountbatten Hospice in West End.

Last year it was noted that the governors felt the framework in which they operated was not conducive to being able to ‘hold the Trust Board to account’. With the support of our chair, Peter Hollins, it is felt that we have gone a long way to changing this situation, in so much that engagement with executive and non-executive directors is at an all-time high.

Your Council of Governors are extremely proud to be associated with University Hospital Southampton and would like to congratulate them with the way they have provided outstanding treatment and care to our patients over the past year.

Bryan Bird
Lead governor
Response to the Quality Account from HealthWatch Southampton

HealthWatch Southampton is pleased once again to comment on the quality account of the Trust for the year. We have continued to be involved and consulted by the Trust on many issues. This year’s account is well laid out and easy to read and as far as we can judge is complete and accurate with no serious omissions.

The statement from the chief executive is a very useful introduction to the account and it is good to read the statistics on staff involvement and satisfaction. On many occasions, we have been heartened to witness really strong team work and the statistics clearly reflect what we have witnessed.

The improvements made to the Piam Brown ward and the planned expansion of the Paediatric Intensive Care Unit, as well as the improvements made to other wards is welcomed. We have previously commented that we would like to have seen some commitment to improving the estates and environmental aspects of the Trust. Consequently, it is good to read the chief executive’s comments that the Trust can plan continued investment in the estate. This is especially welcomed as parts of the hospital are clearly in need of investment. The completion of the new main entrance at the General Hospital has drawn many complimentary comments from the public.

Some HealthWatch members act as patient representatives on the Clinical Accreditation Scheme and these unannounced visits allow us to discuss with patients and subsequently comment on all aspect of patient care and experience; importantly, the Trust has acknowledged the importance of the patient representatives to this scheme. Similarly, we are engaged with the Clinical Quality Reviews.

We are pleased that the priority to improve end of life care continues to make progress. Naturally we are disappointed that the Trust does not appear to have improved seeking feedback from bereaved relatives and we would strongly encourage further action in this regard. We support the fact that this should remain a priority for 2017.

Similarly, whilst recognising some progress on patient discharge we agree it should remain a priority for 2017/18 with the latest inpatient survey results showing that the Trust has worsened significantly on several key questions.

It is pleasing to note that response to patient complaints has improved and that the complaints upheld by the PHSO is lower than the national average.

The commitment to safety is applauded and again our experience is backed up by the national statistics. The Trust is very open when discussing issues that could be improved. On patient safety, it is good to see a reduction in pressure ulcers and falls although it would have been good to see the target of zero avoidable high harm falls achieved. The number of ‘never events’ reported is an improvement on the previous year. We welcome the open and transparent approach and the desire to learn for these events.

The review of the priorities covered by clinical effectiveness covers the complex subject of clinical outcomes and standardised mortality rates. It is pleasing to see that 36 specialities successfully identified outcome measures but as the Trust did not fully achieve this priority we agree it should be continued into 2017/18. We welcome the fact that SHMI data shows a consistent quarterly performance below the benchmark and that the Trust has maintained its level three status.

Last year we were a little critical of the way some of the future year’s priorities were described but this year the descriptions are clear and easily understandable. The three subheadings of ‘Why we have chosen this priority’; What we are trying to achieve; What will success look like? make it easy to understand and importantly easy to monitor progress. We were particularly pleased that this year the Trust took the
opportunity to discuss the patient improvement framework (PIF) with us prior to its adoption. As chair of HealthWatch I can confirm that as well as discussing it with HealthWatch it was well debated at several committees concerned with patient experience. We support the PIF and the associated priorities for 2017/18.

Patient satisfaction with the food and food service is an ongoing issue and often a very subjective judgement. Nevertheless, we hope that the new provider will respond to patient feedback and the patient survey results will improve. We repeat our concern that despite a number of very positive initiatives to improve patient experience at mealtimes it is our experience that there is quite a variation between wards.

The participation in clinical research, and the fact that the Trust is in the first rank of UK clinical research sites, is of good news and has a wide implication for long-term improvement for treatments and patient experience.

As reported last year, a small group was established to review the experience of patients and the public with visual and auditory impairment. HealthWatch Southampton is well represented on this Group which fits very well with the requirements of the Accessible Information Standard. Progress of this group has been slow but nevertheless very positive with several recommendations due to be implemented shortly. These will greatly improve the experience of patients and visitors who have visual or hearing disability.

HealthWatch Southampton will continue to work with the Trust to ensure that the best interests of the patients are maintained. We like the Trust’s stated intention ‘to be better every day’ and will support the Trust to achieve it.

H F Dymond MBE
Chair HealthWatch Southampton
Response to the Quality Account from the
Health Overview and Scrutiny Panel

The Southampton Health Overview and Scrutiny Panel welcomes the opportunity to comment on the University Hospital Southampton NHS Foundation Trust Quality Account for 2016/17.

The Panel were pleased to see positive progress reported against a number of priorities set for 2016/17, including the improved detection, prevention and management of acute kidney injury, reduction in falls and high harm pressure ulcers and progress with the end of life care programme. In addition the Panel were encouraged by the findings from the 2016 National Staff Survey, a clear reflection on the quality of leadership within the Trust.

Recognising workforce challenges the Panel welcomed the introduction by the Trust of a talent management programme to support staff development within the organisation and that consideration was being given to initiating an apprenticeship scheme.

The Panel commend the Trust’s management of winter pressures this year, in terms of patient care, and the honest assessment within the Quality Account of performance relating to the safe and timely discharge of patients. The HOSP recognise that progress has been made and that outcomes improved for Southampton residents after Christmas 2016 but that more needs to be done, in conjunction with partners, to ensure that outcomes with regards to delayed transfer of care improve and are sustainable. It is therefore welcome that the safe and timely discharge of patients remains a priority for University Hospital Southampton in 2017/18.

Whilst the Panel recognise that Quality Accounts are required to focus on the performance of individual providers, it would be a welcome addition, given that pathways are becoming more seamless, if future reports make reference to the wider health and care systems and relationships operating in Southampton, and how the Trust are contributing to these joint priorities. Reference in particular to the Trust’s contribution to the Hampshire and Isle of Wight STP, and specifically the Acute Alliance would add context and value to the report.

The Quality Account makes reference to an unannounced Care Quality Commission inspection in January 2017. The Southampton HOSP welcome the opportunity to review the feedback from the inspection and the subsequent action plan in 2017/18 and look forward to working closely with the Trust over the coming year to ensure that the quality of services continues to improve.

Cllr Sarah Bogle
Chair of the Health Overview and Scrutiny Panel Southampton City Council
Statement of directors’ responsibilities for the quality report

The quality report must include a statement of directors’ responsibilities, in the following form of words:

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year. NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

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

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2016/17 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  1. board minutes and papers for the period April 2016 to May 2017
  2. papers relating to quality reported to the board over the period April 2016 to March 2017
  3. feedback from commissioners dated 8th May 2017
  4. feedback from governors dated 3rd April 2017
  5. feedback from local HealthWatch organisations dated 1st May 2017
  6. feedback from Overview and Scrutiny Committee dated 27th April 2017
  7. the trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 21st June 2016
  8. the national patient survey June 2016
  9. the national staff survey March 2017
  10. the Head of Internal Audit’s annual opinion of the Trust’s control environment dated May 2017
- the Quality Report presents a balanced picture of the NHS foundation Trust’s performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with NHS Improvement’s annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

Date

Chair

Date

Chief executive
INDEPENDENT AUDITOR’S REPORT TO THE COUNCIL OF GOVERNORS OF UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of University Hospital Southampton NHS Foundation Trust to perform an independent assurance engagement in respect of University Hospital Southampton NHS Foundation Trust’s Quality Report for the year ended 31 March 2017 (the ‘Quality Report’) and certain performance indicators contained therein.

Scope and subject matter
The indicators for the year ended 31 March 2017 subject to limited assurance consist of the following two national priority indicators (the indicators):

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period;
- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge;

We refer to these national priority indicators collectively as the ‘indicators’.

Respective responsibilities of the directors and auditors
The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed requirements for quality reports for foundation trusts 2016/17 (‘the Guidance’); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Requirements for external assurance for quality reports for foundation trusts 2016/17.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes and papers for the period April 2016 to May 2017;
- papers relating to quality reported to the board over the period April 2016 to May 2017;
- feedback from commissioners, dated 8 May 2017;
- feedback from governors, dated 3 April 2017;
- feedback from local Healthwatch organisations, dated 1 May 2017;
- feedback from Overview and Scrutiny Committee, dated 27 April 2017;
- the trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the latest national patient survey, dated May 2015;
- the latest national staff survey, dated May 2015;
- Care Quality Commission Inspection, dated December 2014;
- the 2016/17 Head of Internal Audit’s annual opinion over the trust’s control environment, dated 15 May 2017; and
- any other information included in our review.
We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the ‘documents’). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of University Hospital Southampton NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust’s quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2017, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and University Hospital Southampton NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

**Assurance work performed**

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – ‘Assurance Engagements other than Audits or Reviews of Historical Financial Information’, issued by the International Auditing and Assurance Standards Board (‘ISAE 3000’). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

**Limitations**

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by University Hospital Southampton NHS Foundation Trust.
Basis for qualified conclusion

As a result of the procedures performed in relation to the referral to treatment within 18 weeks for patients on incomplete pathways indicator, we have not been able to gain assurance over the six dimensions of data quality as required by NHS Improvements, with issues identified in relation to the operating effectiveness of the control environment.

Qualified conclusion

Based on the results of our procedures, except for the effects of the matters described in the ‘Basis for qualified conclusion’ section above, nothing have come to our attention that causes us to believe that, for the year ended 31 March 2017:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the remaining indicator in the Quality Report subject to limited assurance (A&E: maximum waiting time of four hours from admission to admission, transfer or discharge) has not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

KPMG LLP
Chartered Accountants
15 Canada Square
Canary Wharf
London E14 5GL

May 2017