Portsmouth Hospitals NHS
NHS Trust

PORTSMOUTH HOSPITALS NHS TRUST
QUALITY ACCOUNTS
2016 - 2017

Our annual report to the public on the quality of services we deliver

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If you require any further information about the 2015 / 2016 Quality Account please contact:

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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 2016/17.

This last year has continued to be very challenging for NHS colleagues across the country. The challenges placed in front of the NHS are well documented and yet despite the growing pressure on our services our staff continued to be outstanding, making a difference to people at a time when they have needed it most. There is a lot that remains unresolved in our hospital, and our urgent care pressures remain, but with the commitment and resilience of our staff we remain as confident and determined as ever that we can continue to improve the services we provide to our patients.

Despite pressures on our finances resulting in a disappointing deficit at year end and the unprecedented demands on our unscheduled care pathway, our performance in many areas remains strong at year end. The Board continues to have a strong focus on quality.

We are proud to continue to host military colleagues from all three services in the hospital. The mutual relationship between Defence Medical Group (South) and the Trust remains as important as ever. Under the command of Lieutenant Colonel Adam Shorrock the military medical personnel, which encompass Consultant Doctors, Specialist and Generalist Nurses and Allied Healthcare Professionals, provides a capable and flexible workforce which works to support the priorities of the Trust. We were also delighted to continue to play a role supporting military reservists.

Despite the relentless pressures throughout the year we have continued to win many awards for our work. We were recognised at the Sport and Physical Activity Awards, along with a select number of other public sector organisations for our work on staff health and well-being. Despite the title this was not about producing a workforce capable of running marathons or swimming the Channel, but was recognition of a workforce capable of delivering better outcomes for our patients, a workforce who values the need to look after themselves in order to look after their patients, and a workforce who recognises that looking after each other is really important. This means supporting one another and working collaboratively across teams.

Looking ahead we continue to explore opportunities to ensure the local NHS and social care services work together as a team, becoming stronger in our common purpose to deliver better care and outcomes for a much wider population than just Portsmouth, Fareham, Gosport and SE Hampshire. Working in collaboration with our partners on the Isle of Wight, and Southampton, and potentially further afield, we aspire to deliver better care and sustainable services for our patients going forward.

By doing this we can work as a larger team, share resource at a time when it is at a premium, and deliver better services for the benefit of all of our patients. Importantly this work will be led by clinical leaders from all organisations to ensure that changes really do deliver better outcomes for patients as we move forward. This is an exciting opportunity without which would see us struggle to keep up with demand over the years ahead.

Statement on quality from Chief Executive

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 an improvement in the results of the National Staff Survey for 2016. In more than half of the 32 Key Findings in the report, Portsmouth Hospitals NHS Trust is rated as being in the top 20 per cent or better than average when compared with other acute Trusts.

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.

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Tim Powell, Chief Executive, Portsmouth Hospitals NHS Trust
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QUALITY IMPROVEMENT PRIORITIES 2017 / 2018

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 Trust has taken a different approach to identifying the key priorities for 2017/2018. In addition to priorities identified through the three quality sub-groups and through consultation with Governors; we have identified an overarching quality priority relating to provision of care for vulnerable patients.

This key priority has been identified through feedback from various Care Quality Commission inspections, Trust identified requirements and national drivers.

The quality sub-group priorities will continue to support delivery of the wider quality agenda.

The proposed quality priorities were presented to and approved at the Trust Board in April 2017.

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 2017/18.

The Account summarises the Trust's performance and improvements against the quality priorities and objectives we set ourselves for 2016/17 (set out in the 2015/2016 Quality Account); where we have not met our targets we have identified further areas for improvement.

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 2017/2018 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.

Quality Account Priorities 2017 / 2018

Portsmouth Hospitals NHS

Improve the safety, experience and effectiveness of care for our most

VULNERABLE PATIENTS

Through a structured education programme focussed on:

Safeguarding including Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Health

Dementia

With the key aim being for our staff to have the appropriate skills and knowledge to deal with our most complex and vulnerable patients, whilst ensuring that the patient is at the heart of all decision making

Supported by the three Quality sub-groups key priorities:

PATIENT SAFETY

- **Mortality Review**
  - Adopt pilot Mortality Review Panel across the Trust.
  - Phased increase in specialties reviewed with all inpatient deaths (excluding deaths in ED) reviewed by end 2017/18.
  - Implement Trust-wide system for documentation of learning from deaths.
- **Sepsis**
  - Improved 1st dose antibiotics and 3 day review of antibiotic prescription, to meet the national requirement.
- **Discharge Medication**
  - Reduced number of incidents reported and decreased complaints/external feedback regarding medication to take home (TTOs).

CLINICAL EFFECTIVENESS

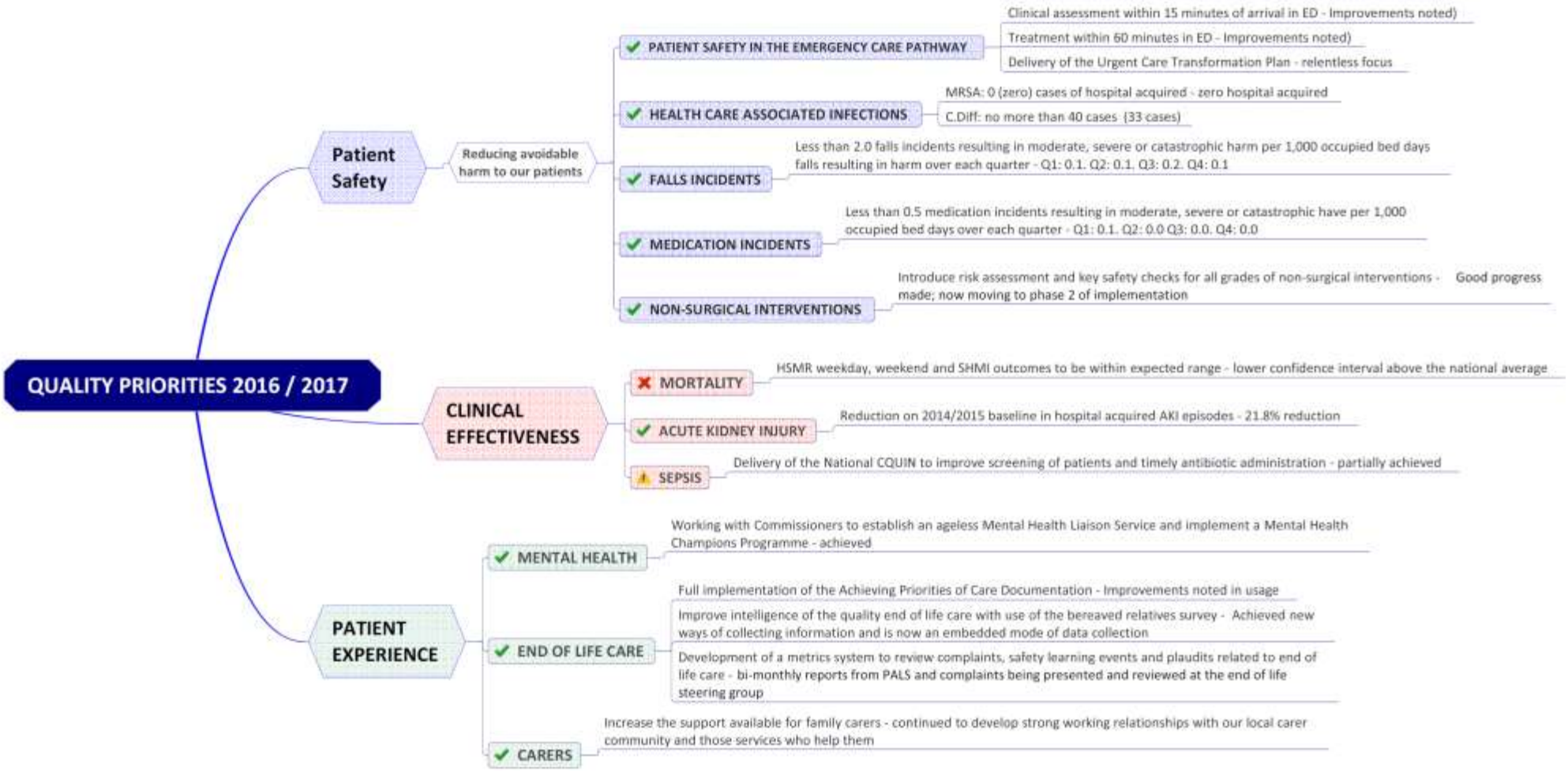
- **HSMR and SHMI**
  - To monitor the Trust HSMR and SHMI rate monthly.
  - Investigate any outlying data with the aim to reduce overall rates.
- **Learning from in-patient deaths**
  - Trust-wide roll out of the Mortality Review Panel; ensuring avoidability of death is recorded and to ensure learning is applied Trust-wide.
  - Structured Judgement Reviews. Using the Royal College of Physicians methodology, target potential concerns around mortality or in individual cases where there is a high likelihood that the death could have been avoided.

PATIENT EXPERIENCE

- **Specialist Mental Health issues**
  - Increase the skills of staff to care for people with specialist mental health issues through the provision of training about attitudes, behaviours and common causes of mental ill health.
- **End of Life Care**
  - Develop a better understanding of the experience of relatives and close friends at the end of life.
  - Making changes to care and services based on feedback.
- **Carers**
  - Develop and implement systems of working together better with carers and partners across health and social care, to support the early identification of carers and a smoother transition between community, hospital and social care services.
- **Learning disabilities**
  - Develop and implement systems for the active participation of people with a learning disability, children and young people, women and families from maternity services, and cancer patients to drive local improvements.

QUALITY IMPROVEMENT PRIORITIES 2016/2017 – OUR ACHIEVEMENTS

The Quality Account published in June 2016 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.



STATEMENTS OF ASSURANCE FROM THE BOARD

Review of services

During 2016/2017 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 2016/2017 represents 89% of the total income generated from the provision of NHS services by the Portsmouth Hospitals NHS Trust for 2016/2017.

Participation in clinical audits

During 2016/2017 40 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 95% (38/40) of national clinical audits and 100% (8/8) of 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 2016/2017, 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 60 (this number is from both 2016/17 and some reports that were published from data supplied in 2015/16) national clinical audits were reviewed by the provider in 2016/2017. Appendix A shows the actions Portsmouth Hospitals NHS Trust intends to take to improve the quality of healthcare provided.

NATIONAL CLINICAL AUDITS			
Audit title	**Details**	**Participation**	**% cases submitted**
British Thoracic Society – Adult Asthma	Audit	☑	100%
National Chronic Obstructive Pulmonary Disease Audit Programme	Audit	☑	Data collection ongoing
Head and Neck Cancer	Audit	☑	Data collection ongoing
Oesophago-Gastric Cancer	Audit	☑	71-80%
Lung Cancer	Audit	☑	85%
Prostate Cancer	Audit	☑	86%
Bowel Cancer	Audit	☑	100%
Vascular Registry	AAA Repair	☑	100%
	Carotid Endarterectomy	☑	55%
National Joint Registry	Registry	☑	100%
National Comparative Audit of Blood Transfusion Programme	Red Cell & Platelet transfusion in adult haematology	☑	67 cases submitted denominator unknown

NATIONAL CLINICAL AUDITS			
Audit title	**Details**	**Participation**	**% cases submitted**
	Re-audit of Patient Blood Management in scheduled surgery	☑	35 cases submitted denominator unknown
	Red Cell transfusion in Palliative care	Not applicable	Not applicable
College of Emergency Medicine – Asthma (Paediatric and Adult) care in emergency departments	Audit	☑	100%
College of Emergency Medicine – Severe Sepsis and Septic Shock – care in emergency departments	Audit	☑	100%
National Neonatal Audit Programme	Audit	☑	100%
Endocrine and Thyroid National Audit	Surgeon Outcomes	☑	Awaiting National report to confirm case ascertainment rate
Paediatric Diabetes Audit	Audit	☑	299 cases submitted denominator unknown
Paediatric Intensive Care Audit Network	Audit	Not applicable	Not applicable
Learning Disability Mortality Review Programme (LeDeR)	Audit	☑	100%
BAUS Cystectomy Audit	Surgeon Outcomes	☑	84.7%
BAUS Nephrectomy Audit	Surgeon Outcomes	☑	82%
BAUS Percutaneous Nephrolithotomy (PCNL)	Surgeon Outcomes	☑	36 cases submitted denominator unknown
BAUS Radical Prostatectomy Audit	Surgeon Outcomes	☑	92.1%
BAUS Stress Urinary Incontinence Audit	Surgeon Outcomes	☑	100%
BAUS Urethroplasty	Surgeon Outcomes	☑	94.7%
National Neurosurgical Audit Programme	Audit	Not applicable	Not applicable
Falls and Fragility Fracture Audit Programme	Hip Fracture database	☑	100%
	Inpatient Falls audit	National body not collecting data for 2016/17	Not applicable
	Fracture Liaison Service	☑	100%

NATIONAL CLINICAL AUDITS			
Audit title	**Details**	**Participation**	**% cases submitted**
Trauma Audit and Research Network	Audit	☑	81.3 – 95.1%
Sentinel Stroke National Audit Programme	Audit	☑	>80%
	Organisational	☑	100%
Paediatric Pneumonia	Audit	☑	Data collection ongoing
National Emergency Laparotomy Audit (NELA)	Audit	☑	100%
ICNARC – Adult Critical Care	Audit	☑	100%
ICNARC – Cardiac Arrest	Audit	☑	100%
Renal Registry – Renal Replacement Therapy	Audit	☑	100%
Chronic Kidney Disease in Primary Care	Audit	Not applicable	Not applicable
Pulmonary Hypertension	Audit	Not applicable	Not applicable
Prescribing Observatory for Mental Health	Audit	Not applicable	Not applicable
Cystic Fibrosis Registry (Adult and Paediatric)	Audit	Not applicable	Not applicable
Rheumatoid and Early Inflammatory Arthritis	Audit	National body not collecting data for 2016/17	Not applicable
National Audit of Dementia	Audit	☑	100%
Adult Cardiac Surgery	Audit	Not applicable	Not applicable
Congenital Heart Disease	Audit	Not applicable	Not applicable
Coronary Angioplasty – Percutaneous Coronary Intervention (PCI)	Audit	☑	100%
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Audit	☑	96.5%
National Ophthalmology Audit	Audit	☒	0%
Specialist Rehabilitation for Patients with Complex Needs	Audit	Not applicable	Not applicable
Cardiac Rhythm Management	Audit	☑	100%
Mental Health Clinical Outcome Review Programme	Audit	Not applicable	Not applicable
Heart Failure	Audit	☑	98%
National Diabetes Audit	Core	Not applicable	Not applicable
	Diabetes in Pregnancy	☑	79%
	Inpatient Audit	☑	100%
	Foot Care	☑	47 cases submitted denominator unknown
Inflammatory Bowel Disease	Audit	☒	0%

NATIONAL CLINICAL AUDITS			
Audit title	**Details**	**Participation**	**% cases submitted**
Patient Reported Outcome Measures	Overall Score	☑	15.7%
	Groin Hernia		5.9%
	Hip Replacement		17.5%
	Knee Replacement		23.1%
	Varicose Veins		0%

NATIONAL CONFIDENTIAL ENQUIRIES		
Audit title	**Participation**	**% cases submitted**
MBRRACE – Maternal Infant and Perinatal Confidential Enquiry – Maternal Mortality	☑	100%
MBRRACE – Maternal Infant and Perinatal Confidential Enquiry – Perinatal Mortality	☑	100%
National Confidential Inquiry into Patient Outcome and Death – Non Invasive Ventilation	☑	56%
National Confidential Inquiry into Patient Outcome and Death – Acute Pancreatitis	☑	69%
National Confidential Enquiry into Patient Outcomes and Death – Mental Health in General Hospitals	☑	100%
Child Health Clinical Outcome Review Programme – Chronic Neurodisability	☑	Ongoing
Child Health Clinical Outcome Review Programme – Young Persons Mental Health	☑	Ongoing
Child Health Clinical Outcome Review Programme – Cancer in Children, Teens and Young Adults	☑	Ongoing

The reports of 106 local clinical audits were reviewed by the provider in 2016/2017. 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 sub-contracted by Portsmouth Hospitals NHS Trust in 2016/2017, that were recruited during that period to participate in research approved by a research ethics committee was 4,680. Of these patients, 4,240 (91%) were recruited into clinical studies adopted onto the National Institute for Health Research (NIHR) Portfolio, with 440 (9%) 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 improved patient outcomes.

During 2016/2017, Portsmouth Hospitals NHS Trust has participated in a total of 308 clinical research studies, 82% of these studies were NIHR Portfolio adopted.

More than 42 clinical Departments participated in research approved by a research ethics committee at Portsmouth Hospitals NHS Trust during 2016/2017, covering a number of specialities and clinical support departments.

Goals agreed with Commissioners

Portsmouth Hospitals NHS Trust income in 2016/17 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 did not rely on detailed CQUIN performance.

NHS England CQUIN performance has yet to be determined and agreed as part of month 12 finance discussions.

Statements from the Care Quality Commission

Portsmouth Hospitals NHS Trust is required to register with the Care Quality Commission and is currently registered.

The Care Quality Commission has taken enforcement action against Portsmouth Hospitals NHS Trust as of 3rd March 2017. The Trust has the following four conditions on registration:

1. The Registered Provider of the Acute Medical Unit, at the Queen Alexandra Hospital, must ensure that beds only remain open in respect of which the required level of staffing can be provided. The Registered Provider must ensure that beds are opened for patient use, and closed to patient use if care and treatment at the appropriate level can no longer be provided for patients on the Acute Medical Unit.
2. The registered provider must ensure that the GP triage referral area has in place, and operates effectively a clearly defined standard operating procedure for crowding and escalation for patient safety concerns. This includes having clearly defined trigger points for escalation of crowding and safety concerns in the GP triage referral area. There is no internationally agreed and widely used definition of crowding. Markers of crowding or escalation might include, but are not exclusive to:
   - Prolonged Ambulance offload times (e.g. > 15 minutes).
   - Long waits for patients to be assessed by clinicians (e.g. > 1 hour).
   - Occupancy of available chairs greater than 100%.
   - Use of the corridor area by patients (e.g. > 5 or more trolleys/ beds)
   - Delays between request for a bed and that bed being made available (e.g. > 1 hour).

- High proportion of patients in the AMU waiting area awaiting placement on an appropriate inpatient ward.

3. The Registered Provider must ensure that there are a sufficient number (based on demand) of suitably qualified, competent, skilled and experienced clinical staff placed in the corridor/waiting area, of the Acute Medical Unit entrance and GP triage referral area. The Registered Provider must ensure that staffing is flexed appropriately to meet the acuity and dependency of patients waiting to be seen, treated or admitted to the hospital, so as to ensure their safety.
4. The Registered Provider must, as soon as is reasonably practicable, and in any event by 12pm on 6 March 2017, describe the system the Registered Provider is operating in the Acute Medical Unit at Queen Alexandra Hospital, which incorporates the GP triage referral area and escalation area, so as to comply with the above conditions. The trust must send the Care Quality Commission an update every two weeks in this respect from the week commencing 13 March 2017 at 3pm.

Portsmouth Hospitals NHS Trust participated in the following CQC themed reviews:

- Review into how NHS trusts investigate and learn from deaths (July 2016).
- Joint targeted Area Inspection of services for children in Hampshire (December 2016).

Data quality

Portsmouth Hospitals NHS Trust submitted records during 2016/2017 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 December 2016:

Included the patient's valid NHS number:

- 99.4% for admitted patient care (national average 99.2%)
- 99.9% for outpatient care (national average 99.5%)
- 98.9% for accident and emergency care (national average 96.6%)

Included the patient's valid General Medical Practice Code:

- 99.9% for admitted patient care (national average 99.9%)
- 100.0% for out-patient care (national average 99.8%)
- 99.6% for accident and emergency care (national average 98.9%)

The Trust was not subject to a Payment by Results (PbR) clinical coding audit in 2016/2017 by the Audit Committee.

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 yearly self-assessments of compliance against the requirements.

Portsmouth Hospitals NHS Trust Information Governance Assessment Report overall score for 2016/2017 was 68% and was graded "Satisfactory".

The Trust reported five serious incidents to the Information Commissioner's Office (ICO). One was downgraded and therefore withdrawn. One remains open and relates to a national data breach by an external supplier which is being investigated by NHS Digital/ICO. The remaining three are all closed and no further action was required to be undertaken by the Trust.

The Trust received one external complaint to the ICO. Following an investigation the ICO closed the case and no further action was required.

An incident reported in 2015/16 has finally been closed following the prosecution of a former employee of the Trust. The former employee pleaded guilty and received a substantial fine.

NATIONAL QUALITY PRIORITIES

The following are a core set of indicators which are to be included in 2016/17 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/)

National Quality Priorities								
Domain	**SHMI**	**April 2015 – March 2016**		**July 2015 – June 2016**		**October 2015 – September 2016**		**Trust Statement**
		PHT	**Nat. Av.**	**PHT**	**Nat. Av.**	**PHT**	**Nat. Av.**	
Preventing people from dying prematurely. Enhancing quality of life for people with long-term conditions,	The value of the summary hospital-level mortality indicator ("SHMI") for the Trust.	1.098	1.00	1.1077	1.00	1.1096	1.00	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, and has taken the following actions to improve mortality and harm, and so the quality of its services, by: • Monitoring and acting upon underlying data. • Introduction of a daily mortality review panel (MRP) in November 2016 to review all deaths within Respiratory and latterly to MOPRS. All deaths within these areas are reviewed by independent clinicians (1/2 Senior Consultants and 1 Senior Nurse) the day after death (<72 hours for those following a death at the weekend). • This is to be rolled-out Trust-wide during 2017.
	The banding of the summary hospital-level mortality indicator ("SHMI") for the Trust.	As expected	As expected	As expected	As expected	As expected	As expected	
	The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust. The palliative care indicator is a contextual indicator	24.1%	28.5%	26.2%	22.3%	21.3%	29.7%	
	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	Patient Reported Outcome Measures (PROMs) finalised (EQ5D Index)	April 2013 – March 2014				April 2014 – March 2015				April 2015 – March 2016 *(Provisional)*				Trust Statement
		PHT	Nat. Av.	Highest	Lowest	PHT	Nat. Av.	Highest	Lowest	PHT	Nat. Av.	Highest	Lowest	
Helping people recover from episodes of ill health or following injury.	Groin hernia surgery	0.097	0.085	0.139	0.008	0.090	0.084	0.154	-0.005	*	0.088	0.157	0.021	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 the following actions to improve this outcome, and so the quality of its services, by: • Continuing to monitor its performance to ensure the operations our patients receive, continue to improve their health compared with their health before they had their operation. • Reviewing participation rates to ensure they meet the national average for each procedure. **Data not published due to small numbers of procedures.*
	Varicose vein surgery	*	0.093	0.150	0.022	*	0.095	0.154	-0.009	*	0.095	0.150	-0.005	
	Hip replacement surgery	0.457	0.436	0.544	0.311	0.422	0.436	0.524	0.331	0.447	0.438	0.544	0.320	
	Knee replacement surgery	0.329	0.322	0.425	0.215	0.278	0.315	0.418	0.183	0.308	0.320	0.398	0.186	

Note: April 2015 – March 2016 currently provisional (Published February 2017). Finalised version due for release August 2017.

Domain	Re-admission within 28 days of being discharged	April 2010 – March 2011				April 2011 – March 2012				Trust Statement
		PHT	Nat. Av.	Highest (Large Acute)	Lowest (Large Acute)	PHT	Nat. Av.	Highest (Large Acute)	Lowest (Large Acute)	
Helping people recover from episodes of ill health or following injury.	Percentage of patients aged 0 to 15	12.31%	9.96%	14.11%	6.41%	12.22%	10.02%	14.94%	6.40%	*This data has not been updated on the NHS Digital Portal since March 2014.* 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: • The Trust is able to identify frequent attenders to hospital. • CSC's identifying relevant patients; this information is included in their performance reviews.
	Percentage of patients aged 16 or over	10.87%	11.38%	14.06%	9.20%	10.75%	11.44%	13.80%	9.34%	

Not updated since 2013. Next version tbc

Domain	Trust responsive to the personal needs of its patients	April 2014 – March 2015				April 2015 – March 2016				Trust Statement
		PHT	Nat. Av.	Highest	Lowest	PHT	Nat. Av.	Highest	Lowest	
Ensuring that people have a positive experience of care.	In-patient survey (overall score)	73.6	76.6	87.4	67.4	75.4	77.3	88.0	70.6	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: • Identifying and agreeing with patients, families and carers, key areas for improvement. • Developing the role of volunteers and lay members in our local quality monitoring processes to provide contemporaneous and unbiased information about "how we are doing". • Further developing the ways in which patients, family members and carers can provide feedback including accessible surveys for people with learning disabilities and outreach to local community groups. • Working more closely with community groups including HealthWatch Portsmouth and Hampshire, to provide a two information flow between the hospital and the community we serve.

Domain	Staff who would recommend the Trust to their friends or family	2015				2016				Trust Statement
		PHT	Nat. Ave. (Acute trusts)	Highest	Lowest	PHT	Nat. Ave. (Acute trusts)	Highest	Lowest	
Ensuring that people have a positive experience of care.	National Staff Survey results	73%	69%	85%	46%	72%	70%	85%	49%	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. • Implementation of a 'Respect Me' prevention of workplace bullying and harassment campaign. • Continuing to develop a culture where staff feel safe to raise concerns and confident that any issues will be addressed and any resulting actions fed back. • Continuing the staff engagement programme so that staff are listened to, feel supported and able to make changes in their place of work for the benefit of patients and themselves. • Continuing to build on improving the quality of appraisals through training for managers. • Encouraging individuals and teams to show initiative and make suggestions for improvements; where staff are empowered to implement positive change and where success is celebrated and best practice is shared.

Domain	Patients who would recommend the Trust as a provider of care to their friends or family – A & E											Trust Statement
	Reporting period	Total Responses		Total Eligible		Response Rate		Score (% recommend)		Score (% not recommend)		
	A & E	England	PHT	England	PHT	England	PHT	England	PHT	England	PHT	
Ensuring that people have a positive experience of care	January '17	122,720	1,654	1,001,606	9,134	12.3%	18.1%	87%	95%	7%	2%	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: • Identifying and agreeing with patients, families and carers, key areas for improvement. • Developing the role of volunteers and lay members in our local quality monitoring processes to provide contemporaneous and unbiased information about "how we are doing". • Further developing the ways in which patients, family members and carers can provide feedback including accessible surveys for people with learning disabilities and outreach to local community groups. • Working more closely with community groups including HealthWatch Portsmouth and Hampshire, to provide a two information flow between the hospital and the community we
	December '16	113,419	1,913	1,027,394	9,119	11.0%	21.0%	86%	93%	8%	1%	
	November '16	131,880	1,442	1,037,613	9,466	12.7%	15.2%	86%	93%	7%	1%	
	October '16	138,532	1,427	1,086,090	9,865	12.8%	14.5%	86%	95%	8%	2%	
	September '16	138,171	2,122	1,062,401	10,001	13.0%	21.2%	86%	93%	8%	2%	
	August '16	144,620	2,319	1,058,768	10,250	13.7%	22.6%	87%	95%	7%	1%	
	July '16	145,631	1,756	1,127,323	10,688	12.9%	16.4%	85%	93%	8%	2%	
	June '16	143,285	2,719	1,071,432	9,729	13.4%	27.9%	86%	95%	7%	2%	
	May '16	142,319	1,523	1,119,540	10,365	12.7%	14.7%	85%	94%	8%	2%	
	April '16	131,176	1,551	1,018,602	9,155	12.9%	16.9%	86%	94%	8%	2%	
	March '16	132,774	1,833	1,108,498	9,742	12.0%	18.8%	84%	95%	9%	2%	
	February '16	133,861	1,386	1,003,240	9,015	13.3%	15.4%	85%	94%	8%	3%	

Domain	Patients who would recommend the Trust as a provider of care to their friends or family – A & E										
	Reporting period	Total Responses		Total Eligible		Response Rate		Score (% recommend)		Score (% not recommend)		Trust Statement
												serve. • Implementing an 'early warning system' for negative FFT responses allowing for early detection and resolution of immediate areas of concern.

Domain	Patients who would recommend the Trust as a provider of care to their friends or family – Inpatients											
	Reporting period	Total Responses		Total Eligible		Response Rate		Score (% recommend)		Score (% not recommend)		Trust Statement
	Inpatients	England	PHT	England	PHT	England	PHT	England	PHT	England	PHT	
Ensuring that people have a positive experience of care	January '17	199,352	2,347	863,097	8,204	23.1%	28.6%	95%	97%	2%	1%	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: • Identifying and agreeing with patients, families and carers, key areas for improvement. • Developing the role of volunteers and lay members in our local quality monitoring processes to provide contemporaneous and unbiased information about "how we are doing". • Further developing the ways in
	December '16	186,577	2,482	851,513	7,845	21.9%	31.6%	95%	96%	2%	1%	
	November '16	223,106	2,177	904,437	8,600	24.7%	25.3	95%	96%	2%	1%	
	October '16	212,375	2,386	882,689	8,524	24.1%	28.0%	95%	95%	2%	1%	
	September '16	212,630	2,386	888,912	8,468	23.9%	28.2%	95%	97%	2%	1%	
	August '16	213,961	2,623	874,563	8,562	24.5%	30.6%	95%	97%	2%	1%	
	July '16	219,256	2,394	886,203	8,153	24.7%	29.4%	95%	96%	2%	0%	
	June '16	230,581	2,786	902,709	8,489	25.5%	32.8%	95%	96%	2%	1%	

Domain	Patients who would recommend the Trust as a provider of care to their friends or family – Inpatients										Trust Statement
	Reporting period	Total Responses		Total Eligible		Response Rate		Score (% recommend)		Score (% not recommend)		
	Inpatients	England	PHT	England	PHT	England	PHT	England	PHT	England	PHT	
	May '16	215,706	1,889	866,254	8,071	24.9%	23.4%	96%	95%	2%	1%	which patients, family members and carers can provide feedback including accessible surveys for people with learning disabilities and outreach to local community groups. • Working more closely with community groups including HealthWatch Portsmouth and Hampshire, to provide a two information flow between the hospital and the community we serve. • Implementing an 'early warning system' for negative FFT responses allowing for early detection and resolution of identified areas of concern.
	April '16	208,422	1,881	852,172	7,943	24.5%	23.7%	96%	96%	1%	1%	
	March '16	200,922	2,253	867,277	8,400	23.2%	26.8%	95%	96%	2%	1%	
	February '16	204,909	2,005	851,475	7,938	24.1%	25.3%	95%	96%	2%	1%	

Domain	VTE Risk Assessment Percentage of patients receiving a VTE Risk Assessment	PHT	National Average (Acute Trusts)	Highest	Lowest	Trust Statement
Treating and caring for people in a safe environment and protecting them from avoidable harm.	Quarter 3 2016-17	94%	96%	100%	76%	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: • Sending daily lists of non-assessed patients to Management and Ward teams to highlight areas where improvement is needed. • Delivery of patient information regarding prevention of VTE has been reviewed and new information is being co-designed with patients.
	Quarter 2 2016-17	96%	95%	100%	72%	
	Quarter 1 2016-17	97%	96%	100%	80%	
	Quarter 4 2015-16	97%	95%	100%	78%	

Domain	Rate per 100,000 bed days of C.Difficile infection	April 2014–March 2015				April 2015–March 2016				Trust Statement
		PHT	Nat. Av.	Highest	Lowest	PHT	Nat. Av.	Highest	Lowest	
Treating and caring for people in a safe environment and protecting them from avoidable harm.	Rate per 100,000 bed days of C.Difficile infection amongst patients aged 2 or over.	11.9	15.0	62.2	0	8.4	14.9	66.0	0	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 rate, and so the quality of its services, by: • Undertaking root cause analyses of all hospital-attributed cases to identify learning and appropriate actions. Prompt isolation and rigorous testing of all suspected cases of C.Diff was a continued focus. In addition to this, the Trust emphasised the importance of excellent cleaning standards as well as hand hygiene for patients and staff. The Trust will continue to concentrate on these aspects throughout 2017/18. • Antimicrobial stewardship will continue to be a focus throughout 2017/18, alongside both the national Sepsis and Antimicrobial stewardship CQUIN requirements. • Re-launching the hand hygiene campaign in 2017/18 which will highlight the importance of hand hygiene for patients as well as staff, in order to reduce the risk of ingestion of spores.

Domain	Patient Safety Incidents (per 1,000 bed days) (Acute non-specialist)	October 2015–March 2016				April 2016–September 2016				Trust Statement
		PHT	National Average	Highest	Lowest	PHT	National Average	Highest	Lowest	
Treating and caring for people in a safe environment and protecting them from avoidable harm.	Number of patient safety incidents.	3,757	4,818	11,998	1,499	6,433	4,955	13,485	1,485	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: • Increasing scrutiny of Serious Incidents through Executive panels. • Increased scrutiny and identification of learning through the Serious Incident Review Group. • Implementing an upgrade to the Datix Web reporting system on 1st April 2016. • Simplifying the reporting form. • Providing extensive training and awareness sessions. • Ensuring timely review and upload of reported patient safety incidents.
	Rate of patient safety incidents.	21.7	39.6	75.9	14.8	36.07	40.7	71.8	21.1	
	Number of patient safety incidents that resulted in severe harm or death.	35	19	94	0	44	19	98	1	
	% of patient safety incidents that resulted in severe harm or death.	0.93%	0.43%	2.04%	0.00%	0.68%	0.40%	1.73%	0.02%	

REVIEW OF QUALITY PERFORMANCE

This part of the Quality Account provides an overview of how we have performed against quality initiatives in 2016/2017. 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 2016/2017 presented to the Trust Board in May 2017.

QUALITY SCORECARD

	Performance Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Variation	Q1	Q2	Q3	Q4	YTD	Monthly trend line	2015/16 Outturn
SAFETY	**Pressure ulcers**																					
	Grade 4 - Avoidable hospital acquired	Monitor	0	0	0	0	0	0	0	0	0	0	0	0	→	0	0	0	0	0		0
	Grade 3 - Avoidable hospital acquired	Monitor	4	2	1	0	0	3	1	2	2	1	0	1	↓	7	3	5	2	17		15
	Grade 3 unavoidable	Monitor	3	10	1	2	1	3	3	3	7	4	3	0	↑	14	6	13	7	40		31
	Grade 1 and 2	Monitor	16	13	5	8	6	6	8	12	16	21	24	20	↑	34	20	36	65	155		218
	Pressure ulcers per 1,000 occupied bed days (Confirmed moderate and severe harm incidents)	Monitor	0.1	0.1	0.0	0.0	0.0	0.1	0.0	0.1	0.1	0.0	0.0	0.0	→	0.1	0.0	0.07	0.00	0.0		-
	Falls																					
	Total falls incidents reported	Monitor	222	229	198	208	238	237	252	234	209	208	248	248	↑	649	683	695	704	2731		-
	Falls resulting in severe harm (confirmed including SIRIs) Monthly numbers subject to change as incidents are confirmed	Monitor	1	1	2	4	0	5	5	2	6	2	3	3	→	4	9	13	8	34		34
	Falls resulting in moderate harm (confirmed) Monthly numbers subject to change as incidents are confirmed	Monitor	1	3	0	0	0	1	1	1	0	1	0	0	→	4	1	2	1	8		15
	Falls per 1,000 occupied bed days (Confirmed moderate and severe harm incidents)	2.0 on average each quarter	0.0	0.1	0.1	0.1	0.0	0.2	0.2	0.1	0.2	0.1	0.1	0.1	→	0.1	0.1	0.2	0.1	0.1		-
	Medication																					
	Total medication incidents reported	Monitor	132	166	129	115	141	150	192	184	188	168	158	189	↑	427	406	564	515	1912		-
	Medication incidents resulting in severe harm (confirmed) Monthly numbers subject to change as incidents are confirmed	Monitor	1	0	0	0	0	0	0	0	0	0	0	1	↓	1	0	0	1	2		1
	Medication incidents resulting in moderate harm (confirmed) Monthly numbers subject to change as incidents are confirmed	Monitor	2	4	1	0	0	0	1	0	0	1	0	0	→	7	0	1	1	9		21
	Medication incidents per 1,000 occupied bed days (Confirmed moderate and severe harm incidents)	0.5 on average each quarter	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	→	0.1	0.0	0.0	0.0	0.0		-
	NHS Safety Thermometer																					
	Total harm free care	Monitor	93.90%	92.28%	94.40%	94.30%	96.60%	94.20%	95.60%	95.80%	96.20%	95.84%	95.90%	96.80%	↑	93.53%	95.03%	95.87%	96.18%	95%		-
	Trust harm free care	Monitor	97.70%	97.80%	97.80%	99.00%	99.00%	98.10%	98.80%	98.40%	97.90%	97.80%	98.50%	98.40%	→	97.77%	98.70%	98.37%	98.23%	98%		-
	Healthcare Acquired Infection																					
	MRSA - Avoidable	Zero	0	0	0	0	0	0	0	0	0	0	0	0	→	0	0	0	0	0		1
	MRSA - Unavoidable	Monitor	0	0	0	0	0	0	1	0	0	0	0	0	→	0	0	1	0	1		0
	C.Difficile	40 cases	4	1	1	3	4	3	1	5	2	6	2	1	↑	6	10	8	9	33		29
	Monitoring of incidents																					
	Never Events	Zero	1	0	1	0	0	0	0	0	2	0	0	1	↑	2	0	2	1	5		0
	Serious Incidents Requiring Investigations (SIRIs)	Monitor	32	40	8	9	3	12	12	9	16	40	94	116	↓	80	24	37	250	391		125
	SIRIs unresolved >60 days	Monitor	3	3	5	3	1	2	2	2	2	1	3	3	→	11	6	6	7	30		28
	Duty of Candour breaches	Zero	0	0	0	0	0	0	0	0	0	0	0	0	→	0	0	0	0	0		0
	Patient safety incidents (excluding SIRIs)	Monitor	1521	1498	1484	1457	1487	1471	1493	1566	1473	1512	1570	1802	↑	4503	4415	4532	4884	18334		11555
	CAS alerts over deadline	Monitor	0	0	0	0	0	0	0	0	0	0	0	0	→	0	0	0	0	0		0
	Other safety metrics																					
	Venous Thrombo-embolus (VTE) screening	95% per month	96.60%	96.80%	96.60%	97.00%	95.80%	95.80%	95.80%	95.70%	91.10%	95.10%	96.10%	96.14%	↓	96.63%	96.20%	94.20%	95.45%	96%		97.49%
	Hospital Acquired VTE SIRIs	Monitor	1	0	0	0	0	0	0	0	0	0	0	0	→	1	0	0	0	1		1

QUALITY SCORECARD

Domain	Performance Indicator	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Variation	Q1	Q2	Q3	Q4	YTD	Monthly trend line	2015/16 Outturn
EFFECTIVENESS	**Diagnosis and treatment of Acute Kidney Injury**																					
	Acute Kidney Injury - data sets on discharge summary	90% on average each quarter	88.0%	89.0%	92.0%	88.0%	94.0%	87.0%	89.0%	93.0%	93.0%	90.0%	92.0%	91.0%	↑	90%	90%	92%	91.0%	91%		
	Trust-wide mortality																					
	Trust Hospital Standardised Mortality Ratio (HSMR)	Within expected range	99.46	98.77	100.64	108.11	109.3	109.3	109.43	108.18	109.77	110.11	109.82	109.92	↓	99.62	108.90	109.13	109.95	106.9		101.5
	Summary Hospital-level Mortality Indicator (SHMI)	Within expected range	107.32	107.32	107.11	107.11	107.11	107.11	107.11	107.11	107.11	111.04	110.77	110.77	→	107.28	107.11	107.11	110.86	108.1		107.5
CARING	**Dementia**																					
	Dementia - case finding question	≥ 90% each quarter	94.20%	93.70%	94.5%	96.2%	90.7%	92.5%	93.2%	77.9%	83.4%	70.3%	74.8%	74.3%	→	94.1%	93.1%	78.2%	73.1%	85%		95.33%
	Dementia - Diagnostic Assessment	≥ 90% each quarter	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	=	100%	100.0%	100.0%	100.0%	100%		100.0%
	Dementia - Care plan on discharge	≥ 90% each quarter	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	=	100%	100.0%	100.0%	100.0%	100%		-
	Mixed sex accommodation breaches																					
	Non-clinically justified single sex accommodation breaches	Zero	0	0	0	0	0	0	0	0	0	4	0	0	=	0	0	0	4	4		1
	Single sex accommodation breaches relating to facilities	Zero	0	0	0	0	0	0	0	0	0	0	0	0	=	0	0	0	0	0		0
WELL-LED	**Complaints and PALS**																					
	Number of Complaints	Monitor	71	55	71	45	70	47	69	56	37	54	63	54	↑	197	162	162	117	638		649
	Complaints acknowledged < 3 working days	Monitor	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	→	100%	100%	100%	100%	100%		100%
	Complaints per 1,000 contacts (all types) (reported 1 month in arrears)	Monitor	0.92	0.70	0.86	0.58	0.85	0.57	0.85	0.65	0.49	0.65	0.83	-	-	0.83	0.67	1.00	0.65	0.83		-
	PALs transferred to complaints	Monitor	-	2	1	0	1	4	4	0	1	3	4	4	→	3	5	5	7	20		35
	Patient moves																					
	Non-clinical patient moves 2100 - 0000	<3 after 2100	170	183	153	202	157	148	178	168	144	209	174	217	↓	506	507	488	383	1884		-
	Non-clinical patient moves 0001 - 0700	<3 after 2100	155	123	82	73	70	58	135	132	79	112	120	115	↓	360	201	346	232	1139		-
	Friends and Family Test																					
	In-patient and day case response rate	Not fall below 15%	23.7%	23.4%	32.8%	29.4%	30.6%	28.2%	28.0%	25.3%	31.6%	28.6%	30.60%	30.40%	=	26.6%	29.4%	28%	30%	28%		24.26%
	Emergency Department response rate	Not fall below 15%	16.9%	14.7%	27.9%	16.4%	22.6%	21.2%	14.5%	15.2%	21.0%	18.1%	14.40%	14.40%	→	19.8%	20.1%	17%	16%	18%		16.78%
	In-patient percentage recommend - positive	Similar or above national average	96.2%	93.9%	95.9%	96.3%	96.5%	96.8%	95.5%	96.1%	95.6%	97.0%	97.0%	96.30%	↓	95.3%	96.5%	96%	97%	96%		96.40%
	In-patient percentage recommend - negative	Similar or above national average	0.6%	1%	0.9%	0.4%	0.7%	1%	1.2%	1%	1%	0.5%	0.5%	0.80%	↓	0.8%	0.7%	1.1%	1%	0.8%		0.80%
	Emergency Department percentage recommend - positive	Similar or above national average	94.5%	93.9%	95.0%	93.5%	94.6%	93.2%	95.1%	93.3%	93.4%	95.2%	94.30%	94.10%	=	94.5%	93.8%	94%	95%	94%		93.40%
	Emergency Department percentage recommend - negative	Similar or above national average	2.1%	2.4%	1.7%	2.3%	1.3%	2.5%	1.6%	1.3%	1.2%	1.6%	2.30%	1.40%	↑	2.1%	2.0%	1%	2%	2%		2.40%
	Maternity percentage recommend - positive	Maximise responses	99.3%	97.8%	99.1%	99.4%	99.0%	99.8%	98.5%	99.4%	100.0%	99.3%	98.60%	99.60%	↑	98.7%	99.4%	99%	99%	99%		98.53%
	Maternity percentage recommend - negative	Maximise responses	0.1%	1.0%	1.0%	0.6%	1.0%	0.2%	1.5%	0.6%	0%	0.7%	1.40%	0.40%	↑	0.7%	0.6%	1%	1%	1%		-
	Maternity response rate	Monitor	17.4%	15.4%	17.5%	18.7%	20.1%	32.3%	15.0%	10.6%	19.3%	17.4%	17.3%	13.7%	↓	16.8%	23.7%	15%	17%	18%		23.73%
	Maternity response rate question 2	Not fall below 15%	25.1%	23.7%	27.7%	24.1%	27.4%	32.0%	17.5%	13.8%	25.7%	16.5%	17.6%	20.7%	↑	25.5%	27.8%	19%	17%	22%		-

Care Quality Commission

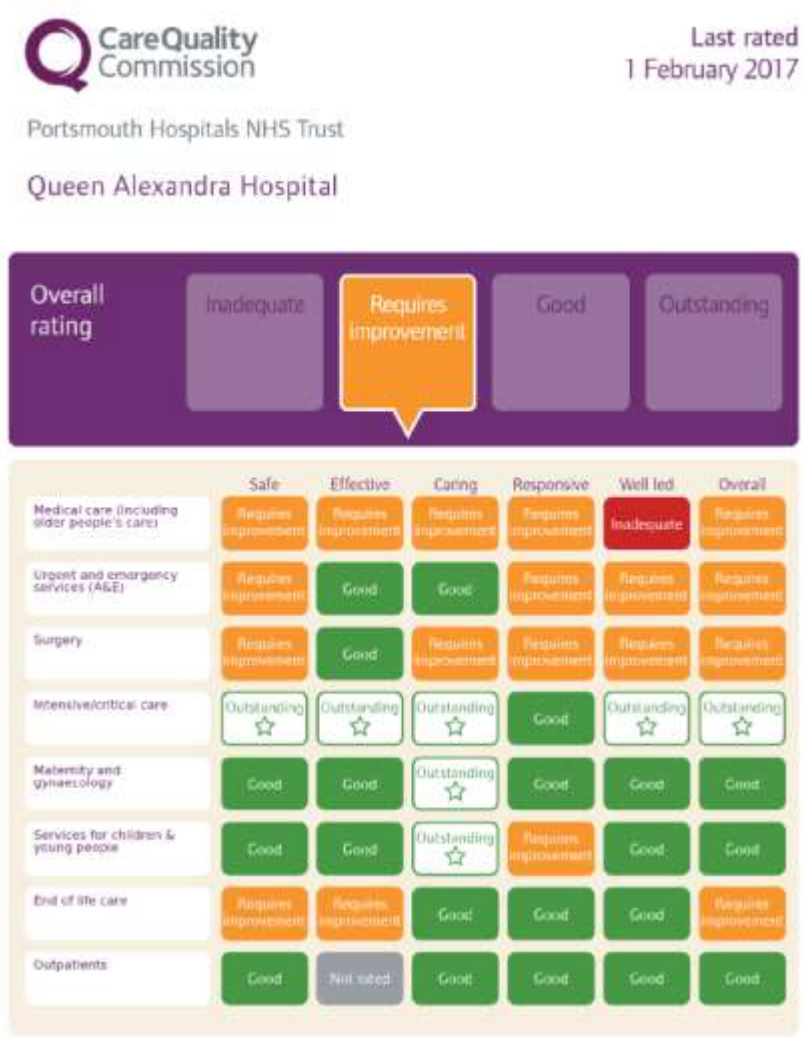
The inspection by the CQC in February 2016 resulted in the Trust receiving an Enforcement Notice due to on-going safety concerns relating to the Emergency Department for which the Trust received an Enforcement Notice.

The CQC undertook an unannounced inspection of the Trust on the 29th and 30th September 2016; during this inspection the CQC found that significant improvements in patient safety had been made and proposed to remove the conditions. Following the inspections in September, the Trust received requirement notices for which an action plan to address the issues was developed. This plan has subsequently been reported monthly to Trust Board. The final report from the September inspections was published by the CQC on the 1st February 2017, following which the Trust was required to provide a detailed action plan.

The CQC undertook further unannounced inspections on the 16th and 17th February, returning again on the 28th February. As a result of these inspections, on the 3rd March, the CQC imposed four conditions on the Trust:

1. The Registered Provider of the Acute Medical Unit (AMU) must ensure that beds only remain open in respect of which the required level of staffing can be provided. The Registered Provider must ensure that beds are opened for patient use, and closed to patient use if care and treatment at the appropriate level can no longer be provided for patients on the AMU.
2. The registered provider must ensure that the GP triage referral area has in place, and operates effectively a clearly defined standard operating procedure for crowding and escalation for patient safety concerns. This includes having clearly defined trigger points for escalation of crowding and safety concerns in the GP triage referral area.
3. The Registered Provider must ensure that there are a sufficient number (based on demand) of suitably qualified, competent, skilled and experienced clinical staff placed in the corridor/waiting area, of the AMU entrance and GP triage referral area. The Registered Provider must ensure that staffing is flexed appropriately to meet the acuity and dependency of patients waiting to be seen, treated or admitted to the hospital, so as to ensure their safety.
4. The Registered Provider must, as soon as is reasonably practicable, and in any event by 12pm on 6 March 2017, describe the system the Registered Provider is operating in the Acute Medical Unit at Queen Alexandra Hospital, which incorporates the GP triage referral area and escalation area, so as to comply with the above conditions. The trust must send the Care Quality Commission an update every two weeks in this respect from the week commencing 13 March 2017 at 3pm.

The Trust undertook a review of all correspondence, both from and to the CQC and developed a short term action plan to ensure all actions raised by the CQC from the February inspections had been addressed and actioned accordingly. The subsequent inspections and issues raised by the CQC have led to the requirement for the need to comprehensively review the action plan submitted to the CQC following receipt of the final report in February. As a result, the Trust is in the process of assembling a more comprehensive action plan than that originally submitted to the CQC.

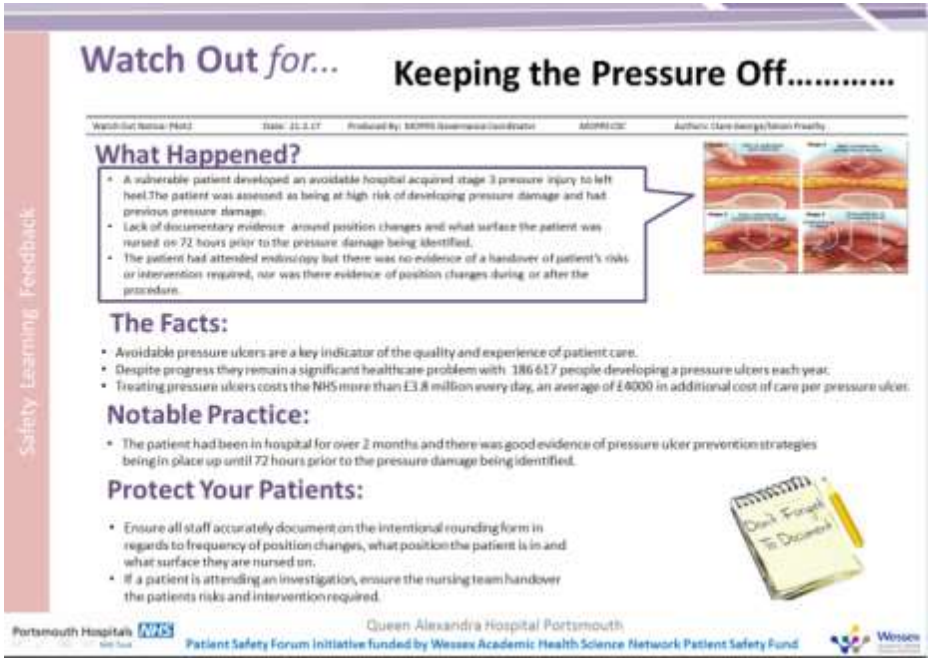


Patient Safety

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.



We are committed to providing a safe and effective care experience for our patients and to reducing harm events to the lowest possible level. During 2016/2017, we have focussed our attention on a number of key safety priorities, including:

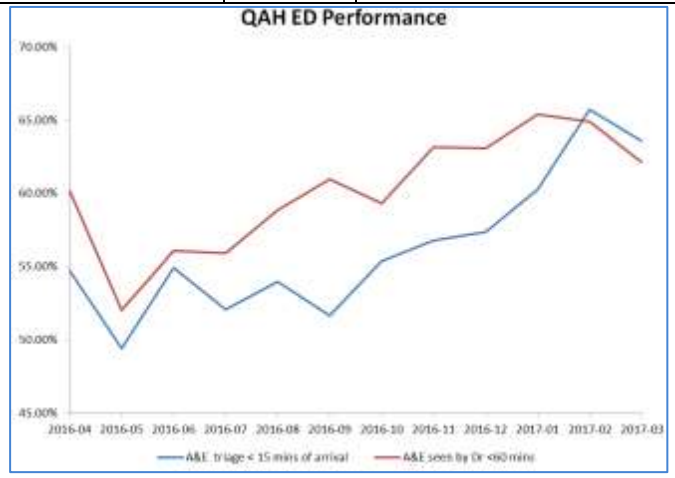
- Participation in the Wessex Patient Safety Collaborative aimed at improving the care of the deteriorating patient. As part of this Collaborative we have developed the ‘time to act’ programme which follows on from ‘Stop the Red Clocks’.
- Invitation to participate in the NHS Improvement Falls Collaborative as it has been recognised that our falls prevention work is further advanced than many acute trusts. We are focussing this work on two specific areas to test out new modes of working.
- Funding from the Wessex Academic Health Science Network Patient Safety Fund has allowed us to site networked screens in a number of staff areas. These screens will show ‘Watch Out’ notices to improve the dissemination of important patient safety messages in a timely and more visible manner to a greater number of staff.

PATIENT SAFETY IN THE EMERGENCY PATHWAY

CLINICAL ASSESSMENT WITHIN 15 MINUTES OF ARRIVAL AND TREATMENT WITHIN 60 MINUTES IN THE EMERGENCY DEPARTMENT ✓

- The creation of PITSTOP (a dedicated assessment and triage area) in ED Majors for patients arriving by ambulance, staffed by a Consultant or Senior Registrar Doctor has enabled the increase in early triage and assessment of ambulance patients.
- A Navigator Nurse role based in ED Reception has led to an increase in self referred patients undergoing a clinical assessment in 15 minutes.
- The challenge remains at weekends and out of hours when demand increases during periods when the number of Consultants or Senior Registrar Doctors decrease despite every effort being made to recruit to these posts.

Metric (ambulance patients)	Average	Commentary
Clinical Assessment within 15 mins.	86-99%	76% of all patients received a clinical assessment in 15 mins.
Seen by appropriate clinician within 60 mins.	98-100%	60% of all patients seen by appropriate clinician in 60 mins.



DELIVERY OF THE URGENT CARE TRANSFORMATION PLAN WHICH SUPPORTS IMPROVEMENT IN THE UNSCHEDULED CARE PATHWAY ✓

The Urgent Care Transformation Programme has supported key work streams explicitly aiming to improve the quality of care and patient experience across the urgent care pathway.

- Acute Medical Unit: A review of ways of working to ensure beds are allocated and patients moved in a timely manner, reducing delays.
- Medical Take Model: Consultant working pattern has been refreshed ensuring Consultants are able to see 'todays patients today' with reduced delays.
- Short Stay Unit opened on 1st June 2016 dedicated to caring for patients with a length of stay of less than 72 hours. Supported by an expanded team of Doctors, Nurses, Therapists, Pharmacists and Social Workers, over 55% of patients admitted are discharged home within 72 hours.
- Ambulatory Emergency Care: Additional care spaces creased to enable more patients to follow an ambulatory pathway, avoiding the need for admission. Ambulatory care pathways have been reviewed to increase access to a wider range of patients reducing pressure on ED and in-patient beds.
- Acute Frailty Pathway: The Frailty and Interface Team (FIT), consisting of Elderly Care Consultants, elderly care experienced nurses, therapists and Social Workers are in place. They are dedicated to supporting frail patients who arrive in ED to be discharged home rather then being admitted; if admission is required they make sure a supported discharge home as soon as safe and possible is achieved.
- Ward Discharges: Implementation of SAFER methodologies, a way of early planning of a patients discharge involving the patient and ensuring all delays to a timely discharge are removed.

HEALTHCARE ASSOCIATED INFECTIONS

MRSA: 0 (ZERO) CASES OF HOSPITAL ACQUIRED ✓

C.DIFF: NO MORE THAN 40 CASES ✓

Healthcare Associated Infections (HCAI) are infections that are acquired in healthcare settings, 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.

MRSA:

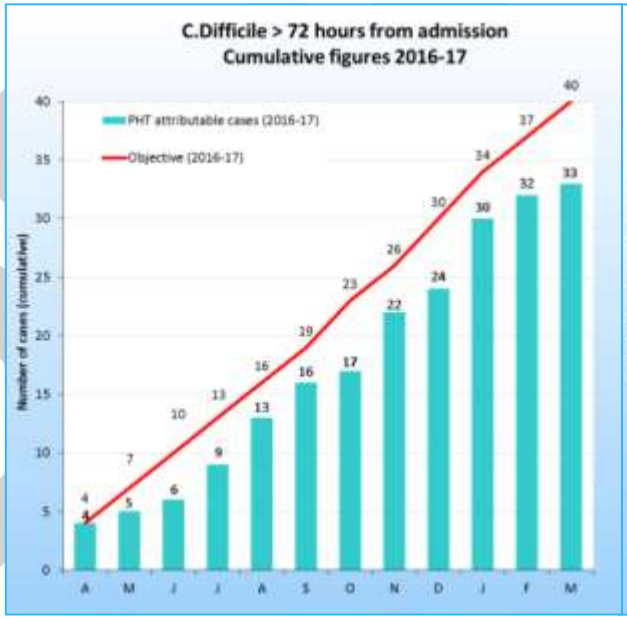
The Trust's year-end position is 1 unavoidable and 0 (zero) avoidable cases, against an objective of 0 (zero) avoidable cases; this remains below the national average.

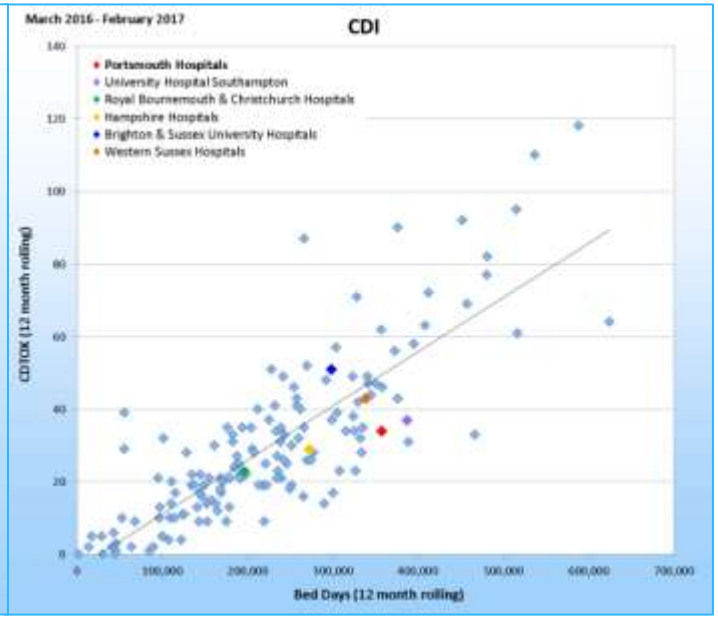
The Trust reported no patients with MRSA bacteraemia attributed to the Trust during 2016/2017. There was one unavoidable MRSA bacteraemia attributed to the Trust in October 2016 within the Neonatal Unit.

C.Difficile:

The Trust's year-end position is 33 cases of C.Diff against an annual objective of 40; the rate of hospital attributed C.difficile remains below the national average.

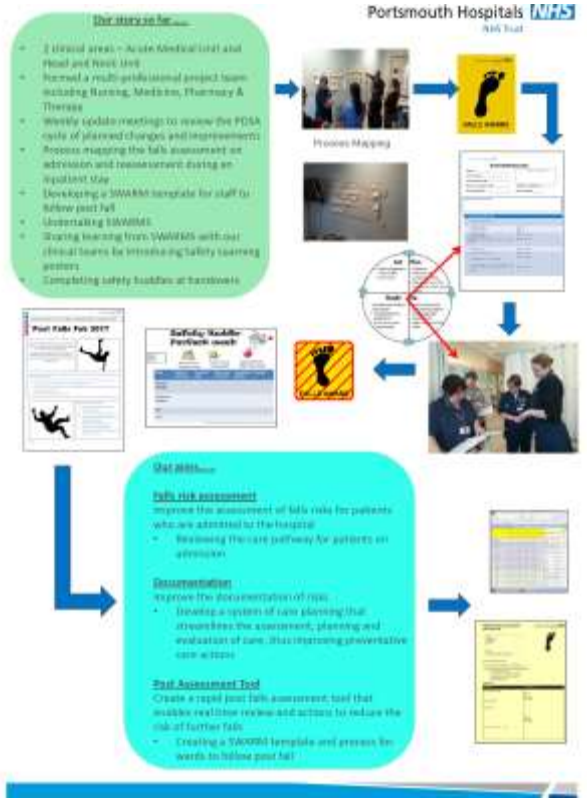
Root cause analysis meetings of cases continue to be held to identify learning and associated actions. Ribotyping of all hospital attributed cases is also carried out as an indication of patient-to-patient cross transmission. In quarter 4, 1 case was later found to be the same strain as another patient on the ward, therefore suggesting cross-transmission. An action plan has been implemented on the ward involved.





FALLS INCIDENTS

A RATE OF LESS THAN 2.0 PER 1,000 OCCUPIED BED DAYS (INCIDENTS CAUSING MODERATE, SEVERE OR CATASTROPHIC HARM) AVERAGE OVER EACH QUARTER ✓



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.

We were invited to participate in the NHS Improvement Falls Collaborative as it has been recognised that our falls prevention work is further advanced than many acute trusts. The Collaborative includes a 90 day improvement programme aimed at reducing injurious falls. We are using a rapid improvement methodology focussing initially on the Acute Medical Unit (AMU) and ward D8. Our intention is to roll out this piece of work across the organisation following the completion of the 90 day programme.

The current year-to-date position is 42 confirmed falls incidents, 34 resulting in severe harm and 8 resulting in moderate harm. This has resulted in the Trust recording a total of 0.1 falls incidents resulting in moderate, severe or catastrophic harm per 1,000 occupied bed days in quarters 1, 2 and 4 and 0.2 in quarter 3; therefore, achieving the required target.

Falls incidents

n.b: incident numbers updated to reflect the current position and therefore may be different to those previously reported.

	Month	Total falls incidents reported	Confirmed incidents		Rate per 1,000 occupied bed days
			Moderate	Severe	
Quarter 1	April '16	210	1	1	0.1
	May '16	204	3	1	0.1
	June '16	192	0	2	0.1
	Total	**606**	**4**	**4**	**0.1**
			8		
Quarter 2	July '16	202	0	4	0.1
	Aug. '16	232	0	0	0.0
	Sept. '16	218	1	5	0.2
	Total	**652**	**1**	**9**	**0.1**
			10		
Quarter 3	Oct. '16	244	1	5	0.2
	Nov. '16	223	1	2	0.1
	Dec. '16	201	0	6	0.2
	Total	**668**	**2**	**13**	**0.2**
			15		
Quarter 4	Jan '17	202	**1**	**2**	0.1
	Feb'17	248	**0**	**3**	0.1
	Mar'17	223	**0**	**3**	0.1
	Total	**673**	**1**	**8**	**0.1**
			9		

MEDICATION INCIDENTS

A RATE OF LESS THAN 0.5 PER 1,000 OCCUPIED BED DAYS (INCIDENTS CAUSING MODERATE, SEVERE OR CATASTROPHIC HARM) AVERAGE OVER EACH QUARTER ✓

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.

Reporting medication safety incidents is actively encouraged as an increase in reporting rate is an indication of a good safety culture and enables increased feedback and learning. A 10% increase in reporting of medication safety learning events has been achieved during 2016/2017, with a total of 2,043 incidents being reported in 2016/17, exceeding 2000 for the first time (1336 in 2014/15, 1849 reported in 2015/16).

Whilst there has been an increase in reporting overall, there has been a reduction in moderate harm incidents compared to last year, with 11 confirmed incidents to date (2 resulting in severe harm and 9 resulting in moderate harm with 3 moderate harm incidents remaining under investigation), compared to 22 last year. The reported percentage of medication safety incidents causing any degree of harm was 12.2% and this will be monitored for variance across the clinical service centres.

Medication incidents

n.b: incident numbers updated to reflect the current position and therefore may be different to those previously reported.

	Month	Total medication incidents reported	Confirmed incidents		Rate per 1,000 occupied bed days
			Moderate	Severe	
Quarter 1	April '16	142	2	1	0.1
	May '16	185	4	0	0.1
	June '16	142	1	0	0.0
	Total	**469**	**7**	**1**	**0.1**
			8		
Quarter 2	July '16	133	0	0	0.0
	Aug. '16	157	0	0	0.0
	Sept. '16	163	0	0	0.0
	Total	**453**	**0**	**0**	**0.0**
			0		
Quarter 3	Oct. '16	197	1	0	0.0
	Nov. '16	191	0	0	0.0
	Dec. '16	200	0	0	0.0
	Total	**588**	**1**	**0**	**0.0**
			1		
Quarter 4	Jan '17	179	**1**	**0**	**0.0**
	Feb'17	165	**0**	**0**	**0.0**
	Mar'17	189	**0**	**1**	**0.0**
	Total	**533**	**1**	**1**	**0.0**
			2		

The current year-to-date position is 11 confirmed medication incidents; 2 resulting in severe harm and 9 resulting in moderate harm.

This has resulted in the Trust recording a total of 0.0 medication incidents resulting in moderate, severe or catastrophic harm per 1,000 occupied bed days in quarters 2, 3 and 4 and in total for 2016/2017; therefore, achieving the required target.

NON-SURGICAL INTERVENTIONS

INTRODUCE RISK ASSESSMENT AND KEY SAFETY CHECKS FOR ALL GRADES OF NON-SURGICAL INTERVENTIONS

NHS England published a set of new safety standards to support NHS hospitals to provide safer surgical care in September 2015.

The National Safety Standards for Invasive Procedures (NatSSIPs) set out the key steps necessary to deliver safe care for patients undergoing invasive procedures, which have the potential to be associated with a Never Event. The Trust remit is to assess our documentation, culture and practice to develop Local Safety Standards (LoCSSIPs) which incorporate the NatSSIPs recommendations. The implementation group has been commissioned by the Trust Medical Director, the Trust Deputy Medical Director and Patient Safety Group and has a Clinical Lead by the way of a Consultant Anaesthetist.

Scope of procedures

- All surgical and interventional procedures performed in operating theatres, outpatient treatment areas, labour ward delivery rooms, and other procedural areas within Portsmouth Hospitals NHS Trust.
- Surgical repair of episiotomy or genital tract trauma associated with vaginal delivery.
- Invasive cardiological procedures such as cardiac catheterisation, angioplasty and stent insertion.
- Endoscopic procedures such as gastroscopy and colonoscopy.
- Interventional radiological procedures.
- Thoracic interventions such as bronchoscopy and the insertion of chest drains.
- Biopsies and other invasive tissue sampling.

We have made a promising start with evidence of engagement with implementation of Local Safety Standards for Invasive procedures. We have prioritised the Individual Patient Pathway Safety Checklist and are on track to have implementation across the Trust, having identified the outlying specialities yet to produce their documentation.

We have tested many aspects of the NatSSIPs standards across the Trust and identified areas of excellent practice. We have also identified some aspects which we can act on in the near future and many which are larger integrated projects.

The next phase is to improve our audit process to ensure implementation is fully realised and to ensure input at department level to ensure that the LocSSIP culture is embedded. We have made progress but need an intensive period of engagement and workshops to improve practice and embed new initiatives.

Harm free care

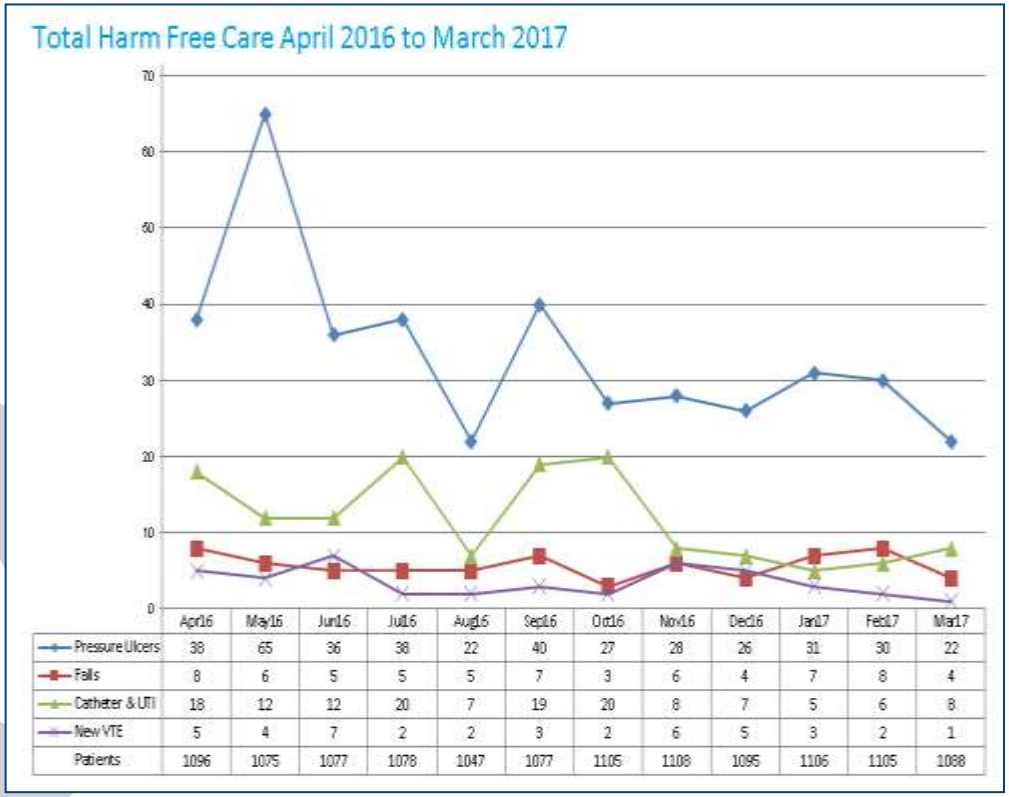
To help us monitor the safety of our patients we use NHS Digital's tool called the Safety Thermometer. We use this tool each month to audit the care given to our patients. The tool helps us to understand how well we are doing and highlights areas for further improvement.

The Safety Thermometer allows us to measure the number of patients that are 'harm free' during the day of the audit. The tool covers four types of harm:

- Pressure ulcers.
- Falls.
- Urinary Tract Infections in patients who have a catheter.
- Blood clots (VTE).

As can be seen by the graph, during 2016/17 improvements have been seen in all categories of harm; directly influencing our total harm free care rate. This has led to an overall improvement as follows:

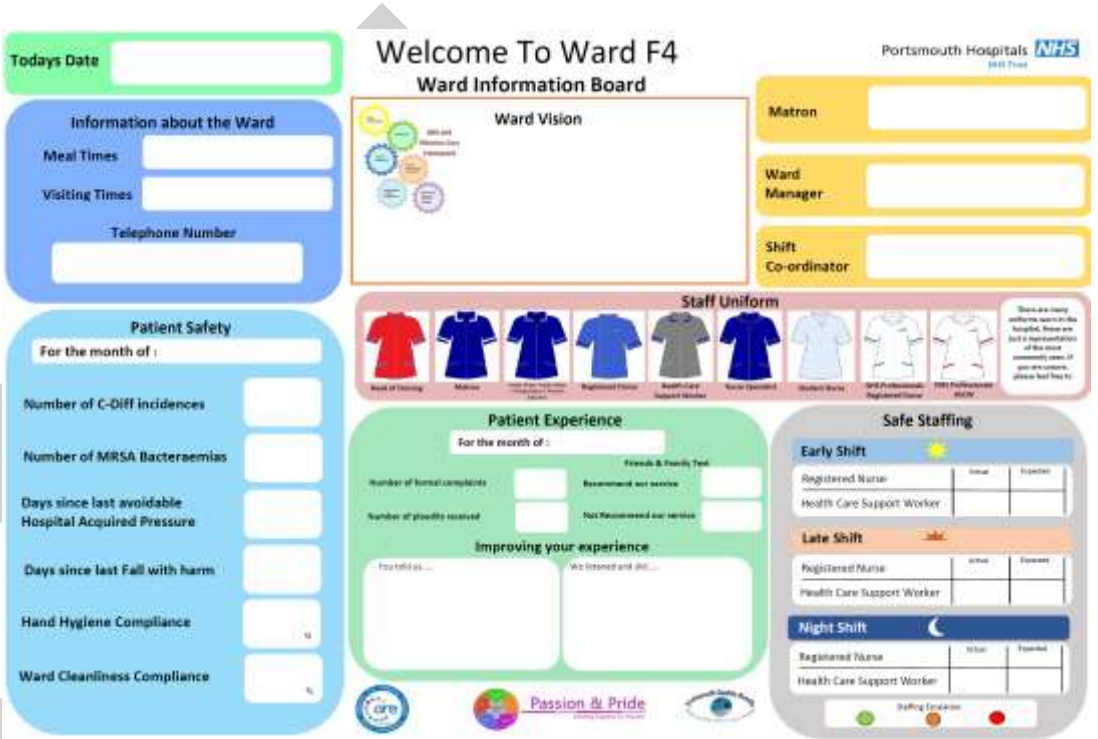
- Total harm free care has improved to 95.2% (2016/17) compared to 94.7% (2015/16).
- The Trust average total harm free care is 98.3% (2016/17) compared to 97.8% (2015-2016).



	Apr16	May16	Jun16	Jul16	Aug16	Sep16	Oct16	Nov16	Dec16	Jan17	Feb17	Mar17
Pressure Ulcers	38	65	36	38	22	40	27	28	26	31	30	22
Falls	8	6	5	5	5	7	3	6	4	7	8	4
Catheter & UTI	18	12	12	20	7	19	20	8	7	5	6	8
New VTE	5	4	7	2	2	3	2	6	5	3	2	1
Patients	1096	1075	1077	1078	1047	1077	1105	1108	1095	1106	1105	1088

Safe staffing

The Trust has continued its work with safe staffing during 2016/17. We have installed 'Hotboards' on each ward to standardise the way information is displayed for the public. This information includes levels of staffing planned and actual. All boards are displayed as close as possible to the entrance of the ward or unit. Boards were designed following consultation with patients, families and carers and nursing teams to ensure they are user friendly and report required information in an understandable way.



The Trust continues to use the Safer Nursing Care Tool as the acuity and dependency measure. We are participating in an exciting piece of research funded by the National Institute of Health Research jointly with the University of Southampton, University Hospitals Southampton Foundation Trust, Poole Hospital NHS Trust and the Royal Marsden. The aim of this is to gain further evidence on the effectiveness of the tool, with an outcome of daily collection of data rather than twice per annum snapshots of the data.

We continue to successfully recruit from local, national, European and international recruitment events both ourselves and jointly with NHSP.

The Trust led as acute provider on the recent commissioning process for another university to deliver Nurse Education. We are delighted to be working collaboratively with University of Portsmouth and look forward to having students in placement shortly.

We report any breaches of <80% staffing at Registered Nurse and Health Care Support Worker level to NHS Improvement and the Clinical Commissioning Group.

Quality Care Reviews – getting to Outstanding

The Trust is in its second year of the Quality Care Reviews and is committed to the provision of high quality, safe and effective care for all patients.

The Quality Care Review programme enables the Trust to provide assurances about the standards provided in each of the clinical areas, aligned with the CQC standards. The Quality Care Review assists each department and team to aspire to excellence and an "outstanding" CQC rating.

This framework assists the ward/unit leader in achieving the best performance for their ward/unit/outpatients area by providing clarity on the most effective use of their supervisory time and measurement of the outcomes of this leadership model. These accreditation measures will be aligned to the Care Quality Commission (CQC) five domains about services.

Quality Care Review Programme

The Care Quality Review Programme will ensure that each service is reviewed on a yearly basis using a process similar to that of CQC inspections and incorporating the elements of the Trust safer care framework. The programme will comprise of a core inspection team responsible for the pre-inspection process final triangulation of all assessed matrices to provide an overall rating, as detailed below.

Rating	Criteria
Outstanding	Excellent performance. People are protected by a strong comprehensive safety system, focus on openness, transparency and learning when things go wrong. Staff involve and treat people with compassion, kindness and dignity and services are organised to meet people's needs. People's care, treatment and support achieves good outcomes. The leadership, management and governance of the area assures the delivery of high-quality person centred care, supports learning and innovation and promotes an open and fair culture.
Good	Improved position of performance maintained with evidence of actions to improve against occasional issues
Requires Improvement	Meeting targets/performance but still has key areas for improvement
Inadequate	Below target/performance with evidence of work in progress that has not resulted in improvement to date

Ward Accreditation

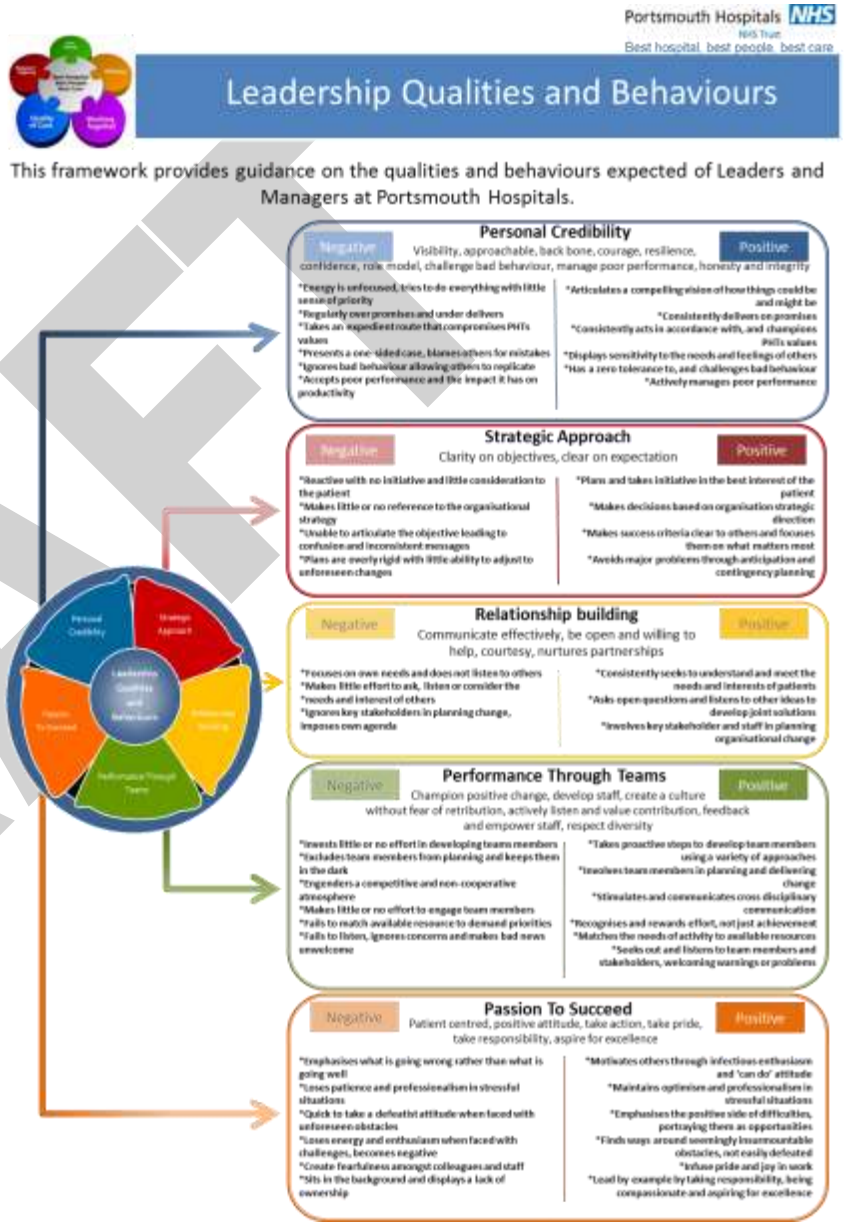
The Trust is committed to the provision of high quality, safe and effective care for all patients. The Ward Accreditation programme enables us to provide assurances about "Knowing How We're Doing" and the standards provided in each of the clinical areas, aligned with the CQC standards. This framework assists the ward leader and teams to aspire to excellence and an "outstanding" CQC rating.

This framework is used as a "live" document to assist the ward/unit leader in achieving the best performance for their ward/department by building a portfolio for ongoing development throughout the year. It also provides clarity for the ward leader on key areas to focus on for their leadership development against the key outcomes of the Trust leadership model and the most effective use of their supervisory time.

The programme consists of five elements:

1. A self and Head of Nursing leadership assessment based upon the Trusts Leadership qualities and behaviours framework.
2. A data pack of quality evidence.
3. An unannounced Quality Care Review conducted prior to the visit.
4. A 30 minute presentation highlighting key successes and challenges for the ward or department and how they know they are safe, effective, caring, responsive and well-led from the data pack.
5. Formal inspection and accreditation of the ward, utilising a 15 Steps tool.

Following assessment an award of either, Platinum, Gold, Silver or Bronze is awarded.



Culture of patient safety

Duty of Candour

The Duty of Candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. It aims to help patients receive accurate, truthful information from health providers.

As a registered provider of health care we are required to comply with the Statutory Duty of Candour, which requires all staff to act in an open and transparent way. The Regulations governing the duty lay out the specific steps health care professionals must follow if there has been an unintended or unexpected event which has caused moderate or severe harm to the patient.

These steps include informing people about the incident, providing reasonable support, truthful information and an apology.

The Trust continues to implement the 2014 Duty of Candour requirements which is reflected in the Duty of Candour and Being Open Policy. Since the re-launch of the updated Datix Safety Learning Reporting (SLE) system improvements have been made which capture compliance with the four distinct Duty of Candour steps.

An action chain setting out each step and the timeframe for completion is now associated with each SLE reported as moderate/severe harm or death. The reporter is required to complete each section and is prompted via notification email when the completion date is due. All documents associated with an investigation, subject to Duty of Candour, are uploaded to Datix and attached to the SLE report including a copy of the letter sent confirming the Trust is undertaking an investigation, thus providing clear assurance of compliance with the requirements.

3

Patient Safety Learning Events

Following the complete review of the Datix SLE reporting function, the new upgraded version was implemented on 1st April 2016. This was supported by a publicity and training campaign to re-focus staff perception of reporting and reinforcing its vital role in supporting and driving the patient safety agenda.

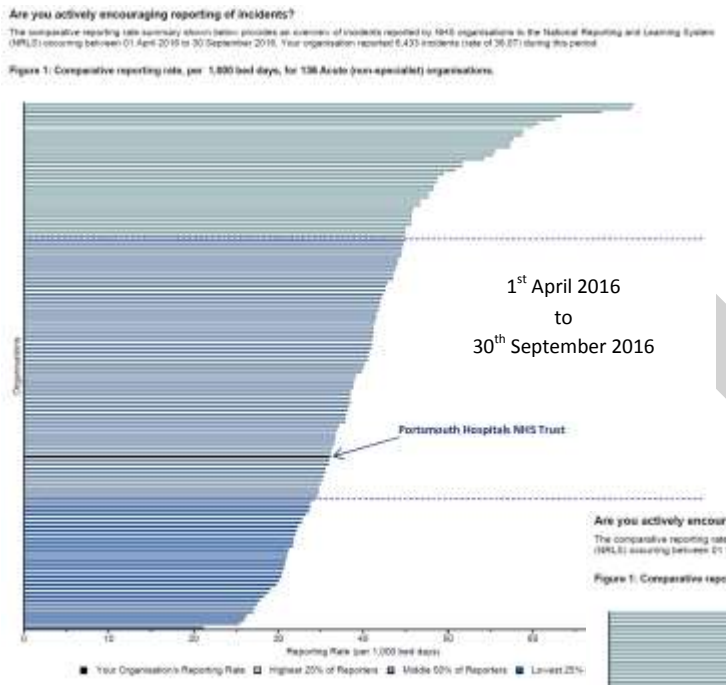
The reporting form was simplified and included feedback to the staff submitting incidents.

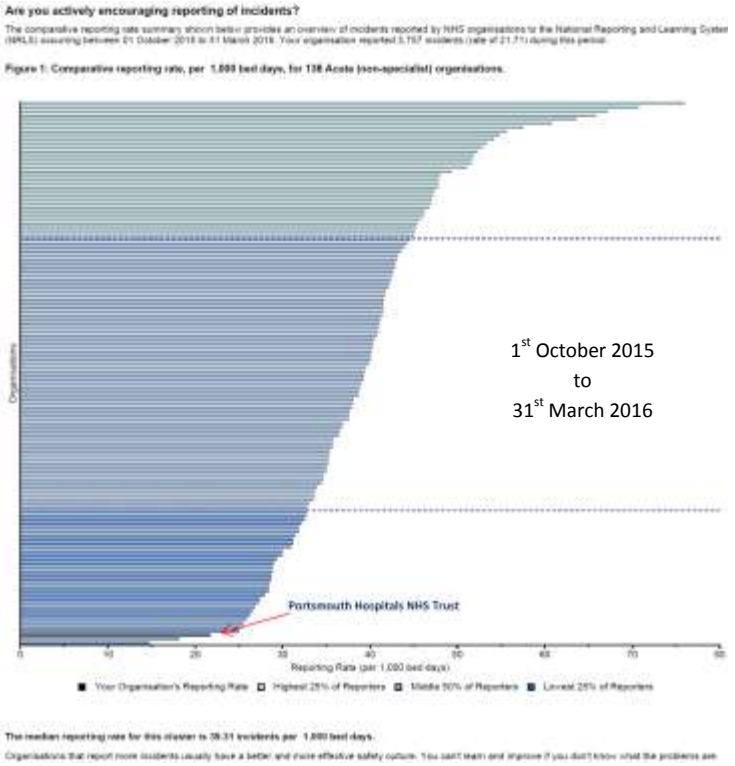
Comparison with the number of reported incidents April 2015 to March 2016 shows that from 1st April 2016 to date the Trust has achieved and sustained a 23% increase in reported events.

The upgraded Datix system included separate modules for web based reporting of formal complaints and claims/inquests which have also been implemented allowing for robust triangulation and increased transparency.

The latest report from the NRLS (1st April 2016 to 30th September 2016) shows the significant improvement in the Trust's position for the reporting of Safety Learning Events compared to the previous reporting period (1st October 2015 to 31st March 2016).

This evidences the value of the upgrade to the Datix reporting system, implemented on the 1st April 2016, and the result of an effective project implementation.





Clinical Effectiveness / Outcomes

MORTALITY – HSMR and SHMI

HSMR AND SHMI TO BE WITHIN THE EXPECTED RANGE, INCLUDING WEEKEND AND WEEKDAY

The Trust introduced a pilot Mortality Review Panel to review deaths in Respiratory medicine on 7th November 2016 and extended to MOPRs in February 2017. A Business Case will be made to the Trust Board, with the aim of expanding the process to cover all deaths within the Trust by September 2017. The aims of the panel are to:

- Improve death certification and ensure accuracy of the cause of death.
- Improve the co-morbidity coding.
- Identify any learning from the patients in-patient stay, including an assessment of avoidability.

HSMR

For the 12 months, January 2016 to December 2016, the Trust's HSMR is 109.92 (confidence interval of 104.94 - 115.08). With the lower confidence interval above the national average of 100, the Trust HSMR is classed as higher than expected.

When focusing on individual monthly performance, as seen in the graph, 9 of the 12 months have confidence intervals below 100. May, July and September have lower confidence intervals above 100 with high HSMR scores. Investigation into the method of admission codes used in these three months is underway, the belief is that coding changes have resulted in radically different HSMR scores when a similar casemix of patient has been seen.

The data used to calculate HSMR is derived from the monthly activity data files Trusts submit nationally to the Secondary User Service (SUS) and are those used to inform payment and Hospital Episode Statistics (HES). These files contain a year to date position and will include any updates or additional data for historical months, as well as the most recent month's activity data. This means that both the Trust and other Trust's historical data can change. Likewise, HSMR and the national average is 're-based' after each update to reflect the most recent national picture.

Both the weekday HSMR for emergency admissions and the weekend HSMR have shown increases.

HSMR: Emergency weekday and weekend
January 2016 – December 2016
Weekday HSMR: 111.27
Weekend HSMR: 109.31 (within expected range)

Summary Hospital Level Mortality Indicator (SHMI)

The 12 months of July 2015 to June 2016 show the Trust's SHMI of 110.77. Although the rate is above the national average of 100, it is within the expected range.

ACUTE KIDNEY INJURY

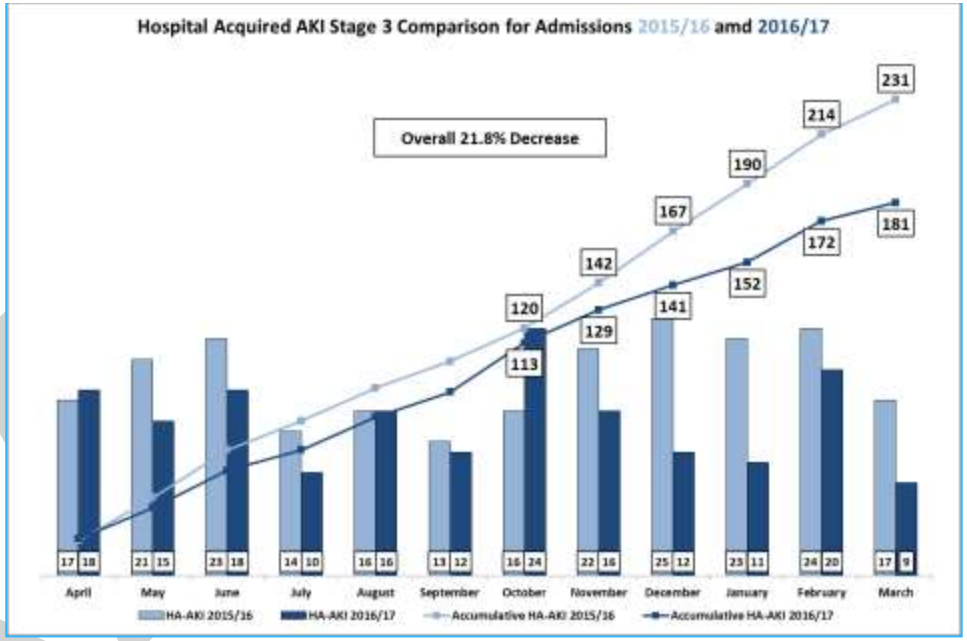
REDUCTION ON 2014/2015 BASELINE, IN HOSPITAL ACQUIRED STAGE 3 AKI EPISODES ✓

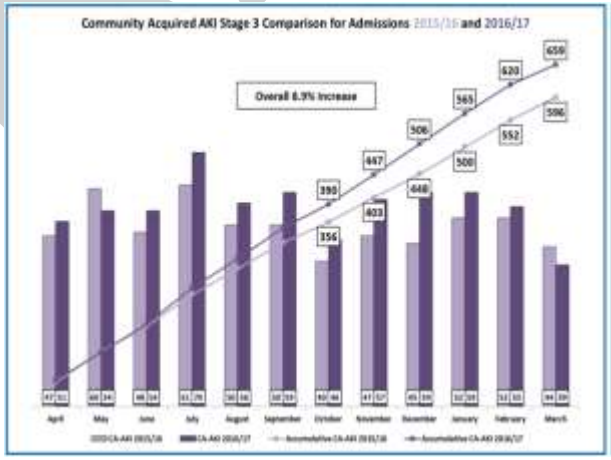
Acute kidney injury (AKI) is sudden damage to the kidneys that causes them to stop working properly and can range from minor loss of kidney function to complete kidney failure. AKI is common and normally happens as a complication of another serious illness. It is not the result of a physical blow to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

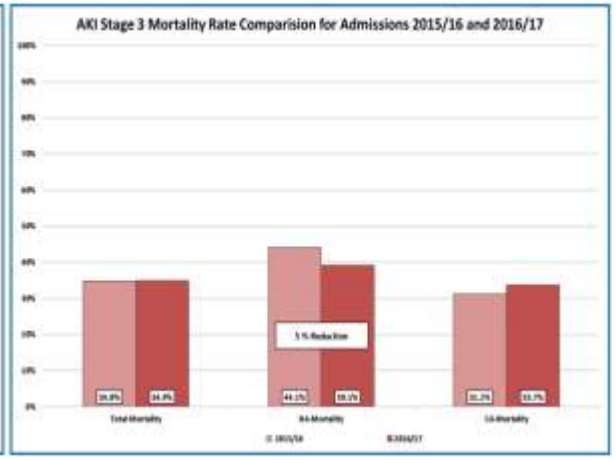
Acute kidney Injury (AKI) is a common cause of patient harm. It is of particular note because some of it is preventable and when it does occur some of the further management and review needs to take place after the patient has left hospital.

Results across the financial year, when compared to last year demonstrate:

- 21.8% decrease in the number of patients acquiring a Stage 3 AKI 48 hours or more after admission to hospital.
- 8.9% increase in the numbers of patients coming into the QAH with an existing stage 3 AKI.
- 5% decrease in the mortality rates of patients with hospital acquired AKI.
- In 2016/17 a total of 70 patients died with a hospital stage 3 AKI compared to 101 in 2015/16.







SEPSIS

DELIVERY OF THE NATIONAL CQUIN TO IMPROVE SCREENING OF PATIENTS AND TIMELY ANTIBIOTIC ADMINSTRATION ✓

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.

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 initiate intravenous antibiotics within 1 hour of presentation, for those patients who have suspected severe sepsis.

SEPSIS – EMERGENCY DEPARTMENT

Timely identification and treatment for sepsis in emergency departments

Screening in ED and direct admit areas:

2016/2017	Compliance	Target	
Quarter 1	94.66%	90%	✓
Quarter 2	94.74%	90%	✓
Quarter 3	98.35%	90%	✓
Quarter 4	Audit underway		

Treatment and 3 day review

Upon arrival

2016/2017	Arrival	Target	
Quarter 1	49.7%	30%	✓
Quarter 2	49.8%	35%	✓
Quarter 3	42.69%	45%	✗
Quarter 4	Audit underway		

Upon triage

2016/2017	Triage	Target	
Quarter 1	56.9%	46%	✓
Quarter 2	53.4%	50%	✓
Quarter 3	47.04%	65%	✗
Quarter 4	Audit underway		

SEPSIS – ACUTE IN-PATIENT SETTING

Timely identification and treatment for sepsis in acute in-patient settings

2016/2017	Compliance	Target	
Quarter 1	94.4%	Baseline data	✓
Quarter 2	97.06%	Discussions with Commissioners regarding target	
Quarter 3	96.90%	90%	✓
Quarter 4	Audit underway		

Treatment and 3 day review

2016/2017	Compliance	Target	
Quarter 1	56.94%	Baseline data	✓
Quarter 2	55.6%	Discussions with Commissioners regarding target	
Quarter 3	57.61%	66%	✗
Quarter 4	Audit underway		

A meeting has been held to determine further actions required to improve compliance. The focus of which will be to improve performance in 2017/2018.

The ED lead is identifying the reasons for the delay in treatment initiation in order that targeted intervention can be put in place.

The Patient Safety Steering Group have identified Sepsis as a key priority improvement for 2017/2018, learning from best practice in other trusts.

PATIENT EXPERIENCE

Patient feedback

We are committed to understanding what matters most to our patients, their families and carers. To do this we have further increased opportunities for people to share with us their personal experiences. In 2015/16 over 54,000 people participated in the Friends and Family test, in 2016/17 that rose to 68,700. Patients are using social media platforms including Facebook, Twitter and NHS Choices to tell us how we are doing, with a 3 fold increase in the last year. The number of people from the BME community providing us with feedback has improved from less than 1% of feedback to over 3%, and so we are increasingly confident that what this is telling us better reflects our patients' experience.

We learned last year, that using this information and discussing what appeared to be most important to patients helped us identify our key priorities. We have used the same approach this year and working with patient groups, community groups and having conversations with key voluntary organisations we have agreed that while we have made some improvements, the key themes remain the same: end of life care, family carers, care of people with specialist mental health needs and engagement. This year however, we will focus on key issues within those areas as identified through our Patient Experience Priorities.

MENTAL HEALTH

WORKING WITH COMMISSIONERS TO ESTABLISH AN AGELESS MENTAL HEALTH LIAISON SERVICE AND IMPLEMENT A MENTAL HEALTH CHAMPIONS PROGRAMME ✓

About 1 in 4 adults will have specialist mental health needs 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.

"You need to see past my mental health issues and see me....."

We identified two reasons for this:

1. A lack of access to specialist mental health advice and treatment for people aged 18 – 64 years old in in-patient areas. Services were at the time, only provided in the ED for this age range of patients, and for in-patients aged 65 years and over by the Older People's Mental Health Team (OPMH).
2. Despite training having been provided to staff, the training had not made a sustainable change. A different approach was needed to ensure the needs of patients were met.

Key developments

There is now a mental health liaison team covering the Emergency Department and in-patient wards for patients aged 18 and over, with a single point of access for staff. The team provide on-site expert advice about patients needing urgent mental health interventions, and support and training for staff.

A 5 day development programme was designed with mental health service users and provided to hospital staff. Covering issues about mental health law, ethical issues, attitudes and behaviours from a patients perspective, the programme led to changes including:

- New training in ED for staff about patients who self harm.
- Health education for patients around alcohol consumption prior to head and neck surgery.
- Changes to the environment to help patients experiencing severe anxiety.
- Development of new documentation to prompt early assessment of patients with specialist mental health needs.

"We don't need you to be experts in mental health, but sometimes your attitudes towards us is not positive, your behaviour tells us you are not confident in caring for us and your skills are sometimes lacking"

Further improvements

- Increase the skills of staff to care for people with specialist mental health issues by the provision of training about attitudes, behaviours and common causes of mental ill health.

END OF LIFE CARE

We aim to promote the best quality of life possible for patients diagnosed with advanced progressive incurable disease and to provide the best quality of care possible for our patients.

The Trust 'achieving priorities of care' documentation has been designed to guide care for people identified as being in their last days and hours of life, to ensure we achieve the national five priorities of care:

- **Recognise:** the possibility the person is likely to be dying
- **Communicate:** with person and those important to them
- **Involve:** them in decision-making about treatment and care
- **Support:** the needs of the person and those important to them
- **Plan and Do:** with an individual plan of care

FULL IMPLMENTATION OF THE ACHIEVING PRIORITIES OF CARE DOCUMENTATION ✓

The Achieving Priorities of Care (APOC) documentation and its principles continue to be championed within the organisation. We are now reaching approximately 50% usage of APOC for those dying at PHT, which has been a vast improvement over the year. This year, 2017/18, work is to be completed to audit the quality of end of life care on ITU and all wards at PHT, but will also ensure continued usage and promotion of the APOC document.

IMPROVE INTELLIGENCE OF THE QUALITY OF END OF LIFE CARE WITH USE OF THE BEREAVED RELATIVES SURVEY ✓

New ways of collecting information have been achieved this year and the bereaved relative's survey is now an embedded mode of data collection.
During 2016/2017:

- 228 relatives of people who had died in the hospital in 2016/17 were asked to feedback about their experience.
- 74 people responded.
- 88% said their relatives was treated with respect and dignity most or all of the time, with 6% saying only some of the time
- 80% of relatives felt adequately supported, but 20% did not.

DEVELOPMENT OF A METRICS SYSTEM TO REVIEW COMPLAINTS, SAFETY LEARNING EVENTS AND PLAUDITS RELATED TO END OF LIFE CARE ✓

We are receiving bi-monthly reports from PALS and complaints regarding any issues surrounding end of life care, these are being presented and reviewed at the end of life steering group with an action plan surrounding the themes developed.

CARERS

INCREASE THE SUPPORT AVAILABLE FOR FAMILY CARERS ✓

Family carers provide unpaid support to people, who without that support would not cope. They make a major contribution to the health and wellbeing of the person they care for. Early identification and provision of support to family carers is key to ensure that they are supported in their role, reducing the risk of hospital admission of the person they care for.

We have been working with Portsmouth City Council carers team since 2015/16 to improve the experience of carers and have now expanded the scope of the work to all Hampshire residents as well.

During 2016/17 we have continued to develop strong working relationships with our local carer community and those services who help them. Carers are becoming integral to our everyday work. They are represented at meetings, involved in quality monitoring activities and provide teaching for clinical and non-clinical staff.

Key developments

- The" QAH – a carer friendly hospital" initiative was launched and has been recognised nationally as an area of best practice.
- Staff awareness has been raised by the provision of workshops, ward and department based training and the development of an e-learning tool which is available to all health and social care staff in Portsmouth.
- Guidance has been developed for staff with carers to help promote carer support when they are resident on a ward, to enable them to help with the care of their loved one whilst they are in hospital and to assist in the early identification of carers.
- A "Carers Café" is now provided once a month for people who need advice, some time for themselves or an understanding ear.

Further developments

- Develop and implement systems of working together better with carers and partners across health and social care, to support the early identification of carers and a smoother transition between community, hospital and social care services.

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.

Dementia volunteers

The Trust has been successful in working in partnership with the local University and Colleges to recruit young people to undertake the role of Dementia volunteers. This role is specifically to support individual patients with a Dementia, reducing their social isolation and improving their safety. The safety element of this role is usually, the simple activity, of walking with 'wandering' confused patients.

Learning Disabilities

People with learning disabilities are at an increased risk of developing health needs but are less likely to access a service and when they do they are less likely to get successful outcomes. The Learning Disability Liaison team are Learning Disability Registered Nurses from Solent NHS Trust who work in Partnership with us to ensure our patients with learning disabilities receive appropriate care and treatment. During 2016/2017 funding was received to enable the team to cover all patients (previously the team only covered patients from the Portsmouth area).

Key developments during 2016/2017 include:

- The 'hospital passport' (a document informing staff of important information) is used throughout the Trust. To further alert staff that the patient has a passport, a magnet has been developed to be placed over the patients bed.
- A sticker has also been developed for patient notes to further ensure staff are alerted to the fact the patient has a hospital passport. An electronic flagging system has also been developed through Bedview.
- Protocols have been developed for patients with a learning disability to improve staff awareness.
- Worked with clinical staff to improve specific pathways for this patient group.
- Service users have undertaken environmental checks in the Outpatient Department; focussing initially on Radiology. Key areas to address included improving signage and easy read leaflets.
- A request has been made to Charitable funds for staff training in Makaton (a language programme using signs and symbols to help people to communicate).
- A request has been made for funding from the Lions Club and Rotary Club for sensory equipment to be used for outpatient appointments.

Discharge from hospital

Bedview

The functionality of Bedview (electronic system supporting clinical staff to manage patients care and discharge journey as well as the safe and timely allocation of the Trusts beds) has increased considerably in the past year, further increasing visibility of information for clinical staff across health and social care teams. This helps ensure empty beds are quickly allocated and patients moved promptly, freeing up care spaces in ED. It has also removed steps in the patients care planning and discharge journey as staff are able to document on one system, visible to all, care for the patient and the next steps or action required to expedite care and/or discharge plan.

The next step is to remove further duplication of information by projecting certain non-confidential information onto the Patient Journey Board within the Wards that the Doctors and Nurses use. This will stop them having to write things twice in two different system releasing time for them to provide more patient care.

Discharge Lounge

Increased facilities have been created in the Discharge Lounge with additional curtained care spaces increasing the number of patients who can be transferred whilst comfortably waiting transport. Additional volunteers have been recruited to support the Nursing Staff, ensuring patients have someone to talk to and assist with their comfort and support whilst waiting to be collected.

In the coming year allocated parking spaces will be created outside the East Entrance for relatives collecting patients from the Discharge Lounge and a cubicle will be built allowing increased privacy and dignity for patients who require it whilst in the Discharge Lounge.

Integrated Discharge Service

On 25th September 2016 the Health and Social Care Teams across primary and secondary care organisations relocated into one dedicated office space creating the Integrated Discharge Service. This has significantly increased joint working and communication allowing combined discharge planning for all patients but specifically those who are delayed in an acute hospital bed once fit to leave. The next steps are to increase cross cover and trusted assessment throughout these teams to reduce further duplication of assessment for patients reducing the time a patient remains in Hospital.

Discharge survey

The discharge survey has a good response rate from patients and continues to demonstrate improvements. It is recognised from other sources of feedback in the local community that there are concerns about some aspects of discharge.

To address this, in partnership with patients, family member and carer groups, local community engagement committees and HealthWatch Portsmouth and Hampshire, a review of the survey has been undertaken. The new survey is more detailed, and includes issues raised by partners in an endeavour to establish greater detail.

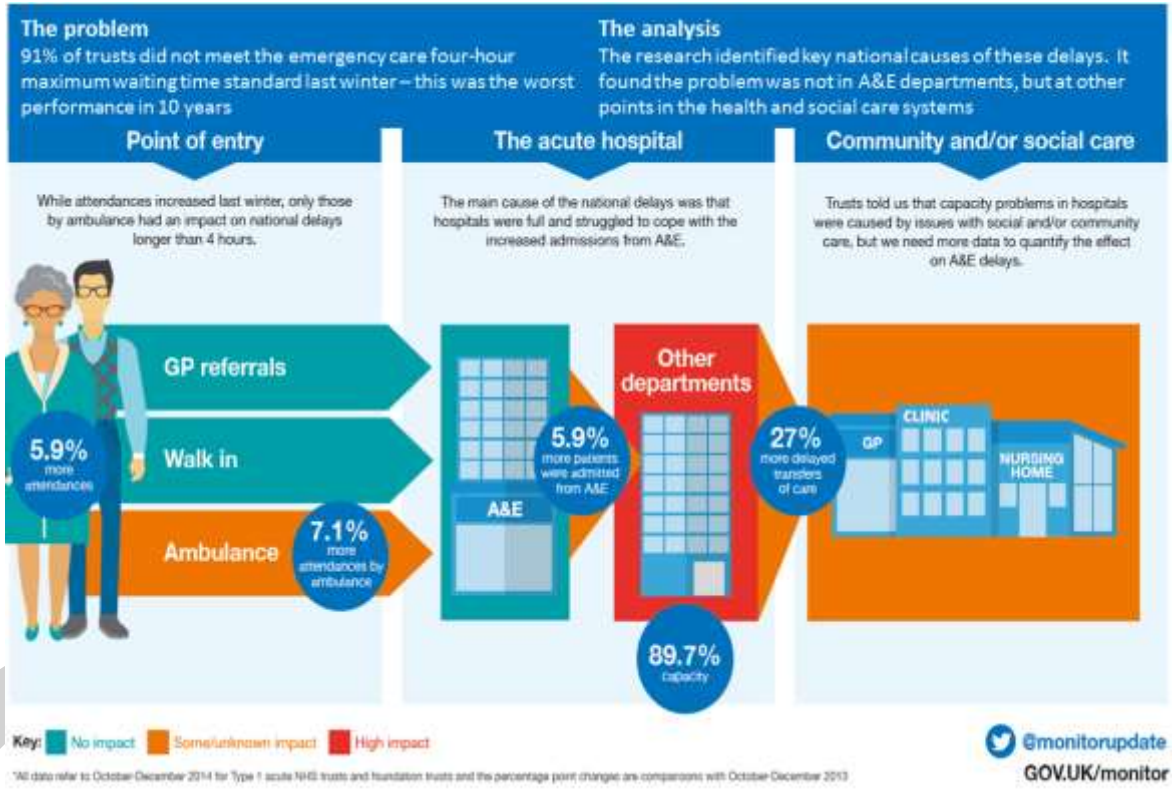
3

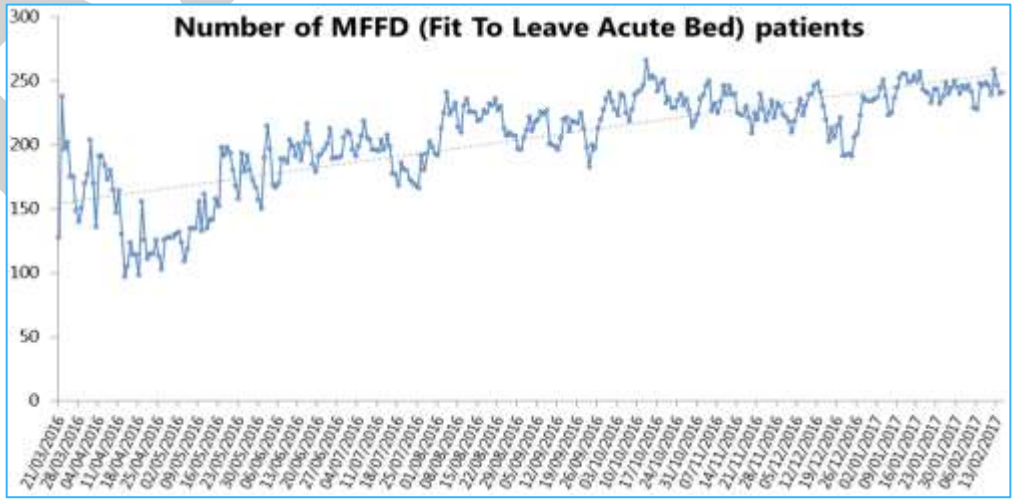
Patients who are Medically Fit for Discharge

Research related to patients delayed in hospital once declared fit to leave hospital highlights:

- Richardson (2006) demonstrated a 43% increase in mortality at 10 days after admission through a crowded ED.
- 10 days in a hospital bed (community or acute) leads to the equivalent of 10 years ageing in the muscles of people aged over 80, Gill et al (2004).
- Patients outlying to the wrong ward: 50% higher mortality and up to 4 day increases in length of stay.
- 48% of people over 85 die within one year of hospital admission.

The Trust has seen a dramatic increase in the number of patients who are declared Medically Fit for Discharge (MFFD).





Learning from our Mortality Review Panels for the 4 months November 2016 to February 2017 indicated that of the 130+ patients reviewed, (predominantly Respiratory and MOPRS patients) approximately 10% of cases reviewed had been declared MFFD during their stay but not discharged.

What are we doing about it…….?

Patient Flow Bundle SAFER

The patient flow bundle is similar to a clinical care bundle i.e. a combined set of simple rules for adult inpatient wards to improve patient flow and prevent unnecessary waiting for patients. If we routinely undertake all the elements of the Patient Flow Bundle SAFER we will improve the journey our patient's experience by reducing unnecessary waiting.

S - **Senior** Review. All patients will have a senior review before midday by a clinician able to make management and discharge decisions.

A – **All** patients will have an **Expected Discharge Date and Clinical Criteria for Discharge**. This is set assuming ideal recovery and assuming no unnecessary waiting.

F - **Flow of patients** will commence at the earliest opportunity from assessment units to inpatient wards. Wards that routinely receive patients from assessment units will ensure the first patient arrives on the ward by 10am.

E – **Early discharge. 33%** of patients will be discharged from base inpatient wards before midday.

R – **Review**. A systematic MDT review of patients with extended lengths of stay (> 7 days – 'stranded patients') with a clear 'home first' mind set.

Red to Green Days

The Trust is also rolling out the Red to Green day initiative, turning red days to green days decreasing a patients delay in hospital and the associated risks as detailed above.

A **Red** day is when a patient is waiting for an action to progress their care and/or this action could take place out of the current setting.

- Could the current interventions be feasibly (not constrained by current service provision) delivered at home?
- If I saw this patient in out-patients, would their current 'physiological status' require immediate emergency admission?

If the answers are 1. Yes and 2. No, then this is a 'Red bed day'.

Examples of what constitutes a **Red** Day:

- Medical management plans do not include the expected date of discharge, the clinical criteria for discharge and the 'inputs' necessary to progress recovery
- A planned diagnostic/referral is not undertaken the day it is requested
- A planned therapy intervention does not occur
- The patient is in receipt of care that does not require a hospital bed.

A RED day is a day of no value for a patient

A **Green** day is when a patient receives an intervention that supports their pathway of care through to discharge

A **Green** day is a day when all that is planned or requested happened on the day it is requested, equalling a positive experience for the patient

A **Green** day is a day when the patient receives care that can only be delivered in a hospital bed

A GREEN day is a day of value for a patient

Patient Story – a patient with complex care needs whose discharge was delayed

- 84 year old frail lady with dementia admitted 10th March via ED with recurrent falls and a urinary tract infection.
- Prior to admission, she had lived in a bungalow with her husband with a private Package of Care 3 times per week. On reviewing her home situation, her husband was unable to provide the care that his wife required and a decision was made that she now required long term bedded care.
- Following treatment, the patient was deemed appropriate to have her care delivered outside the hospital 3 days after her admission and discharge planning continued with the support of the Integrated Discharge Service.
- There was a delay in sending the appropriate documentation from the ward, which was sent on 16th March.
- 22nd March the patient was seen by the social worker team.
- To determine what type of care she required when she left hospital, the ward were required to complete a Continuing Healthcare Checklist. This was completed and sent to the Commissioners as the patient required healthcare which would be funded by the CCG.
- A decision support tool meeting required completion, this could be undertaken outside of the hospital setting; however, due to the delays this was completed on the ward.
- 30th March: Continuing Healthcare Decision Support Tool Paperwork sent to CCG.
- The patient's family were given information regarding which Care Homes had vacancies which were most appropriate for their mother.
- 4th April: Family chose a Care Home, patient waiting to be assessed by the Matron of the Care Home.
- 6th April: Patient assessed by Care Home.
- 7th April: Funding agreed for the lady to be placed at the Care Home; however, waiting for the Care Home to agree to accept her.
- 10th April: Patient became unwell with hospital acquired pneumonia; discharge plans were put on hold.
- 19th April: Following recovery from pneumonia, the patient was able to be discharged from hospital. Length of stay in hospital 5½ weeks; the majority of the time, this lady was medically fit for discharge.

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 in to local and national assessments of quality, safety, and delivery of the NHS Constitution. The Results of the 2016 National NHS Staff Survey conducted in the Trust between September and December 2016 can be found below.

Portsmouth Hospitals NHS Trust chose to survey all staff in 2016 as in previous years. A total of 3949 staff took the opportunity to complete and return a survey, representing a 58% response rate which is in the highest 20% for acute trusts in England and compares with a response rate of 59% in the 2015 survey.

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. The overall staff engagement score when compared with all acute trusts has remained at 'above average'. From being in the worst 20% in 2012 and 2013, average in 2014 and above average in 2015 with a scale summary score of 3.85 (a slight decline of 0.03 from 2015).

The detailed content of the report has been presented in the form of Key Findings (KFs) and contains 32 KFs, all of which are comparable with the 2015 survey. When comparing the Key Findings to the 2015 survey:

- 1 shows improvement.
- 28 have remained unchanged.
- 3 have deteriorated (however of these, one KF is better than average when compared to all acute trusts).

Of the 32 Key Findings (KFs) when measured against all acute trusts in England:

- 12 are in the best 20%, 7 are above average.
- 7 are average, 3 are below average and 3 are in the worst 20%.

Top ranking scores:

- More staff are satisfied with flexible working opportunities.
- There is good communication between senior management and staff.
- There is recognition and value of staff by managers and the organisation.
- The percentage of staff working extra hours is low.
- There is support from immediate managers.
- There is organisation and management interest in and action on health and wellbeing.

Bottom ranking scores:

- Staff recommendation as a place to work or receive treatment.
- Staff experiencing bullying or harassment or abuse from patients, relatives/public.
- Staff experiencing physical violence from patients, relatives or the public.
- Staff witnessing potentially harmful errors, near misses or incidents.
- Staff attending work despite feeling unwell because they felt pressure from their manager, colleague or themselves.
- Staff reporting most recent experience of harassment, bullying or abuse.
- Staff experiencing physical violence from staff.

The focus given to our staff engagement, leadership development, staff health and well-being and appraisal has resulted in our workforce feeling more recognised and valued, reporting improved communication, less likely to work extra hours, having more support from managers and feeling that more attention is given to their health and well-being. It is pleasing to see the overall staff engagement level maintain over the last 12 months during a time of unsettling change, unprecedented activity and external scrutiny. This climate for change will be built upon during 2017 to ensure that we not only maintain our 12 KFs being in the top 20% of all acute trusts but also aspire to be in the top 20% for overall staff engagement.

However, it is crucial that to maintain this upward direction of travel, we continue to build on our successes and pay much attention to those areas that are still in need of improvement. The survey provides evidence of a highly engaged but pressured workforce.

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 CSCs and has meet quarterly.
- 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 and Silver Award of the Equality Standard.
- 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 WRES is published on the Trust website 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 an action plan has been developed to improve organisational performance in regard to workforce race equality.
- The Trust equality and diversity website has been re-designed and will continue to be updated during implementation of the Equality Standard.

Future actions 2017/18:

- 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 2018 for the Gold Award.
- Complete Phase 1 of the WRES action Plan. This includes (i) on-boarding experience; (ii) WRES LiA event; (iii) WRES Board Session and organisational WRES review); and (iv) WRES Scorecard.

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.

KF25: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months (A lower score is better).

- In 2016 29% of white staff agreed with this statement, which is 2% (27%) higher than the acute trust average and a 2% (27%) decline on the 2015 score.
- In 2016 34% of BME staff agreed with this statement, which is 8% (26%) higher than the acute trust average and an 8% (66%) decline on the 2015 score.
- 5% more BME staff felt that they had experienced harassment, bullying or abuse from patients, relatives or the public than white staff in 2016.

KF26: Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months. (A lower score is better).

- In 2016 24% of white staff agreed with this statement, which is the same as other acute trusts nationally and 1% (25%) lower than 2015.

- In 2016 24% of BME staff agreed with this statement, which is 3% (27%) lower than acute trusts nationally and 4% (28%) lower than 2015.
- The same percentage of BME and white staff felt that they had experience harassment, bullying or abuse from staff.

KF21: Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion. (A higher score is better).

- In 2016 91% of white staff agreed with this statement, which is 3% (88%) higher than the acute trust average and 1% lower than 2015.
- In 2016 78% of BME staff agreed with this statement which is 2% (76%) higher than the acute average for acute trusts and 3% (75%) higher than 2015.
- 13% fewer BME staff feel that there are equal opportunities for progression or promotion than white staff in 2016.

Q17b: In the last 12 months have you personally experienced discrimination at work from manager/team leader or other colleagues? (A lower score is better)

- In 2016 5% of white staff agreed with this statement, which is 1% lower than the acute trust average and 1% lower than 2015.
- In 2016 12% of BME staff agreed with this statement, which is 2% lower than the acute trust average and the same as 2015.
- 7% more BME staff personally experienced discrimination at work than white staff in 2016.

Learning and Development

We have made great progress over the last year in embedding and expanding our range of apprenticeships offered and supported within the hospital. The Trust is currently supporting 140 staff to complete apprenticeships in areas such as pathology, pharmacy, administration and healthcare support. We have 8 Apprentice Healthcare Support Workers (HCSW) and 4 Trainee HCSW who have completed their programmes over this year. A further 20 staff are currently working through their HCSW programme. Future plans include the introduction of Nursing Apprenticeships in conjunction with the University of Portsmouth and the Open University. We continue to support events such as STEM (Science, Technology, Engineering & Mathematics) Fairs to promote apprenticeships and careers in Science and Technology to local schoolchildren.

Since the introduction of the Care Certificate in June 2015 for all Healthcare Support Workers, we have supported over 160 staff in achieving this award. 16 newly qualified nursing and AHP staff have completed a Preceptorship Programme designed to enable them to quickly settle into their first role.

Building on the award of the Quality Mark in January 2016 we have continued to develop staff involved in the delivery of education in the workplace by offering the opportunity to undertake a Postgraduate Certificate in Education.

The fantastic work of our team members has been recognised through numerous accolades in our local Best People Awards including the categories of Best Peer Support, Best Staff Led Change, Chairman's Award and Best Leader. Within our region we have also received awards for leadership and excellence in education and training.

Our range and delivery of courses continues to evolve to meet current demands, with a widening of programmes available supporting dementia, mental awareness, health and wellbeing.

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.

Research and Innovation continues to thrive within the Trust. This year, our clinical teams have won a number of prestigious national awards for their research and several of our research studies have featured in local and national media. There are 150 research staff working across all clinical specialties and over 4000 patients have taken part in a clinical research study this year. 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 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.

Defence Medical Group South (DMGS)

2016/17 continues to see the nominated Head of Governance and Assurance within Defence Medical Group South (the Military contingent working within the Trust) working closely with key PHT Governance and Assurance personnel. A pivotal aspect of the role requires providing the Trust with assurance that military personnel working within the hospital have the appropriate qualifications and training in order 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 between these two organisations to continuingly grow and develop. 2016/17 continues to see improved integration with the Trust; examples include increasing numbers of military personnel attending Trust Leadership and Management study days and regular participation of military personnel as part of the monthly Care Quality Reviews.

Defence Medical Group South (DMGS) military personnel have a structured Headquarters staff based within the hospital site who are fully integrated within the Trust at all levels. DMG(S) Commanding Officer holds responsibility for all military personnel including training teams, practice educators and clinical personnel, and as such strives to ensure full integration with the Trust in delivering provision of safe, professional care to service users by military personnel.

Information Technology (ICT)

Electronic Radiology tests requesting and results reporting for GPs

This year the Trust completed its implementation of a facility to allow local GP practices to request Radiology diagnostic tests for their patients and view the results from within their own GP systems. Local GPs have welcomed the new facility, which they say is easy to use and fits well alongside their own systems. It has also reduced the amount of paper used through faxing requests and, most importantly, speeded up receipt of results by GPs and thus reduced time-to-treatment for patients.

Bed Management

A key issue for the Trust has been the management of patient flow in unscheduled care to optimise bed use and prevent the Emergency Department from becoming blocked. The Trust evaluated a number of commercial offerings for bed management systems from its incumbent IT suppliers, but could not find a solution that would enable it to better monitor and manage its inpatient beds. The IT Department therefore worked with unscheduled care leads to develop and implement an in-house IT solution it has called 'BedView'. This enables ward staff to quickly update details on the utilisation of each of their beds and this information is immediately available to Operations Centre staff who manage the flow of patients from ED into wards and through to discharge. Enhancements have been made during the year to improve the granularity of the data available so that the readiness of individual inpatients for discharge and details of any outstanding tests or other work preventing discharge can be readily assessed.

Clinical Service Centre Quality Improvements

Highlights 2016/2017

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)

- A new educational programme for the management of violent and aggressive Critical Care patients has been implemented following an increase in incidents and staff concerns. This programme will ensure staff have the necessary skills and support to deal with these types of patients.
- Focused work has taken place to improve the quality of care and safety for surgical outliers in recovery including a new Standard Operating Procedure (SOP), induction processes for ward nurses, implementation of VitalPAC and Bedview and a patient/relative information leaflet.
- A patient passport has been introduced in Pre-op to improve communication and information regarding medications, Nil by Mouth and investigations to improve the patient experience and minimise cancellations on the day of surgery.
- The WHO checklist has been revised along with the Surgical instrument count following two Never Events, improving patient safety.
- The CHAT teams have successfully implemented the new Enhanced Recovery Programmes (ERP) for elective joint replacement patients and an ERP for colorectal patients will be rolled out in May. This peri-operative initiative greatly improves outcomes.

CLINICAL SUPPORT SERVICES

- **Pharmacy – TTO turnaround times** at ward level have improved year on year and PHT is now 6th best in the UK and really helping to improve discharge processes for patients and flow throughout the Trust
- **Visual Field Testing within Neurophysiology** – The team within Neurophysiology recognised that many neurology patients were experiencing long waits for visual field testing so they trained one of their scientists to perform the tests which is now delivered alongside other Neurophysiology test within the department.
- **Development of new roles within Clinical Support -** Within the last year the CSC has worked with a number of departments and staff groups to introduce new ways of working and roles to meet the increasing demand for care and treatment in difficult to recruit areas, these include advanced practice within support roles in Physiotherapy, Occupational Therapy and Dietetics, and Pharmacists and Clinical Scientists and Radiographers.
- **Improved Typing Turnaround** – The transcription teams have reduced the typing turnaround time over the last 2 years from 17 days to 36 hours, ensuring that GP's have accurate information and advice form PHT clinicians much quicker.
- **Radiotherapy Treatments** - The Radiotherapy Physics team have increased their delivery of Intesity-modulated Radiation therapy (IMRT) and

Volumetric modulated arc therapy (VMAT) radiotherapy to 70% of all radiotherapy treatments exceeding the national target of 24%, which will lead to improved outcomes for patients with Cancer.

- **Electronic requesting within Imaging for GP's** - We wanted to speed up requesting for Diagnostic Imaging for GP's which we have achieved over the last year by the introduction of electronic requesting.

EMERGENCY DEPARTMENT (ED) AND ACUTE MEDICINE

Emergency Department

- Friends and Family feedback forms were highly positive for the ED. Response rate was 16.7% which is higher than the national average of 12%. At 93.9% the satisfaction reported by patients is significantly higher than the national average of 85% (February 2017 data). The percentage of patients reporting a negative experience is very much lower at 1.3% than the national average of 7%.
- The Frailty Intervention Team (FIT) delivers early focussed review of older patients with an aim to provide a comprehensive care review leading to discharge home with the correct package of care or to minimise the length of stay in the hospital. The team works closely with relatives, patients and the medical team to deliver a holistic approach to care. As part of this process the senior ED nurse who leads in this area worked with FIT to deliver an observational study of the impact of this team with a view to maximising effectiveness. This involved a senior nurse sitting with a patients representative to observe practice across the ED. The output of this was both improvements and changes in the delivery of the service and direct feedback to staff around their performance with inclusion in their portfolios. One intervention was to improve the signage across the department in response to feedback.
- The Urgent Care Improvement Programme focussed on the processes for patients who walk into the department and book in at reception. Complaints, incidents and feedback had highlighted the process of booking in prior to being streamed or triaged often led to delays in identifying serious illnesses or delaying analgesia. Following the formation of a working group led by a Senior ED Sister and a Consultant in Emergency Medicine, a new process was introduced. A senior nurse called a 'Navigator' sees all patients as they arrive and determines in which part of the department they are best seen. Patients can be allocated to Majors, Resus, Minors to see an Emergency Nurse Practitioner, to a GP in the co-located Urgent Care Centre or to Paediatrics. This has significantly reduced the wait to be seen, picked up significant illnesses including a myocardial infarction within minutes and delivered early analgesia as a result. This process is now well established and works 24/7. There has been a marked drop in complaints since implementation.
- The Emergency Department has a requirement to triage all ambulance arrivals by 15 minutes and for this group of patients to be seen by a doctor within 60 minutes. Various reviews of the ED both by the CQC and the Emergency Care Improvement Programme visits highlighted that the ambulance arrival area could not deliver this robustly. A two cubicle ambulance assessment area could not meet the demand of multiple ambulance arrivals per hour. A working group was established to review the process and to look at the physical space available for the processes. This involved looking at best practice elsewhere and determining the best solution for our ED. As a result the Trust re-developed this area to provide a 6 bedded assessment area with further capacity for ambulant patients. This now delivers early assessment of all ambulance arrivals with consistent delivery of 15 minute assessments and the initiation of time critical interventions for stroke and sepsis. This has decreased the number

of complaints and incidents within this area and patient feedback is positive around early assessments.

- Due to the demands on the ED and the time spent by patients waiting for beds on the wards, one area raised by patients and relatives is a lack of continuity of care. This was worsened by moves from one area of majors designated for patients in a queue to another designated as the official majors area. On each move the nominated nurse changed. In response to this there was a re-designation of the various areas to minimise moves across the department and to ensure that patients and relatives had a consistent nominated nurse throughout their stay.

Acute Medical Unit (AMU)

- In response to staff and patient feedback as well as feedback from external agencies, the AMU team have focussed on environmental improvements, particularly to improve orientation for patients and visitors. This has included enhanced signage for ward areas, which are placed to help both patients and visitors. The team have also placed date clocks in the ward areas. Storage of medical records has been improved by the use of newly purchased medical notes trolleys and listening to staff, there are now computers on wheels to improve access to computers.
- Daily safety huddles have been introduced in each ward area, this gives the clinical staff an opportunity to discuss and perceived patient safety issues. It allows time to focus on what can be done by the team for individual patients to reduce any safety risks by multidisciplinary problem-solving and allows time for additional education. This has been married with the introduction of bed-side shift handovers. Patients have feedback that they have appreciated meeting the incoming staff in this way. AMU CSC have purchased new bedside lockers for all ward areas, these include electronic key fob mechanisms and have greatly improved the safe storage of medications.
- The AMU team have introduced clinical rounding which gives a formal structure to focussing on a small group of patients by a senior member of clinical and management staff. All aspects of care are reviewed for individual patients in a detailed way and fed back to the staff on duty. This has opened conversations about documentation and how staff assure themselves about care that they are delivering for patients.
- The AMU team have joined the NHS Improvements Falls Collaborative; a programme aimed at improving local falls prevention practices and management. Recent initiatives have included enhancing staff training and the introduction of a “swarm” approach to learning from incidents. The ability to feedback to staff and understand how care can improve in this real-time way has received positive staff feedback.
- The local “Bedview” electronic patient tracking system has been enhanced by a bespoke “Take List” developed with AMU clinicians. This enables clinicians to track when a patient has been referred to the medical admissions pathway and to coordinate their care. The programme allows staff to review when investigations have been requested and what actions are required. These programmes together facilitate handover of information between teams and shifts. They have received high praise from clinicians using them and continue to be developed in line with the needs of the team.

HEAD AND NECK

- Complaints re-structure to ensure timely reviews, alongside customer care training to reduce complaints in the first instance.
- Audiology:
  After successfully meeting the high levels required in 2015, Audiology has maintained our IQIPs accreditation for 2016 and are currently resubmitting for 2017.
  We have increased our service by working in partnership with Care UK to provide a service in two new sites, St Mary's in Portsmouth and Oak park in Havant.
- ENT:
  TORS – trans oral robotic surgery for oropharyngeal cancer and obstructive sleep apnoea.
  The benefits of Trans-Oral Surgery have been shown to be numerous. Robot assisted surgery provides much better access for the surgeon over traditional surgery. Robotics offers a 3-D visual environment that places the surgeon exactly where the surgery is happening. This advanced technology enables the surgeon to use precise instrumentation in ways previously not possible.
  The acquisition of the Da Vinci Robot system here in Portsmouth is a huge leap into the future of surgery. With it we have a unique opportunity to develop this exciting and important service to benefit our patients directly.
- MAST trolleys purchased for Paediatric assessment area. These make the airway safe team (MAST) is an initiative to improve the emergency management of children with upper airway obstruction through multidisciplinary team training and the standardisation of care.
- EYES:
  Reduction in glaucoma surgery waiting time
  Implementation of LOCSIP (new WHO Checklist) Implementation of joint paeds ophthalmology and rheumatology service, with monthly shared clinic, reducing patient visits, streamlining service and quality improvement utilising specialist nurse and increasing capacity in general paeds ophth clinic
  Introduction of cross cover for paeds squint lists so lists aren't cancelled when surgeons on annual leave – increasing capacity and better utilisation of GA theatre and paeds anaesthetist availability
  Nationally we're now in the top 5 recruiters for Clinical Research Network trials compared to Eye Units in all acute trusts.
- Unscheduled care improvements:
  ENT Nurse Practitioner investment to support Ambulatory and ED pathway, reduced front door and contain quality and safety pathway
  Extended Ophthalmology provision over key seasonal holidays
- Scheduled Care
  CT Cone Beam installation in Maxillofacial; provides clear images of highly contrasted structures and is extremely useful for evaluating bone, with minimal radiation doses.
- Cancer
  Partnership working with Earl Mountbatten Hospice and Macmillan – Psychological Support services
  Restorative Dentistry – refurbishment in line with infection control.
  NCPES outputs – really positive about the CNS Team
  Charity Donations – funding from Golf Club to allow development of quiet room, to support patients and families in time of quiet reflective space. The family and friends of Ann Tambling donated in excess of £9,000 to the Head and Neck Unit of Queen Alexandra Hospital in her memory.

MEDICINE

- In June 2016, D2 ward open as a short stay unit. D2 ward working in collation with AMU, aims to admit patients with a length of stay <72 hours.
- To improve the management of medical patients in non medical beds, the buddy system was introduced with consultant teams allocated to set wards across the organisation to support the management of the patients when transferred.
- To improve patient flow, introduction of twice daily operation meeting, with an increased focus on the principles of SAFER, pilot of Red2Green on c5, Criteria led discharge C7
- Pathway change introduced within hepatology services has led to initial investigation for patients being completed prior to to the first appointment, which a potential reduction in the number of appointments patients are invited to attend.
- For cardiology patients, whereby diagnostic only to standby elective angiograph procedure have been introduced avoiding the need for a second appointment for patients.

MEDICINE FOR OLDER PEOPLE, REHABILITATION AND STROKE

- The Stroke pathway has achieved a Sentinel Stroke National Audit Programme of Level B; a significant improvement over the last 18 months and evidence of the high-quality patient care and experience delivered by a committed and passionate Multi-disciplinary team (MDT).
- Ride to Rio charity bike ride successfully raised funds for two specialist therapy bicycles for stroke patients as documented in Portsmouth News:
- http://www.portsmouth.co.uk/news/health/determined-portsmouth-hospital-fundraisers-raise-funds-for-specialist-bike-in-ride-to-rio-challenge-1-7529920
- Amulree Treatment centre successfully as Team of the Year at the QA news awards: http://www.jpsouthevents.co.uk/events/event/the-news-best-of-health-awards-2016/
- Bev Vaughan awareded Hospital Nurse of the Year.
- G4 successfully changed from being an acute Older Persons ward to a Nurse Led ward for complex discharges, including normalising hospital stay for frail patients by ensuring that they are up and dressed as much as possible.
- Sister on F2 completed the Mental Health Champion course and has used the learning from this course to provide pocket cards for staff to support the care of patients who may have challenging behaviour as to how the staff can support de-escalation.
- Continued reduction in injurious falls in MOPRS despite a very frail patient group. Number of injurious falls in 2016-17 totalled 10 compared to 24 in 2014-15 and 14 in 2015-16 14.
- The Frailty Interface MDT is embedded across ED/AMU. This team support the Comprehensive Geriatric Assessment which is important to review for all Frail patients. The team have also been successful in avoiding the admissions of on average 3 patients per day, by sourcing other support where required or early Geriatrician input to ensure that patients are safe to be discharged.
- The CSC has completed a year long programme with the Acute Frailty Network. Consultant Geriatrician has completed a patient experience survey for older people across the pathway, which has led to improvements in care of patients in ED/AMU and has been successful in

gaining a grant where she has interviewed patients about their experience which will be used as a training video via the AFN.

- Micro-processor Knee prosthetic joints have been agreed by NHS England for use in the Portsmouth Enablement Centre due to the service that they provide for veterans and the quality of the rehabilitation that the team is able to deliver. Named as one of the top 10 centres in the country.
- Hip fracture service continues to perform highly in the top 10% of all Trusts and best in the region.

TRAUMA, ORTHOPAEDICS, RHEUMATOLOGY AND PAIN (MSK)

- New Virtual Fracture Clinic are maintaining the discharge rate of 33%-34%. Attendances to date being 7300; maintaining an improved experience for our patients.
- Follow up Fracture patients now seen by the appropriate Consultant and Clinic.
- Physiotherapist now seeing 1 year clinical follow ups, which release the Consultants and reduce waiting times
- Biologics- Rheumatology patients receiving less drug therapy, which is less disruptive to their life style, whilst not effecting the number of flare ups. Financially saving the Health Economy over £ 1 million
- MSK patient experience group meet patients and feedback to Ward Managers. New Newsletter for patients as a result planned for the future.

RENAL AND TRANSPLANTATION

- A Charity Steering group has been created within the CSC, which consists of representatives from Nursing, Allied Health Professionals (AHP), Administrative staff and two patient representatives. The aim of this meeting is to discuss and create charity events to raise awareness, publicity and potential donations towards the renal amenity fund. This committee also reviews all requests for expenditure from the amenity fund to ensure this is in line with Trust policy, before sign off by the CSC Management team.
- The Vascular Access team have been fundraising to raise money for a specialist ultrasound scanner which will improve the patient experience for patients attending vascular access appointments, overall reducing the time spent and visits to the hospital. Thanks to the team of fundraisers and fundraising events including a quiz night and live music event, the shortfall was raised (between the amount given by the Trust) for the scanner and the first one-stop clinic is set to begin in April 2017.
- Continuing events and projects are in the pipeline within the CSC to continue to fundraise, the next projects being renovation of the Renal Day Room, which is used by relatives and patients and also purchase of a BCM machine, which (body composition monitor) for use in PD clinics/assessment.
- Safety Huddle: Modified the safety huddle to incorporate a review of the discharges and updating of Bed View and introduced the use of bed view to non ward-based teams.
- New Consultant Ward Cover: rolled out across the CSC in January 2017 with good effect.
- Standard Operating Procedure (SOP) for safe to transfer finalised; awaiting decision from Operations team regarding rolling out across the region.
- Renal ReAct area: Aim was to implement a new approach in managing direct admissions with the development of a triage area in outpatients to facilitate review of emergency attenders. This area successfully opened in

March, with the instigation of a comprehensive SOP, creating a much safer care solution in the management of the direct admissions and those patients requiring urgent review and treatment.

SURGERY AND CANCER

- The Surgery and Cancer CSC management team have undergone a restructure with new personnel in key roles working together for the benefit of their patients
- Following a visit to the surgical specialities the Deanery were impressed at a very much improved learning environment, with excellent feedback.
- 6 out of the 8 wards within the CSC have been awarded 'Gold' Accreditation in the Trust ward accreditation programme.
- Our Radiotherapy department had a very successful ISO9001 review this year. The certification acknowledges the quality standard of care delivered to the patients undergoing radiotherapy at PHT.
- The Haematology and Oncology Day Unit were awarded the Macmillan Quality Environmental Mark (MQEM). The MQEM assesses whether cancer care environments meet the standards required by people living with cancer. Following on from HODU's success the Haematology and Oncology Wards have applied for the Quality mark also and will be assessed later in 2017.
- The Colorectal team have launched their 'Enhanced Recovery Pathway'. Enhanced recovery is a modern evidence-based approach that helps people recover more quickly after having major surgery.
- The colorectal team also had a visit from the local CCG. This visit was very successful with good feedback from the CCG.
- The Surgery and Cancer CSC continue to improve on its cancer performances, with fewer patients waiting for their cancer treatment.
- The Surgical Assessment Ambulatory area has now received the funding to provide a 7 day service. This will continue to ensure that the surgical patients are reviewed in a timely manner, and helps relieve some of the pressure on the Emergency Department.
- The Urology team have reviewed and redesigned the Prostate Pathway. They are also able to provide a straight to test service, following the success of this service in Colorectal.
- The Haematology and Oncology Day Unit continue to offer their patients extended opening hours and endeavor to improve their patient experience. This is continuously evidenced via their patient satisfaction surveys.
- The CSC has carried out an audit of the specialist nurses, following this they successfully bid for additional Nurse specialists in Urology and Breast. This will ensure that the patients receive the best support and care during their treatment pathways.
- The Haematology ward nurses have been spending the last few months rotating onto the Transplantation ward at Southampton General Hospital. This was to gain specialist experience in preparation to receive their first Peripheral Blood Stem Cell Transplant patient at the end of April 2017. This is significate achievement and will mean that patients receiving Autologous Transplant (their own stem cells back), will be able to complete their treatment in Portsmouth.

WOMEN AND CHILDREN

NICU outcomes:

- Neonatal Survival – we have excellent neonatal survival rates, particularly for the most high-risk infants at the limits of viability. Over the past 3 years, survival to discharge home at 23, 24 and 25 weeks was 69%, 88% and 89% respectively. This compares very favourably with rates of 38%, 61% and 77% reported by the large international Vermont Oxford Network (VON) to which we contribute. The network reported over 62,000 very low birth weight (VLBW) infants in 2015 and provides a superb benchmarking resource for our service. The overall mortality for the 126 VLBW infants (<1500g) we cared for in 2015 was exceptionally low at 8.1% vs 14.8% for VON. We also perform very well against our local Network peers (Southampton and Oxford). The latest national MBRRACE-UK report for 2014 (reports on national perinatal mortality) showed a neonatal mortality rate of 1.54/1000 live births for PHT against a national rate of 1.77/1000 live births (classed as 'green' denoting more than 10% below expected).
- Morbidity Rates - high survival rates should not be at the expense of increased morbidity and our continued focus on the quality of care is reflected in our low morbidity rates reported by VON. This is particularly striking for neurological morbidity with a severe intra ventricular haemorrhage rate of 2.5% vs. 6.9% for the network – this is very encouraging in terms of later neurodevelopmental outcomes. A wide range of other morbidity rates are much lower than for the whole network e.g. intra ventricular haemorrhage in 11.7% vs. 23.2% and late infection in 6.7% vs. 8.3%. VON also reports standardized mortality and morbidity ratios (adjusting for unit case mix) – our performance is excellent when reported in this format with an 'SMR' of <1 in 15 of 16 key performance measures. This reflects the high quality care we provide, achieving remarkable results despite a very high-risk patient population.
- National Neonatal Audit Programme – we submitted data on 100% of cases for the latest report (2015) - this showed very good performance against peers with 89% vs. 85% of mothers given antenatal steroids, 100% vs. 88% of parents having a senior medical consultation within 24 hours of admission and 100% vs. 50% with 2 year follow up data entered.

Safeguarding Children Team:

- Successful implementation of CP-IS (Child protection information sharing), an IT solution that makes it possible for the first time nationally to exchange essential child protection information between children's social care and health to make better informed clinical assessments and decisions about a child. Improving the way in which health care in unscheduled care settings communicate with local authorities. This enables exchange of key child protection information to better protect vulnerable children. Access to the system is via the national spine and it is currently live in ED with plans in place to implement into CAU and maternity within the next quarter.

Maternity Unit:

- Maternity continues to adapt and change services to achieve the national guidance for Saving Babies Lives Care Bundle, maternity have only had 1 reportable case to Every Baby Counts since December 2015 which is much lower than expected for a service our size.
- Successful in securing the £70,872 for training from the Health Education England South for maternity safety training. The money has supported the set of the SHIP Maternity Academy sharing MDT training across the Wessex area.
- Successful bid to become a pioneer group to establish a SHIP Maternity Network. This supports the guidance as set out in the Better Births (2016) Maternity Review .

- Successful bid to become the first wave of Trusts participating in the National Maternal and Neonatal Health Safety Collaborative which supports the aims of Better Births (2016) maternity review and the Maternity transformation programme led by NHS Improvements.
- Staff raised £14,042 for the refurbishment of the Bereavement suite on maternity to improve the experience for mothers and families who experience loss.

3

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE QUALITY ACCOUNT

Quality Accounts

Annex A Statement by a senior employee in respect of the Quality Account

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (in line with requirements set out in Quality Accounts legislation).

In preparing their Quality account, directors should take steps to assure themselves that:

The Quality Account presents a balanced picture of the trust's performance over the reporting period

The performance information reported in the Quality Account is reliable and accurate

There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm they are working effectively in practice

The data underpinning the measure of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review

The Quality Account has been prepared in accordance with any Department of Health guidance

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

By order of the Board

NB: sign and date in any colour ink except black

16 June 2017	Date		Chair
16 June 2017	Date		Chief Executive

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

NHS
Fareham and Gosport
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19 May 2017

Tim Powell
Acting Chief Executive
Portsmouth Hospitals NHS Trust
Queen Alexandra hospital
Southwick Hill Road,
Cosham
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PO6 3LY

Dear Mr. Powell

Commissioner Supporting Statement

NHS South Eastern Hampshire Clinical Commissioning Group (CCG), NHS Fareham & Gosport CCG, NHS Portsmouth CCG and the Hampshire and the Isle of Wight associate commissioners welcome the opportunity to comment on Portsmouth Hospitals NHS Trust (PHT) 2016/17 quality account. This statement reflects the collective views of commissioners concerning the trust's quality achievements, improvements and challenges in 2016/17, and on the priorities set for 2017/18.

Areas of quality achievement in 2016/17
Commissioners have been pleased to note that the trust has maintained or improved the quality of services in a number of key areas. These include:

- Continued positive ratings in the 2016 **national staff survey**
- Consistently positive **friends & family test** responses
- The rate of **clostridium difficile** has met the trust's trajectory
- There has been just one non-avoidable and zero avoidable **MRSA** cases.
- A reduced number of **moderate harm rated falls** patient safety incidents, and achievement of the **falls rate** per 1,000 bed days as agreed in the contract, with sustained numbers of falls categorised as severe harm, when compared to the number reported in 2015/16. Whilst commissioners' consider further reductions in the incidence of falls are achievable in certain specialties, there is evidence that repeating themes are being addressed and there is full trust engagement in the NHS Improvement Falls Collaborative.
- **Harm free care** (patient safety thermometer) has increased, with the trust average of total harm free care at 98.3% compared to 97.8% in 2015/16.
- The trust has improved its **safety culture** by achieving a 23% increase in reported incidents via National Reporting Learning System (NRLS), and introduced initiatives to

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promote learning within the organisation. The Trust sits just below the national average for the rate of patient safety incidents reported.

- Commissioners were delighted to note the improved performance in the **Sentinel Stroke National Audit Programme (SSNAP) audit outcomes** for patients presenting with a cerebrovascular accident, with the trust achieving level B. Sustainability of this performance will need the correct focus in the coming year.
- Despite significant operational pressures experienced this year the trust has maintained very low levels of non-clinically justified **mixed sex accommodation breaches**.
- The trust has focussed work on improving care for patients with **learning disabilities** with the utilisation of the "hospital passport". This helps informs staff of essential patient information.

Quality challenges in 2016/17

- The trust has reported five **never events**, most relating to surgical procedures. All have been subject to full root cause analysis and to date, no specific themes have arisen. Commissioners were invited to visit the operating theatres and their observations presented back to the trust. The introduction of local safety standards for invasive procedures is underway.

- Historically, the trust has performed well in **dementia case finding**, but performance has deteriorated over the last two quarters, and commissioners are keen to see a plan for improvement of dementia case finding. This will be monitored via the contractual agreements.

- 2016/17 was a challenging year for the trust and its health and social care partners in relation to performance within the **urgent and unscheduled care pathway (emergency department and acute medical unit)**. The trust has been unable to achieve constitutional standards and other key performance and quality measures within the emergency department. This has resulted in some significant quality challenges including:
  - An increased numbers of days when the trust has needed to declare "black alerts" which impacted on elective care and patient flow.
  - 281 breaches for the 12-hour decision to admit threshold
  - A high number of ambulances held at the department
  - High numbers of patients who are medically fit for discharge
  - High bed occupancy rates.
  - High numbers of additional capacity beds open
  - High numbers of patient moves for non-clinical reasons and night time discharges.

The above challenges have impacted on the experience and safety of patients, causing delays in treatment and the continuity of care. Pressures experienced in urgent and unscheduled care have also impacted on other health partners. However, there have been noted improvements in the safe care of patients in emergency department and this was evidenced when in February 2017, the Care Quality Commission (CQC) lifted a September 2016 enforcement notice under Section 31 of the Health and Social Care Act (2013). In addition, the trust demonstrated such improvement that resulting in the 2016 NHS England "risk summit" process being de-escalated with the condition of continued enhanced monitoring.

It is, however, extremely concerning to see that there **is lack of evidence** to indicate that the quality of care, including the fundamentals of care delivery within the **acute medical unit**, has been improved and commissioners strongly consider the trust needs to

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demonstrate immediate and sustainable improvements. This will be closely monitored and subject to escalated focus by all regulatory and relevant health organisations.

- Despite the above improvements within the emergency department, commissioners were also concerned to note that following further inspections in quarter four, the CQC issued a new enforcement notice under Section 31 of the Health and Social Care Act (2013) along with a requirement notices under Regulation 17, placing 4 conditions on the trust to improve care specifically within the **acute medical unit**. These conditions reflected concerns about staffing levels to enable safe care and treatment in the acute medical unit, effective management, care and treatment in the GP triage referral area. The CQC also raised concerns around the need to improve fundamental nursing care including privacy and dignity, medication management and care of the vulnerable patient, including DOLs and mental capacity act compliance as well as ensuring robust governance.
- Commissioners acknowledge that the trust has developed improvement plans to address the CQC findings concerns and that enhanced surveillance and monitoring is in place to track progress with these plans. Commissioners remain actively engaged with the urgent and emergency care work programmes the trust is progressing in collaboration with local partners, NHS England, NHS Improvement and the Emergency Care Improvement Programme (ECIP).

- The CQC inspection in September 2016 provided an overall rating of **"requires improvement" for urgent and emergency services and medical care**. It is concerning to note that a rating of "inadequate" was applied for the assessment of "well-led" in medical services including older people's care, reflecting the concerns around effective governance. It will be essential to ensure that the ward to board governance operates to provide assurance of sustainable practice change.

- The trust has undergone significant **executive leadership changes** this year and has yet to fully establish its substantive leadership team to support the strategic and operational delivery which will enable the sustained quality improvements required.

Quality Account Structure

The quality account appears well presented and provides clear information across the three areas of quality; patient safety, clinical effectiveness and patient experience. The account is reflective of the mandated items required and the local priorities.

Quality Improvement Priorities for 2017/18
The quality account demonstrates that in setting 2017/18 quality priorities, the trust has considered both internal and external intelligence and local and national requirements. Commissioners are encouraged to see the level of independent and nationally validated data which has been used to demonstrate the quality of services which provides an "independent" external voice on quality and enables external assurance mechanisms to reflect both in priority setting and quality assurance.

Commissioners' note that some priorities appear very similar to those identified in the 2016/17 quality account, and some priorities are duplicated in the patient safety and clinical effectiveness domains. It will be important that the trust's efforts for improvement are recognisable, and that measurable improvements in the quality of care are achieved by year end.

The trust has set an **overarching priority** to improve the safety, experience and effectiveness of the most vulnerable patients through a structured education programme, focussed on

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safeguarding, mental capacity act and deprivation of liberty safeguards, mental health and dementia. This pledge is fully supported by commissioners.

Patient Safety

Commissioners are supportive of the trust setting a priority to further embed the **mortality** review panel process across the trust and implement the standardisation of documentation for learning, as outlined in the commissioner statement in 2016/17. Commissioners intend to work with the trust to seek assurance on progress with:

- The implementation of the framework for NHS trusts *Reporting, Investigating and Learning from Deaths in Care*, (National Quality Board, 2017).
- The recommendations of the CQC *Learning, Candour and Accountability* report. It would be helpful to be able to review the milestones for full implementation.

The trust priority for improvement across the **sepsis pathway** is welcome. This priority aligns with the Commissioning for Quality & Innovation scheme, (CQUIN) which has been operational for two consecutive years. Data is not yet available to determine the full achievements in 2016/17; however the trust had not met the agreed trajectories for antibiotics administration and 3 day review at quarter 3 for either patient's attending the emergency department or for inpatients.

Commissioners are aware of concerns raised by partners relating to **discharge medication** and support the trust's priority to improve this. However, whilst reducing the number of incidents reported, the trust needs to ensure that it maintains or improves the reporting culture. Commissioners will continue to work with the trust to provide feedback from local healthcare professionals when issues arise relating to discharge medication and look forward to reviewing the improvement plan stating the actions and milestones to achieve this. It is acknowledged that the trust is also working with HealthWatch volunteers to support patient surveys following discharge.

Commissioner quality priorities for trust consideration

In addition to the above priorities, commissioners consider further work is required to improve the standards for **communication of patient diagnostic test results internally and on discharge from hospital**. The CCGs are working with the trust to confirm implementation of an electronic solution.

Commissioners have made the trust aware of a number of patient safety incidents arising from **unreported plain x-ray films** and recognise the trust has discussed possible resolution at the board and a decision has been take to tolerate the risk with no further mitigation. The CCG will continue to monitor this issue.

The CCG also consider continued work is required to improve **safety on discharge**, ensuring that relevant communications are in place from hospital staff to community or primary care health care professionals. Whilst it is acknowledged that the trust is implementing the SAFER Patient Flow Bundle, which is aimed at improving patient flow and preventing unnecessary waits at discharge, it is essential that safety checks on discharge are fully integrated into this programme.

It is acknowledged that the trust's intention to implement a **network spinal model**, improving access and expertise into the spinal services, is delayed. This delay is disappointing and the CCGs will continue to work with the relevant partners to support a resolution.

Clinical Effectiveness / Outcomes
The trust has maintained a priority focus on mortality with four linked aspirations. The outcome to be achieved within 2017/18 has been identified as "monitoring" mortality ratios compared to a

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specific target performance outlined in the previous two years (unmet). The trust has also set a priority around investigating outlying data to reduce overall mortality rates. Commissioners consider this as normal practice and would encourage a more aspirational target.

The ***Hospital Standardised Mortality Ratio*** (HSMR) is reported to be within confidence intervals but the rate has increased in quarter four and continues to be classed as high. The ***Summary Hospital-level Mortality Indicator*** (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, PHT SHMI is above expected. Commissioners support the intention to record avoidable deaths, structured judgement reviews using national methodology to tailor interventions where there is likelihood of avoidability. Commissioners will continue to monitor this and work closely with the trust to further analyse the trust position, its work programmes and obtain further assurance around any trust or system wide actions required.

Long waits for Referral to Treatment (RTT)

As the trust has been unable to deliver the **referral to treatment (RTT)** constitutional targets within all specialities and has reported a small number of 52 week breaches, commissioners have sought assurance in respect of the quality impact assessment and monitoring process for patients experiencing significant waits, which includes a clinical triage process. In addition, commissioners are aware of further work required to support timely diagnostics in light of demand and capacity issues. It is pleasing to see that the trust forecast achievement of all eight key national cancer standards in March 2017.

Patient Experience

Commissioners support the continued focus on improving the experience of patients **with mental health needs** and notes the trust is reporting an improved service for adult patients via the psychiatric liaison team. It is essential that the findings from the CQC inspection are used to drive forward improvements.

The trust has again set a priority for improving **end of life care** through better understanding of the experience of relatives and close friends at the end of life. It is good to see the pledge including "making changes to care and services based on feedback". The trust has confirmed that the Achieving Priorities of Care documentation has been more widely implemented which was one of the elements identified in the CQC inspection in 2015 as "requires improvement" and, in addition, commissioners highlighted in the quality account statement of 2016/17 a wish to see ongoing support for the bereavement service to improve accessibility to relatives in a timely way. Commissioners are aware that the trust has extended the office opening times for the bereavement services and enabled families to be seen in a timelier manner.

The trust has set its intention to further develop **engagement with carers** to support early identification and transition between services. This is a positive intention and the trust is developing the role of volunteers to strengthen their assurance processes.

Commissioners consider that **patient and carer experience of the discharge process** requires ongoing improvement and is sighted on the engagement work the trust is leading to engage carers and volunteers in surveying patients to improve practice.

Commissioners acknowledge the work the trust has undertaken to improve the experience of patients who have been moved outside their clinical speciality due to operational pressures,

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especially moves at night. As part of the care quality commissioner quality metrics, this is monitored on a weekly basis, including the number of moves for vulnerable patients.

Achievements reported against 2016/17 priorities and overall quality performance

The trust sets out a useful summary of achievement against the 2016/17 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 achievement of nine priorities, partial achievement of one priority and non-achievement of one priority. Commissioners note the extensive commitment to quality and the work which has been undertaken to enable this.

It was encouraging to note delivery of the priority to improve harm related medication incidents and the increasing positive reporting culture. In addition, to the priority set for discharge medications in 2017/18, commissioners would like to further understand the work programmes to improve the findings in the National Diabetes Inpatient Audit 2016 which indicates that the trust had significantly above-average proportions of patients experiencing prescription errors, medication errors and insulin errors.

It has been positive to note the use of service quality care reviews, ward accreditation schemes and patient safety learning events to support ongoing improvement and assurance. The Trust should be congratulated on delivering the priority of reducing hospital acquired stage 3 acute kidney injury episodes and it will be good to see this work sustained in 2017/18.

There has been an improvement in sepsis screening (based on data as at quarter 3) but disappointingly the trust has not reported full delivery against the targets for treatment and 3-day review. This remains a key priority and will be supported through a CQUIN scheme in 2017/18. 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.

Data Quality

It is good to see that the trust is again reporting a high percentage of achievement for inclusion for a valid NHS 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 95% of eligible national clinical audits (38/40) and 100% of confidential enquiries (8/8). The percentage of cases submitted ranged from 55% "Carotid Endarterectomy" to 100% submission for other audits. The audits for which no data was submitted include the National Ophthalmology Audit (data systems now upgraded) and Inflammatory Bowel Disease.

It is positive to see the continued good performance in the National Neonatal Audit Programme and the Falls and Fragility Fracture Audit Programme. Also to note is the improved data submission to the Trauma Audit and Research Network audit. As indicated, under the actions to improve quality from audits, commissioners are pleased to see the Trust's commitment to improve

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cancer nurse staffing in year and the quality improvement project to review the care pathway for bowel cancer. The overall performance in the National Diabetes Audit is noted, alongside the collaborative work to improve outcomes identified from the foot care audit. There is clear evidence of research participation.

Commissioner Assessment Summary

The trust has demonstrated some very positive quality improvements in 2016/17 despite a significantly challenging year operationally across the urgent and unscheduled care pathway which created continued concerns for patient safety, outcomes and experience. Commissioners have escalated these risks to regulators. The enforcement notices issued by the CQC and the prolonged risk summit process reflect the shared concerns. Enhanced quality monitoring has been required for most of 2016/17 and will continue to be in place. It is extremely concerning to note the lack of progress on quality improvement in the acute medical unit. This needs to improve immediately, and be driven through a substantive executive team. .

It is imperative that these challenges remain the trust's highest focus in the coming year and that there is strong leadership and commitment to work as a partner in the health and social care system to deliver timely and sustained improvements.

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. In 2017/18, this will be further supported through the new contracting framework which will enable more aligned processes for quality, and through joint working in the shadow accountable care system recently established for the Portsmouth and South East Hampshire system. Commissioners welcome the trusts increasingly open and transparent approach exemplified through opportunities to participate in internal quality peer reviews and will maintain the schedule of clinical visits and share/evaluate healthcare professional feedback to support a wide range of quality improvement endeavours.

We look forward to continued positive and productive relationships as we increasingly take a more joined up approach to quality improvement in 2017/18.

Yours sincerely,

Alex Berry
Acting Chief Operating Officer
Fareham & Gosport & South Eastern Hampshire Clinical Commissioning Groups

CC: **Maggie MacIsaac**, Accountable Officer, Hampshire Commissioning Partnership
Julia Barton, Chief Quality Officer/Chief Nurse Fareham & Gosport and South Eastern Hampshire CCGs
Susanne Hasselmann, Lay Member, South Eastern Hampshire CCG
Lucy Docherty, Lay Member, Fareham and Gosport CCG
Roderick Bowerman, GP Representative, South Eastern Hampshire CCG
Suzannah Rosenberg, Director of Quality & Commissioning, Portsmouth City CCG

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HAMPSHIRE HEALTH AND ADULT SOCIAL CARE SELECT COMMITTEE COMMENTARY ON PORTSMOUTH HOSPITALS NHS TRUST (PHT) QUALITY ACCOUNTS 2015/2016

No comments received.

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

No comments received.

PORTSMOUTH HEALTH OVERVIEW AND SCRUTINY PANEL COMMENTARY ON PORTSMOUTH HOSPITALS NHS TRUST (PHT) QUALITY ACCOUNTS 2015/2016

The Health Overview and Scrutiny Panel do not comment on Quality Accounts.

LIMITED ASSURANCE REPORT

INDEPENDENT AUDITORS' LIMITED ASSURANCE REPORT TO THE DIRECTORS OF PORTSMOUTH HOSPITALS NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

We are required to perform an independent assurance engagement in respect of Portsmouth Hospitals NHS Trust's Quality Account for the year ended 31 March 2017 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance consist of the following indicators:

- percentage of patients risk-assessed for venous thromboembolism (VTE); and
- Friends & Family Test patient element score.

We refer to these two indicators collectively as "the indicators".

Respective responsibilities of Directors and auditors

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations). In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

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

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 published on the NHS Choices website in March 2015 ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the period April 2016 to June 2017;
- papers relating to quality reported to the Board over the period April 2016 to June 2017;
- feedback from the Commissioners dated 19 May 2017;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated August 2016;
- feedback from other named stakeholder involved in the sign off of the Quality Account;
- the latest national patient survey dated 15 December 2015;
- the latest national staff survey for the 2016/17 year;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated May 2017;
- the annual governance statement dated 1 June 2017; and
- the Care Quality Commission's quality and risk profiles.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the "documents"). Our responsibilities do not extend to any other information.

This report, including the conclusion, is made solely to the Board of Directors of Portsmouth Hospitals NHS Trust.

We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Portsmouth Hospitals NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Portsmouth Hospitals NHS Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

Helen Thompson
Executive Director
For and on behalf of Ernst & Young LLP
Southampton
27 June 2017

The following foot note should be added to the assurance report when it is published or distributed electronically:

The maintenance and integrity of the Portsmouth Hospitals NHS Trust web site is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the Quality Accounts since they were initially presented on the web site.

Legislation in the United Kingdom governing the preparation and dissemination of the Quality Accounts may differ from legislation in other jurisdictions.

Glossary of terms

Term	Description
Acute Kidney Injury (AKI)	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. *Source: NHS Choices*
Care Quality Commission (CQC)	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.
C.Diff	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). *Source: NHS Choices*
Clinical Service Centre (CSC)	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.
Commissioners	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.
Commissioning for Quality and Innovation (CQUIN)	The CQUIN payment framework enables Commissioners to reward excellence, by linking a proportion of Providers' income to the achievement of local quality improvement goals.
Dr Foster	The UK's leading provider of comparative information on health and social care services.
HSMR	The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the mortality rate at a hospital is higher or lower than 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.
HQIP (Healthcare Quality Improvement Partnership)	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.
MRSA	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 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. *Source: NHS Choices*

Term	Description
National Audit	A National quality improvement process that seeks to improve patient care and outcomes through the systematic review of care.
National Institute for Health and Clinical Effectiveness (NICE)	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.
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.

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APPENDIX A - NATIONAL CLINICAL AUDIT: ACTIONS TO IMPROVE QUALITY

NATIONAL CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES THAT PORTSMOUTH HOSPITALS NHS TRUST PARTICIPATED IN DURING 2016/2017	
Audit Title	**Outcome/Actions to improve quality of healthcare**
National Clinical Audits	
British Thoracic Society – Adult Asthma	The BTS Adult Asthma report was published in February 2017; the Trust is currently reviewing this report and will produce an action plan if required.
British Thoracic Society – Chronic Obstructive Pulmonary Disease	Awaiting publication of the national report/results.
Head and Neck Cancer	Awaiting publication of the national report/results.
Oesophago-Gastric Cancer	The Oesophago-Gastric Cancer report was published September 2016; the Trust is currently reviewing this report and will produce an action plan if required.
Lung Cancer	The Lung Cancer report was published December 2016, with a supplementary Pleural Mesothelioma report published in January 2017. There has been some success improving outcomes against the audit benchmarks in Portsmouth from the previous data. Treatment rates for Small Cell Lung Cancer patients have risen to above the national average and although the anti cancer treatment rate remains slightly below the national average this also improved from the previous data. The case load of newly diagnosed patients remains significant causing considerable strain on the service as a whole. The department will see improved cancer nurse staffing this year with a full-time cancer nurse which is funded 100% by charitable donations and the Asbestos Support Group. A new Lung Cancer Specialist has recently started and should really improve the service within the team. The Trust continues to strive to meet the national targets and remain committed to providing an excellent service for patients.
Prostate Cancer	The Prostate cancer report was published in December 2016; the Trust is currently reviewing this report and will produce an action plan if required.
Bowel Cancer	The Bowel Cancer report was published December 2016 and the Trust are currently reviewing this report and will produce an action plan if required. The Trust has a high rate of laparoscopic surgery with high nodal yield (quality surgery), but length of stay has been high. The Trust has undertaken a quality improvement project to review the care pathway including the enhanced recovery pathway. Plans are now in place to further improve this pathway. The Trust surgeons have been identified as positive outliers (better than expected) when compared to the national average in regard to mortality rates within 90 days of surgery.
National Vascular Registry	The National Vascular Registry report was published December 2016; 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. Vascular services are moving to University Hospital Southampton NHS Foundation Trust from 1st April 2017, therefore this national audit will no longer be applicable to the Trust.
National Joint Registry	The report highlights that the Trust continues to have good results following Hip and Knee replacement in terms of revision rates and

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NATIONAL CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES THAT PORTSMOUTH HOSPITALS NHS TRUST PARTICIPATED IN DURING 2016/2017	
Audit Title	**Outcome/Actions to improve quality of healthcare**
	mortality. There is full compliance with the NJR data collection process in terms of obtaining consent from patients for recording their details and recording all cases within the Registry. The Trust surgeons have not been identified as outliers (not above expected mortality) in regard to reported surgical outcomes and mortality rates as published in the surgeon outcomes report.
National Comparative Audit of Blood Transfusion Programme	*Red Cell and Platelet transfusion in adult haematology* – This report was recently published; the Trust is currently reviewing this report and will produce an action plan if required.
	Patient Blood Management in scheduled surgery - Awaiting publication of the national report/results.
	Red Cell transfusion in Palliative Care - Not relevant to Portsmouth Hospital NHS Trust.
Royal College of Emergency Medicine – Asthma (Paediatric and Adult) care in emergency departments	Awaiting publication of the national report/results.
Royal College of Emergency Medicine – Severe Sepsis and Septic Shock – care in emergency departments	Awaiting publication of the national report/results.
National Neonatal Audit Programme (NNAP)	The ninth National Neonatal Audit Programme report covered data collection for the calendar year 2015. The Trust are performing at, or above, the national and network average for all defined standards and are one of the best performing units in the country. The Trust need to maintain these excellent results and are constantly monitoring outcomes. Some areas for improvement have been identified and action plans are in place for this.
Endocrine and Thyroid National Audit	Awaiting publication of the national report/results.
Paediatric Diabetes Audit	The Paediatric Diabetes report was published in March 2017; the Trust is currently reviewing this report and will produce an action plan if required. The report highlights that the Trust are performing below national and/or regional average for four of the seven key care processes recommended by NICE – Blood Pressure 63.2%, National 90.8%, Thyroid 78.7%, Regional 81.6%, Eye Screening 54.9%, National 66.2%, Foot Examination 69.6%, Regional 76.4%. The Trust are performing above both national and regional averages for the other three key care processes – HbA1c 100%, National 99.3%, Body Mass Index 100%, National 97.9%, Albuminuria 70.7%, National 66%. 33.8% of young people aged 12 years and older seen by the Trust had received all seven care processes compared to 35.5% across England and Wales. The Trust has a higher proportion of children and young people with 4 or more Insulin injections daily as their treatment regime –66.8%, National 54%.
Paediatric Intensive Care Audit Network	Not relevant to Portsmouth Hospital NHS Trust.
Learning Disability Mortality Review Programme (LeDeR)	Data collection for this audit is ongoing. The Trust will review the results once they are published.

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NATIONAL CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES THAT PORTSMOUTH HOSPITALS NHS TRUST PARTICIPATED IN DURING 2016/2017	
Audit Title	**Outcome/Actions to improve quality of healthcare**
BAUS Cystectomy Audit	The report identified that at the Trust, 86.9% of procedures were completed by open surgery. Trust transfusion rate of 9.8% is significantly below the national average (approximately 20%). The Trust 30 day mortality rate was reported as 0% and 90 day mortality rate as 1.6% which is below the national average (2.5%). The Trust surgeons have not been identified as an outlier (not above expected mortality).
BAUS Nephrectomy Audit	The report identified the Trust complication rates are 0.85%, which is below the national average (3.5%). Mortality was reported as 0.79% which is slightly above the national average (approximately 0.5%), but within expected limits. No surgeons were identified as an outlier (not above expected mortality).
BAUS Percutaneous Nephrolithotomy (PCNL)	Transfusion rates at the Trust were reported as 8.8% which is above the national average of approximately 2%, but within expected limits. Post operative length of stay is in line with the national average. No surgeons were identified as an outlier.
BAUS Radical Prostatectomy Audit	The report shows that 100% of procedures carried out at the trust are robotically assisted. The Trust complication rate of 0% was reported as below the national average (approximately 1.5%), and the transfusion rate was in line with the national average at 0.62% (national average <1%). No surgeons were identified as an outlier (not above expected mortality).
BAUS Stress Urinary Incontinence Audit	No surgeons were identified as an outlier (not above expected mortality).
BAUS Urethroplasty Audit	The report shows that both the Trust's intra operative complication rate and post operative complication rate of 0% are below the national average (intra operative complication approximately 2.5% and post operative complication approximately 7%). No surgeons were identified as an outlier (not above expected mortality).
National Neurosurgical Audit Programme	Not relevant to Portsmouth Hospital NHS Trust.
Falls and Fragility Fracture Audit Programme	*National Hip Fracture Database* (NHFD) - The national report compares local figures with benchmarking performance data within the South Central region and for all hospitals in the NHFD. The Trust continues to achieve consistently better scores in the majority of domains. Comparing Portsmouth to the top 9 trusts nationally in terms of hip fracture numbers, the Trust is the 6th highest, Portsmouth have achieved a higher percentage in the majority of domains compared to the other 8 trusts and similarly better in comparison to other hospitals in the South Central region and the overall national figures. There were 3 trusts that scored better than the national average in all blue book standards – Portsmouth, Poole and Bradford with Portsmouth being the only trust to have achieved this for 3 consecutive years. The Trust scored better in the majority of domains. The Trust continues to show consistency in high level achievement for these quality outcomes. 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 performance and ensure that quality is maintained and look for opportunities to improve further.
	Inpatient Falls Audit - Awaiting publication of the national report/results.
	Fracture Liaison Service (FLS) (Facilities Audit) - The National FLS facilities audit is a complex piece of work which has shown that there is

NATIONAL CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES THAT PORTSMOUTH HOSPITALS NHS TRUST PARTICIPATED IN DURING 2016/2017	
Audit Title	**Outcome/Actions to improve quality of healthcare**
	a broad diversity of FLS models in place across the country. The model chosen by Portsmouth was only established in April 2014 but it seems to be working well in many respects. It is however, yet to be completely resourced and deployed to capture all fracture patients and attend to both their bone heath and falls needs. The Trust continues to work towards this goal. There has been significant work completed this year to ensure that the Trust data collection/submission system is in line with the national audit dataset.
Trauma Audit and Research Network (TARN)	Three reports were published during 2016/17 with focus on specific areas of care. A significant improvement in data completeness was highlighted compared to previous reports; this is mainly due to the appointment of a TARN nurse within Emergency Medicine. There was an increase in Emergency Department (ED) consultant involvement in the care of severely injured patients from 23% to 54%. An improvement in the median time to CT was noted, with the worst times also relating to the time for the poorest performance against the ED 4 hour target. *Thoracic and Abdominal Injuries* – Data suggests an increase in numbers of patients with thoracic and abdominal injuries being seen, however this may be related to improved data submissions. Consultant involvement in the care of patients with thoracic injury has increased from 33% to 55-64%. The presence of general surgeon involvement in ED for patients with abdominal injuries does not appear to have improved, however this may be due to poor recording. Time to theatre for patients with severe abdominal injuries has almost halved, however this still requires further improvement as remains outside the expected standard. All of these operations were performed by a consultant. *Orthopaedic Injuries* – Results for injuries classified under BOAST 4 show that 100% were stabilised within 24 hours and 33% of wounds covered in 72 hours. A consultant was the surgeon in 66% of cases and Specialist Trainee (ST3) in 33% of cases. Only 1 severe pelvic fracture operation occurred during the data collection period, this is due to these cases being transferred to the Major Trauma Centre. Time to imaging for severe pelvic fractures has improved from 4.8 hours to 2.6 hours. There has been an increase of a third of open fractures of the limbs seen at the Trust. Imaging time requires further improvement; however there has been a significant reduction in time to operation, from 40 hours to 20 hours. *Head and Spinal Injuries* – Consultant presence within 5 mins of patient arrival has improved from 8.9% to 11.9% across all patients, but has dropped from 90.3% to 69.2% in trauma calls – this is due to increased trauma calls out of hours where the consultant is not on site. Time to CT has improved for all patients from a median of 3 hours to 2.5 hours; however those patients meeting NICE Head injury criteria still have a median of 1.4 hours which is above the recommendation of less than 1 hour. Results show that the median length of stay for critical care patients has increased from 9 to 15 days and there was an increase in readmissions from 2 to 8.3%. 80% of patients with Head Injuries AIS 3+ are managed within the trust and only 50% of those with a GCS<9 are transferred out. This reflects the fact that the majority of these patients are elderly and are not candidates for neurosurgery. However the guidance is that they should be managed in a neurosurgical centre, but the unit at UHS does not have capacity to deal with these numbers.

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NATIONAL CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES THAT PORTSMOUTH HOSPITALS NHS TRUST PARTICIPATED IN DURING 2016/2017	
Audit Title	**Outcome/Actions to improve quality of healthcare**
Sentinel Stroke National Audit Programme (SSNAP)	*Audit* - Stroke Care is a challenging specialty nationally, with evidence for interventions in the hyper-acute phase gathering pace, and with rehabilitation and long-term care developments lagging behind. The opportunities for improving outcomes, reducing morbidity and mortality are vast, however, continued investment in the service will be required to enable the Trust to realise the benefits for the whole health and social care community. Whilst the Trust have been successful in recruiting across all disciplines, particularly to nursing teams, development of specialist skills and knowledge is work in progress, and retention of staff a continuing challenge. The improvement from a Level C to a category B is welcome, especially against a background of continuing unscheduled care pressures; nationally the standard and expectations continue to rise with the recent publication of Royal College of Physicians 2016 guidance. The Trust is committed to maintaining and furthering this improvement in the SSNAP level, as it reflects the improvement in standards of care and outcomes for our patients.
	Organisational – The Trust currently meet 4 out of 10 indicators, however by ensuring Hyper Acute Stroke Unit (HASU) beds are ring-fenced for stroke patients, (so all HASU patients are seen by a consultant daily), and performing a patient survey at least annually, the Trust score should increase to be within 70% of Trusts. Since the audit the Trust has employed a clinical psychologist, although to meet the SSNAP requirement the Trust would need more than one psychologist in post. The Trust do not currently propose to offer a Carotid Doppler Service at weekends to ensure high risk patients are investigated within 24 hours, as this would incur additional costs with no real gain to patients as the Trust are not currently offering a weekend carotid endarterectomy service. There are currently no plans to have therapy services other than physio therapy available at weekends due to resource implications.
Paediatric Pneumonia	Data collection for this audit is ongoing. The trust will review the results once they are published.
National Emergency Laparotomy Audit (NELA)	The Trust data collection/completion remains excellent and is above the national average, especially given the high numbers of patients. Engagement of consultants, both anaesthetic and surgical, with the quality improvements recommended by NELA, has resulted in excellent outcomes for patients with an average 30 day mortality of 9.8%. Clinicians are continually looking at ways to improve documentation, especially of clinical risk and consultant input. Managerial input is now needed to improve access to emergency theatres, especially at weekends and during excessively busy times, with development of a policy to postpone elective surgery if the emergency demand warrants it. The Trust need expansion of High Dependency Unit (HDU) and Intensive Therapy Unit (ITU) facilities and an involvement of elderly care physicians in peri-operative care.
ICNARC – Adult Critical Care	The Trust Critical Care Unit (CCU) is the second busiest in the network, with 1,395 admissions in 2015-6. The Standardised Mortality Ratio (SMR) for Quarter 1 and Quarter 2 in 2016-7 is 0.89 and 0.94 indicating fewer deaths than would be expected for our case-mix.

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Audit Title	**Outcome/Actions to improve quality of healthcare**
	Further improvement is required in out of hour discharges (between 22:00 and 06:59). Our Critical Care Unit is performing well compared with comparator units across a number of quality indicators. This includes unit acquired infection rates and non-clinical transfers (none during Quarter 1 and Quarter 2). The CCU continues to have a strong reputation for quality care, research, training, use of informatics and innovation.
ICNARC – Cardiac Arrest	The two main outcomes that this report analyses are successful resuscitation (Return of Spontaneous Circulation [ROSC] > 20 mins) and survival to hospital discharge. Within the Trust there were 96 successful resuscitations of 209 individuals having a cardiac arrest (45.9%), and 40 of those individuals (209) survived to discharge (19.1%). There are no areas for concern when reviewing the risk adjusted and stratified data for The Trust which are all within the confidence limits of the national averages.
Renal Registry – Renal Replacement Therapy	Awaiting publication of the national report/results. The trust will review the results once they are published.
Chronic Kidney Disease in Primary Care	Not relevant to Portsmouth Hospital NHS Trust.
Pulmonary Hypertension	Not relevant to Portsmouth Hospital NHS Trust.
Prescribing Observatory for Mental Health	Not relevant to Portsmouth Hospital NHS Trust.
Cystic Fibrosis Registry (Adult and Paediatric)	Not relevant to Portsmouth Hospital NHS Trust. Data submitted via Southampton.
Rheumatoid and Early Inflammatory Arthritis	The National body did not collect data for this audit during 2016/17. The Trust reviewed the national report published in August 2016. The national audit of the management of early rheumatoid and inflammatory arthritis is complex with multiple factors potentially influencing results. The trust recruited anticipated numbers of patients for the 2015 data collection period. The Trusts catchment population wait longer for specialist referral (NICE quality standard 1) and report more severe disease activity at presentation to secondary care; reasons for this require exploration. The trust performed better than the national and regional average for most aspects of care assessed but not as well as a comparator trust with similar catchment population demographics.
National Audit of Dementia	Awaiting publication of the national report/results. The trust will review the results once they are published.
Adult Cardiac Surgery	Not relevant to Portsmouth Hospital NHS Trust.
Congenital Heart Disease (Adult Cardiac Surgery)	Not relevant to Portsmouth Hospital NHS Trust.
Congenital Heart Disease (Paediatric Cardiac Surgery)	Not relevant to Portsmouth Hospital NHS Trust.
Coronary Angioplasty – Percutaneous Coronary Intervention (PCI)	Patient outcomes are significantly better than expected from the complex and high risk case load seen within the Trust. Radial access continues to increase (90% in 2014 compared to 87% in 2013, 79% in 2012, 80% in 2011 and 72% in 2010 and a national average of

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	75.3%). Use of radial access is associated with a halving of complications. The MACCE (major adverse cardiovascular and cerebral event) rate for Portsmouth Hospitals was 2.60% compared to 2.79% in 2013, 3.87% in 2012 and 2.98% in 2011 and compares very favourably with an expected mortality of 3.61%. The Trust time to treatments in both STEMI and NSTEMI are better than the national average. The Trust complies with all of the major recommendations within this report.
Parkinson's Audit	The national body did not collect data for this audit during 2016/17. The Trust reviewed the national report published in May 2016. Overall, there were improvements across several domains since the 2011/12 audit and many local audit sites compared favourably to the national data. The action plans will assist the teams to make continued improvement. The patient reported experience measurements (PREM) included in the audit for the first time indicates the majority of patients value their local services and feel they are either remaining the same or improving. The national audit has an aspiration to deliver many more fully integrated clinics. This is likely to be challenging to deliver both nationally and locally without a lead from commissioners and significant service redesign and investment in nursing and therapy staff as well as a change of venue for many clinics to allow co-location of the Multidisciplinary team. Locally, collaborative working between Parkinson's Nurse Specialists, Neurologists and Geriatricians will deliver 'work around' solutions to some of the challenges imposed by space and staffing constraints.
Acute Coronary Syndrome or Acute Myocardial Infraction (MINAP)	The MINAP report was published in February 2017; the Trust is currently reviewing this report and will produce an action plan if required.
National Ophthalmology Audit	The Trust did not participate in this national audit during 2016/17, the delay to the required software upgrade to the hospital systems prevented participation before the date collection submission cut off date. This upgrade has now been installed and the Trust will now be able to submit data and participate in the 2017/18 audit.
Specialist Rehabilitation for Patients with Complex Needs	Not relevant to Portsmouth Hospital NHS Trust.
Cardiac Rhythm Management	The Trust submitted 100% of the required data (all implants carried out) to this national audit. The results reported confirm that the Trust is supplying a quality service for the implantation of Pacemakers, Implantable Cardioverter-Defibrillator (ICD's) and Cardiac Resynchronisation Therapy (CRT's) showing comparable results with peers and the national averages. The Trust will continue to carry out local audits along side the national audit to confirm ongoing compliance with the relevant NICE guidelines.
Mental Health Clinical Outcome Review Programme	Not relevant to Portsmouth Hospital NHS Trust.
Heart Failure	Results for the Trust are above the national average and higher than other local trusts. The Trust submitted only 56% against a data requirement of 70% but is working on a business plan to address the issues raised in this national audit report. The British Heart

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NATIONAL CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES THAT PORTSMOUTH HOSPITALS NHS TRUST PARTICIPATED IN DURING 2016/2017	
Audit Title	**Outcome/Actions to improve quality of healthcare**
	Foundation national figures indicate that the number of hospital visits by heart failure patients increased by 36% from 107,000 to 146,000 between 2004/5 and 2014/15. The Trust has addressed this by employing a new Heart Failure Consultant.
End of Life Care	The national body did not collect data for this audit during 2016/17. A review of the results published in the latest report show that the Trust has performed well in the national audit of end of life care, with the majority of domain results being better than national average. From the key recommendations, the Trust is already following the action plan from the Trusts End of Life Steering Group. The Trust's main aims are to continue to promote holistic individualised care using a specifically designed care plan. Communication, documentation and discussion around feeding and drinking are being reviewed by the Trust's Speech and Language specialists. Advanced care planning is a necessity which needs to be further promoted within the Trust and will form part of the 2017 action plan.
National Diabetes Audit	*Core Audit* - Not relevant to Portsmouth Hospital NHS Trust.
	Diabetes in Pregnancy – This audit indicates that the Trust compares favourable to national averages. The Trust continues to develop strategies to raise awareness of the importance of pre-conceptual care and improving achievement of safe glucose controls in pregnancy. There is a need to integrate pre-conceptual education into existing public health and related programs and address barriers that prevent women accessing pre-conceptual care such as age, culture and language. The Trust will continue to monitor and improve local performance against the NICE Quality Standard - Diabetes in pregnancy (109).
	Inpatient Audit - The Inpatient Diabetes report was published in March 2017 and the Trust are currently reviewing this report and will produce an action plan if required. Review of the report published in March 2016 indicates that Diabetes inpatient care in Portsmouth remains better than average, despite staffing reductions in recent years. However there are areas in which this audit has highlighted a risk for future deterioration and a national drive for improvement. The Trusts electronic health records (her) project will support some of the improvement drive (when implemented) but it is clear that staff education and confidence around enacting care processes remains the mainstay of improving services. Resources to support staff education (especially around insulin management and foot assessments) should thus be a priority.
	Foot care Audit - The primary results from this audit highlights that the Trust sees patients with a higher than average ulcer severity. Currently time to assessment is poor with only 1.8% of patients seen by a specialist within 2 days of initial Health Care Professional review (against 13.4% nationally) and 40% not seen within 2 months (compared with 8.6% nationally). The Trust has significantly poorer 12 and 24 week outcomes than national averages. 12 week outcome (healed and alive) 18.2% compared to 55.1% nationally and 24 week outcomes 33.3% compared to 58.3% nationally. There is a requirement for cross trust - commissioner collaboration with involvement from podiatry, diabetes and primary care to improve the pathway.
Inflammatory Bowel Disease (IBD)	The IBD report has consistently flagged that the Department is under resourced however there have not been concerns regarding clinical quality. The Trust remains very much sighted on all areas of the service that need improvement as highlighted by the previous year's results. A fortnightly IBD Multidisciplinary team meeting has been introduced to ensure that major changes in treatment and decisions about surgery are carefully discussed and recorded. The Trust did not submit any data during 2016-17 due to a particularly low number of specialist registrars (SpRs) attached to the department and no IBD administrator, however there has been recent recruitment

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	and appointment of a full-time administrative assistant who will work with the lead clinician on ensuring progress with the new IBD registry data submission for 2017-18. The Trust is in the process of completing the registration process to ensure participation in the IBD Registry.
Patient Reported Outcome Measures – Elective Surgery	The Trust was slightly below the national average for both Hip and Knee Surgery (Apr 14 – Mar 15), but well within the expected limits. The recent results for hip and knee surgery have now improved (Apr 15 – Mar 16 provisional) to above the national average for hip surgery but still below the national average for knee surgery, still well within the expected range. Participation rates were poor which impacted results. These have now improved.
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) – Maternal Infant and Perinatal Confidential Enquiry	*Maternal Mortality - MBRRACE-UK* Saving Lives, Improving Mothers' Care report into maternal morbidity and mortality was published in December 2016; the report provides incidence and causation of direct and indirect deaths in the triennia from 2012-2014. The report provides detailed analyses of cases surrounding cardiovascular disease in pregnancy; early pregnancy care and hypertensive disorders of pregnancy. The report also has recommendations for critical care and pathology. An action plan has been created based on the recommendations and Maternity Services and associated specialties across the Trust are working towards providing assurance of compliance.
	Perinatal Mortality - MBRRACE-UK perinatal mortality report reviewing 2014 cases was published in May 2016; The Trust rates were found to be very good: • Stillbirths rate was 3.73 per 1000 total births which is recorded as up to 10% lower than the national rate (4.83/1000); • Neonatal deaths rate was 1.54 per 1000 births which is recorded as more than 10% lower than the national rate (1.77/1000) • Extended perinatal mortality rate was 5.30 per 1000 total births up to 10% lower than national rate (6.44/1000). A number of the recommendations are nationally driven and the service is awaiting the outcome of this activity. The service is actively working towards completion of the action plan. The service is working as part of the Wessex Maternity network to implement standardised review processes and meetings have been held to take this important process forward; a secondary pathway is for external scrutiny of cases and to share learning to the wider health economy.
National Confidential Enquiry into Patient Outcomes and Death – Non-Invasive Ventilation	Awaiting publication of the national report. The trust will review the results once they are published.
National Confidential Enquiry into Patient Outcomes and Death – Acute Pancreatitis	All patients with acute pancreatitis seen within the Trust are looked after by surgeons, usually the upper GI surgeons. The Trust routinely adheres to the British Society of Gastroenterology (BSG) and the American College of Gastroenterology (ACG) guidelines as closely as possible, and provides urgent cholecystectomy or Endoscopic Retrograde Cholangiopancreatography (ERCP) for patients wherever possible. The capacity of Hepato-Pancreato-Biliary (HPB) centres to manage the complications of acute severe pancreatitis has

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	been highlighted on a national basis; the Trust has inherited expertise in this area, although this may change in the next 5 years. No action plan to change practice is currently required.
National Confidential Enquiry into Patient Outcomes and Death – Mental Health in General Hospitals	The 'Treat as one' report was published in February 2017; the Trust is currently reviewing this report and will produce an action plan if required.
Child Health Clinical Outcome Review Programme – Chronic Neuro-disability	This NCEPOD study is ongoing.
Child Health Clinical Outcome Review Programme – Young Person's Mental Health	This NCEPOD study is ongoing.
Child Health Clinical Outcome Review Programme – Cancer in Children, Teens and Young Adults	This NCEPOD study is ongoing.

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APPENDIX B – LOCAL CLINICAL AUDIT: ACTIONS TO IMPROVE QUALITY

LOCAL CLINICAL AUDITS	
Audit Title	**Comments and actions to improve quality of healthcare**
Compliance with PHT antimicrobial prescribing policy and guidelines	This audit has raised awareness of appropriate use of antimicrobials across the Trust thereby ensuring that patients with infections are managed optimally with the right antibiotic prescribed via the right route at the right dose.
Critical Care IV Insulin Infusion Protocol: Is it being followed and is it fit for purpose?	This audit has improved patient care by identifying areas where the Department of Critical Care IV insulin protocol is not being followed. An action plan was put in place with the aim of achieving better glycaemic control for patients on IV insulin in ITU and avoiding complications associated with excessive hyperglycaemia.
Repeat audit on screen detected B3 and B4 lesions on core biopsies of breast 2014-15	Improving non-operative biopsy diagnosis reduces turnaround time for cancer diagnosis and reducing unnecessary excision rate, therefore theatre time. Vacuum assisted biopsy (VAB) was introduced to improve this rate and has shown significant results. It is also noted that VAB should be considered more frequently especially in cases when there is need of a repeat biopsy in radiologically suspicious lesions. Quality of VAB is also important for accurate representation of the lesional area which is also monitored continuously. The audit recommendations have been discussed with the director of breast screening with a view that there will be an improvement as the percentage of B4 and B3 diagnosis (suspicious/uncertain) for the year 2014-15 decreased very minimally.
Audit to establish if woman with pre-existing diabetes are taking folic acid 5mg pre-conceptually in accordance with NICE guidelines.	This audit highlighted that the Trust compares favourably to national audits. The Trust continues to develop strategies to raise awareness of the importance of pre-conceptual care and prescription of higher dose folic acid for women with diabetes. The Trust needs to integrate pre-conceptual education into existing public health and related programmes and address barriers that prevent women accessing pre-conceptual care such as age, culture and language.

Portsmouth Hospitals NHS Trust

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