PORTSMOUTH HOSPITALS NHS TRUST
QUALITY ACCOUNTS
2015 - 2016

Our annual report to the public on the quality of services we deliver
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Telephone: 023 9228 620
STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

On behalf of the Trust Board and staff working at Portsmouth Hospitals NHS Trust, I am pleased to introduce you to our Quality Account for the year 2015/16.

This last year has been a very challenging time for NHS colleagues across the country, with the NHS’ financial constraints; unscheduled care pressures; missed national targets; ever increasing demand on services and, of course, the junior doctors’ strike action. We have faced these pressures ourselves.

Despite pressures on our finances resulting in a disappointing deficit at year end, and the unprecedented demands on our unscheduled care pathway, our performance against key quality metrics remains strong at year end.

Our reputation for patient centred care continues to grow, and we were recognised as being among the best in 2015 when the Care Quality Commission (CQC) ranked us as outstanding for the care we give our patients. This is something we are hugely proud of.

The CQC undertook a full inspection of our services in February 2015 against the five domains of safe, effective, caring, responsive and well led. Our critical care service was rated as outstanding. Maternity and gynaecology, children and young people’s services and outpatient’s services were rated as good. Whilst the overall rating given by the CQC for the hospital Trust was ‘requires improvement’ we have much to celebrate. Concerns were raised regarding the unscheduled care pathway resulting in a rating of ‘inadequate’ for the safety domain of urgent and emergency services. Two warning notices were served on 4th March 2015 under safety, for ‘care and welfare of patients’ and ‘assessing and monitoring the quality of service provision’ in the Emergency Department. An unannounced focussed inspection to follow up on the warning notices served was undertaken on 25th April 2015 which resulted in the ‘inadequate’ rating improving to a rating of ‘requires improvement’; and an overall core service rating of ‘requires improvement’. A Trust-wide quality improvement plan was developed and has been implemented over the year.

The CQC conducted a further unannounced visit on the 22nd and 23rd February 2016, with a review specifically focussed on unscheduled care. This visit resulted in an enforcement notice requiring immediate actions to ensure improvements in the emergency care pathway. We took immediate action through effective leadership, dedicated resource and implementation of a Trust improvement plan. Every staff member is playing their part in these improvements which are focussed on keeping the patient at the heart of everything we do.

I want to take this opportunity to sincerely thank all of our staff who despite continuing pressures, work really hard to continually improve patient care. We are proud to see a marked improvement in the results of the National Staff Survey for 2015, rating us in the top 20% of acute hospital trusts; reflecting the success of our staff engagement programme.

We have seen a number of successes over the year, including winning a prestigious HSJ award for our work using technology to improve patient care (VitalPAC). We have made excellent progress in reducing infection rates within our hospital, with no cases of MRSA and some of the lowest rates of C.Difficile in the Country, reducing hospital acquired pressure ulcers and maintaining a real focus on falls prevention.

To the best of my knowledge the information presented in this report is accurate and represents a balanced view of the quality of services that the Trust provides. I hope you will find it informative and stimulating. Any feedback is welcome.

Ursula Ward, Chief Executive, Portsmouth Hospitals NHS Trust
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Telephone: 023 9228 6877 Ext: 6670 E-mail: Ursula.Ward@porthosp.nhs.uk
QUALITY IMPROVEMENT PRIORITIES 2016 / 2017

The Trust develops its priorities for quality improvement by triangulating evidence available through a variety of internal and external sources. These include complaints, incident reporting, Dr Foster, national and local patient surveys, clinical audit and NICE guidance. Each year, key priorities are chosen that are expected to have the greatest impact on reducing harm and mortality for patients. From these the Patient Safety, Experience and Clinical Effectiveness Steering Groups identified a number of proposed priorities.

The proposed quality priorities were presented to the Trust Board in March 2016 for agreement. The priority relating to patient safety in the emergency department was requested to include the whole patient pathway, rather than just a focus in the emergency department. A draft Account was presented to the Trust Governance and Quality Committee in April inclusive of the amended priority.

This Quality Account and associated priorities are presented around the three domains of quality; patient safety, patient experience and clinical effectiveness and outlines the targets the Trust Board have agreed for 2016/17.

The Account summarises the Trust’s performance and improvements against the quality priorities and objectives we set ourselves for 2015/16 (set out in the 2014/2015 Quality Account); where we have not met our targets we have identified further areas for improvement.

To ensure that we focus on the important issues for patients, a different approach was used this year to identify our patient experience quality improvement priorities. A review of feedback combined with conversations with community groups, individual patients and their families identified a number of key issues for improvement. This was developed into a list which people were asked, through a variety of forums and a web based survey, to rank each of the issues in priority order, the aim being to produce a list of 4-5 key issues for 2016/17. This exercise resulted in 5 priorities which matter most to patients being the focus: End of life care, family carers, care of people with specialist mental health needs, communication and engagement.

We constantly strive to improve the quality, safety and effectiveness of the care we provide to patients and their families/carers. We aim to improve services based on what patients tell us matters most to them. To achieve this we will deliver a number of initiatives and projects to improve the quality and safety of the care we provide to patients which will ultimately improve and exceed their expectations. The priorities outlined over the following pages, are just a few of the areas we will be working on in 2016/2017 to make improvements to our services. A full range of quality measures and how we are working towards achieving these will continue to be reported to the Trust Board monthly and Governance and Quality Committee quarterly.
Patient Safety

Delivery of the patient safety improvement plan

**WHY:** Reduce avoidable harm to our patients.

**MEASURES:**
- Patient safety in the emergency pathway: Clinical assessment within 15 minutes of arrival and treatment within 60 minutes in the Emergency Department and delivery of the urgent care improvement plan which supports improvement in the unscheduled care pathway.
- Health Care Associated Infections: MRSA - 0 (zero cases) and C.Diff - no more than 40 cases.
- Falls resulting in harm: A rate of less than 2.0 per 1,000 bed days (amber and red incidents) average over each quarter.
- Medication incidents: A rate of less than 0.5 per 1,000 bed days (amber and red incidents) average over each quarter.
- Non-surgical interventions: Introduce risk assessment and key safety checks for all grades of non-surgical patient interventions.

**MONITORED:** Through the Patient Safety Steering Group and reported to the Trust Board monthly and Governance and Quality Committee monthly and quarterly.

**BY WHEN:** April 2017

**OUTCOME:** Treat and care for people in a safe environment; protecting them from avoidable harm.

Clinical Effectiveness / Outcomes

Improve clinical outcomes for our patients

**WHY:** To ensure our patients receive the best care and outcomes.

**MEASURES:**
- Mortality: HSMR and SHMI to be within the expected range, including weekday and weekend.
- Acute Kidney Injury: Reduction in hospital acquired stage 3 AKI episodes.
- Sepsis: Delivery of the National CQUIN to improve screening of patients and timely antibiotic administration.

**MONITORED:** Through the Clinical Effectiveness and Mortality Steering Group and reported to the Trust Board monthly and Governance and Quality Committee monthly and quarterly.

**BY WHEN:** April 2017

**OUTCOME:** Ensure our patients receive the best clinical outcomes.
Patient Experience

Improve and act upon patient experience

WHY: To ensure our patients; their relatives and carers receive a good experience and base service improvements upon their feedback.

MEASURES:
- **Mental Health:** Working with Commissioners to establish an ageless mental health liaison service and implement a mental health champion’s programme.
- **End of Life Care:** Full implementation of the Achieving Priorities of Care documentation. Improve intelligence of the quality of End of Life care with use of the bereaved relative’s questionnaire, development of a metrics system to review complaints/safety learning events and plaudits related to end of Life care.
- **Carers:** Increase the support available for family carers.

MONITORED: Through the Patient Experience Steering Group and the Mental Health and Learning Disabilities Committee and reported to the Trust Board monthly and Governance and Quality Committee monthly and quarterly.

BY WHEN: April 2017

OUTCOME:
Ensure the experience and quality of care we provide is rated positive by the people who experience it and act upon areas for improvement. To treat all patients with the respect and dignity they deserve, meeting physical, psychological and social needs.
QUALITY IMPROVEMENT PRIORITIES 2015/2016 – OUR ACHIEVEMENTS

The Quality Account published in June 2015 identified areas of quality improvement to focus on during the year. A brief summary of our achievements against the priorities is outlined below, with further detail contained in part 3 of this account.

**Patient Safety**

- **PRESSURE ULCERS**
  - No more than 24 avoidable hospital acquired grade 3 and 4 pressure ulcers ✓ (year end total 15: 37.5% reduction)

- **FALLS**
  - Less than 2.5 per 1,000 occupied bed days falls resulting in harm over each quarter ✓
  - 95% of falls risk assessment completed within 48 hours each month ✓

- **HEALTH CARE ASSOCIATED INFECTIONS**
  - MRSA: 0 (zero) cases ✓
  - C.Diff: no more than 40 cases - ✓ (29 cases)
  - Improve on 2014/2015 outcome of 1,336 incidents ✓ (1,849 incidents reported; subject to increase)

- **MEDICATION**
  - Improving the percentage of required key items on the discharge summary to achieve 90% in quarter 4 ✓

**Clinical Effectiveness**

- **ACUTE KIDNEY INJURY**
  - Improving the percentage of patients screened and receiving antibiotics each quarter ✓

- **SEPSIS**
  - HSMR weekday, weekend and SHMI outcomes to be within expected range ✓

- **MORTALITY**
  - Ensure no surgeons are identified as an outlier within an identified list of National Audits ✓

- **SURGICAL OUTCOMES**
  - Roll out of the Adult Priorities of Care documentation ✓

**Patient Experience**

- **END OF LIFE CARE**
  - Improve communication between staff, carers and those cared for and actively involve carers and the cared for in feedback opportunities ✓

- **CARERS**
  - Review the patient experience of the discharge process ✓

- **DISCHARGE FROM HOSPITAL**
  - Review the current arrangements for engaging with service users, their families and carers and develop a patient engagement strategy ✓

- **PATIENT ENGAGEMENT**
STATEMENTS OF ASSURANCE FROM THE BOARD

Review of services
During 2015/2016 Portsmouth Hospitals NHS Trust provided and sub-contracted 36 NHS services. 3 significant services are sub-contracted to non-NHS providers; these being the Disablement Services Centre orthotic service and community dialysis services.

The Portsmouth Hospitals NHS Trust has reviewed all the data available to them on the quality of care in all 36 of these NHS services.

The income generated by the NHS services reviewed in 2015/2016 represents 89% of the total income generated from the provision of NHS services by the Portsmouth Hospitals NHS Trust for 2015/2016.

Participation in clinical audits
During 2015/2016 38 national clinical audits and 8 national confidential enquiries covered NHS services that Portsmouth Hospitals NHS Trust provides.

During that period Portsmouth Hospitals NHS Trust participated in 97% (37/38) national clinical audits and 100% (8/8) national confidential enquiries of those it was eligible to participate in.

The national clinical audits and national confidential enquiries that Portsmouth Hospitals NHS Trust participated in, and for which data collection was completed during 2015/2016, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

The reports of 49 (this number is from both 2015/16 and some reports that were published from data supplied in 2014/15) national clinical audits were reviewed by the provider in 2015/2016. Appendix A shows the actions Portsmouth Hospitals NHS Trust intends to take to improve the quality of healthcare provided.

<table>
<thead>
<tr>
<th>NATIONAL CLINICAL AUDITS</th>
<th>Audit title</th>
<th>Details</th>
<th>Participation</th>
<th>% cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Thoracic Society – Adult Asthma</td>
<td>Audit</td>
<td>National body not collecting data for 2015/16</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>British Thoracic Society – Non Invasive Ventilation</td>
<td>Audit</td>
<td>National body not collecting data for 2015/16</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>British Thoracic Society - Chronic Obstructive Pulmonary Disease</td>
<td>Secondary Care</td>
<td>National body not collecting data for 2015/16</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>British Thoracic Society – Paediatric Asthma</td>
<td>Audit</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>British Thoracic Society – Emergency Oxygen Use</td>
<td>Audit</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Oesophago-Gastric Cancer</td>
<td>Audit</td>
<td>83%</td>
<td>83%</td>
<td></td>
</tr>
<tr>
<td>Lung Cancer</td>
<td>Audit</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Prostate Cancer</td>
<td>Audit</td>
<td>67%</td>
<td>67%</td>
<td></td>
</tr>
<tr>
<td>Bowel Cancer</td>
<td>Audit</td>
<td>96%</td>
<td>96%</td>
<td></td>
</tr>
<tr>
<td>National Vascular Registry</td>
<td>Organisational</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>AAA Repair</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Carotid Endarterectomy</td>
<td>69%</td>
<td>69%</td>
<td>69%</td>
<td></td>
</tr>
</tbody>
</table>
# National Clinical Audits

<table>
<thead>
<tr>
<th>Audit title</th>
<th>Details</th>
<th>Participation</th>
<th>% cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Joint Registry</td>
<td>Registry</td>
<td>✔️</td>
<td>&gt;95%</td>
</tr>
<tr>
<td>National Comparative Audit of Blood Transfusion Programme</td>
<td>Use of blood in Haematology</td>
<td>✔️</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Patient Blood Management in scheduled surgery</td>
<td>✔️</td>
<td>100%</td>
</tr>
<tr>
<td>College of Emergency Medicine – Asthma</td>
<td>Audit</td>
<td>✔️</td>
<td>90%</td>
</tr>
<tr>
<td>College of Emergency Medicine – Procedural Sedation in Adults</td>
<td>Audit</td>
<td>✔️</td>
<td>100%</td>
</tr>
<tr>
<td>College of Emergency Medicine – Vital Sign in Children</td>
<td>Audit</td>
<td>✔️</td>
<td>100%</td>
</tr>
<tr>
<td>College of Emergency Medicine – VTE Risk in Lower Limb Immobilisation</td>
<td>Audit</td>
<td>✔️</td>
<td>53%</td>
</tr>
<tr>
<td>National Neonatal Audit Programme</td>
<td>Audit</td>
<td>✔️</td>
<td>100%</td>
</tr>
<tr>
<td>Paediatric Diabetes Audit</td>
<td>Audit</td>
<td>✔️</td>
<td>100%</td>
</tr>
<tr>
<td>Paediatric Intensive Care Audit Network</td>
<td>Audit</td>
<td>✔️</td>
<td>Not applicable</td>
</tr>
<tr>
<td></td>
<td>Hip Fracture database</td>
<td>✔️</td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td>Inpatient Falls audit</td>
<td>✔️</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Fracture Liaison Service</td>
<td>✔️</td>
<td>100%</td>
</tr>
<tr>
<td>Falls and Fragility Fracture Audit Programme</td>
<td>Audit</td>
<td>✔️</td>
<td>50.5%</td>
</tr>
<tr>
<td>Trauma Audit and Research Network</td>
<td>Audit</td>
<td>✔️</td>
<td>&gt;90%</td>
</tr>
<tr>
<td>Sentinel Stroke National Audit Programme</td>
<td>Audit</td>
<td>✔️</td>
<td>100%</td>
</tr>
<tr>
<td>Paediatric Pneumonia</td>
<td>Audit</td>
<td>✔️</td>
<td>National body not collecting data for 2015/16</td>
</tr>
<tr>
<td>Emergency Laparotomy</td>
<td>Audit</td>
<td>✔️</td>
<td>100%</td>
</tr>
<tr>
<td>ICNARC – Adult Critical Care</td>
<td>Audit</td>
<td>✔️</td>
<td>100%</td>
</tr>
<tr>
<td>ICNARC – Cardiac Arrest</td>
<td>Audit</td>
<td>✔️</td>
<td>100%</td>
</tr>
<tr>
<td>Renal Registry – Renal Replacement Therapy</td>
<td>Audit</td>
<td>✔️</td>
<td>Data collection ongoing</td>
</tr>
<tr>
<td>Chronic Kidney Disease in Primary Care</td>
<td>Audit</td>
<td>✔️</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Pulmonary Hypertension</td>
<td>Audit</td>
<td>✔️</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Prescribing Observatory for Mental Health</td>
<td>Audit</td>
<td>✔️</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Cystic Fibrosis Registry (Adult and Paediatric)</td>
<td>Audit</td>
<td>✔️</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Rheumatoid and Early Inflammatory Arthritis</td>
<td>Audit</td>
<td>✔️</td>
<td>100%</td>
</tr>
<tr>
<td>Intermediate Care</td>
<td>Audit</td>
<td>✔️</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Adult Cardiac Surgery</td>
<td>Audit</td>
<td>✔️</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Congenital Heart Disease (Paediatric Cardiac Surgery)</td>
<td>Audit</td>
<td>✔️</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Coronary Angioplasty – Percutaneous Coronary Intervention (PCI)</td>
<td>Audit</td>
<td>✔️</td>
<td>100%</td>
</tr>
<tr>
<td>Parkinson's Audit</td>
<td>Audit</td>
<td>✔️</td>
<td>100%</td>
</tr>
<tr>
<td>Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)</td>
<td>Audit</td>
<td>✔️</td>
<td>46.5%</td>
</tr>
</tbody>
</table>
The reports of 196 local clinical audits were reviewed by the provider in 2015/2016. Appendix B shows examples of local audits and the actions Portsmouth Hospitals NHS Trust intends to take to improve the quality of healthcare provided.
Research: participation in clinical research
Commitment to research as a driver for improving the quality of care and patient experience
The number of patients receiving NHS services provided or subcontracted by Portsmouth Hospitals NHS Trust in 2015/2016, that were recruited during that period to participate in research approved by a research ethics committee was 3,399.

Of these patients, 3,250 (96%) were recruited into clinical studies adopted onto the National Institute for Health Research (NIHR) Portfolio, with 149 (4%) recruited into other, non-Portfolio research projects.

Participation in clinical research demonstrates Portsmouth Hospitals NHS Trust’s commitment to improving the quality of care that we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

During 2015/2016, Portsmouth Hospitals NHS Trust has participated in a total of 316 clinical research studies, 84% of these studies were NIHR Portfolio adopted.

More than 35 clinical Departments participated in research approved by a research ethics committee at Portsmouth Hospitals NHS Trust during 2015/2016, covering a number of specialities and clinical support departments.

Goals agreed with Commissioners
Portsmouth Hospitals NHS Trust income in 2015/16 was not conditional on achieving quality improvement and innovation goals agreed through the Commissioning for Quality and Innovation (CQUIN) payment framework, as the Trust CCG income from most CCGs was agreed as an overall year-end settlement, and the details agreed later did not rely on actual CQUIN performance.

Statements from the Care Quality Commission
Portsmouth Hospitals NHS Trust is required to register with the Care Quality Commission and is currently registered and has the following four conditions on registration:
1. The Registered Provider must ensure there is effective leadership of the emergency care pathway.
2. The Registered Provider must operate an effective escalation system which will ensure that every patient attending the Emergency Department at Queen Alexandra Hospital is triaged, assessed and streamlined by appropriately qualified staff as set out in the guidance issued by the College of Emergency Medicine and others in their Triage Position Statement April 2011.
3. The registered provider must ensure the large multi-occupancy ambulance known as the “Jumbulance” will not be permitted to be used on site at the Queen Alexandra Hospital.
4. The Registered Provider must provide CQC with daily monitoring information that is to be provided on a weekly basis and based on the provided list of metrics.

The Care Quality Commission has taken enforcement action against Portsmouth Hospitals NHS Trust as of 15th March 2016. Portsmouth Hospitals NHS Trust participated in a special reviews by the Care Quality Commission relating to Integrated Care for Older People during October and December 2015. The Trust is awaiting the outcome of this thematic review.
Data quality
Portsmouth Hospitals NHS Trust submitted records during 2015/2016 to the Secondary Users Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data. The percentage of records in the published data for the period April 2015 to January 2016:

Included the patient’s valid NHS number:
- 99.3% for admitted patient care (national average 99.2%)
- 99.9% for outpatient care (national average 99.4 %)
- 98.9% for accident and emergency care (national average 95.3%)

Included the patient’s valid General Medical Practice Code:
- 99.9% for admitted patient care (national average 99.9%)
- 100.0% for outpatient care (national average 99.8%)
- 99.8% for accident and emergency care (national average 99.1%)

The Trust was not subject to a Payment by Results (PbR) clinical coding audit in 2015/2016.

Information Governance Toolkit attainment levels
Information Governance is concerned with the way we handle or “process” our information. It covers Personal Confidential Data (relating to patients/service users and employees) and corporate information (such as financial and accounting records) and provides a framework for employees to deal consistently with the many different rules about how information is handled.

The Information Governance Toolkit is a performance tool produced by the Department of Health. It draws together the legal rules and central guidance and presents them in one place as a set of information governance requirements. We are required to carry out self-assessments of compliance against the requirements.

Our Information Governance Assessment Report overall score for 2015/2016 was 75% and was graded “Satisfactory”.

There has been one serious incident relating to information governance in 2015/16, which was reported to the Information Commissioner’s Office (ICO). The ICO has investigated the incident and concluded that no further action is necessary.
**NATIONAL QUALITY PRIORITIES**

The following are a core set of indicators which are to be included in 2015/16 Quality Accounts. All trusts are required to report against these indicators using standardised statements. The information is based on data made available to the Trust by the Health and Social Care Information Centre. This data is presented in the same way in all Quality Accounts published in England; this allows fair comparison between hospitals.

It should be noted that the most up-to-date data provided by the Health and Social Care Information Centre, stated below, may relate to a different reporting period to that of the Quality Account. (Data source: [https://indicators.ic.nhs.uk/webview/](https://indicators.ic.nhs.uk/webview/))

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>PHT</td>
<td>National Average</td>
<td>PHT</td>
<td>National Average</td>
</tr>
<tr>
<td>Preventing people from dying prematurely.</td>
<td></td>
<td>1.08</td>
<td>1.00</td>
<td>1.05</td>
<td>1.00</td>
</tr>
<tr>
<td>Enhancing quality of life for people with long-term conditions.</td>
<td></td>
<td>As expected</td>
<td>As expected</td>
<td>As expected</td>
<td>As expected</td>
</tr>
<tr>
<td>The value of the summary hospital-level mortality indicator (&quot;SHMI&quot;) for the Trust.</td>
<td></td>
<td>27.3%</td>
<td>25.7%</td>
<td>26.7%</td>
<td>26.0%</td>
</tr>
<tr>
<td>The palliative care indicator is a contextual indicator</td>
<td></td>
<td>1.08</td>
<td>1.00</td>
<td>1.05</td>
<td>1.00</td>
</tr>
<tr>
<td>Portsmouth Hospitals NHS Trust considers that this data is as described as it is taken from the national dataset using data provided by the Trust.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Trust intends to and has taken the following actions to improve mortality and harm, and so the quality of its services, by:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Monitoring and acting upon underlying data.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The formation of a multi-professional mortality review group, chaired by the Medical Director to promote the implementation of the Mortality Review Tool and improve the number of mortality reviews undertaken.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Continue the roll-out of the Mortality Review Tool to standardise the data collected during mortality reviews, enabling better identification of any issues and their reporting for action.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** banding category: 1 – where the trust’s mortality rate is ‘higher than expected’, 2 – where the trust’s mortality rate is ‘as expected’, 3 – where the trust’s mortality rate is ‘lower than expected’.

For the SHMI, a comparison should not be made with the highest and lowest trust level SHMIs because the SHMI cannot be used to directly compare mortality outcomes between trusts and, in particular, it is inappropriate to rank trusts according to their SHMI.
### Domain: Helping people recover from episodes of ill health or following injury.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Patient Reported Outcome Measures (PROMs) finalised (EQ5D Index)</th>
<th>April 2012 – March 2013</th>
<th>April 2013 – March 2014</th>
<th>April 2014 – March 2015 (Provisional)</th>
<th>Trust Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PHT</td>
<td>National Average</td>
<td>Highest</td>
<td>Lowest</td>
<td>PHT</td>
</tr>
<tr>
<td>Groin hemia surgery</td>
<td>0.093</td>
<td>0.085</td>
<td>0.152</td>
<td>0.014</td>
<td>0.097</td>
</tr>
<tr>
<td>Varicose vein surgery</td>
<td>0.093</td>
<td>0.176</td>
<td>0.015</td>
<td>0.015</td>
<td>0.093</td>
</tr>
<tr>
<td>Hip replacement surgery</td>
<td>0.432</td>
<td>0.437</td>
<td>0.539</td>
<td>0.319</td>
<td>0.457</td>
</tr>
<tr>
<td>Knee replacement surgery</td>
<td>0.338</td>
<td>0.318</td>
<td>0.415</td>
<td>0.209</td>
<td>0.329</td>
</tr>
</tbody>
</table>

*Data not published due to small numbers of procedures.*

Note: April 2014 – March 2015 currently provisional (Published February 2016). Finalised version due for release August 2016.
## Re-admission within 28 days of being discharged

<table>
<thead>
<tr>
<th>Domain</th>
<th>April 2010 – March 2011</th>
<th>April 2011 – March 2012</th>
<th>Trust Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PHT</td>
<td>National Average</td>
<td>Highest (Large Acute)</td>
</tr>
<tr>
<td>Helping people recover from</td>
<td>12.31%</td>
<td>9.96%</td>
<td>14.11%</td>
</tr>
<tr>
<td>episodes of ill health or</td>
<td>Percentage of patients aged 0 to 15</td>
<td>12.31%</td>
<td>9.96%</td>
</tr>
<tr>
<td>following injury.</td>
<td>Percentage of patients aged 16 or over</td>
<td>10.87%</td>
<td>11.38%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Next version expected August 2016
<table>
<thead>
<tr>
<th>Domain</th>
<th>Trust responsive to the personal needs of its patients</th>
<th>April 2013 – March 2014</th>
<th>April 2014 – March 2015</th>
<th>Trust Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>PHT</td>
<td>National Average</td>
<td>Highest</td>
</tr>
<tr>
<td>Ensuring that people have a positive experience of care.</td>
<td>In-patient survey (overall score)</td>
<td>73.8</td>
<td>76.9</td>
<td>87.0</td>
</tr>
</tbody>
</table>

- Portsmouth Hospitals NHS Trust considers that this data is as described as it is taken from the national dataset using data provided by the Trust.

The Friends and Family Test has superseded this measure for patient experience; as detailed below.

The Trust has taken actions by:
- Continuing to improve both the use of experience and experiences of, local people to inform and advise us of the changes we need to make, and the areas of care we need to celebrate and share.
- Further enabling and encouraging the participation of and consultation with people from groups traditionally poorly represented, working with already established community groups.
- Developing more ways for people to feedback about their experience of services, and improve our understanding of patients and carers priorities.
- Improving our partnership working with stakeholders including Healthwatch, community engagement communities and voluntary sector organisations.
### Ensuring that people have a positive experience of care.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Staff who would recommend the Trust to their friends or family</th>
<th>2014</th>
<th>2015</th>
<th>Trust Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>PHT</td>
<td>National Average (Acute trusts)</td>
<td>Highest</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>National Staff Survey results</td>
<td>66%</td>
<td>65%</td>
<td>89%</td>
</tr>
</tbody>
</table>

Portsmouth Hospitals NHS Trust considers that this data is as described as it is taken from the national dataset using data provided by the Trust.

The Trust has taken the following actions to improve this percentage, and so the quality of its services, by:

- Implementing effective communication processes to share outcomes of what staff said matters and what changes have been implemented as a result of what they have done.
- Reviewing and improving our DATIX reporting systems to ensure staff have easy access to report incidents, errors and near misses.
- Developing an open, honest, safety culture by ensuring staff feel supported to raise issues and continuously learn and improve.
- Giving ward based teams permission to lead improvements within their local areas as a result of patient, service user and staff feedback.
### Patients who would recommend the Trust as a provider of care to their friends or family – A & E

<table>
<thead>
<tr>
<th>Domain</th>
<th>Reporting period</th>
<th>Total Responses</th>
<th>Total Eligible</th>
<th>Response Rate</th>
<th>Score (% recommend)</th>
<th>Score (% not recommend)</th>
<th>Trust Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A &amp; E</td>
<td>England</td>
<td>PHT England</td>
<td>PHT</td>
<td>England</td>
<td>PHT</td>
<td></td>
</tr>
<tr>
<td>Ensuring that people have a positive experience of care</td>
<td>January 2016</td>
<td>132,657</td>
<td>1,168</td>
<td>1,028,001</td>
<td>9,123</td>
<td>12.9%</td>
<td>12.8%</td>
</tr>
<tr>
<td></td>
<td>December 2015</td>
<td>127,888</td>
<td>1,267</td>
<td>1,005,618</td>
<td>8,831</td>
<td>12.7%</td>
<td>14.3%</td>
</tr>
<tr>
<td></td>
<td>November 2015</td>
<td>132,952</td>
<td>1,643</td>
<td>1,014,627</td>
<td>9,461</td>
<td>13.1%</td>
<td>17.4%</td>
</tr>
<tr>
<td></td>
<td>October 2015</td>
<td>142,320</td>
<td>1,523</td>
<td>1,047,858</td>
<td>9,727</td>
<td>13.6%</td>
<td>15.7%</td>
</tr>
<tr>
<td></td>
<td>September 2015</td>
<td>142,975</td>
<td>1,956</td>
<td>1,012,414</td>
<td>9,329</td>
<td>14.1%</td>
<td>21.0%</td>
</tr>
<tr>
<td></td>
<td>August 2015</td>
<td>141,952</td>
<td>1,283</td>
<td>993,547</td>
<td>9,444</td>
<td>14.0%</td>
<td>14.0%</td>
</tr>
<tr>
<td></td>
<td>July 2015</td>
<td>154,267</td>
<td>1,383</td>
<td>1,011,593</td>
<td>7,898</td>
<td>15.2%</td>
<td>17.5%</td>
</tr>
<tr>
<td></td>
<td>June 2015</td>
<td>147,551</td>
<td>1,676</td>
<td>978,786</td>
<td>7,391</td>
<td>15.1%</td>
<td>22.7%</td>
</tr>
<tr>
<td></td>
<td>May 2015</td>
<td>140,276</td>
<td>1,066</td>
<td>991,374</td>
<td>7,288</td>
<td>14.1%</td>
<td>14.6%</td>
</tr>
<tr>
<td></td>
<td>April 2015</td>
<td>130,745</td>
<td>1,228</td>
<td>885,962</td>
<td>7,032</td>
<td>14.8%</td>
<td>17.5%</td>
</tr>
<tr>
<td></td>
<td>March 2015</td>
<td>160,745</td>
<td>1,033</td>
<td>703,016</td>
<td>5,580</td>
<td>22.90%</td>
<td>18.5%</td>
</tr>
<tr>
<td></td>
<td>February 2015</td>
<td>128,502</td>
<td>853</td>
<td>607,478</td>
<td>5,047</td>
<td>21.2%</td>
<td>16.9%</td>
</tr>
</tbody>
</table>

Portsmouth Hospitals NHS Trust considers that this data is as described as it is taken from the national dataset using data provided by the Trust.

The Trust has taken actions by:

- Continuing to improve both the use of experience and experiences of, local people to inform and advise us of the changes we need to make, and the areas of care we need to celebrate and share.
- Further enabling and encouraging the participation of and consultation with people from groups traditionally poorly represented, working with already established community groups.
- Developing more ways for people to feedback about their experience of services, and improve our understanding of patients and carers priorities.
- Improving our partnership working with stakeholders including Healthwatch, community engagement communities and voluntary sector organisations.
## Review of quality performance

### Domain

**Ensuring that people have a positive experience of care**

<table>
<thead>
<tr>
<th>Reporting period</th>
<th>Total Responses</th>
<th>Total Eligible</th>
<th>Response Rate</th>
<th>Score (% recommend)</th>
<th>Score (% not recommend)</th>
<th>Trust Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2016</td>
<td>195,394</td>
<td>832,793</td>
<td>23.5%</td>
<td>95%</td>
<td>2%</td>
<td>Portsmouth Hospitals NHS Trust considers that this data is as described as it is taken from the national dataset using data provided by the Trust.</td>
</tr>
<tr>
<td>December 2015</td>
<td>187,429</td>
<td>828,214</td>
<td>22.6%</td>
<td>95%</td>
<td>2%</td>
<td></td>
</tr>
<tr>
<td>November 2015</td>
<td>205,951</td>
<td>844,386</td>
<td>24.4%</td>
<td>95%</td>
<td>2%</td>
<td></td>
</tr>
<tr>
<td>October 2015</td>
<td>213,205</td>
<td>874,964</td>
<td>24.4%</td>
<td>95%</td>
<td>2%</td>
<td></td>
</tr>
<tr>
<td>September 2015</td>
<td>207,844</td>
<td>846,924</td>
<td>24.5%</td>
<td>95%</td>
<td>2%</td>
<td></td>
</tr>
<tr>
<td>August 2015</td>
<td>191,194</td>
<td>771,682</td>
<td>24.8%</td>
<td>96%</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>July 2015</td>
<td>218,075</td>
<td>815,888</td>
<td>26.7%</td>
<td>95.6%</td>
<td>1.5%</td>
<td></td>
</tr>
<tr>
<td>June 2015</td>
<td>204,295</td>
<td>764,782</td>
<td>26.7%</td>
<td>95.6%</td>
<td>1.5%</td>
<td></td>
</tr>
<tr>
<td>May 2015</td>
<td>184,711</td>
<td>713,594</td>
<td>25.9%</td>
<td>95.4%</td>
<td>1.5%</td>
<td></td>
</tr>
<tr>
<td>April 2015</td>
<td>173,959</td>
<td>679,609</td>
<td>25.6%</td>
<td>95.2%</td>
<td>1.6%</td>
<td></td>
</tr>
<tr>
<td>March 2015</td>
<td>147,007</td>
<td>327,069</td>
<td>44.9%</td>
<td>95%</td>
<td>2%</td>
<td></td>
</tr>
<tr>
<td>February 2015</td>
<td>118,950</td>
<td>298,746</td>
<td>39.8%</td>
<td>95%</td>
<td>2%</td>
<td></td>
</tr>
</tbody>
</table>

The Trust has taken actions by:

- Continuing to improve both the use of experience and experiences of, local people to inform and advise us of the changes we need to make, and the areas of care we need to celebrate and share.
- Further enabling and encouraging the participation of and consultation with people from groups traditionally poorly represented, working with already established community groups.
- Developing more ways for people to feedback about their experience of services, and improve our understanding of patients and carers priorities.
- Improving our partnership working with stakeholders including Healthwatch, community engagement communities and voluntary sector organisations.
## Domain

**Ensuring that people have a positive experience of care**

### Patients who would recommend the Trust as a provider of care to their friends or family – Maternity

<table>
<thead>
<tr>
<th>Reporting period</th>
<th>Maternity Setting</th>
<th>Total Responses</th>
<th>Total Eligible</th>
<th>Response Rate</th>
<th>Score (% recommend)</th>
<th>Score (% not recommend)</th>
<th>Trust Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>January 2016</strong></td>
<td>Antenatal Care</td>
<td>6,626</td>
<td>61</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>96% 98% 1% 0%</td>
</tr>
<tr>
<td></td>
<td>Birth</td>
<td>11,740</td>
<td>106</td>
<td>50,527</td>
<td>477</td>
<td>23.2% 22.2%</td>
<td>97% 99% 1% 0%</td>
</tr>
<tr>
<td></td>
<td>Postnatal Ward</td>
<td>11,856</td>
<td>110</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>94% 95% 2% 1%</td>
</tr>
<tr>
<td></td>
<td>Postnatal Community</td>
<td>5,462</td>
<td>68</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>98% 99% 1% 1%</td>
</tr>
<tr>
<td><strong>December 2015</strong></td>
<td>Antenatal Care</td>
<td>6,226</td>
<td>38</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>95% 100% 2% 0%</td>
</tr>
<tr>
<td></td>
<td>Birth</td>
<td>11,004</td>
<td>126</td>
<td>51,641</td>
<td>482</td>
<td>21.3% 26.1%</td>
<td>97% 95% 1% 0%</td>
</tr>
<tr>
<td></td>
<td>Postnatal Ward</td>
<td>11,623</td>
<td>165</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>94% 95% 2% 1%</td>
</tr>
<tr>
<td></td>
<td>Postnatal Community</td>
<td>5,309</td>
<td>82</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>98% 99% 1% 0%</td>
</tr>
<tr>
<td><strong>November 2015</strong></td>
<td>Antenatal Care</td>
<td>7,048</td>
<td>31</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>96% 100% 1% 0%</td>
</tr>
<tr>
<td></td>
<td>Birth</td>
<td>12,005</td>
<td>156</td>
<td>51,229</td>
<td>479</td>
<td>23.4% 32.6%</td>
<td>96% 97% 1% 0%</td>
</tr>
<tr>
<td></td>
<td>Postnatal Ward</td>
<td>13,159</td>
<td>189</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>94% 98% 2% 1%</td>
</tr>
<tr>
<td></td>
<td>Postnatal Community</td>
<td>5,504</td>
<td>100</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>98% 95% 1% 3%</td>
</tr>
<tr>
<td><strong>October 2015</strong></td>
<td>Antenatal Care</td>
<td>7,353</td>
<td>16</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>95% 88% 1% 0%</td>
</tr>
<tr>
<td></td>
<td>Birth</td>
<td>12,057</td>
<td>88</td>
<td>54,072</td>
<td>464</td>
<td>22.3% 19.0%</td>
<td>96% 94% 1% 3%</td>
</tr>
<tr>
<td></td>
<td>Postnatal Ward</td>
<td>13,694</td>
<td>81</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>94% 99% 2% 1%</td>
</tr>
<tr>
<td></td>
<td>Postnatal Community</td>
<td>5,777</td>
<td>49</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>98% 96% 1% 2%</td>
</tr>
<tr>
<td><strong>September 2015</strong></td>
<td>Antenatal Care</td>
<td>7,179</td>
<td>71</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>95% 94% 2% 0%</td>
</tr>
</tbody>
</table>

Portsmouth Hospitals NHS Trust considers that this data is as described as it is taken from the national dataset using data provided by the Trust. The Trust intends to take and has taken actions to improve this score and response rate, and so the quality of its services continues to improve. All mothers who have had complex care have a 6 week phone call from which information is collated into service and care improvement.
## Patients who would recommend the Trust as a provider of care to their friends or family – Maternity

<table>
<thead>
<tr>
<th>Domain</th>
<th>Reporting period</th>
<th>Maternity Setting</th>
<th>Total Responses</th>
<th>Total Eligible</th>
<th>Response Rate</th>
<th>Score (% recommend)</th>
<th>Score (% not recommend)</th>
<th>Trust Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>England PHT</td>
<td>England PHT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Birth</td>
<td>12,091</td>
<td>194</td>
<td>53,364</td>
<td>498</td>
<td>22.7%</td>
<td>39.0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Postnatal Ward</td>
<td>13,435</td>
<td>269</td>
<td>-</td>
<td>-</td>
<td>93%</td>
<td>97% 2% 0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Postnatal Community</td>
<td>5,483</td>
<td>158</td>
<td>-</td>
<td>-</td>
<td>98%</td>
<td>96% 1% 1%</td>
</tr>
<tr>
<td></td>
<td>August 2015</td>
<td>Antenatal Care</td>
<td>6,680</td>
<td>34</td>
<td>-</td>
<td>-</td>
<td>95%</td>
<td>94% 2% 0%</td>
</tr>
<tr>
<td></td>
<td>Birth</td>
<td>11,293</td>
<td>91</td>
<td>53,240</td>
<td>476</td>
<td>21.2%</td>
<td>19.1%</td>
<td>97% 100% 1% 0%</td>
</tr>
<tr>
<td></td>
<td>Postnatal Ward</td>
<td>11,993</td>
<td>114</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>94%</td>
<td>99% 2% 0%</td>
</tr>
<tr>
<td></td>
<td>Postnatal Community</td>
<td>5,326</td>
<td>64</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>98%</td>
<td>97% 1% 0%</td>
</tr>
<tr>
<td></td>
<td>July 2015</td>
<td>Antenatal Care</td>
<td>8,401</td>
<td>52</td>
<td>-</td>
<td>-</td>
<td>95%</td>
<td>96% 2% 0%</td>
</tr>
<tr>
<td></td>
<td>Birth</td>
<td>12,256</td>
<td>168</td>
<td>54,695</td>
<td>463</td>
<td>22.4%</td>
<td>36.3%</td>
<td>97% 99% 1% 0%</td>
</tr>
<tr>
<td></td>
<td>Postnatal Ward</td>
<td>13,142</td>
<td>202</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>94%</td>
<td>96% 2% 0%</td>
</tr>
<tr>
<td></td>
<td>Postnatal Community</td>
<td>6,826</td>
<td>152</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>97%</td>
<td>96% 1% 1%</td>
</tr>
<tr>
<td></td>
<td>June 2015</td>
<td>Antenatal Care</td>
<td>7,911</td>
<td>59</td>
<td>-</td>
<td>-</td>
<td>96%</td>
<td>100% 1% 0%</td>
</tr>
<tr>
<td></td>
<td>Birth</td>
<td>12,223</td>
<td>96</td>
<td>51,779</td>
<td>473</td>
<td>24%</td>
<td>20.3%</td>
<td>97% 100% 1% 0%</td>
</tr>
<tr>
<td></td>
<td>Postnatal Ward</td>
<td>12,802</td>
<td>93</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>93.4%</td>
<td>99 2% 0%</td>
</tr>
<tr>
<td></td>
<td>Postnatal Community</td>
<td>6,098</td>
<td>63</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>98%</td>
<td>97% 1% 2%</td>
</tr>
<tr>
<td></td>
<td>May 2015</td>
<td>Antenatal Care</td>
<td>7,431</td>
<td>119</td>
<td>-</td>
<td>-</td>
<td>96%</td>
<td>95% 2% 2%</td>
</tr>
</tbody>
</table>
## Patients who would recommend the Trust as a provider of care to their friends or family – Maternity

<table>
<thead>
<tr>
<th>Domain</th>
<th>Reporting period</th>
<th>Maternity Setting</th>
<th>Total Responses</th>
<th>Total Eligible</th>
<th>Response Rate</th>
<th>Score (% recommend)</th>
<th>Score (% not recommend)</th>
<th>Trust Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Care</td>
<td></td>
<td>12,323</td>
<td>234</td>
<td>53,052</td>
<td>457</td>
<td>23.2%</td>
<td>51.2%</td>
</tr>
<tr>
<td></td>
<td>Birth</td>
<td></td>
<td>12,964</td>
<td>240</td>
<td>-</td>
<td>-</td>
<td>93%</td>
<td>98% 2% 0%</td>
</tr>
<tr>
<td></td>
<td>Postnatal Ward</td>
<td></td>
<td>5,525</td>
<td>160</td>
<td>-</td>
<td>-</td>
<td>98%</td>
<td>97% 1% 0%</td>
</tr>
<tr>
<td></td>
<td>Postnatal Community</td>
<td></td>
<td>7,307</td>
<td>53</td>
<td>-</td>
<td>-</td>
<td>95%</td>
<td>94% 1% 2%</td>
</tr>
<tr>
<td></td>
<td>April 2015</td>
<td>Antenatal Care</td>
<td>11,803</td>
<td>101</td>
<td>50,071</td>
<td>471</td>
<td>23.6%</td>
<td>21.4%</td>
</tr>
<tr>
<td></td>
<td>Birth</td>
<td></td>
<td>12,617</td>
<td>144</td>
<td>-</td>
<td>-</td>
<td>94%</td>
<td>96% 2% 1%</td>
</tr>
<tr>
<td></td>
<td>Postnatal Ward</td>
<td></td>
<td>5,677</td>
<td>43</td>
<td>-</td>
<td>-</td>
<td>98%</td>
<td>98% 1% 2%</td>
</tr>
<tr>
<td></td>
<td>Postnatal Community</td>
<td></td>
<td>8,082</td>
<td>13</td>
<td>-</td>
<td>-</td>
<td>95%</td>
<td>85% 1% 8%</td>
</tr>
<tr>
<td></td>
<td>March 2015</td>
<td>Antenatal Care</td>
<td>12,389</td>
<td>112</td>
<td>50,624</td>
<td>481</td>
<td>24.5%</td>
<td>23.3%</td>
</tr>
<tr>
<td></td>
<td>Birth</td>
<td></td>
<td>13,008</td>
<td>154</td>
<td>-</td>
<td>-</td>
<td>93%</td>
<td>97% 2% 1%</td>
</tr>
<tr>
<td></td>
<td>Postnatal Ward</td>
<td></td>
<td>6,041</td>
<td>19</td>
<td>-</td>
<td>-</td>
<td>98%</td>
<td>89% 1% 5%</td>
</tr>
<tr>
<td></td>
<td>Postnatal Community</td>
<td></td>
<td>8,166</td>
<td>42</td>
<td>-</td>
<td>-</td>
<td>95%</td>
<td>90% 1% 0%</td>
</tr>
<tr>
<td></td>
<td>February 2015</td>
<td>Antenatal Care</td>
<td>11,668</td>
<td>128</td>
<td>47,798</td>
<td>420</td>
<td>24.4%</td>
<td>30.5%</td>
</tr>
<tr>
<td></td>
<td>Birth</td>
<td></td>
<td>12,030</td>
<td>134</td>
<td>-</td>
<td>-</td>
<td>93%</td>
<td>98% 2% 1%</td>
</tr>
<tr>
<td></td>
<td>Postnatal Ward</td>
<td></td>
<td>5,878</td>
<td>72</td>
<td>-</td>
<td>-</td>
<td>98%</td>
<td>99% 1% 0%</td>
</tr>
</tbody>
</table>
### VTE Risk Assessment

<table>
<thead>
<tr>
<th>Domain</th>
<th>VTE Risk Assessment</th>
<th>PHT</th>
<th>National Average (Acute Trusts)</th>
<th>Highest</th>
<th>Lowest</th>
<th>Trust Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treating and caring for people in a safe environment and protecting them from avoidable harm.</td>
<td>Quarter 3 2015-16</td>
<td>98%</td>
<td>95%</td>
<td>100%</td>
<td>61%</td>
<td>Portmouth Hospitals NHS Trust considers that this data is as described as it is taken from the national dataset using data provided by the Trust.</td>
</tr>
<tr>
<td></td>
<td>Quarter 2 2015-16</td>
<td>98%</td>
<td>96%</td>
<td>100%</td>
<td>75%</td>
<td>The Trust has taken the following actions to improve this percentage, and so the quality of its services, by:</td>
</tr>
<tr>
<td></td>
<td>Quarter 1 2015-16</td>
<td>98%</td>
<td>96%</td>
<td>100%</td>
<td>86%</td>
<td>• The Trust is in the process of producing some patient safety animations to go on the Trust website; progressing to some outpatient and waiting areas.</td>
</tr>
<tr>
<td></td>
<td>Quarter 4 2014-15</td>
<td>98%</td>
<td>96%</td>
<td>100%</td>
<td>79%</td>
<td>• Continued focus on risk assessment, achieving over 96% of patients risk assessed for VTE each month.</td>
</tr>
</tbody>
</table>

### Rate per 100,000 bed days of C.Difficile infection

<table>
<thead>
<tr>
<th>Domain</th>
<th>Rate per 100,000 bed days of C.Difficile infection</th>
<th>April 2013–March 2014</th>
<th>April 2014–March 2015</th>
<th>Trust Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treating and caring for people in a safe environment and protecting them from avoidable harm.</td>
<td>Rate per 100,000 bed days of C.Difficile infection amongst patients aged 2 or over.</td>
<td>9.1</td>
<td>14.7</td>
<td>37.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Review of quality performance

### Domain: C. Difficile Infection

<table>
<thead>
<tr>
<th></th>
<th>April 2013–March 2014</th>
<th>April 2014–March 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PHT</td>
<td>National Average</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Trust Statement**
  - An area of increased focus will be antimicrobial stewardship especially given the challenges associated with achieving both the national Sepsis and Antimicrobial stewardship CQUIN requirements.

### Domain: Patient Safety Incidents

<table>
<thead>
<tr>
<th></th>
<th>April 2014–September 2014</th>
<th>October 2014–March 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PHT</td>
<td>National Average</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Trust Statement**
  - Portsmouth Hospitals NHS Trust considers that this data is as described as it is taken from the National Reporting and Learning System (NRLS) dataset using data provided by the Trust.
  - The Trust has taken the following actions to improve this number, and so the quality of its services, by:
    - Comprehensive review of the incident reporting system. Full upgrade to the system being implemented from the 1st April 2016.
    - Multi-professional panels to review incidents and share learning.
REVIEW OF QUALITY PERFORMANCE

This part of the Quality Account provides an overview of how we have performed against quality initiatives in 2015/2016. This information is presented under the three quality domains (safety, effectiveness and experience). We monitor and track all aspects of quality and report against these monthly and quarterly through the Board and Governance and Quality Committee reports. The following is the Trust Quality dashboard demonstrating Trust performance over 2015/2016 presented to the Trust Board in May 2016.
The Trust was inspected by the Care Quality Commission (CQC) on the 10th to 13th February 2015, followed by two unannounced visits on 22nd February and 2nd March 2015. Overall, the Trust was rated as Requires Improvement and rated as ‘Outstanding’ for providing caring services and ‘Good’ for effective services. The quality concerns related to the safety of patients within the Emergency Department and the Unscheduled Care pathway; resulting in a rating of ‘inadequate’ for safety domain of urgent and emergency services. An unannounced focussed inspection to follow up on warning notices that were served was undertaken on 25th April 2015 which resulted in the ‘inadequate’ rating improving to a rating of ‘requires improvement’. A Trust-wide quality improvement plan was developed and has been implemented over the last year; with monthly reporting to Trust Board, Governance and Quality Committee, NHS Trust Development Authority, CQC and Commissioners.

The CQC subsequently inspected the Trust in February 2016 and identified on-going safety concerns relating to the Emergency Department for which the Trust has received an Enforcement Notice. The Enforcement Notice outlines four conditions as noted in section 2 (page 11). The Trust has worked with partners to further enhance the Urgent Care Improvement Plan.
Sign up to Safety Campaign

Sign up to safety is a national campaign launched by NHS England aimed at reducing avoidable harm by 50% and saving 6,000 lives over 3 years. The campaign is designed to make the NHS the safest healthcare system in the world by creating a system devoted to continuous learning and improvement. The main message of the campaign is; “sign up to safety aims to deliver harm free care for every patient, every time, everywhere. It champions openness and honesty and supports everyone to improve the safety of patients.”

The Trust joined the sign up to safety campaign in September 2014. The campaign is based around organisations committing to specific pledges and we have based our pledges on 3 criteria; our most frequent causes of moderate to severe patient harm, our NHS Litigation Authority data and our obligations under national and local quality contract schemes. The table below summarises the national campaign pledges and our specific in-house pledges which will constitute our safety priorities for the coming 3 years.
Harm free care
To help us monitor the safety of our patients we use the Department of Health tool called the Safety Thermometer. We use this tool each month to audit the care given to our patients. The audit helps us to understand how well we are doing and highlights areas for further improvement.

The Safety Thermometer records how many of our patients suffer from four types of harm:
- Pressure ulcers
- Falls
- Urinary Tract Infections in patients who are catheterised
- Blood clots (VTE)

The Trust has maintained over 96% Trust harm free care during 2015/2016.

Work streams for each of the four harms measured by the Safety Thermometer are led by specialist teams to drive forward improvements. To assist patients in keeping safe whilst in our care, we have developed a patient safety briefing video which is played through our hospital entertainment system at the bedside and introduced a patient safety leaflet providing key tips on keeping safe.
Pressure Ulcers

Pressure ulcers are caused when an area of skin is placed under pressure and are sometimes known as "bedsores" or "pressure sores". They can develop when a large amount of pressure is applied to an area of skin over a short period of time. They can also occur when less pressure is applied over a longer period of time.

Pressure ulcers tend to affect people with health conditions that make it difficult to move, especially those confined to lying in a bed or sitting for prolonged periods of time. Pressure ulcers can range in severity, grade 1 being the least severe and grade 4 the most severe.

Pressure ulcers can be prevented by ensuring patients are kept mobile, regularly changing positions whenever possible. The Trust has a wide range of pressure relieving equipment including cushions, mattresses and boots.

WHAT: Reduce the number of avoidable grade 3 and 4 pressure ulcers

HOW MUCH: No more than 24 avoidable hospital acquired grade 3 and 4 pressure ulcers

BY WHEN: April 2016

ACHIEVED – YEAR END TOTAL OF 15 (37.5% REDUCTION)

Key developments:
- 2 months with zero hospital acquired grade 3 or 4 pressure ulcers (May 2015 and February 2016).
- New TVN team formed with improved outcomes and reduced harm for patients as the incident rate for avoidable pressure ulcers has dropped from 24 in 2014/15 to 15 in 2015/16.
- Robust education programme delivered to all Nursing Staff during the year to improve pressure damage awareness.
- Improved access for pressure relieving equipment for patients through a clinically reviewed daily process
- Introduction a new dressing formulary to immediately improve care for patients by reducing variation.

Further improvements identified for 2016/2017:
- New pressure damage called Purpose T.
- Further develop swarm process.
- Identify new ways to disseminate learning.
**Falls**

Patient falls are one of the leading causes of incidents in hospital and can lead to injury and prolonged hospital stays. Falls can also have a long term physiological effect on patients as they can lead to a loss in confidence and a fear of falling again.

In England 1 in 3 people over the age of 65 fall at least once a year, accounting for more than 4 million bed days (Royal College of Physicians 2011). Falls are the common cause of death from injury in the over 65s as many falls result in facture and / or head injuries.

Falls in hospitals account for 26% (324,000) of all patient safety incidents in hospitals in 2011 (NHS Commissioning Board Special Health Authority 2013). NHS costs associated with fragility fractures are estimated to exceed £2 billion a year.

**WHAT:** Reduction in falls resulting in harm.

**HOW MUCH:** Less than 2.5 per 1,000 occupied bed days falls resulting in harm over each quarter.
95% of falls risk assessment completed within 48 hours each month

**BY WHEN:** April 2016

- **Per 1,000 occupied bed days: ACHIEVED**
  - Quarter 1: 0.1
  - Quarter 2: 0.1
  - Quarter 3: 0.2
  - Quarter 4: 0.2

- **Falls risk assessment: ACHIEVED**

**Key developments:**
- The Trust has appointed a new falls prevention specialist to lead on the falls prevention programme.
- Safety huddles are being used to identify high falls risk patients to the whole clinical team to allow all members of the multidisciplinary team to be aware of patients who are likely to sustain falls.
- Work is on-going to recognise the risk of an increase in falls in vulnerable patients.
- Falls prevention training programme continues for staff.
- Continued focus on integrated care and the fracture liaison service in the community.
- Falls prevention continues to form part of the Trust’s Sign up to Safety Key pledges and forms a key objective within the Trust’s Patient Safety Strategy.
- Appointment of several new falls champions across the CSC’s.

**Further improvements identified for 2016/2017:**
- A plan to implement a trust wide strategic falls group, to promote effective Trust-wide learning and sharing of good practice.
- Identifying and implementing a more robust system for using and obtaining falls alarms
- Continued review and implementation of training programmes for all levels of staff
- Bi-annual Trust-wide auditing compliance with Falls prevention and post fall care strategies
- Planned participation in National audits for falls prevention
Healthcare Associated Infections

Healthcare Associated Infections (HCAI) are infections that are acquired in hospitals or as a result of healthcare interventions. There are a number of factors that can increase the risk of acquiring an infection, but high standards of infection control practice minimise the risk of occurrence for example hand washing and cleaning.

Methicillin resistant Staphylococcus aureus (MRSA) is a common bacteria carried by around one in three healthy people, usually on their skin or in the nose. In most cases, it is not harmful for healthy people to carry MRSA. But hospital patients are sick and, therefore, liable to infection.

Clostridium difficile (C.Diff) is a common bacterium that is harmlessly in the bowel of 3% of healthy adults and up to 30% of elderly patients. Antibiotics disturb the balance of bacteria in the bowel and Clostridium difficile can then multiply rapidly and produce toxins which cause diarrhoea and illness.

WHAT: Meet national targets for MRSA and C.Diff

HOW MUCH: MRSA: 0 (zero)
C.Diff: no more than 40 cases

BY WHEN: April 2016

Key developments:
- Reiterated the importance of timely C.Diff sampling, which has reduced the number of C.Diff toxins being incorrectly assigned to the Trust
- Infection Prevention and Control host the multi-disciplinary root cause analysis meetings for all C.Diffs attributed to the Trust, to ensure all cases are learnt from.
- Developed and introduced a cannula insertion pack to improve compliance with Trust policy and therefore, reduce Staph Aureus infections
- Commenced a Trust-wide peer-review hand hygiene audit programme in combination with practical face-to-face hand hygiene teaching sessions
- Upgraded our Hydrogen Peroxide decontamination machines to ensure a quicker turn around
- Provided an enhanced surveillance programme around clinical cleaning including re-audits of any areas where problems have been identified, to ensure improvements are made and sustained

Further improvements identified for 2016/2017:
- Re-launch the hydrogen peroxide decontamination service
- Continue the enhanced surveillance programme around cleaning and the environment
- Continue the hand hygiene audit programme.
Medication
A medication error is an error in the process of prescribing, dispensing, preparing, administering, monitoring or providing medicine advice, regardless of whether any harm occurred.

The focus over 2015/2016 was to improve awareness and reporting of medication incidents. With this additional focus the Trust has seen a significant increase in the overall reporting of medication incidents. The increase relates to the reporting of no/low harm incidents, not incidents relating in high level harm.

The themes identified have enabled focussed pieces of work to improve medicines management.

WHAT: Improve awareness and reporting of medication incidents
HOW MUCH: Improve on 2014/2015 outturn of 1,336 incidents
BY WHEN: April 2016

Key developments:
- Funding for safety initiatives granted to produce antibiotic reference cards as a quick guide to penicillin containing antibiotics and to improve the medicines information available for nursing staff when carrying out drug rounds.
- The Safety Learning Event Reporting system has been updated to make reporting more straightforward. The system now feeds back to reporters via email when the incident is closed to keep them informed about actions and learning which will help to encourage staff to report.
- There has been an increase in training and update sessions by pharmacy staff regarding Medicines Management; all used to highlight and feedback common safety issues.
- Following a review of gentamicin prescribing and administration, a gentamicin prescribing chart has been designed in conjunction with junior doctors and is being trialled to enable dosing, blood levels and dosing to be recorded in a clear structured way.

Further improvements identified for 2016/2017:
- Continue to actively encourage reporting and increase data report quality, feedback and learning.
- Feedback and Medication Safety Alerts concerning common themes identified from reported incidents is being introduced.
- The role of Medication Link Nurses and Drug Champions is being developed to enable closer links with ward based staff.
- A working group is being established to set up an IT prescribing support solution, to make advice and information more easily accessible.
Safe staffing

As a result of the Francis Report (2013) the government pledged that from April 2014, all hospitals would publish staffing levels on a ward by ward basis together with the percentage of shifts meeting safe staffing guidelines.

The Trust displays staffing levels every day for all wards on the transparency boards at the entrance to our wards. The transparency boards are one of the first things visitors see when they come onto the ward and provides them with details of the shift co-ordinator, the numbers of Registered Nurses and healthcare support workers the ward should have for each shift, and the numbers they actually do have. This enables patients and their relatives and carers to see staffing level information in an open and transparent way. Ward based staffing is reviewed by the Trust Board twice a year following the ward based staffing reviews. These are undertaken using the NICE recommended Safer Nursing Care Tool which is followed by a professional judgement review all recommendations to improve ward based staffing have been agreed by the Trust Board. The Trust has also been robustly recruiting over the last three years in Europe as well as the U.K. and now finds itself in a good position for staffing compared to local providers and against the National picture of Registered Nurse shortfalls.
Perfect Care Weeks

The Trust is committed to ensuring that patients receive the Best care in the Best hospital by the Best people. To help us achieve this, the ‘Perfect Care Week’ was designed to ensure patients receive optimal care and experience. These ‘weeks’ take place on one or two wards and focus on the top 4 safety incidents the Trust is aiming to reduce (medication incidents, falls, pressure damage and Health care associated infections).

The following initiatives take place during the event:

- A safety huddle at each hand over (designed to increase awareness of patient safety issues and share information).
- A SWARM team approach to incidents (a number of experts will congregate on the ward to provide analysis and feedback learning in the immediate aftermath of any safety incidents).
- Observations of care.
- Patients will be shadowed by non-clinical staff to observe care from the patient’s perspective.
- Patient surveys which mirror the in-patient survey.
- Allied Health Professionals and Specialist practitioners to assist the clinical teams and patients.
- A patient safety questionnaire for staff.
- Feedback of the day’s results.
- Coaching sessions supported by the Learning and Development team to elicit and aid in the implementation of post- perfect care learning and change.
- Evaluation of the programme.
Culture of patient safety

Duty of Candour

The Trust implemented the Duty of Candour requirements in 2014 and has a Being Open and Duty of Candour Policy which covers the process of ensuring correctly implementing Duty of Candour. Completion of the requirements is monitored through the Trust incident reporting system of which there are mandatory sections for completion of Duty of Candour. The Trust holds investigation panels for all incidents where the outcome for the patient has resulted in moderate, severe harm or death; completion of Duty of Candour is discussed with timescales for completion and responsibility to undertake confirmed. A weekly report is provided to all Clinical Service Centres detailing completion of Duty of Candour and any non compliance to be addressed.

Patient Safety Learning Events

The Trust recognises the importance of encouraging staff to report concerns to ensure that we learn from incidents and continuously improve quality of patient care. We asked staff what would make it easier for them to report incidents and they identified that the existing system was difficult and time consuming to use and that the naming of the incident form should be changed to Safety Learning Event form.

We therefore, undertook a complete review of the system and subsequently have implemented an upgrade to the system to include reporting of incidents, complaints and claims. This will enable us to triangulate information much easier to identify themes and trends and issues to be addressed. The new system has been simplified with feedback from staff to make completion of Safety Learning Event forms easier.
Acute Kidney Injury

Acute kidney injury (AKI) is sudden damage to the kidneys that causes them to stop working properly and can range from minor loss of kidney function to complete kidney failure. AKI is common and normally happens as a complication of another serious illness. It is not the result of a physical blow to the kidneys, as the name may suggest.

Acute kidney Injury (AKI) is a common cause of patient harm. It is of particular note because some of it is preventable and when it does occur some of the further management and review needs to take place after the patient has left hospital.

The national CQUIN requires hospitals to identify AKI when it occurs, manage the patient appropriately and then inform the GP of ongoing monitoring requirements.

WHAT: Delivery of the National AKI CQUIN by improving diagnosis and treatment in hospital and provision of information for GPs for on-going care

HOW MUCH: Improving the percentage of required key items on the discharge summary each quarter to achieve 90% in quarter 4

BY WHEN: April 2016

Key developments:
- Implementation of new electronic discharge summaries with a compulsory AKI section to complete.
- New Acute Kidney Injury Nurse Specialist appointed.
- New automatic laboratory AKI alerting system that generates alerts directly from blood test results if the patient has triggered the criteria for an AKI whilst in hospital; these alerts are seen by clinicians when reviewing blood results.
- New AKI Care Pathway implemented throughout the hospital.
- Hospital-wide AKI education programme for all clinical staff on AKI prevention, early identification and treatment.

Further improvements identified for 2016/2017:
- Reduction in number of severe post-admission AKI within the hospital.
- New AKI information leaflets and improved education for patients diagnosed with AKI. To improve patient understanding of their AKI and how to reduce the risk of it happening again.
- Implementation of AKI Alerts onto our existing electronic patient observation application “VitalPAC”. To increase ward level awareness of patients with AKI.
Sepsis
Sepsis is a potentially life-threatening condition, triggered by an infection or injury; without quick treatment, sepsis can lead to multiple organ failure and death.

The Trust has introduced the Sepsis 6 bundle; a number of medical therapies designed to reduce patients dying from sepsis. Early intervention is known to save lives and has been shown to reduce the length of hospital stay and the need for critical care admissions. Once Sepsis is recognised, prompt assessment and implementation of the Sepsis 6 can save lives.

National guidance suggests that treatment should be started within 1 hour of sepsis being suspected; the National CQUIN focusses on the screening for sepsis for all patients for whom sepsis screening is appropriate, and to rapidly initiate intravenous antibiotics within 1 hour of presentation, for those patients who have suspected severe sepsis.

WHAT: Delivery of the National Sepsis CQUIN to improve screening of patients and timely antibiotic administration

HOW MUCH: Improving the percentage of patients screened and receiving antibiotics each quarter

BY WHEN: April 2016

✔ Achieved (Q1-3) Extension agreed for quarter 4 submission

Key developments:
- Sepsis 6 pathway stickers to be used to guide management of sepsis.
- Trust wide teaching on Sepsis.
- Blood culture packs to facilitate the prompt and effective testing for Sepsis.
- Electronic sepsis alerts in the emergency department.
- Participation in national and local audits to benchmark Sepsis management.
- Very active multidisciplinary Sepsis group.
- Good recognition of Sepsis 6 across the Trust.

Further improvements identified for 2016/2017:
- Need to improve time compliance with 1 hour antibiotics for all patients suspected of having Sepsis in emergency corridor and direct admission units.
- Awaiting ratification of NICE guidance on Sepsis which will change the way we identify septic patients.
- Need to improve diagnostic coding for Sepsis.
- Need to sustain improvements in the management of Neutropaenic sepsis.
- Need to establish patient group directives to allow nurses to give time critical first dose of antibiotic.
Mortality

Much work has been undertaken in the NHS over the last few years looking at reducing avoidable in-hospital deaths, with recent focus on Acute Kidney Injury and Sepsis.

The Trust monitors mortality rates through the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) rates.

The Trust has also introduced a Mortality Review Tool (MRT) to meet the recommendations of the Trust Development Authority (TDA), mortality best practice guidance. The tool supports review of all in-hospital deaths to identify good practice and identify any issues which need investigating further.

**HSMR** measures whether the mortality rate at a hospital is higher or lower than would be expected. The national average is 100 and a score of below this indicates fewer deaths than this average. HSMR covers 56 groups of diagnosis and only relates to patients that have died whilst in hospital.

**SHMI** is a high level mortality indicator; which follows a similar principal to HSMR, however, SHMI covers all diagnosis groups and relates to all patients that have died (whether the patient died whilst in hospital or not).

**WHAT:** Reduce avoidable death

**HOW MUCH:** HSMR weekday, weekend and SHMI outcomes to be within the excepted range

**BY WHEN:** April 2016

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**Key developments:**

- Revision of the Clinical Effectiveness Steering Group to the Clinical Effectiveness and Mortality Steering Group. The first half of the meeting to discuss mortality with representation from CSCs and specialities, the second half being dedicated to Clinical Effectiveness.
- Further development of the Mortality Review Tool to improve compliance with conducting mortality reviews and recording.

**Further improvements identified for 2016/2017:**

- On-going development and further embedding of the Mortality Review Tool.
- Sharing of best practice and learning from Mortality Reviews.
**Surgical outcomes**

Publication of consultant outcomes is an NHS England initiative that lets you see the results of Consultants’ practice for a range of Specialities.

Publication of this information means Consultants’ performance can be compared openly for a given Speciality to help spread best practice and identify any issues which need investigating.

**WHAT:** Ensure transparency of surgical outcomes

**HOW MUCH:** Ensure no surgeons are identified as an outlier within an identified list of National Audits

**BY WHEN:** April 2016

- ✔ Achieved no Surgeons identified as outliers

**Key developments:**

- Development of a surgical weekly mortality review to review deaths in the previous week.
- Revision of the Clinical Effectiveness Steering Group to the Clinical Effectiveness and Mortality Steering Group. The first half of the meeting to discuss mortality with representation from CSCs and specialities, the second half being dedicated to Clinical Effectiveness.
- Further development of the Mortality Review Tool to improve compliance with conducting mortality reviews and recording.

**Further improvements identified for 2016/2017:**

- Ensure review of all specialities.
- Improve benchmarking against other hospitals.
Patient Experience

Patient feedback

We are committed to understanding what matters most to our patients, their families and carers and working with them to share areas of best practice and make improvements needed. We have increased the opportunities for people to feedback about their experiences using the Friends and Family Test (FFT), worked much more closely with community groups, the voluntary sector and HealthWatch.

In 2015/16 we also completed a project which looked in detail at all sources of feedback, including posts on social media, complaints, letters to newspapers, FFT and plaudits. The results were not surprising in telling us that we needed to improve communication. We made some small but significant changes immediately including improving information about waiting times in clinics, and have a number of workstreams to address the themes identified. A workshop for patients, families and carers is planned to help us design sustainable solutions.

To ensure that we focus on the important issues for patients, a different approach was used this year to identify our patient experience quality improvement priorities. A review of feedback combined with conversations with community groups, individual patients and their families identified a number of key issues for improvement. This was developed into a long list and people were asked through a variety of forums and a web based survey to rank each of the issues in priority order, the aim being to produce a list of 4-5 key issues for 2016/17. This exercise resulted in 5 priorities which matter most to patients being the focus: End of life care, family carers, care of people with specialist mental health needs, communication and engagement.
End of Life Care

Caring for people who are close to death demands compassion, kindness and a skilled application of knowledge; the approach to caring for dying people developed by the Leadership Alliance for the Care of Dying People (LACDP) focuses on five key priorities of care:

1. The possibility that a person may die within the coming days and hours is recognised and communicated clearly, decisions about care are made in accordance with the person’s needs and wishes, and these are reviewed and revised regularly.

2. Sensitive communication takes place between staff and the person who is dying and those important to them.

3. The dying person, and those identified as important to them, are involved in decisions about treatment and care.

4. The people important to the dying person are listened to and their needs are respected.

5. Care is tailored to the individual and delivered with compassion, with an individual care plan in place.

WHAT: Improve End of Life Care by rolling out the Adult Priorities of Care documentation

HOW MUCH: Roll out of the Adult Priorities of Care (Achieving Priorities of Care) documentation

BY WHEN: April 2016

Achieved

Key developments:
- The Trust, in conjunction with Hampshire wide partners, have developed and introduced new documentation ‘Achieving Priorities of Care’ (APOC). Following a phased launch, the documentation was fully launched across all clinical in-patient areas on the 14th September 2015.
- Testing of the APOC documentation and further refinement to ensure Trust compliance.
- Education and full roll-out within all in-patient areas.
- The Trust performed above the National Average in the 2015 National End of Life Care Audit – Dying in hospital for all key quality indicators.
- Amalgamation of the End of Life teams; increasing availability of support across the Trust.

Further improvements identified for 2016/2017:
- Continue education of staff in using the APOC.
- Audit the use of APOC.
- Ensuring the Trust continues to meet the five priorities of care.
Dementia
Dementia is a broad umbrella term used to describe a range of progressive neurological disorders. There are many different types of dementia and some people may present with a combination of types. Regardless of which type is diagnosed, each person will experience their dementia in their own unique way.

The Medicine for Older Persons Rehabilitation and Stroke CSC has had a focus on delivering social activities for patients with dementia. The Memory Lane room has been utilised several days each week where patients with dementia and/or their carers attend. The CSC have been lucky to source funding to support Music Therapy, provided by Bournemouth Symphony Orchestra who have played to patients either around the wards or in Memory Lane. They have also been fortunate in that one of their doctors is a classically trained singer; who has sung to the patents on several occasions. The patients have really enjoyed this and so have the staff!

Devices from the My Dementia network have been purchased that provide electronic activities either for one or a group of patients, and also play films, archive material and all genres of music. This has been very well received by patients and has proven successful in calming patients who are agitated and distressed.

Weekly visits have also been made from the ‘Pets as Treatment’ Cat Ruby, who has been making patients smile and is happy to be stroked by one and all. Ruby belongs to one of the CSCs Matrons, and has been featured on local news, the Trust Facebook page and has been shared as far away as Singapore.

Dementia volunteers
The Trust has implemented a new project to provide especially trained volunteers to work with patients with Dementia. The first volunteers commenced working in the Medicine for Older People Rehabilitation and Stroke Clinical Service Centre in January, providing social support for patients. We are working with Portsmouth College and Portsmouth University to recruit volunteers for this project.
Carers
Family carers provide support to people who would not cope on their own. They make a major contribution to the health and wellbeing of some of the most vulnerable members of our community. Their understanding of the needs of the person they care for helps us provide a more positive experience for patients.

The early identification of carers and the provision of proactive support is known to benefit the carer’s health. This results in them being able to continue to provide essential care and reduce the risk of hospital admission. Carers however, told us that they do not always feel acknowledged or recognised or involved in discussions about treatment and discharge. They find the normal systems of providing feedback, often surveys, difficult as they are very often pressed for time and said we needed to think differently about how we helped them share their experience.

To better understand how we could do things differently held 2 events in 2015/16:
- What matters most to carers – a workshop held in partnership with Portsmouth City Council and Carers UK
- Making Queen Alexandra Hospital a Carer Friendly Hospital – a co-design workshop with carers from across Portsmouth and South East Hampshire.

WHAT: Communication between staff, carers and those cared for and improving feedback opportunities

HOW MUCH: Improve communication between staff, carers and those cared for and actively involve carers and the cared for in feedback opportunities

BY WHEN: April 2016

Key developments:
- The involvement of carers in key groups including the Patient Experience Steering Group which sets and monitor experience improvement activities across the Trust.
- In partnership with Portsmouth City Council, the further development of QA Carers Service, providing early support and signposting to services.
- “You’re welcome” – guidance for staff supporting family carers and visitors has been developed.
- Involvement of carers in engagement events including Compassion in Care Research, Frailty Network Focus Group,
- Feedback opportunities have been expanded to include face to face meetings and telephone conversations to reduce time pressure on carers.

Further improvements identified for 2016/2017:
- Carers Passports will be completed and implemented; these provide key information about the cared for person for clinical staff from a carers perspective.
- Share and learn events will be held for health and social care staff and carers to help us know how we are doing and identify further areas for improvement.
Discharge from hospital
During 2015/2016 there has been significant focus on discharge processes to improve the experience for patients. Key developments are noted below:

Bedview

Stage 1:
The ‘Visual Hospital’ process was developed by the Trust’s Operations Team to better visualise and manage the hospital bed capacity and status. The Trust’s Operations Centre initially used physical whiteboards to visually represent each ward’s current status. Wards now complete the electronic version to allow full oversight by all.

Stage 2:
This involved integrating the handover and the previous information held regarding discharge information into one resource; allowing community partners to have access ensuring a central point of information. Although Bedview is in early implementation, multi-disciplinary teams are utilising the system and it is being well received. The system gives ‘real-time’ information regarding the patient journey.

Discharge lounge
The Trust discharge lounge is now in a purpose built area; allowing patients to have their last hours in the hospital in a controlled, calm environment. Staff can onward refer the patient to services and explain discharge medication without the interruptions often experienced in a ward environment. We are promoting ‘Home for Lunch’ and the team can monitor transport to ensure this can be enacted.

The Trust discharge team do not work in isolation; working with our four key partners services to introduce innovations to further support the patient journey through Discharge to Assess models, with discharge home as the priority. We are also working alongside volunteer services such as Red Cross which provides further confidence to our vulnerable patients.
Discharge from hospital
A safe, timely and supported discharge from hospital is key to a positive patients, family and carer experience. There is a clear need to involve patients and those who support them in the discussions and planning for discharge but with a decreasing length of time spent in hospital this can pose some challenges. To better understand what we do well for patients on discharge and those areas we need to improve we undertake regular surveys. Specially trained volunteers run a telephone survey for people who have been discharged over the previous few months and ask them to share their experiences. The results of the survey have provided a foundation for further training and awareness sessions for staff, the aim being to ensure everyone understands the positive impact of a well supported discharge and the negative of a poor discharge.

The surveys told us that practical and emotional support is essential prior to and at the point of discharge to help people remain safe and supported in their own home. It was also recognised that some patients live in isolation with little or no support. The British Red Cross now provides the Portsmouth at Home Service, free at the point of care.

WHAT: Patient experience of the discharge process
HOW MUCH: Review the patient experience of the discharge process
BY WHEN: April 2016

Key developments:
- Portsmouth Support at Home Service is now provided by the British Red Cross.
- Discharge Planning Roadshow September 2015 used patient, family and carer feedback to share peoples experience of the process.
- Post discharge telephone feedback has been implemented in Medicine for Older People, Rehabilitation and Stroke.

Further improvements identified for 2016/2017:
- Create a centralised discharge planning team to cover all adult beds ensuring each pathway reflects best practice, working jointly with Health and Social Care Teams.
- To provide continuous training and support to ward staff on discharge planning enabling ward staff to have more responsibility regarding discharge.
- Ward staff to work in partnership with community support and social services to support appropriate discharge.
Mental Health
About 1 in 4 adults will have a specialist mental health need at some time. Of these, many will require planned, outpatient or emergency care from one of our services. Patients with specialist mental health needs, their families and carers have told us that their care is not always of a consistently high standard. We have introduced some extra training for staff but feel we need to develop our understanding of what matters most to this group of patients and to work with them to make the changes to improve their experience.

The Mental Health Champions Programme has been designed to address the areas of concern raised by patients and identified through audits and adverse incidents. The programme is based on what we know about people’s experience, and will be delivered in partnership with mental health service users, specialist providers of mental health services, and Trust staff.

WHAT: Improve experience for patients with mental health needs
HOW MUCH: Improve the quantity and validity of feedback from patients with specialist mental health needs who use our service.

Undertake a review of current mental health training opportunities; working with patients, their families and carers.

BY WHEN: April 2016

Achieved

Key developments:
- Development of a mental health web-page for staff providing key resources.
- Specific training sessions for staff provided by an external trainer from a Mental Health provider.
- Developed a checklist to ensure that when a patient is placed under a Mental Health Act section the correct process is followed and patients understand their rights and are signposted to the appropriate support.

Further improvements identified for 2016/2017:
- Evaluate the effectiveness of the Mental Health Champions Programme.
- Continue to work with Commissioners in establishing an ‘ageless’ mental health liaison service.
Patient engagement

Public, patient and carer voices are at the centre of our healthcare services from planning to delivery. We recognise that the involvement and engagement of patients, relatives, carers and members of our local community in the design, development and improvement of services is key to the delivery of safe, effective and a positive experience of care.

Whilst we have made significant improvements in recent years in working in partnership with patients and members of the community to better understand what matters most to them, further work is needed.

Our strategy, agreed in August 2015 describes how we will achieve this in our vision for the meaningful participation of local people in the design, development and improvement of the services we provide.

Every part of the services we provide can and should be shaped and improved by involving those who use them. We shall move from simply listening and starting to understand what matters most to people, to greater responsiveness and collaboration. We shall use the asset of knowledge and experience that patients and our local communities provide to ensure engagement and involvement is part of our everyday business.

WHAT: Improve patient engagement

HOW MUCH: Review the current arrangements for engaging with service users, their families and carers and develop a patient engagement strategy

BY WHEN: April 2016

Achieved

Key developments:
- Implementation of a new framework of engagement based on the principles of outreach to our local community.
- Development and implementation of a set of key principles to ensure that engagement events are widely accessible.
- Increasing the number of staff skilled in supporting patients, families and carers have a voice about their services and care.

Further improvements identified for 2016/2017:
- Focus groups to be held with volunteers to establish priorities.
- Further engagement with local community groups and disease specific groups (such as mental health).
Staff feedback
National Staff Survey
The NHS Staff Survey is recognised as an important way of ensuring that the views of staff working in the NHS inform local improvements and input into local and national assessments of quality, safety, and delivery of the NHS Constitution. The Results of the 2015 National NHS Staff Survey conducted in the Trust between September and December 2015 can be found below.

As per 2013 and 2014, we chose to survey all staff. A total of 4,295 staff took the opportunity to complete and return a survey, representing a 59% response rate which is in the highest 20% for acute trusts in England and compares with a response rate of 54% in the 2014 survey.

The overall staff engagement rating increased from the worst 20% in 2013, average in 2014 to above average in 2015 when compared with all acute trusts. The scale summary score of 3.87 in 2015 is above the national average, progress over the last 5 years is detailed below.

The overall staff engagement score represents staff members’ perceived ability to contribute to improvements at work, their willingness to recommend the organisation as a place to work or receive treatment, and the extent to which they feel motivated and engaged in their work.

Due to the number of changes made to the survey for 2015, only 22 of the 32 key findings are comparable, and of these a number of the 2014 figures have been recalculated to enable a meaningful comparison which is statistically significant. Of the 22 key findings (KF) considered comparable; 8 show improvement, 12 have remained unchanged and 2 have deteriorated (however of these, one KF is in the best 20% of acute trusts and the other is average).
There are 99 acute trusts participating in the staff survey in England. The table below demonstrates the Trust ranking for all 32 Key Findings against all acute trusts for both the 2014 and 2015 results.

<table>
<thead>
<tr>
<th>Benchmark group</th>
<th>2014 Compared to all acute trusts</th>
<th>2015 Compared to all acute trusts</th>
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<tr>
<td>Average</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>Below (worse than) average</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Worst 20% (highest/lowest)</td>
<td>0</td>
<td>0</td>
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</tbody>
</table>

**Workforce**

**Equality Delivery System and Workforce Race Equality Standard**

The Trust meets the requirements and improves performance against the Equality Delivery System (EDS2) and Workforce Race Equality Standard (WRES) through the following:

- The Equality Impact Group (EIG) has representation from all clinical divisions.
- The Trust has reviewed the equality and diversity policy.
- Equality impact assessments are completed on corporate and clinical policies.
- All Clinical Service Centres achieved the Bronze Award of the Equality Standard and are working towards the Silver Award.
- The Trust has published its Equality and Diversity Strategy which addresses the requirements of the Equality Act including the public sector equality duty. This includes equality data for patients and our workforce.
- The Deputy Director of Human Resources completed and published the WRES; the second report will be published in line with national requirements (1 July 2016).
- Equality objectives have been published to meet the requirements of the EDS2 and a new WRES strategy and action plan has been developed to improve organisational performance in regard to workforce race equality.
- The Trust has re-designed equality and diversity training delivered at organisational induction.
- A Trust Board equality and diversity update was delivered in February 2016.
• The Trust was selected as a national Equality and Diversity Partner by NHS Employers 2015/16 and has attended all national development meetings.

Future actions include:
• A monthly programme of equality and diversity training will be delivered from April to July 2016.
• Full implementation of the EDS2 and WRES strategy and engagement plan to drive improvements in regard to the national metrics.
• Completion of the EDS2 via the Equality Standard for each Clinical Service Centre with a deadline of March 2017 for the Gold Award.
• Completion of the Clinical Service Centre EDS2 patient experience and involvement in-depth review (deadline July 2016).
• Completion of the corporate divisions EDS2 customer service in-depth review (deadline July 2016).

Workforce Race Equality Standard – Staff Survey
The data presented is drawn from the National Staff Survey, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.

Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months (KF25). A lower score is better.
• In 2015 25% of white staff agreed with this statement, which is 3% (28%) lower than the acute trust average and a 4% (29%) improvement on the 2014 score.
• In 2015 26% of BME staff agreed with this statement, which is 2% (28%) lower than the acute trust average and a 10% (36%) improvement on the 2014 score.
• 1% more BME staff felt that they had experience harassment, bullying or abuse from patients, relatives or the public than white staff in 2015.

Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months (KF26). A lower score is better.
• In 2015 25% of white staff agreed with this statement, which is the same as other acute trusts nationally and 2% (23%) higher than 2014.
• In 2014 27% of BME staff agreed with this statement, which 1% (27%) lower than acute trusts nationally and the same as 2014.
• 2% more BME staff felt that they had experience harassment, bullying or abuse from staff than white staff in 2015.
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion (KF21). A higher score is better.

- In 2015 91% of white staff agreed with this statement, which is 2% (89%) higher than the acute trust average and the same as 2014.
- In 2015 76% of BME staff agreed with this statement which is 1% (75%) higher than the acute average for acute trusts and 4% (72%) higher than 2014.
- 15% fewer BME staff feel that there are equal opportunities for progression or promotion than white staff in 2015.

**Learning and Development**

In January 2016 the Learning and Development Team were awarded the “Skills for Health Quality Mark” based on the submission of evidence of the education we provide and an onsite inspection. This Mark is awarded by the National Skills Academy for Health and is a recognised endorsement of the high quality education and training delivered to staff. The Inspector made particular note that; “the manner in which training staff conduct themselves and pass on knowledge and insight to others is highly professional and supportive”. This achievement illustrates the Trust’s commitment to providing quality education and support through its multi-professional Learning and Development Team.
Other achievements

Research and Innovation

Our vision is to be recognised as a world-class hospital, leading the field through innovative healthcare solutions focused on the best outcomes for our patients delivered in a safe, caring and inspiring environment with quality at the heart of everything we do.

The last twelve months have been busy and rewarding for the Research and Innovation team. We have won 2 prestigious national awards, the HSJ Value and Improvement award in the Use of Diagnostics and the HSJ award for Improving Care with Technology.

Research and Innovation continues to thrive within the Trust. There are 150 research staff working across all clinical specialties. Nearly 3,000 patients have taken part in a clinical research study this year. Our research income increases year on year and we have received over £4.5million for our research activity.

We continue to rank in the top 20% nationally for our research activity. Twelve of our clinical specialties are in the national top 10 rankings for recruitment including ageing; gastroenterology; critical care; haematology; hepatology and respiratory with the latter 3 nationally top of the rankings.

We ensure all of our health professionals make research part of their core business. We have also made research easier to do here in Portsmouth. We have an excellent Research and Innovation office that now designs and facilitates research for the benefit of our staff and patients. We also continue to develop clinical academic training pathways for nurses, midwives and junior doctors who are trained in the design and delivery of high quality research. In 2015/16 we supported 13 nurses and midwives to undertake a PhD whilst in clinical practice and 16 medical Fellows.

Defence Medical Group South (DMGS)

2015/16 saw the arrival of a nominated Head of Governance and Assurance within Defence Medical Group South (the Military contingent working within the Trust). A key part of the role provides the Trust with assurance that military personnel working within the hospital have the appropriate qualifications and training to provide safe, effective and professional care to patients.
The Head of Governance and Assurance is a member of a number of Trust Governance Committees enabling communication and the strengthening of key relationships. 2015/16 has seen improved integration with the Trust; examples include working with pharmacy to formulate a standardised process in the management of medication errors and creating a formalised communication chain between the Patient Advice and Liaison Service (PALS), the Complaints Department and Defence Medical Group South.

The clinicians working in the Trust as DMG(S) military personnel have a structured headquarters staff who are fully integrated with the Trust at all levels, from the Commanding Officer to the training teams. The headquarters works to ensure full integration ensuring provision of safe, professional care to service users by military personnel.

**Information Technology (ICT)**

**Electronic Discharge Summaries**

The Trust experienced major problems with the first Electronic Discharge Summaries (EDS) tool it implemented; including wasted doctor time due to the EDS taking too long to complete, which in turn led to low completion rates. This delayed clinical information on discharged patients reaching their GPs and some non-delivered discharge summaries, potentially impacting on patient follow-up care. This was recognised as a patient safety risk. The Trust decided to implement a new EDS solution; the roll-out across wards was carried out from June to December 2015. The new solution is much quicker for doctors to complete resulting in increasing completion rates. GP feedback has been positive as the discharge summary is sent directly into their practice systems and ensures they quickly see any follow-up requirements for discharged patients.

**Clinical Safety Officers**

As clinical workflows become more dependant upon IT systems the potential for errors in IT systems to cause clinical harm increases. In recognition of this, and in response to the identification of undelivered discharge summaries, the Trust began to implement national guidance to address clinical safety issues in IT systems in 2015/16. All IT projects introducing new or changed clinical IT systems now have clinical staff assigned to them as Clinical Safety Officers. Their role is to risk assess the project, the IT systems and resulting clinical data flows from a clinical risk perspective and to agree action plans to address any risks identified.
Clinical Service Centre Quality Improvements

Highlights 2015/2016

Each of our CSCs has made a number of service improvements over the year some of these are highlighted below:

CRITICAL CARE, HSDU, ANAESTHETICS AND THEATRES (CHAT)

- Implementation of a new falls pathway to improve patient safety following a Serious Incident.
- Introduction of a Listening into Action Anaesthetist led Multi-Disciplinary Team simulation programme in theatres and in-situ simulation training in the Intensive Care Unit, based on clinical scenarios to improve skills and patient safety.
- The Surgical Elective Improvement Group has been introduced to reduce cancellation of surgery on the day through detailed Root Cause Analysis and key actions to improve services. This has resulted in the number of foreseeable reasons for cancellations on the day.

- Patient safety screens and ‘Watch out’ notices on the Intensive Care Unit to improve the communication of key safety messages. Work is underway to see if this can be rolled out in Theatres.
- Focused Listening into Action led work training in the Intensive Care Unit with the introduction of ‘step down’ magnets has improved ward transitions, helping patients and relatives adjust to the change. This was a direct result of ITU patient/relative survey feedback.
- The WHO Safer Surgery Checklist across all remote areas has been audited to improve patient safety.

CLINICAL SUPPORT SERVICES

Integrated therapy assessment tool development - F4 stroke therapy team

- This project was carried out jointly between occupational therapy and physiotherapy colleagues – the F4 stroke ward team have developed an integrated therapy assessment tool that can be used by both professionals. This work has improved the efficiency of MDT working, released clinical time and clinical capacity, and improved response times to assessment (impacting on SSNAP data).

Expansion of radiology services

- Introduction of an Interventional Radiology on-call service in August 2015, providing this service for the first time in Portsmouth out of hours improving access to treatment for our patients.

Patient involvement in hospital menu changes.

- Dieticians engaged patient involvement in menu changes with Soft Facilities Management provider as part of a quality initiative. The Soft

FM services change the hospital menu every year, and this is normally completed with the dietitians who check for nutritional quality. This year the menus have been checked and approved by members of the public to ensure that we are meeting the needs and choices that are popular.

Radiotherapy Physics (part of the Medical Physics Team) improving radiotherapy techniques:

- Over the past year there have been several advancements in techniques used to deliver cancer treatments led by the radiotherapy physics team including; streaming the quality control processes for radiotherapy to increase the percentage of patients receiving advanced radiotherapy IMRT/VMAT to around 50% each month, against a national target of 24%; introducing 4DCT radiotherapy treatment planning processes, to mitigate the uncertainty of the effects of respiration on radiotherapy delivery; introducing deep
inspiration breath hold (DIBH) to breast radiotherapy to reduce cardiac doses & the department has also commissioned and commenced clinical treatments on a new HDR brachytherapy treatment unit, the first of this particular product worldwide, which has attracted visitors from several countries to see our clinical physics processes.

**Improving turnaround times of blood samples from ED**

**EMERGENCY DEPARTMENT (ED) AND ACUTE MEDICINE**

- The Ambulatory Emergency Care Service has seen a continual increase in the percentage of patients being redirected from AMU and ED. Daily seeing approximately 25% of the days medical take and therefore reducing the need for medical admission. The invested redevelopment of this area looks to forecast an even greater % of use as it will be able to accept more Ambulatory pathways. The implementation of ‘Pit Stop’ in ED reduced the time seen by a clinician by 25%. The implementation of this process also saw an increase in earlier diagnostic tests in ED allowing safer and earlier decisions around admittance or discharge.
- The continuing focus on ambulance streaming for all patients conveyed on an ambulance to ED ensuring early streaming to correct clinical team within or external to the ED.
- The Oceano Electronic Patient Tracking IT system has been established and embedded in the CSC for over two years. Achievement of a ‘paperless system’ saw the ED as one of the first large ED to go paperless with all clinical notes to be entered directly on the system significantly releasing clinical time once embedded.

**HEAD AND NECK**

- The National Head and Neck Cancer Audit (10th Annual Report); published in September 2015 highlighted that the Multi-Disciplinary Team has performed well in comparison to local units and national averages in all key areas analysed by Audit specifically in relation to:
  - Dental assessment (4.5% -54.2%)
  - Dietetic pre assessment (19.6% - 83.5%)
- Blood Sciences validated and introduced a Rapid Spin Tube into the ED department in May 2015. This tube has a thrombin additive that allows clotting to take place in 5 mins rather than the 30 mins recommended for a standard SST tube used elsewhere in the Trust/community. The purpose of introducing this new tube was to reduce turn around times in the Unscheduled Care Pathway. Average turnaround times reduced from 59mins to 42mins after the introduction of the tube.
- The continued utilisation and growth of the Nervecentre IT System (used to raise calls with the Hospital @ Night team to improve communication and co-ordination of workload), has seen a 100% reduction in adverse mortality and just under 50% reduction in incidents resulting in moderate and severe harm. This success led to the Hospital @ Night team being awarded the EHI Award of 2015 – Best use of IT to Promote Patient Safety.
- The Implementation and roll out of an Electronic Patient tracking list to manage medical admissions in AMU – the in-house developed IT package allows the daily medical take to be seen and managed in its location through the Emergency corridor allowing early warning and notifications of medical patients in Emergency Department and of those patients that are GP heralded.
- Within departmental research projects we can report that our CRASH2 and HALT-it trails as a whole we are performing well above the 100% compliance for recruiting new patients. This performance has led to the increased research activity and interest from other researchers.
  - Recording of Comorbidity and performance status (86.5% - 99.2% and 90.5% - 97.6%)
- The Oral Cancer Toolkit for Dental Practitioners and GPs was officially launched on the 10th November 2015. Professor Peter Brennan, Consultant Oral and Maxillofacial surgeon supported the...
Portsmouth Hospitals NHS Trust
QUALITY ACCOUNTS 2014/15
Review of quality performance – CSC Quality improvement highlights

development of this National resource in conjunction with Cancer Research UK.

- The Head and Neck and Thyroid Cancer Patient focus group launched on the 30th November 2015, attended by patients from across Hampshire, West Sussex and the Isle of Wight.

**Audiology**

- IQIPS standard awarded by UKAS following inspection in July 2015 for Adult Audiology across all 15 sites in Portsmouth, Hampshire, West Sussex and Isle of Wight.
- This is the first physiological measurement service for Portsmouth Hospitals to achieve IQIPS accreditation.
- As of 31st March 2016 we completed our first review and are currently assisting Portsmouth Hospitals Vascular service to achieve accreditation.

**MEDICINE**

- Asthma Nurse Specialist in post who has implemented discharge plans and has a nurse led clinic.
- Extended access to bowel cancer screening.
- Tele-Dermatology in place (allows GPs to send photos to hospital Consultants to aid diagnosis).
- Improved access to MOH’S treatment (specialist dermatology treatment).
- Introduced daily Consultant Ward Rounds – Gastro and Hepatology.

- Plans are being developed to achieve IQIPS accreditation for Paediatric and Vestibular Services in 2017.

**Ophthalmology**

- Continue to maintain Outpatient waiting list.
- New Research trials commencing.
- Lead Clinician Identified for POAC.
- Launched our first Patient Forum.
- Launched our first nurse injector for treatment of DMO.
- Completed a project at improving the quality of our POAC service.
- Commenced project looking at improving the quality of service in EDCU.

**MEDICINE FOR OLDER PEOPLE, REHABILITATION AND STROKE**

- The Specialist Palliative care teams combined with the End of Life team in April 2015 to provide an enhanced experience to patients and carers. This has been able to deliver advice and support to all palliative and end of life patients that is consistent across the 7 day week.
- The CSC has had a focus on delivering social activities for patients with dementia. The Memory Lane room has been utilised several days each week where patients with dementia and/ or their carers attend. We have been lucky to source funding to support Music Therapy, provided by Bournemouth Symphony Orchestra who have played to patients either around the wards or in Memory Lane. The patients have really enjoyed it and so have the staff.
- Also in memory lane we have had one of the doctors who is classically trained sing with the patients/and had tea parties/ bingo events.
- We are training up Volunteers to become Dementia friends and support our patients.
• We have purchased devices from the My Dementia network that provide electronic activities either for one or a group of patients, and also play films, archive material and all genres of music. Very well received by patients and has proven successful in calming patients who are agitated.

• And what we are most proud of is the permanent appointment of 2 Dementia Case workers who provide support to patients and carers throughout the organisation - really making a difference to some of the most challenging patients.

• One of the Matron’s cat, Ruby, has become a PAT Cat and visits the wards weekly, to the delight of patients who may be away from their own pets. Ruby has been featured on local news, the Trust Facebook page and has been shared as far as Singapore.

• Disablement services has been renamed and relaunched as the Portsmouth Enablement Centre. The launch of the rename of the centre has remained live on social media for the last 6 months with stories

• Portsmouth Enablement Centre (PEC) took part in an Amputee Football event organised by Portsmouth in the Community, This was a great success and saw three football teams and interested spectators come together to watch some amazing football skills by amputees. On the day PEC spoke to a number of amputees and local people, informing them about our prosthetic service, the department took along a stand giving examples of our technology. PEC were proud to be a part of the event and hope to continue to work with Portsmouth in the Community in the future.

• Specialised prosthetic made by experts means youngster can fulfil her dream. Gymnast Taliya’s doing cartwheels thanks to new hand. Staff at the Portsmouth Enablement Centre created a flat rubber accessory that screws into her prosthetic arm, giving her a solid and durable platform for gymnastics.

TRAUMA, ORTHOPAEDICS, RHEUMATOLOGY AND PAIN (MSK)

• The CSC has a patient panel that walks the wards and Departments once a month and takes feedback from our patients which is feedback to the staff and actions taken

• Rheumatology is undertaking a large number of research trials in conjunction with Research and Development which will benefit our patients as well as the Rheumatology community

• ‘Activity trollies’ for our Dementia patients were introduced as part of a Dementia Fellowship undertaken by the Band 7’s.

• New Hybrid pressure relieving mattresses purchased as part of the ‘Aim for Zero’ work in MSK.

RENA L AND TRANSPLANTATION

• The Home Haemodialysis team have finalised renovations to their training area, which has increased space whilst retaining the original room for a base location. This has enhanced the patient experience and these distinct improvements allow the service to be more responsive to patient choice
• Patient safety bands have been introduced. These rubber wrist bands act as an alert to the patient having a fistula, during an medical emergency, which will be vital in providing emergency care.
• Privacy screens have been implemented within the dialysis unit on the Isle of Wight. These screens are essential in providing patient dignity and improving the patient experience.
• An Acute Kidney Injury Nurse Speciality has been secured and employed by the CSC, to achieve the AKI CQUIN, which has been achieved for this year.

**SURGERY AND CANCER**
• The Haematology and Oncology Day Unit have secured funding for a Pharmacy room within the unit. This will mean that the waiting time for patients TTO’s is greatly reduced and patient experience will be much improved.
• The Haematology and Oncology Day Unit has increased its working hours from 8 to 8 to create additional spaces and to offer treatment sessions outside of work hours.

**WOMEN AND CHILDREN**
• 'What Matters to Me’ – a new concept which aims to provide truly person centred care by uncovering and addressing what is important to children and young people during their hospital stay. The Scottish Government’s Healthcare Quality Strategy (2010) supports the development of person centred care. This led me to ask the question ‘Do we really know what matters to the children and young people we care for?’. For example Joseph Aged 8, What Matters to Me… ‘My family because I love them all’; I don’t like burnt toast; ‘I want to be kept occupied while having injections and a cannula put in’
• The Practice Education for the Paediatric unit has developed a key finder which will be trialled in various areas of the Trust before it becomes available nationally. There is also a hospital in Australia about to undergo trialling the device before it is made available internationally. The device will be affiliated with Portsmouth Hospitals Trust.
• Neonatal Intensive Care Unit outcome data for 2014/15 is best ever seen (78% 7/9 survival of 23-24 week babies, National rate <40%)
• Recognition - MyBirthplace invited to present at the NICE National conference
• Opened our Ambulatory 4 beds on A5 permanently to accommodate female Urology patients from D7.
• Ambulatory Clinics for Diagnosis and treatment of gynaecology conditions had reduced RTT times, increased patient satisfaction and also impacted on patient safety by eliminating the need for women who go through the ambulatory route to have anaesthetic in theatre.

Patients were invited to celebrate the 50th anniversary of the Wessex Kidney Unit in November 2015, with an afternoon tea and speeches from Dr Jasna Macanovic and Mr Paul Gibbs, improving communication and relations between the unit and their patients. This was very well received.
STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE QUALITY ACCOUNT

To follow.........
Portsmouth Hospitals NHS Trust

QUALITY ACCOUNTS 2015/16

External stakeholders commentary

CCG COMMENTARY ON PORTSMOUTH HOSPITALS NHS TRUST (PHT) QUALITY ACCOUNTS 2015/2016

24th May 2016

Ursula Ward
Chief Executive
Portsmouth Hospitals NHS Trust
Queen Alexandra hospital
Southwick Hill Road,
Cosham
Portsmouth,
P06 3LY

Dear Mr. Ward

Commissioner Introductory Statement

NHS South Eastern Hampshire Clinical Commissioning Group (CCG), NHS Fareham & Gosport CCG, NHS Portsmouth CCG and associate commissioners welcome the opportunity to participate in the governance ‘sign off’ process for the 2015/16 quality account of Portsmouth Hospitals NHS Trust (PHT).

This year has been one of the most challenging years for the trust in relation to quality and performance within the unscheduled care pathway. This is demonstrated by the trust being unable to deliver against key performance measures within the emergency department and the issue of a Care Quality Commission (CQC) enforcement notice under Section 31 of the Health and Social Care Act (2012). Following the CQC inspection in February 2016, the impact of these challenges has resulted in patient safety concerns and poor patient experience, attributed to long waits and overcrowding in the emergency department. In addition, there has been a negative impact on the trust achieving its planned care contractual standards and as a result on patient health and social care organisations in terms of their ability to achieve key performance measures and be in line with the safety of their services. The CCG remains significantly concerned about quality and safety within the unscheduled care pathway and continues to work with all health and social care partners and regulatory bodies to support improvement, enhanced monitoring and learning from patient safety incidents and poor patient experience. This must remain the key priority for the trust and result in measurable sustained improvements.

The statement on quality from the trust’s chief executive clearly references the severity of these challenges and commends the staff for their continued dedication and compassion. The CCG inspection in February 2016 provided an overall rating of ‘requirements improvement’ however, specific services and categories of care were rated as outstanding. The trust has achieved positive ratings in the 2015 National Staff Survey, consistently positive Friends & Family Test responses, decreased rates of Clostridium difficile, a reduction in the number of patients developing pressure ulcers and the delivery of a new electronic system for issuing discharge summaries. There is evidence of significant improvement achievements at clinical service level as demonstrated through the clinical service centre (CSC) quality improvement section in part three of the quality account.

The quality account demonstrates that in setting future quality priorities, the trust has considered both internal and external intelligence and for 2016/17 has enhanced the processes for ensuring that the patient’s voice continues to be the prioritisation process. The trust has included a range of quality priorities for the forthcoming year, which are based on national and local requirements. It is noted that some of these priorities are similar to those identified within the 2015/16 quality account.

Commissioners are encouraged to see the level of independent and nationally validated data which has been used to demonstrate the quality of services for patient safety, experience and clinical effectiveness. Examples of these are national audits, NHS staff survey, family & friends test, national reporting learning system safety data and mortality data. This provides an independent external voice on quality and enables external assurance mechanisms to reflect both in priority setting and quality assurance.

Report Structure

The quality account appears well presented and provides clear information across the three areas of quality:

- Patient safety
- Clinical effectiveness
- Patient experience

The account is reflective of the mandated items required and the local priorities.

Quality Improvement Priorities for 2016/17

Patient Safety

Commissioners are supportive of the trust setting a priority to improve patient safety in the urgent and emergency care pathway. It is imperative that this is delivered with pace and in line with the milestones detailed within the urgent care improvement plan and, reflects the continued need to work with all health and social care partners to deliver a sustainable, safe and patient-focused service. There are two identified performance metrics listed against this within the account: a clinical assessment within 15 minutes of arrival and treatment within 90 minutes in the emergency department. These are both key to the early assessment and diagnosis required within the emergency care setting. In addition, the delivery of the urgent care improvement plan involves a wider range of requirements (trust specific and system specific), including opening the short stay unit/pathway and implementation of the medical take model. It is imperative that this delivers improved safety for patients not only at attendance and admission, but also when patients are moved within different departments, transferred from one health service to another or discharged. Both local and national quality intelligence has identified in-hospital transition and discharge as areas for improvement. To this effect, commissioners would encourage the trust to consider further enhancements in the monitoring of patient safety and experience to ensure it is fully integrated into the urgent care improvement plan and subject to the same close monitoring and delivery timescales. Commissioners are also committed to monitoring the trust’s delivery against the recommendations from national guidance (NCEQ27 – Transition between inpatient hospital settings and community or care home settings for adults with social care needs’), national reviews,
such as the recent publication by Healthwatch England (‘safely home...’) - July 2015 and service changes in response to local intelligence.

The Trust has national targets set in respect of clostridium difficile and MRSA. The trust has excelled in their achievement of a reduction of clostridium difficile, reporting 29 cases within the year against a threshold of 49 and achieved 27.5% below their trajectory. Commissioners are confident that the threshold set in the quality account of no more than 40 cases will be met.

The trust has again, identified the priority to reduce harm associated with patient falls. The trust has set a measurable target for high harm falls of a rate less than 2.0 per 1,000 occupied bed days in comparison to the target this year of 2.5. Harm related to patient falls is a national and local concern within acute hospitals and the actual number of high harm falls reported in 2015/16 exceeded the number reported in 2014/15. Therefore commissioners support the ongoing work required to minimise falls and encourage the trust to pursue significant improvement especially connected to recurring themes in serious incident analysis.

Commissioners are pleased to see a measurable target (a rate of less than 0.5 per 1,000 bed days) for high harm related medication incidents. As identified in 2015/16, there is a potential that medication incidents, similar to other incidents, are under-reported and the trust has shown a 36% improvement in reporting medication incidents. Again, although the Trust are reporting achievement of no more than 1.0 per 1,000 bed days of moderate or severe harm related medication incidents, there were 22 high harm incidents reported in year compared to 16 in 2015/16. Within the improvements for medicine management it would be good to see an improvement plan for medicines reconciliation as the trust has not achieved the agreed thresholds for pharmacotherapeutic reconciliation of medication within 24 hours of admission.

The intention to introduce risk assessment and key safety checks for all grades of non-surgical patient interventions as part of the ‘non-surgical interventions’ programme is welcomed. The account would benefit from describing the measurable outcomes.

All safety initiatives need to be driven alongside supporting a learning culture and enhanced reporting. It is noted the most recent National Reporting Learning System results (April – September 2016) indicates an improved position for reporting of patient safety incidents; however the Trust remains in the bottom 25% for the rate of incidents reported. This therefore needs to remain a priority for the Trust.

Commissioners would like to see improvements in the management of test results, including a robust process for ensuring the clinical accountability for follow-up on all tests planned by the requesting clinicians. This is in line with national recommendations. In addition, in 2016/17 commissioners anticipate further work will be needed to ensure discharge summaries issued from the ambulatory clinic, day surgery department and paediatric department are issued electronically and compliant with the agreed data set. This is in line with local and national recommendations.

The trust has seen an increase in the number of serious incidents reported in 2015/16. The increase is primarily influenced by the number of formal ambulance divers and 15-hour ‘decision to admit’ breaches within the emergency department. There have also been a number of serious incidents reported within the maternity services and the trust has instigated a peer review. Whilst some of the investigations into serious incidents have demonstrated no lack of care, it will be good to review the outcome of the peer review and the implementation of the improvements identified within the MIBRACE National Confidential Enquiry.

Clinical Effectiveness / Outcomes

The trust has maintained a priority around weekday and weekend mortality, with a retained target of performance within the expected range, compared to the priority set in 2015/16 when the intention was to achieve “expected or better than expected” Hospital Standardised Mortality Ratio (HSMR) and Summary Level Mortality Indicator (SHMI). The mortality rates in year have been within the expected range with HSMR at 99.84 weekday and HSMR at 100.22 at weekends. From the published data, SHMI has remained within expected range according to one of the two methodologies used by Health & Social Care Information Centre (HSCIC) to detect outliers. Using the 2nd methodology, SHMI SHMI is above expected. This has led to further analysis being considered within the year, with Dr Foster, commissioners and the trust. Regular commissioner representation at the trust’s Clinical Effectiveness and Mortality Steering Group has provided assurance of the robust process for measuring mortality within the trust. However it is noted that the progress to ensure the mortality review toolkit is embedded and active in each relevant clinical service centre has been delayed. This will need to remain a key priority in 2016/17.

The intention to reduce stage 3 acute kidney injury episodes is welcome and further enhances the achievements delivered in 2015/16.

Commissioners support further advancement of sepsis management and this is also reflected in the national CQUIN scheme. Commissioners have not been briefed on the end of year achievements against the national sepsis CQUIN for 2015/16 at the time of writing.

As the trust have been unable to deliver the referral to treatment (RTT) constitutional targets within all specialties, commissioners will continue to monitor the delivery of the improvement plans against the contract performance notices issued in 2015/16. Specific challenges have been reported in urology, spinal services, colorectal and hepatology. In addition, commissioners will monitor delivery of the required improvements for stroke provision and improvements in cancer services, as outlined in the concerns identified following a cancer peer review and acknowledged challenges in delivering the 62 cancer waiting times.

Patient Experience

Commissioners support the focus on improving the experience of patients with mental health needs. Commissioners are sceptical on the progressive work to enhance staff understanding which the trust are taking forward in partnership with providers of mental health services and patients. In addition, the enhanced monitoring supports identification of concerns with the management of patients with mental health needs and offers the opportunity to identify trends which may lead to service improvements. This however, has not been without challenge and the implementation of the specification for mental health liaison and continuation of this work programme is a welcomed improvement.

End of Life Care: This year, we have seen the rating of ‘requires improvement’ from the CQC inspection in February 2015, including areas of improvement required for adequacy of consultant cover, utilisation of end of life documentation and, on occasions, implementation in end of life care. In addition, the national end of life audit has been published in 2016, showing the trust’s clinical indicators from the 2015 End of Life Care audit to be higher than the national average, but not significantly so. Commissioners are therefore pleased to see the priority includes development of a metrics system to support the assessment of the effectiveness of end of life provision. In addition, commissioners would wish to see the ongoing support for the bereavement service to ensure it is accessible to relatives in a timely way. The trust is committed to be an active member in the development of the system wide strategy for improving end of life provision within this locality.
The trust has made good progress with the identification and support for carers. Commissioners are also sighted on the engagement activities, primarily within Portsmouth and to some extent Hampshire. It is our understanding that this work will be presented at the National State of Caring conference. There has also been positive actions taken as a result of the engagement activity and it is pleasing to see an intention to improve the links with Hampshire carers providing increased support across the locality.

Commissioners consider that patient and carer experience of the discharge process requires ongoing improvement. Specifically in relation to delays attributed to waits for medication. This will be monitored in year through the local discharge survey and also the feedback from the Friends and Family Test.

In addition, work has progressed in year to monitor and improve the experience of patients who are moved to other wards and cared for outside their clinical specialist. As the emergency care pressures have resulted in more patients being subject to moves (sometimes at night) and outlaid to alternative specialty beds, it is essential that there is greater pace to implement the changes required in response to patient feedback. The recent report highlights that the majority of patients did not receive the information leaflet about their move. This will therefore remain a priority for commissioners and monitored through review of metrics and patient feedback.

Despite the significant operational pressures experienced this year the trust has maintained very low levels of mixed sex accommodation breaches.

Achievements reported against 2015/16 priorities and overall Quality Performance

The trust sets out a useful summary of achievement against the 2015/16 priorities in part one of the quality account. This is supplemented by a more in-depth review of quality performance in part three. The quality account reports all 12 priorities as achieved and commissioners would like to note the extent of work to progress these. However, commissioners remain significantly concerned in respect of the impact of operational pressures including additional bed capacity and the impact on safety of outlaid patients. Commissioners are also not sighted on the full delivery of the sepsis screening achievement and remain aware of the improvements required on discharge from hospital.

It is good to see the progress of the pledges the trust committed to, as part of the national ‘Sign up to Safety Campaign’ and the high compliance with submission of data to the patient safety thermometer – maintaining data submissions at 96%. The trust is to be congratulated on their reported achievement of a 37.6% reduction in grade 3 and 4 avoidable hospital acquired pressure ulcers (n=15) reported against a threshold of 24%. In addition, it is positive to see the trust approach to duty of candour and support for staff learning.

The impact of harm-related falls is noted and commissioners remain concerned about the long term physiological effect on patients, mortality as well as the financial cost. It is imperative that all NHS providers work together to minimise falls. Although compliance is reported, the number of falls reported is higher than the previous year. Commissioners look forward to seeing a reduction in harm-related falls and evidence of the trust’s engagement in the local falls prevention programme.

Excellent results are reported in respect of reducing clostridium difficile cases. With the trust achieving 27.5% below their target, it is good to see the continued commitment to reducing healthcare associated infections. There is one MSA post-infection review to conclude.

It was encouraging to see the key developments and service changes listed to improve medication management. It is imperative these work programmes continue and deliver a reduction in harm-related incidents. In addition, as part of the urgent care plans, the trust will need to ensure that medication is provided in a timely manner to patients at the point of discharge and that medication information is consistently given to receiving health care providers. Lack of information on medication was frequently mentioned as a key area of concern by health and social care partners.

The trust displays the daily staffing levels for all wards on their ‘transparency’ boards. This provides information for the public on key safety performance and includes patient falls, medication incidents and pressure sores. This is a good example of openness. The trust has made significant progress with nursing recruitment and successfully recruited from overseas. There are, however, consultant vacancies within some specialties and midwifery vacancies reported as part of the staffing review. Commissioners are fully sighted on the workforce data and work to understand the quality impact. It will be necessary to continue the work to support the needs of overseas nurses in the forthcoming years to maximise effectiveness and retention.

Good progress has been made with the identification of acute kidney injury. This initiative was supported through the national CGUIN scheme. It is good to see the intention to further embed this and to enhance patient understanding of acute kidney injury and this will form part of our quality contract agreements for 2016/17.

It has not been possible to determine the outcomes of the sepsis CGUIN as data has not been submitted to commissioners.

The Trust continues to perform strongly against the percentage of positive responses for the national Friends & Family Test for in-patients, patients using the emergency department and maternity services. Likewise there are positive results for the staff Friends & Family Test. The NHOS staff survey continues to show significant improvement with 73 key findings rated in the best 20%. This is to be commended.

The trust will need to continue its drive to improve response rates specifically within the emergency department to create a sustained sample size. In addition the responses reported for the out-patient department (OPD) have reduced in quarter 4 of this financial year however, the satisfaction score is 92.3%. Commissioners consider that it would be helpful to triangulate with greater granularity at service level, the feedback obtained from FTT narrative, complaints and concerns data and progress against the trust improvement priorities for OPD.

The work programme for carers is welcomed and the dementia volunteers are a positive step towards supporting the more vulnerable in our locality. Commissioners look forward to reviewing the impact of carers passports and the future programmes for dementia patients.

Discharge from hospital remains a key priority for commissioners. Whilst it is evident that work is being taken forward to minimise risk, the impact on patients, carers and health care professionals when the discharge is not optimum, should not be underestimated. With the impact of urgent care pressures, it is essential that safety and experience are paramount in any plans which focus on earlier discharge.

Data Quality

It is good to see that the trust is again reporting a high % achievement for inclusion for a valid NHOS number. General Medical Practice Codes and a satisfactory grading for the Information Governance Assessment report. No further data quality details were included in the quality account considered by commissioners.
Clinical Audit and Research

The clinical audit section demonstrates that the trust participated in 57% of eligible national clinical audits (37/68) and 110% of confidential enquiries (68/61). The percentage of cases submitted ranged from 46.9% “Acute coronary syndrome or acute myocardial infarction – MMRP” (decreased numbers due to patient unavailability) to 100% submission for other audits. It is disappointing to see that the data submissions to the Trauma Audit and Research Network (TARN) remains lower, as assurances were received that appropriate resource had been placed to support improvement. In addition, the Trust has committed to reviewing participation rates for the Patient Reported Outcome Measures (PROMs). Some positive results from audit activity have been reflected in the account, for example performance in the Falls and Frailty Fracture Audit programme demonstrates consistently better scores in the majority of domains. Additionally, the Sentinel Stroke National Audit programme does show some improvement but has areas which concern and will benefit from more dedicated focus for the coming year. Commissioners look forward to seeing these delivered at pace in conjunction with improved outcomes against the key performance metrics. There is clear evidence of research participation.

Commissioner Assessment Summary

The Trust has demonstrated some very positive quality achievements and improvements in 2015/16 despite a significantly challenging year operationally for the urgent and unscheduled care pathway which is creating continued and unresolved concerns for patient safety and experience. Commissioners have escalated these risks to both regulators and this has resulted in the issue of an enforcement notice by the CQC and the trust being in the ‘Risk Summit’ process since December 2015. Enhanced quality monitoring has been required since this point.

There have been pressures on all services and other health and social care organisations with the highest risks being held by South Central Ambulance NHS Foundation Trust. The number of ambulance hours and decision to admit breaches have been far more frequent this year and this impacts on timeliness of treatment, and on occasions, patients and relatives needing to travel to other hospitals for care. It is essential that we fully understand the impact on safety and swiftly put all actions into place to ensure safety and experience is addressed. It is imperative that these challenges are the highest focus for the trust in the coming year and there is strong leadership and commitment to work, as a health and social care system to deliver timely and sustainable improvements.

It is understandable therefore that the quality priorities set for 2016/17 are somewhat similar to those of 2015/16.

Commissioners look forward to continued partnership working to address the key quality challenges facing the organisation and impacting on the whole health system and the Trust’s full engagement in delivering the new models of care. Commissioners also welcome the opportunity to participate in the Trust’s internal quality peer reviews and will maintain the schedule of clinical visits and share/evaluate healthcare professional feedback.

Yours sincerely,

Alex Berry
Acting Chief Officer
Fareham & Gosport & South Eastern Hampshire Clinical Commissioning Groups
Hampshire Health and Adult Social Care Select Committee commentary to Quality Accounts process

Thank you for sharing with the Hampshire Health and Adult Social Care Select Committee (HASC) the draft 2015/16 Quality Accounts for Portsmouth Hospitals NHS Trust.

I have circulated these priorities to Members of the HASC for their comments, and have received general feedback which suggests that the Committee are supportive of the approach taken.

We note the positive progress that has been made by the Trust in reducing the number of avoidable grade 3 and 4 pressure ulcers, and healthcare associated infections.

It is disappointing to note however that the urgent and unscheduled care issues raised in the quality accounts for 2015/14 and 2014/15 still persist, which have resulted in recent enforcement notices. We have monitored this issue throughout 2015/16, and will continue to keep this topic on our work programme.

The upward trend in ‘medication error’ is also of concern, and therefore we would have expected that the working group would have been initiated by this time. The report section on ‘discharge from hospital’ does not give any indication of problems with ‘delayed discharge’ which we would have expected to have been tackled.

We would like to request, and look forward to receiving, the action plan that will be drafted following the publication of your Quality Accounts, in order to ensure that the priorities raised can be monitored, and progress against them can be reviewed.

Please do not hesitate to contact me should you require any additional information on my comments above.

Yours sincerely,

Cliff Huxstep
Chairman, Health and Adult Social Care Select Committee
LIMITED ASSURANCE REPORT

To follow...........

Portsmouth Hospitals NHS Trust
QUALITY ACCOUNTS 2015/16
Limited assurance report

Portsmouth Hospitals NHS Trust
Quality Account 2015-2016
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## Glossary of terms

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<th>Term</th>
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<tr>
<td><strong>Acute Kidney Injury (AKI)</strong></td>
<td>Acute kidney injury (AKI) is sudden damage to the kidneys that causes them to stop working properly. It can range from minor loss of kidney function to complete kidney failure. AKI is common and normally happens as a complication of another serious illness. It is not the result of a physical blow to the kidneys, as the name may suggest. This type of kidney damage is usually seen in older people who are unwell enough to be admitted to hospital. If it's not picked up in time, the kidneys become overwhelmed and shut down, leading to irreversible injury, which can be fatal. Abnormal levels of salts and chemicals build up in the body, stopping other organs working properly. It is essential that AKI is detected early and treated promptly. &lt;br&gt;Source: NHS Choices</td>
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<td><strong>Care Quality Commission (CQC)</strong></td>
<td>The independent regulator of all health and social care services in England. Their job is to make sure that care provided by hospitals, dentists, ambulances, care homes and services in people's own homes and elsewhere meets government standards of quality and safety.</td>
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<td><strong>C.Diff</strong></td>
<td>A Clostridium difficile infection is a type of bacterial infection that can affect the digestive system. It most commonly affects people who have been treated with antibiotics. A C. difficile infection can lead to life-threatening complications such as severe swelling of the bowel from a build-up of gas (toxic megacolon). &lt;br&gt;Source: NHS Choices</td>
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<td><strong>Clinical Service Centre (CSC)</strong></td>
<td>Key centres within which the Trust’s services are delivered to patients. Each CSC has a Chief of Service, General Manager and Head of Nursing. There are 10 CSCs.</td>
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<tr>
<td><strong>Commissioners</strong></td>
<td>Commissioners (i.e. health authorities/Primary Care Trusts) have a statutory responsibility to buy the best health care for a defined population with a defined amount of money.</td>
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<td><strong>Commissioning for Quality and Innovation (CQUIN)</strong></td>
<td>The CQUIN payment framework enables Commissioners to reward excellence, by linking a proportion of Providers’ income to the achievement of local quality improvement goals.</td>
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<td><strong>Dr Foster</strong></td>
<td>The UK’s leading provider of comparative information on health and social care services.</td>
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<td><strong>HSMR</strong></td>
<td>The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the mortality rate at a hospital is higher or lower would be expected. The national average is 100 and a score of below this indicates less deaths than this average. HSMR covers 56 groups of diagnosis and only relates to patients that have died whilst in hospital</td>
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<td><strong>HQIP (Healthcare Quality Improvement Partnership)</strong></td>
<td>The Healthcare Quality Improvement Partnership (HQIP) was established in April 2008 to promote quality in healthcare, and in particular to increase the impact that clinical audit has on healthcare quality in England and Wales. HQIP is a charity and company limited by guarantee, led by a consortium comprising the Academy of Medical Royal Colleges, Royal College of Nursing and National Voices.</td>
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<td><strong>MRSA</strong></td>
<td>MRSA is a type of bacteria that's resistant to a number of widely used antibiotics. This means MRSA infections can be more difficult to treat than other bacterial infections. The full name of MRSA is meticillin-resistant Staphylococcus aureus. Staphylococcus aureus (also known as staph) is a common...</td>
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<td>type of bacteria. It's often carried on the skin and inside the nostrils and throat, and can cause mild infections of the skin, such as boils and impetigo. If the bacteria get into a break in the skin, they can cause life-threatening infections, such as blood poisoning or endocarditis. <strong>Source:</strong> NHS Choices</td>
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<td>National Audit</td>
<td>A National quality improvement process that seeks to improve patient care and outcomes through the systematic review of care.</td>
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<td>National Institute for Health and Clinical Effectiveness (NICE)</td>
<td>Provide independent, authoritative and evidence-based guidance on the most effective ways to prevent, diagnose and treat disease and ill health, reducing inequalities and variation.</td>
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| Pressure ulcers                                    | Pressure ulcers are also known as ‘pressure sores, bed sores and decubitus ulcers’. A pressure ulcer is defined as “An area of localised damage to the skin and underlying tissue caused by pressure, shear, friction and/or a combination of these”. Pressure ulcers occur when a bony prominence is in contact with a surface. The most common sites include the buttocks, hips and heels but they can occur over any bony prominence  
**Grade 1:** Discolouration of intact skin not affected by light finger pressure  
**Grade 2:** Partial thickness skin loss or damage involving epidermis. The pressure ulcer is superficial and presents clinically, as an abrasion, blister or shallow crater.  
**Grade 3:** Full thickness skin loss, involving damage of tissue. The pressure ulcer present clinically as a deep crater, but bone, tendon or muscle are not exposed.  
**Grade 4:** Full thickness skin loss, with exposed tendon or muscle.                                                                                                                                 |
| Sepsis                                             | Sepsis is a common and potentially life-threatening condition triggered by an infection. In sepsis, the body's immune system goes into overdrive, setting off a series of reactions including widespread inflammation, swelling and blood clotting. This can lead to a significant decrease in blood pressure, which can mean the blood supply to vital organs such as the brain, heart and kidneys is reduced. If not treated quickly, sepsis can eventually lead to multiple organ failure and death. Each year in the UK, it is estimated that more than 100,000 people are admitted to hospital with sepsis and around 37,000 people will die as a result of the condition. **Source:** NHS Choices |
| SHMI                                               | The Summary Hospital-level Mortality Indicator (SHMI) is a high level mortality indicator that is published by the Department of Health on a quarterly basis. It follows a similar principal than HSMR, however SHMI covers all diagnosis groups and relates to all patients that have died (whether the patient died whilst in hospital or not). It does not take account of deprivation. |
### NATIONAL CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES THAT PORTSMOUTH HOSPITALS NHS TRUST PARTICIPATED IN DURING 2015/2016

<table>
<thead>
<tr>
<th>Audit title</th>
<th>Outcomes / Actions to improve quality of healthcare</th>
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<tbody>
<tr>
<td><strong>British Thoracic Society: Paediatric Asthma</strong></td>
<td>The Trust is currently reviewing the results of this recently published audit and will produce an action plan if required. The Trust is meeting or exceeding national comparative data with above average performance in regards to discharge information. The Trust has identified a potential for improvement with regards to follow up in primary care, use of peak flow meters and the use of Asthma/ Viral induced wheeze discharge sheets.</td>
</tr>
<tr>
<td><strong>British Thoracic Society: Emergency Oxygen Use</strong></td>
<td>The Trust had more written bedside orders for oxygen than the national average; however prescribing rates need to be improved. Introduction of a combined drug and oxygen prescription chart has improved rates of oxygen prescription for inpatients at Portsmouth Hospitals NHS Trust. Work is ongoing to increase the uptake of oxygen prescribing further through Trust-wide education of staff and an update of the prescription chart.</td>
</tr>
<tr>
<td><strong>Oesophago-Gastric Cancer</strong></td>
<td>The Oesophago-Gastric Cancer report was published December 2015 and the Trust are currently reviewing this report and will produce an action plan if required. The Trust surgeons have not been identified as outliers in regard to surgical outcomes and 30 day mortality and 90 day mortality rates.</td>
</tr>
<tr>
<td><strong>Lung Cancer</strong></td>
<td>The Lung Cancer report was published December 2015; the Trust are currently reviewing this report and will produce an action plan if required. The Trust achieved a higher than the national average (69%) cancer confirmed diagnosis pathologically achieving 82%. Most Trusts (70%) did not achieve this. Nationally, 94% of cases submitted were recorded to have been discussed in an MDT meeting. The Trust achieved 97%. At least 80% of patients should have a lung cancer nurse specialist present at the time of diagnosis. The Trust achieved 71% against a national average of 78%. Nationally, 58% of patients were recorded to have had anticancer treatment (surgery, chemotherapy or radiotherapy). The Trust achieved 59%. The target for this recommendation is 60% and 50% of Trusts did not achieve this standard. National chemotherapy rates for small-cell lung cancer are recommended to be above 70%. The Trust achieved 73% against a national result of 68%. 40% of Trusts did not achieve this standard.</td>
</tr>
<tr>
<td><strong>Prostate Cancer</strong></td>
<td>The national Prostate cancer audit report comprises 3 subsections. The first is analysis of clinical data on men diagnosed with prostate cancer between 2010 and 2013. Secondly, a report on trust participation and finally a launch of the patient surveys. Nationally fewer men are diagnosed with advanced disease, indicating increased awareness. There is also an increase in the number of men presenting with locally advanced disease receiving radical treatments and potentially curative therapy. There is also a welcome reduction in radical treatment of men with low risk localised prostate cancer. Increased use of Robotic prostatectomy is welcomed in the report. Trust participation rates have improved and are now at 88%, however the report highlights the need for improvement in case ascertainment and completeness of basic staging and treatment data collection. The Trusts pre-biopsy MRI rates are low in line with other Trusts but the Trust is working on establishing this service. Performance status and TNM staging are also under-reported and will be highlighted through the MDT process to rectify this. Further actions to improve include:</td>
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<tr>
<td>Audit title</td>
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<tr>
<td>Norfolk Stroke</td>
<td>A move to up-front multi-parametric MRI scanning for men with raised Prostate-Specific Antigen (PSA). A move to a sessional MDT and more robust data collection to improve TNM staging entries.</td>
</tr>
<tr>
<td>Bowel Cancer</td>
<td>The Bowel Cancer report was published December 2015 and the Trust are currently reviewing this report and will produce an action plan if required. The Trust surgeons have not been identified as outliers in regard to reported surgical outcomes and mortality rates. Improvements are required in the completeness of recording performance status. The Trust performed well in patients being seen by a Clinical Nurse Specialist achieving 94% against a national average of 93%. Length of stay greater than 5 days, the Trust achieved 62% against a national average of 69%. The Trust also performed well in regard to 90-day mortality, 90-day unplanned re-admissions and 2-year mortality metrics. 18-month stoma rates were excellent for patients having surgery and were well above the national average rates.</td>
</tr>
<tr>
<td>National Vascular Registry</td>
<td>The National Vascular Registry report was published November 2015 and the Trust are currently reviewing this report and will produce an action plan if required. The Trust surgeons have not been identified as outliers in regard to reported surgical outcomes and mortality rates as published in the surgeon outcomes report.</td>
</tr>
<tr>
<td>National Joint Registry</td>
<td>The Trust performs well in a number of ways. Although there is a small delay in inputting data to the National Joint Registry database, there are excellent compliance and consent rates. There is a thorough system in place, run by the data clerks who are diligent in ensuring that all data is captured. The trust has a high rate of usage of ODEP rated implants. Outcome measures including Patient Reported Outcome Measures (PROMs) for 3 different knee and hip scoring methods are within the expected range compared to the national figures. 90 day mortality was equal for hips and less for knees than the national average. Revision rates were better than average for hips and equal to the average for knees. All surgeons performed within the expected ranges as reported in the surgeon outcomes report.</td>
</tr>
<tr>
<td>National Comparative Audit of Blood Transfusion Programme</td>
<td>The small number of patients meeting the criteria for this audit indicates that our use of donor blood in surgery is relatively low. The Trust results were comparable with many other trusts; however there are improvements the Trust can make. Particular emphasis is to be placed on pre-operative anaemia correction, use of lower haemoglobin (Hb) thresholds and patient re-assessment before each unit. Information on cell salvage is to be improved to include autologous transfusions.</td>
</tr>
<tr>
<td>College of Emergency Medicine: Asthma</td>
<td>QAH continues to provide high quality care in the management of Paediatric asthma, but there is room for improvement especially in early immediate treatment and repeating vital signs. Service development, education and re-auditing of existing pathways and proforma’s will help the department to draw closer to the Royal College of Emergency Medicine suggested standards.</td>
</tr>
<tr>
<td>National Neonatal Audit Programme (NNAP)</td>
<td>This is the eighth National Neonatal Audit Programme report covering the calendar year 2014. The Trust are performing at or above the national (and equivalent for a level 3 unit) average for all defined standards and have improved on the previous years results. The Trust compares very favourably with the two other level 3 units within our network, namely Southampton and Oxford. The Trust needs to continue to work hard to maintain this level of excellence. The Trust has identified some areas that can be improved further and have action plans in place for this. Recording of data on blood cultures could improve; the Trust introduced a sticker in February 2015 to note clinical indicators behind the reason for the blood cultures, which allows data clerks to enter the information. This should</td>
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<tr>
<td>Paediatric Diabetes Audit</td>
<td>The Paediatric Diabetes team are achieving median blood glucose levels (HbA1c) better than the national average. The team are achieving better than the national average in completeness of care processes, but this still requires improvement. The Trust aims to improve the number of young people with an HbA1c &lt;58mmol/mol and those with an HbA1c &gt;80mmol/mol by working more intensively with motivated families and engaging those that have poor control by using the psychology support that has been put in place since this audit and have evidence from the database that these have improved.</td>
</tr>
<tr>
<td>Falls and Fragility Fracture Audit Programme: Hip Fracture database</td>
<td>The national report compares local figures with benchmarking performance data within the South Central region and for all hospitals in the National Hip Fracture Database (NHFD). Once again the Trust has achieved consistently better scores in the majority of domains. Comparing Portsmouth to the top 11 trusts nationally in terms of hip fracture numbers, the Trust being the 6th highest, the Trust has achieved a higher percentage in the majority of domains compared to the other ten trusts and similarly better in comparison to other hospitals in the South Central region and the overall national figures. Portsmouth continues to have low 30 day mortality – crude rate of 5.4% compared to 7.5% nationally and 7.2% for South Central and case mix adjusted 5.9% in 2014 compared to 6.0% 2011-2013. The results achieved are a reflection of the whole team’s commitment to the quality of care for this frail group of patients. The Trust will continue to regularly monitor our performance and ensure that quality is maintained. Areas for further improvement include the Emergency and Orthopaedic Departments to review the processes of admission to the ward to improve the percentage of patients admitted within 4 hours, to include Orthopaedic review of fast track hip fracture beds. Orthopaedic surgeons and Anaesthetists have undertaken a review of the operational delays and there is agreement to introduce another dedicated hip fracture theatre session on Monday afternoons. Dedicated hip fracture lists to be staffed by a consultant or senior SpR for the majority of lists. This requires a job planning review. All therapy uplift posts to be filled and to explore support to set up regular inter-organisational governance and clinical pathway meetings to include community providers. Set up a display board on ward D6 for the monthly “live” run charts so that all team members are aware of the current performance and can review practice as appropriate.</td>
</tr>
<tr>
<td>Falls and Fragility Fracture Audit Programme: Inpatient Falls audit</td>
<td>Portsmouth Hospitals have had a commitment to effective falls prevention and post-fall management for many years. Specialist clinicians together with a Clinical Nurse Specialist post for Falls and Frailty resulted in a Falls Policy being put in place with a carefully designed pathway that ensures that all patients entering the hospital by whatever route will be assessed and managed for falls risk. The Trust achieved above average results in all the key indicator standards of this national audit and made improvements in most areas on the previous audit. There are still some areas where improvements are required especially more clarity and a better way of ensuring that the elements are in place, particularly Lying and Standing Blood Pressure recording. The Trust needs to settle on a delirium assessment that can be applied across the Trust. Overall the Trust is delighted with the outcomes and it is just the boost needed to consolidate and continue with the falls strategy.</td>
</tr>
<tr>
<td>Trauma Audit and Research Network</td>
<td>The results of this national audit have highlighted that data entry is still below standard but results show our survivorship of trauma is above the national average and there have been improvements made in trauma care. Employment of new staff will ensure next years</td>
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### NATIONAL CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES THAT PORTSMOUTH HOSPITALS NHS TRUST PARTICIPATED IN DURING 2015/2016

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<td><strong>Sentinel Stroke National Audit Programme</strong></td>
<td>Data for this national audit is collated on an ongoing basis and is reported quarterly. The Trust has improved from a level E and have maintained at a level D. Improvements have been seen within the Occupational Therapy (C to B), Physiotherapy (B to A) and MDT (D to C) domains. Further improvements are required in the admission process, avoidance of non-stroke admissions to the stroke unit and prevention of stroke patients being outlied to other wards. The speech and language therapy team requires further resources due to workload despite efforts to increase the workforce. The thrombolysis door to needle and direct admission times will also need further improvement. A stroke action plan is in place and is reviewed and monitored monthly.</td>
</tr>
<tr>
<td><strong>Emergency Laparotomy</strong></td>
<td>The Trust was ranked in the busiest 10% of acute hospitals in the country. The Emergency Surgery service at the Trust has modernised and improved over the last few years. Key drivers have been the recognition that surgeons should be dedicated to the service; that it is an in-and-working role rather than an on-call role; and that patients are better served by continuity of care. The Emergency Surgery service at the Trust is run 24/7 by dedicated specialist consultant surgeons with no concurrent elective commitments. This facilitates timely patient review, consultant-delivered decision-making, and consultant-delivered operating whenever necessary. Engagement from consultant surgeons has been variable but generally good; and this is reflected in the high workload, the exceptional level of consultant-delivered operating, and the low 30-day mortality rates. Areas for improvement include better assessment and recording of mortality risk; ensuring the Septic Six Bundle is included in admission paperwork; improved access to emergency theatres; implementation of a 24/7 radiology service; improved anaesthetic rotas; improved daily rounds of Medical Care of Older People consultants.</td>
</tr>
<tr>
<td><strong>Rheumatoid and Early Inflammatory Arthritis</strong></td>
<td>The national audit of the management of early rheumatoid and inflammatory arthritis is complex with multiple factors potentially influencing results. Data indicates that most people with early inflammatory arthritis wait too long (including our catchment population) from the onset of their symptoms until they start disease modifying treatment. There are often delays in referral from primary care and then further delays following referral. Rheumatology services, general practitioners and CCGs need to work together to improve early recognition of possible inflammatory arthritis (IA), and the need for prompt referral when IA is suspected. Nationally consultant staffing levels significantly influence achievement of NICE quality standard 2 (patient seen within 3 weeks of referral). Despite lower than national average consultant staffing levels the Trust met this quality standard in a higher proportion of patients than nationally or regionally but the consultant shortfall may contribute to the poorer patient outcomes shown at 3 months. The Trust actions from the results and recommendations include designating a lead consultant for the early inflammatory arthritis pathway; to define a new improved early inflammatory arthritis patient pathway; implement any service changes required; advertise the pathway to our patients, local GPs and referrers to minimise referral delays; to liaise with primary care colleagues to better understand the barriers to early identification and referral of patients.</td>
</tr>
<tr>
<td><strong>Coronary Angioplasty: Percutaneous Coronary Intervention (PCI)</strong></td>
<td>The Trust is a high volume centre with high volume operators providing 24/7 primary Percutaneous Coronary Intervention (PCI). The Trust continues to have a rate of radial access significantly higher (and therefore better) than the national average and door to balloon times also remain better than the national average. The Trust surgeons have not been identified as outliers in regard to published surgical outcomes and mortality rates.</td>
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<tr>
<td>Parkinson’s Audit</td>
<td>Awaiting publication of the national report/results.</td>
</tr>
<tr>
<td>Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)</td>
<td>Awaiting publication of the national report/results. There has been a decrease in the number of cases submitted by the Trust from previous years, this is due to a patient criteria change in the audit and all Trusts nationally are in a similar position.</td>
</tr>
<tr>
<td>National Ophthalmology Audit</td>
<td>The Trust did not participate in this new national audit during 2015/16, despite collating the data locally, due to concerns about a lack of data validation process and the requirement of a software update to local systems to securely transfer the appropriate data – the upgrade is currently being implemented so that participation this year will be possible.</td>
</tr>
<tr>
<td>Cardiac Rhythm Management</td>
<td>Awaiting publication of the national report/results.</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>The Heart Failure report for 2014/15 was published November 2015, the Trust are currently reviewing this report and will produce an action plan if required. Data collection is ongoing. The criteria for data submission has changed requiring 70% of all hospital admissions to be captured (previously 50%). To help ensure this requirement is met the Heart Failure Service has been improved with the appointment of a Heart failure consultant; Heart failure nurse capacity has been increased further and will need to be increased again to enable heart failure team input on the elderly care wards; a support worker has also been appointed and will be heavily involved in data collection to enable data to be submitted on patients with a primary diagnosis of heart failure.</td>
</tr>
<tr>
<td>End of Life Care</td>
<td>The End of Life Care report was published March 2016 and the Trust are currently reviewing this report and will produce an action plan if required. The Trust have performed above the national average in the clinical audit for all key quality indicators, however there is room for improvement on some of the indicators and the organisational audit highlighted two areas for improvement. The Trust is not an outlier in any area.</td>
</tr>
<tr>
<td>National Diabetes Audit: Diabetes in Pregnancy</td>
<td>The Trust maternity services diabetes team only started collecting data for this audit in December 2014 and to date have only had two women who were eligible to enter. The team is continuing to support the audit and are awaiting any recommendations to benchmark against.</td>
</tr>
<tr>
<td>National Diabetes Audit: Inpatient</td>
<td>The Inpatient Diabetes report was published March 2016 and the Trust are currently reviewing this report and will produce an action plan if required.</td>
</tr>
<tr>
<td>National Diabetes Audit: Foot Care</td>
<td>Data collection for this audit is ongoing. The trust will review the results once they are published.</td>
</tr>
<tr>
<td>Inflammatory Bowel Disease</td>
<td>The Trust participated in the Biologics component of the National Inflammatory Bowel Disease (IBD) Audit. Results were good and compared favourably with national findings and against the national standards. The results were discussed at the IBD multidisciplinary meeting and governance meeting and any areas where the overall quality of the IBD service could be improved were highlighted. Improvements include use of the Harvey Bradshaw index to document disease severity scores and to improve input of follow up data.</td>
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<tr>
<td>Patient Reported Outcome Measures: Elective Surgery</td>
<td>The Trust is performing in line with the national average for groin hernia and primary hip and below the national average, but within the expected parameters for primary knee in adjusted average health gains. The participation rates are dependant on patients giving consent and completing a questionnaire before their procedure and then completing a second questionnaire within 3 months or 6 months depending on the procedure. The number of patients participating has reduced this year and the Trust is taking actions to improve the processes to enable patients the opportunity to participate.</td>
</tr>
<tr>
<td>Confidential Enquiries</td>
<td></td>
</tr>
<tr>
<td>MBRACE – Maternal Infant and Perinatal Confidential Enquiry: Maternal Mortality</td>
<td>Maternity Services are currently constructing an action plan based on the reports recommendations. The service would like to recognise concurrent work by the multi professional team surrounding the women who are pro-actively reviewing this service provision and updating the current guidance. Perinatal mental health is being reviewed by the clinical network and activity to create a usable pathway is advancing but provision is external to the Trusts service.</td>
</tr>
<tr>
<td>MBRACE – Maternal Infant and Perinatal Confidential Enquiry: Perinatal Mortality</td>
<td>The Trusts Maternity Service is compliant with the majority of the recommendations contained within this report and has active actions in place to reach compliance for the other recommendations. The service has pro-actively structured its review of still-births of all gestations and each case is rigorously analysed to identify any gaps in care; also to identify excellent standards. The team ensure that all lessons learned are shared at the still-birth meetings. To ensure that all staff are aware of learning, posters for each meeting have been created and circulated.</td>
</tr>
<tr>
<td>National Confidential Enquiry into Patient Outcomes and Death - Sepsis</td>
<td>There is no Trust specific data in this report but the Trust have reviewed all the recommendations to ensure lessons can be learned. A self-assessment review has been completed and whilst the Trust is meeting most of the recommendations an action plan has been put into place to improve practice which include: a development of an invasive surgical site bundle for the Intensive Care Unit; an information leaflet required for patients and relatives on the recognition of sepsis, its long-term complications, recovery and risk of recurrence; patients discharged should have sepsis recorded on the discharge summary; however, coding for sepsis remains variable.</td>
</tr>
<tr>
<td>National Confidential Enquiry into Patient Outcomes and Death - Gastrointestinal Haemorrhage</td>
<td>There is no Trust specific data in this report but the Trust have reviewed all the recommendations to ensure lessons can be learned. A self-assessment review has been completed and whilst the Trust is meeting most of the recommendations an action plan has been put into place to improve practice which include: patients should be admitted to hospitals with 24/7 access to on-site endoscopy and interventional radiology; There are clear pathways for upper GI bleeding and lower GI bleeding but they are separate and should be joined; all (modest) bleeds to have an endoscopy within 24 hours; there is no service for out of hour’s colonoscopy; out of hours endoscopy to be undertaken by endoscopy trained nurses; equipment contingency plan to be developed for equipment failure; patients to receive gastroscopy within 24 hours.</td>
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### LOCAL CLINICAL AUDITS

<table>
<thead>
<tr>
<th>Audit Title</th>
<th>Comments and actions to improve quality of healthcare</th>
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<tr>
<td>Paediatric Accident and Emergency Department (PED) re-attendance</td>
<td>The audit demonstrated that the Trust PED has a re-attendance rate of 1.9% thus is meeting the national quality indicator of a re-attendance rate of between 1-5% and better than published data of 2%. The audit highlighted that 38% of re-attendance was due to problems with plaster applications. Recommendations have been made to audit plaster application and a service improvement suggestion made for a self referral system to the plaster room so that these patients by-pass PED. The audit also highlighted a need for staff education around the importance of providing patients with analgesia advice and crutches if patients should not be able to weight bear.</td>
</tr>
<tr>
<td>Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR)</td>
<td>This re-audit showed significant improvement from the previous year audit results in evidencing discussions with patients/relatives and others. Patients were being informed of DNACPR decisions. Some areas for improvement were also highlighted, including 8% of DNACPR forms were not the first page of patient notes; an action plan is in place to address these areas during all annual resuscitation training sessions.</td>
</tr>
<tr>
<td>Audit assessing compliance with British Thoracic Society guidelines for adult community-acquired pneumonia (CAP) in the Emergency Department</td>
<td>The audit found that patients are being reviewed in a timely manner and investigations are being completed quickly ensuring treatment is given promptly. However, the audit also highlighted that management according to the guidelines need to be reinforced and that most patients are not receiving the antibiotic therapy according to the severity of their pneumonia. Recommendations and an action plan were made for the introduction of a CAP Care Bundle (care pathway).</td>
</tr>
<tr>
<td>Are the Sepsis 6 national guidelines being followed in the renal department?</td>
<td>Fluid assessment is being performed and appropriate fluid therapy is being given to septic patients on the renal unit. However, the Acute Adult Sepsis Pathway sticker is being used very little and the Sepsis 6 guidelines were only followed in 25.9% of the patients that were audited. More common usage of Acute Adult Sepsis Pathway Sticker is required in order to improve the documentation and recording that the department is following the Sepsis 6 guidelines; emphasis on use of the Acute Adult Sepsis Pathway stickers is to be made to Senior House Officers and nursing staff. A re-audit is recommended.</td>
</tr>
<tr>
<td>Audit of clinical outcomes for home haemodialysis (HHd)</td>
<td>This audit identified good clinical and biochemical outcomes in line with the renal association guidelines and no increase in vascular access related infections. Concern was raised that the staff to patient ratio had reached its maximum safe limit and an urgent need to increase staff numbers and increase the training programme was identified. Interviews for new band 5 nurses were conducted in November. The need for a consistent approach to documentation was also identified and a proforma for home visits was recommended. This audit highlighted a lack of national standards for HHd, as a result local standards have now been produced and the team will also seek input from the renal association to look at establishing national guidelines.</td>
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APPENDIX B – LOCAL CLINICAL AUDIT: ACTIONS TO IMPROVE QUALITY