Portsmouth Hospitals NHS
NHS Trust

PORTSMOUTH HOSPITALS NHS TRUST
QUALITY ACCOUNTS
2017 - 2018

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

Table of contents

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STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

On behalf of the Trust Board and all staff at Portsmouth Hospitals NHS Trust I am delighted to introduce our Quality Account for 2017/18.

The last twelve months have been extremely challenging across the NHS and the winter period in particular was one of the most difficult that many of us have experienced for quite some time. However in spite of this, our staff were exceptional and worked tirelessly when the pressures on our hospital were sustained over a period of weeks.

I joined the organisation on 31 July 2017 and was immediately struck by the passion, dedication and commitment to patient care demonstrated by our staff across the entire organisation. Throughout the winter period I saw this exemplified again and again, so I would like to thank and pay tribute to each and every member of staff, who have continually focussed on our patients and on improving the quality of care we provide.

We ended the financial year with a substantial deficit, however we delivered on the financial plan we set out following our re-forecast of our year end position in January. This was achieved through a huge amount of energy and focus across the Trust and whilst we do not underestimate the scale of the task ahead to bring the organisation into financial balance over the next three years, I believe we have set ourselves a strong foundation.

The challenges our organisation faces, particularly in our urgent care pathway, are well documented. However we have continued to deliver excellence in many areas, gaining recognition through a number of external awards and accolades. We were successful in our application for a National Oncoplastic Breast Fellowship, allowing us to remain as one of only twelve Nationally Accredited Training Centres. In February we were only one of three Trusts in the country approached to host a live transmission of complex coronary angioplasty cases from our labs to the Advanced Cardiovascular Intervention conference in London. We were also only one of eight Trusts to have achieved all three of the efficiency targets set out in the Carter Review. These examples highlight just a few of the everyday examples of excellence.

I am extremely proud that, following the collapse of Carillion in January, there was no significant impact on the services we provide. Our hospital operated as normal thanks to all of our colleagues in Facilities Management who truly went above and beyond, putting our patients before any concerns they had about their own circumstances.

In February we hosted our inaugural Trust wide safety conference. The event featured examples of patient safety and quality improvement projects across all departments, and was truly inspirational. It demonstrated a commitment to ensuring quality improvement remains at the top of our agenda which is wholly endorsed by our Board. We are looking forward to continuing our progress in this important area.

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 sincerely hope you find it informative.

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QUALITY IMPROVEMENT PRIORITIES 2018 / 2019

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, national quality initiatives, 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 and improving patient experience. From these the Patient Safety, Experience and Clinical Effectiveness Steering Groups identified a number of proposed priorities.

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 May 2018.

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 2018/19.

The Account summarises the Trust's performance and improvements against the quality priorities and objectives we set ourselves for 2017/18 (set out in the 2017/2018 Quality Account).

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. 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 the Quality and Performance Committee.

Portsmouth Hospitals NHS Trust

QUALITY ACCOUNT PRIORITIES 2018 / 2019

Improving the safety, experience and effectiveness of care for our patients

PATIENT SAFETY

- **Serious Incidents and Never Events**
  - Complete investigations within 60 days.
  - Feedback to patient / family within 30 days of CCG sign off.
  - Reduce number of SIRIs per 1,000 occupied bed days (5% improvement on 2017/18 baseline).
  - Increase Root Cause Analysis (RCA) and Structured Judgement Review Training (SJR) for staff.
- **Mortality & learning from deaths**
  - The lower limit of the Trust Hospital Standardised Mortality Ratio (HSMR) not to exceed 100.
  - Increase number of stage 2 reviews using SJR methodology.
  - Increase SJR and RCA training of staff.
- **Sepsis & deteriorating patients**
  - Appointment of a dedicated Sepsis Nurse.
  - Roll out sepsis rapid "response support".
- **Falls & pressure injury**
  - Sustain or reduce the rate per 1,000 occupied bed days of avoidable injurious falls (2017/18 baseline).
  - Reduce the rate per 1,000 occupied bed days of avoidable pressure injury (2017/18 baseline).

CLINICAL EFFECTIVENESS

- **Dementia assessment**
  - Improving dementia screening assessment to ensure achievement of the national standards for dementia (to meet or exceed 90%).
- **SSNAP National Audit**
  - To improve and sustain the Trust score of the Sentinel Stroke National Audit Programme (SSNAP) to an overall Level B.
- **National Lung Cancer Audit**
  - To improve Trust standards in the National Lung Cancer Audit to ensure the expected standards are met.
- **Cancelled on the day operations**
  - To reduce the number of cancelled on the day operations.

PATIENT EXPERIENCE

- **Patient, family and carer feedback**
  - Increase access to opportunities for providing feedback, with a focus on seldom heard groups.
- **Understanding what matters most to patients**
  - Improve our understanding of patient family and carer lived experience of care and treatment from the increased feedback opportunities.
- **Quality Improvements**
  - Ensure service developments and quality improvements are based on what really matters most to patients, by enabling the meaningful participation of patients, families, carers and members of the local community in service design, quality monitoring and evaluation.
- **Measuring Improvement**
  - Support the development of person centred quality improvement measures, to ensure we are measuring the right thing.

Underpinned by the delivery of the
Care Quality Commission Quality Improvement Plan

QUALITY IMPROVEMENT PRIORITIES 2017/2018 – OUR ACHIEVEMENTS

The Quality Account published in June 2017 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.

Quality Account Priorities 2017 / 2018
PATIENT SAFETY

How did we do?

- **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). ✗

Quality Account Priorities 2017 / 2018
CLINICAL EFFECTIVENESS

How did we do?

- **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. ✓

Quality Account Priorities 2017 / 2018
PATIENT EXPERIENCE

How did we do?

- **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. ✓

STATEMENTS OF ASSURANCE FROM THE BOARD

Review of services

During 2017/2018 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 2017/2018 represents 98% of the total income generated from the provision of NHS services by Portsmouth Hospitals NHS Trust for 2017/2018.

Participation in clinical audits

During 2017/2018 41 national clinical audits and 7 national confidential enquiries covered NHS services that Portsmouth Hospitals NHS Trust provides.

During that period Portsmouth Hospitals NHS Trust participated in 100% (41/41) national clinical audits and 100% (7/7) 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 2017/2018, 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 45 national clinical audits (this number is from both 2017/18 and some reports that were published from data supplied in 2016/17) were reviewed by the provider in 2017/2018. Appendix A highlights 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**
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Audit	☑	100%
Adult Cardiac Surgery	Audit	Not applicable	Not applicable
BAUS Cystectomy Audit	Surgeon Outcomes	☑	93% (*2014-2016*)
BAUS Nephrectomy Audit	Surgeon Outcomes	☑	89% (*2014-2016*)
BAUS Percutaneous Nephrolithotomy (PCNL)	Surgeon Outcomes	☑	55 cases (*2015-2016*)
BAUS Radical Prostatectomy Audit	Surgeon Outcomes	☑	96% (*2014-2016*)
BAUS Urethroplasty	Surgeon Outcomes	☑	77% (*2014-2016*)
BAUS Stress Urinary Incontinence Audit	Surgeon Outcomes	☑	50% (*2014-2016*)

NATIONAL CLINICAL AUDITS			
Audit title	**Details**	**Participation**	**% cases submitted**
Bowel Cancer	Audit	☑	100%
Cardiac Rhythm Management	Audit	☑	100%
Case Mix Programme (CMP) - Intensive Care National Audit and Research Centre (ICNARC)	Audit	☑	100%
Congenital Heart Disease	Audit	Not applicable	Not applicable
Coronary Angioplasty – Percutaneous Coronary Intervention (PCI)	Audit	☑	100%
Diabetes – Paediatric (NPDA)	Audit	☑	100%
Elective Surgery Patient Reported Outcome Measures (PROMS)	Overall Score	☑	43%
	Groin Hernia	☑	14%
	Hip Replacement	☑	58%
	Knee Replacement	☑	56%
	Varicose Veins	☒	0%
Endocrine and Thyroid National Audit	Surgeon Outcomes	☑	Data collection ongoing
Falls and Fragility Fracture Audit Programme	Fracture Liaison Service Database (FLS-DB)	☑	48%
	Hip Fracture Database	☑	100%
	Inpatient Falls Audit (NAIF)	☑	100%
Head and Neck Cancer Audit (HANA)	Audit	☑	Data collection ongoing
Inflammatory Bowel Disease (IBD) Programme	Audit	☑	Data collection ongoing
Learning Disability Mortality Review Programme (LeDeR)	Audit	☑	100%
Major Trauma Audit - Trauma Audit and Research Network (TARN)	Audit	☑	97-100%
Mental Health Clinical Outcome Review Programme (NCISH)	Audit	Not applicable	Not applicable
National Audit of Breast Cancer in Older People (NABCOP)	Audit	☑	100%
National Audit of Dementia	Audit	☑	100%
National Audit of Intermediate Care	Audit	Not applicable	Not applicable
National Bariatric Surgery Register (NBSR)	Audit	☑	Data collection ongoing
National Cardiac Arrest Audit (NCAA) - ICNARC	Audit	☑	Data collection ongoing
National Chronic Obstructive Pulmonary Disease Audit Programme (COPD)	Audit	☑	148 cases
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	Audit	Not applicable	Not applicable
National Comparative Audit of Blood Transfusion Programme	Audit of red cell and	☑	100%

NATIONAL CLINICAL AUDITS			
Audit title	**Details**	**Participation**	**% cases submitted**
	platelet transfusion in adult haematology patients		
	TACO Audit	☑	100%
	Audit of O negative red cells	☑	Delayed start date
National Diabetes Audit - Adults	Transition	☑	100%
	Diabetes in Pregnancy	☑	76 cases
	Inpatient Audit	☑	100%
	Foot Care	☑	81 cases
National Emergency Laparotomy Audit (NELA)	Audit	☑	>80%
National Heart Failure Audit	Audit	☑	63%
National Joint Registry (NJR)	Audit	☑	100%
National Lung Cancer Audit (NLCA)	Audit	☑	100%
National Maternity and Perinatal Audit (NMPA)	Audit	☑	100%
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	Audit	☑	100%
National Ophthalmology Audit	Audit	☑	100%
National Vascular Registry	Audit	Not applicable	Not applicable
Neurosurgical National Audit Programme	Audit	Not applicable	Not applicable
Oesophago-Gastric Cancer (NAOGC)	Audit	☑	71-80%
Paediatric Intensive Care Audit Network (PICANet)	Audit	Not applicable	Not applicable
Prescribing Observatory for Mental Health (POMH-UK)	Audit	Not applicable	Not applicable
Prostate Cancer	Audit	☑	100%
Royal College of Emergency Medicine - Fractured Neck of Femur	Audit	☑	100%
Royal College of Emergency Medicine - Pain in Children	Audit	☑	100%
Royal College of Emergency Medicine - Procedural Sedation in Adults (care in emergency departments)	Audit	☑	100%
Sentinel Stroke National Audit Programme (SSNAP)	Audit	☑	>90%
	Organisational	☑	100%
Serious Hazards of Transfusion (SHOT): UK National Haemo-vigilance Scheme	Audit	☑	100%
UK Parkinson's Audit	Audit	☑	100%

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%
Child Health Clinical Outcome Review Programme – Chronic Neurodisability	☑	67%
Child Health Clinical Outcome Review Programme – Young Persons Mental Health	☑	67%
Child Health Clinical Outcome Review Programme – Cancer in Children, Teens and Young Adults	☑	100%
National Confidential Enquiry into Patient Outcomes and Death – Peri-operative Diabetes	☑	Ongoing
National Confidential Enquiry into Patient Outcomes and Death – Heart Failure	☑	100%
National Confidential Enquiry into Patient Outcomes and Death – Pulmonary Embolism	☑	Ongoing

The reports of 37 local clinical audits were reviewed by the provider in 2017/2018. 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 2017/2018, that were recruited during that period to participate in research approved by a research ethics committee was 5,813. Of these patients, 5,549 (95%) were recruited into clinical studies adopted onto the National Institute for Health Research (NIHR) Portfolio, with 264 (5%) 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 2017/2018, Portsmouth Hospitals NHS Trust has participated in a total of 312 clinical research studies, 88% of these studies were NIHR Portfolio adopted.

More than 35 clinical Departments participated in research approved by a research ethics committee at Portsmouth Hospitals NHS Trust during 2017/2018, covering a number of specialities and clinical support departments.

Goals agreed with Commissioners

Portsmouth Hospitals NHS Trust income in 2017/18 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 with Conditions.

The Care Quality Commission has taken enforcement action against Portsmouth Hospitals NHS Trust during 2017/2018 resulting in conditions on registration being applied.

The CQC undertook a responsive focused inspection of the corporate and leadership functions of the Trust in May 2017, inspecting the key question of 'well led'. The inspection resulted in the Trust receiving an Enforcement Notice in May 2017 due to the concern than patients who use services within the emergency medical pathway of the Queen Alexandra Hospital will or may be exposed to the risk of harm. This Notice comprised six conditions:

1. The Registered Provider must deploy sufficient numbers of suitably qualified and competent staff in the emergency decision unit in the emergency department to provide safe, good quality care to patients with mental health problems along with all other patient. Staffing levels and skill mix must take into account the acuity of all patients in the department at any given time.
2. The Registered Provider must ensure all patients presenting to the emergency department with mental health problems receive a full assessment of all risks assessment and corresponding risk management plan/care plan. This risk assessment and plan must include, but is not exclusive to, the following:
    - Assessment of risks across a broad range of mental health issues and the identification of any specific risks for the individual patient and

others in the department (patients, carers, staff, members of the public) and any safeguarding concerns.
- The environmental risks to the patient and mitigating actions
- Robust immediate risk management/care plan documenting the appropriate frequency of observation, specific intervention (care and treatment) required to meet the patient's needs and escalation plans should the patient's condition deteriorate.
- An identified time and date for review specific to the individual patient's needs.

3. The Registered Provider must identify, monitor and observe detained and / or high risk patients with mental health concerns or vulnerable safeguarding issues across the hospital and must have oversight of the location of these identified and plan of care of patients at all times.
4. The Registered Provider must ensure that there are clearly identified leads for mental health provision within the emergency department and acute medical unit at all management levels. The Registered Provider must also ensure that there is executive level leadership that has accountability for mental health care, safeguarding and Deprivation of Liberty Safeguards within the hospital.
5. The Registered Provider must ensure that Deprivation of Liberty Safeguards are applied as per the requirements of Mental Capacity Act, 2005, prior to depriving a person of their liberty.
6. The Registered Provider must immediately take action to ensure patients are safe. As a minimum, deploying sufficient, suitably qualified and competent staff and completing robust risk assessments, plans and delivering the identified care and treatment for patients presenting with mental health issues. Then, as soon as reasonably practicable, and in any event by 12pm on Monday 15 May 2017, describe the actions the Provider will take to meet the requirements of this notice and the timescales in which it will implement the required actions to comply with the conditions set out in this notice. The Registered Provider must demonstrate that they are assured that such care is actually being delivered. The trust must send the Care Quality Commission an update weekly in this respect from the week commencing 22 May 2017.

The CQC undertook an unannounced inspection at the Queen Alexandra Hospital site in July 2017 to review specific aspects of the care provided by the diagnostic imaging department. The inspection resulted in the Trust receiving an Enforcement Notice in July 2017 due to concern that patients in receipt of the regulated activity of diagnostic and screening procedures will or may be exposed to the risk of harm. This Notice comprised four conditions:

1. The Registered Provider must take evidenced based appropriate steps to resolve the backlog of radiology reporting using appropriately trained members of staff. This must include a clinical review, audit and prioritisation of the current backlog of unreported images, (including those taken before January 2017); assess impact of harm to patients, and apply Duty of Candour to any patient adversely affected.
2. The Registered Provider must ensure that they have robust processes to ensure any images taken are reported and risk assessed in line with Trust policy.
3. The Registered Provider must submit their evidenced based decision-making on how the backlog will be addressed to the Commission by the 21 August 2017.
4. From 6 September 2017, and on the Wednesday of each week after, the Registered Provider must report to the Care Quality Commission, NHS Improvement and the NHS England Local Area Team:
   - The total number of images remaining in the backlog (including unreported images pre-January 2017) shown by year of image taken.
   - The current trajectory date of when the backlog (including unreported images pre-January 2017) will be cleared.
   - The proportion of patients waiting less than the trusts KPI for x-rays, CT and MRI.
   - The average waiting time (in days and hours) for a reported plain film (excluding GP requests).
   - The average waiting time (in days and hours) for chest and abdominal films (excluding GP requests).

- Number of plain film requests (excluding GP requests).
- Longest waiting time for a reported radiology plain film request.

The CQC issued the Trust with a Warning Notice under Section 29a of the Health and Social Care Act 2008 in July 2017 in relation to the inspections undertaken in February and May 2017. The Notice was issued to ensure significant improvements were made to the quality of health care provided within the Trust.

The Enforcement Notice following the inspection by the CQC in February 2017 and place on the Trust in March 2017 relating to AMU has remained in place during 2017/2018.

We published a Quality Improvement Plan on 31st October 2017 to address the areas for improvement noted following the inspections. A Quality Improvement Assurance Group (QIAG) was established to provide monitoring and oversight of the delivery of the plan. A high level dashboard with key performance indicators has been developed to measure the impact of delivery of the actions within the plan.

Data quality

Portsmouth Hospitals NHS Trust submitted records during 2017/2018 to the Secondary Users Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data. The latest available scores from NHS Digital's Maturity Index (mid 2017, focusing on the previous 12-months) shows the following data quality scores:

Included the patient's valid NHS number:

- 98.3% for admitted patient care (national average 99.2%)
- 99.2% for outpatient care (national average 99.5%)
- 99.9% for accident and emergency care (national average 96.6%)

Included the patient's valid General Medical Practice Code:

- 100% for admitted patient care (national average 99.9%)
- 100% for out-patient care (national average 99.8%)
- 100% for accident and emergency care (national average 98.9%)

Portsmouth Hospitals NHS Trust will be taking the following actions to improve data quality:

- A robust mechanism is in place to review and promote deliver against the IG Toolkit metrics relating to data quality
- Ensuring all data quality procedures are reviewed regularly and up to date
- Ensuring all data submission standard operating procedures detail proxy/ready reckoner values for reference
- Completeness and validity checks are in place, as detailed specifically within the IG Toolkit
- Governance is in place to ensure PAS / Data Warehouse / master files are kept up to date (including GP Details, Patient Address).

The Trust was not subject to a Payment by Results (PbR) clinical coding audit in 2017/2018 by the Audit Committee.

Information Governance Toolkit attainment levels

Information Governance is concerned with the way the Trust handles or "processes" information. It covers Personal Data (relating to patients/service users and employees) and corporate information (such as financial and accounting records.

The Information Governance Toolkit is a performance tool produced by the Department of Health which draws together the legal rules and central guidance surrounding data protection and presents them in one place as a set

of information governance standards. The Trust are required to carry out yearly self-assessment of compliance against these standards.
Portsmouth Hospitals NHS Trust Information Governance Assessment Report overall score for 2017/2018 was 68% and was graded “Satisfactory”.

The Trust reported six serious incidents to the Information Commissioner’s Office (ICO). Three remain open and relate to personal information of patients being sent to the wrong GP, an employee discussing patient information with a friend and another employee looking up patient information for personal use. The remaining three are all closed and no further action was required to be undertaken by the Trust.

Learning from deaths

27.1. During 2017/2018, 2,543 of Portsmouth Hospitals NHS Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 629 in the first quarter.
- 526 in the second quarter.
- 648 in the third quarter.
- 740 in the fourth quarter.

27.2. By 31st March 2018, 1,552 case record reviews and 459 investigations [1] have been carried out in relation to 2,543 of the deaths included in item 27.1.

We are unable to provide the number of cases in which a death was subjected to both a case record review and an investigation. This is due to the database not being able to differentiate between cases having just a case review or just a Mortality and Morbidity (M&M) review or those having both. From March 2018, all adult inpatient deaths receive a case review. Therefore, this requirement will not be necessary.

The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 218 in the first quarter.
- 342 in the second quarter.
- 455 in the third quarter.
- 538 in the fourth quarter.

27.3. 4 cases, representing 0.16% of the patient deaths during the reporting period, were initially judged to be more likely than not to have been due to problems in the care provided to the patient. Following further review 3 of the cases have been deemed unavoidable; 1 case is awaiting post mortem outcome.

In relation to each quarter, this consisted of:

- 1 representing 0.16% for the first quarter (case subsequently downgraded).
- 2 representing 0.38% for the second quarter (both cases subsequently downgraded).
- 0 representing 0% for the third quarter.
- 1 representing 0.13% for the fourth quarter (awaiting post mortem outcome).

These numbers have been derived from case reviews at mortality review panels and in-depth reviews by M&Ms.

27.4. The following the key patient care and treatment themes identified from MRP and M&M reviews. There are a significant number of cases where appropriate and timely anticipatory care planning could have enabled the patient to receive end of life care in a non hospital setting. Decisions relating to setting a ceiling of care and moving to end of life care are not always made in a timely fashion, prolonging unnecessary treatment for patients. There are difficulties achieving timely discharge for patients approaching end of life (fast track process). There are also patients who suffer significant delays in their discharge processes and subsequently deteriorate.

[1] Investigations equal review by the relevant morbidity and mortality meeting.

27.5. Actions taken to address the themes identified include the sharing of the information with partner organisations, including CCGs. Primary care and other NHS Trusts with a focus on increasing awareness of the importance of anticipatory care planning. Case summaries are used as educational tools for medical staff with emphasis put on the impact of delaying decision making around ceiling of care and the move to end of life care. Work by the unscheduled care board to reduce the delays in the discharge process is ongoing. Direct feedback to CCGs about delays in the fast track process has been provided.

27.6. There has been an improvement in the documentation of decision making around end of life care and a noticeable increase in the number of patients where ceiling of care is clearly identified early in the patients inpatient stay, particularly in specialties who have been attending the MRP for over a year. There has been some improvement in documented anticipatory planning for patients being discharged from the Trust but to date there has not been any noticeable change for patients coming in from the community.

27.7. Data is not available for data outwith the reporting period.

NATIONAL QUALITY PRIORITIES

The following are a core set of indicators which are to be included in 2017/18 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 NHS Digital. 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 NHS Digital, stated below, may relate to a different reporting period to that of the Quality Account. (Data source: http://content.digital.nhs.uk/qualityaccounts).

National Quality Priorities								
Domain	**SHMI**	**April 2016 – March 2017**		**July 2016 – June 2017**		**October 2016 – September 2017**		**Trust Statement**
		PHT	**National Average**	**PHT**	**National Average**	**PHT**	**National Average**	
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.	1.0889	1.00	1.0912	1.00	1.0719	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: • Close monitoring and review of all mortality data by the Trust Mortality Review Group. • Ongoing review of all adult inpatient deaths through the multi-professional mortality review panel • In depth case review, using Structured Judgement Review methodology, of all cases of concern identified by Dr Foster and/or initial case review. • Further development of the electronic Mortality Review Tool to standardise the data collected during mortality reviews, enabling better identification of any issues and their reporting for action.
	The banding of the summary hospital-level mortality indicator ("SHMI") for the Trust.	As expected (2)	As expected (2)	As expected (2)	As expected (2)	As expected (2)	As expected (2)	
	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	19.9%	30.7%	21.5%	31.1%	23.1%	31.5%	
	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 2014 – March 2015				April 2015 – March 2016				April 2016 – March 2017				Trust Statement
		PHT	National Average	Highest	Lowest	PHT	National Average	Highest	Lowest	PHT	National Average	Highest	Lowest	
Helping people recover from episodes of ill health or following injury.	Groin hernia surgery	0.090	0.084	0.154	0.000	*	0.088	0.157	0.021	0.110	0.086	0.135	0.006	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	*	0.094	0.154	-0.009	*	0.096	0.150	0.018	*	0.092	0.155	0.010	
	Hip replacement surgery	0.422	0.436	0.524	0.331	0.447	0.438	0.512	0.320	0.440	0.445	0.537	0.310	
	Knee replacement surgery	0.278	0.315	0.418	0.204	0.309	0.320	0.398	0.198	0.342	0.324	0.404	0.242	

Note: April 2016 – March 2017 currently Finalised figures for Groin Hernia and Varicose vein (published February 2018), provisional figures for Hip and Knee (Published February 2018)

Domain	Re-admission within 28 days of being discharged	April 2010 – March 2011				April 2011 – March 2012				Trust Statement
		PHT	National Average	Highest (Large Acute)	Lowest (Large Acute)	PHT	National Average	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 December 2013 and future releases have been temporarily suspended pending a methodology review.* 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: • Providing daily updates on readmissions and 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 2015 – March 2016				April 2016 – March 2017				Trust Statement
		PHT	National Average	Highest	Lowest	PHT	National Average	Highest	Lowest	
Ensuring that people have a positive experience of care.	In-patient survey (based on the average score of five questions from the National Inpatient Survey)	67.2	69.6	86.2	58.9	67.6	68.1	85.2	60.0	• 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 actions by: • Increasing the access to feedback opportunities for people from seldom heard groups to ensure the views received are fairer representation of the hospital community. • Used feedback to inform service improvement and practice changes. • Developing continuous feedback systems by working with local community groups.

Publication date August 2017. Next update due August 2018.

Domain	Staff who would recommend the Trust to their friends or family	2016				2017				Trust Statement
		PHT	National Average (Acute trusts)	Highest	Lowest	PHT	National Average (Acute trusts)	Highest	Lowest	
Ensuring that people have a positive experience of care.	National Staff Survey results	72%	70%	85%	49%	69%	70%	86%	47%	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: • From April 2018 PHT is undertaking a 3 stage Culture and Leadership programme over 3 years to develop strategies which deliver collective and compassionate leadership and aims to create high quality care cultures. Using a best practice toolkit and led by a team of trained Change Agents with full support from the Board we will: - Define our leadership culture to deliver the PHT strategy, values and behaviours ethos - Develop a leadership model; management, clinical - Develop and implement a comprehensive leadership development plan aligned to business strategy and the leadership model - Understand current and future leadership capacity, skills, capabilities, structures and roles - Examine and address core HR business processes - Examine and address equality and diversity and staff health and wellbeing

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
	A & E	England	PHT	England	PHT	England	PHT	England	PHT	England	PHT	
Ensuring that people have a positive experience of care	January 2018	126,236	1,084	1,038,385	9,078	12.2%	11.9%	86%	94%	8%	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: • Increasing the access to feedback opportunities for people from seldom heard groups to ensure the views received are fairer representation of the hospital community. • Used feedback to inform service improvement and practice changes • Developing continuous feedback systems by working with local community groups.
	December 2017	118,368	1,432	1,018,820	9,409	11.6%	15.2%	85%	96%	8%	1%	
	November 2017	131,651	1,088	1,019,592	9,711	12.9%	11.2%	87%	94%	8%	1%	
	October 2017	138,135	1,121	1,089,747	10,539	12.7%	10.6%	87%	96%	7%	1%	
	September 2017	128,891	1,066	1,032,466	9,994	12.5%	10.7%	87%	94%	7%	2%	
	August 2017	140,504	1,173	1,034,292	10,026	13.6%	11.7%	87%	95%	7%	2%	
	July 2017	140,600	1,228	1,100,516	10,851	12.8%	11.3%	86%	95%	8%	2%	
	June 2017	137,985	973	1,061,434	10,635	13.0%	9.1%	88%	95%	7%	2%	
	May 2017	136,434	1,517	1,095,333	10,423	12.5%	14.6%	87%	95%	7%	2%	
	April 2017	127,328	1,451	1,017,271	9,979	12.5%	14.5%	87%	94%	7%	2%	
	March 2017	138,932	1,487	1,077,657	10,308	12.9%	14.4%	87%	94%	7%	1%	
	February 2017	117,835	1,197	930,633	8,308	12.7%	14.4%	87%	94%	7%	2%	

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	
Ensuring that people have a positive experience of care	January 2018	204,295	1,917	898,542	7,424	22.7%	25.8%	95%	97%	2%	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 actions by: • Increasing the access to feedback opportunities for people from seldom heard groups to ensure the views received are fairer representation of the hospital community. • Used feedback to inform service improvement and practice changes • Developing continuous feedback systems by working with local community groups.
	December 2017	177,504	1,970	827,543	7,330	21.4%	26.9%	95%	97%	2%	1%	
	November 2017	215,472	2,418	857,976	8,156	25.1%	29.6%	96%	97%	2%	1%	
	October 2017	226,762	2,345	912,514	8,345	24.9%	28.1%	96%	97%	2%	1%	
	September 2017	213,492	2,409	866,467	7,975	24.6%	30.2%	96%	96%	2%	0%	
	August 2017	225,997	2,436	876,973	8,042	25.8%	30.3%	96%	97%	2%	1%	
	July 2017	227,610	2,644	890,608	8,165	25.6%	32.4%	96%	97%	2%	1%	
	June 2017	231,063	2,137	908,723	8,326	25.4%	25.7%	96%	96%	1%	1%	
	May 2017	228,858	2,848	896,356	8,253	25.5%	34.5%	96%	97%	1%	0%	
	April 2017	205,417	2,574	812,896	7,508	25.3%	34.3%	96%	97%	1%	1%	
	March 2017	240,539	2,667	946,249	8,766	25.4%	30.4%	96%	96%	2%	1%	
	February 2017	201,513	2,263	827,936	7,395	24.3%	30.6%	96%	97%	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 2017-18	94%	95%	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: • The Trust is in the process of reviewing the electronic system used for risk assessment to improve the visibility and therefore compliance. • The Trust refreshing it's Thrombosis Committee and VTE Link Nurse Network to help embed the changes required by the newly released NICE VTE Prevention Guidelines NG89.
	Quarter 2 2017-18	95%	95%	100%	72%	
	Quarter 1 2017-18	96%	95%	100%	51%	
	Quarter 4 2016-17	95%	95%	100%	63%	

Domain	Rate per 100,000 bed days of C.Difficile infection	April 2015–March 2016				April 2016–March 2017				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.	Rate per 100,000 bed days of C.Difficile infection amongst patients aged 2 or over.	8.4	14.9	67.2	0	9.2	13.2	82.7	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: • Increased focus on prompt isolation of suspected cases • Updating C.Difficile pathway to include new antimicrobial treatments for C.Difficile • Closer working with relationship with community partners. • Increased emphasis on correct use of PPE. • Encourage hand hygiene in patients as well as staff. • Re-emphasise importance of cleaning the near patient environment including commodes and toilettes.

Domain	Patient Safety Incidents (per 1,000 bed days) (Acute non-specialist)	October 2016 – March 2017				April 2017 – September 2017				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.	7,108	5,122	14,506	1,301	7,682	5,226	15,228	1,133	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 sustain and improve on this number, and so the quality of its services, by: • Continuing to refine incident reporting within the Datix system to encourage use and provide a rich source of data. • Reviewing investigation and shared learning processes to simplify refine and extract relevant lessons. • Implement process for auditing the effectiveness of actions put in place as a result of lessons learnt.
	Rate of patient safety incidents.	39.2	41.1	69.0	23.1	42.6	42.8	111.7	23.5	
	Number of patient safety incidents that resulted in severe harm or death.	44	19	92	1	50	18	121	0	
	% of patient safety incidents that resulted in severe harm or death.	0.24%	0.15%	0.53%	0.01%	0.28%	0.15%	0.64%	0.00%	

REVIEW OF QUALITY PERFORMANCE

This part of the Quality Account provides an overview of how we have performed against quality initiatives in 2017/2018. This information is presented under the three quality domains (safety, effectiveness and experience).

We monitor and track all aspects of quality through detailed reporting to the Trust Board and the Governance and Quality Committee through production of the Integrated Performance report and quarterly quality reports analysing performance.

Whilst many of the quality performance indicators have demonstrated good quality of care, there have been challenges in relation to:

- Never events.
- Hospital Standardised Mortality Rates
- Dementia screening.
- Falls resulting in harm.
- Health care associated infections.

The identified quality priorities for 2018/2019 aim to address the above concerns, amongst other priorities to improve patient safety, experience and outcomes.

Care Quality Commission

All NHS organisations are required to be registered under the Health and Social Care Act 2008 (Regulated Activity) Regulations 2009 and the Care Quality Commission (Registration) Regulations 2009.

The Trust has been subject to various inspections by the CQC which resulted in the following Conditions being placed upon the Trust registration; full details can be found in Section 2:

- Section 31 (AMU) issued 3rd March 2017 following inspection 28th February 2017.
  The Notice related to ensuring sufficient staffing levels and skill mix in AMU and the GP triage referral area to meet the needs of patients, and to ensure appropriate Standing Operating Procedures are in place.

- Section 31 (Mental Health) issued 12th May 2017 following inspection 10th and 11th May 2017.
  The Notice related to ensuring suitably qualified and competent staff in the Emergency Decision Unit to provide safe, good quality care to patients with Mental Health Problems. That appropriate risk assessments and treatment plans are completed for patients presenting to the ED. Ensuring the identification and oversight of vulnerable patients across the organisation and that Deprivation of Liberty Safeguards and the Mental Capacity Act are being applied appropriately.

- Section 29a Warning Notice issued 4th July 2017 following inspections 16th, 17th and 28th February and 10th and 11th May 2017.
  The Notice related to issues of privacy and dignity, consent to treatment, safety across the acute medical pathway, safeguarding of vulnerable adults and governance arrangements.

- Section 31 (Diagnostic and Screening Procedures) issued 28 July 2017.
  The Notice related to the backlog of Radiology reporting.

We published a Quality Improvement Plan on 31 October 2017 to address the areas for improvement noted following the inspections. A Quality Improvement Assurance Group (QIAG) was established to provide monitoring and oversight of the delivery of the plan. A high level dashboard with key performance indicators has been developed to measure the impact of delivery of the actions within the plan.

Patient Safety

Introduction

In recognition of the importance of the safety agenda, the Trust has created a Senior Safety Team and has identified a number of Key Patient Safety Priorities that the team are focussing on.

These priorities are

- The Trust held its first Patient Safety Conference in January 2018. This was a well attended event, with good feedback being received.
- Learning from Deaths.
- Improving patient outcomes related to Unexpected Patient Deterioration (including Sepsis).
- Reducing patient harm from medication errors.
- Reducing patient harm from Pressure ulcers and inpatient falls.
- Improving patient outcomes during hand over and transfer of care.
- Reducing the number of healthcare associated infections.
- Learning and improving in response to patient safety incidents.

Quality Account Priorities 2017 / 2018

PATIENT SAFETY

How did we do?

- **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). ✗

MORTALITY REVIEW

ADOPT PILOT MORTALITY REVIEW PANEL ACROSS THE TRUST ✓

PHASED INCREASE IN SPECIALITIES REVIEWED WITH ALL INPATIENT DEATHS REVIEWED BY END 2017/2018 ✓

IMPLEMENT TRUST-WIDE SYSTEMS FOR DOCUMENTATION OF LEARNING FROM DEATHS ✓

In March 2017, following increased focus on the ways in which NHS provider Trusts review and learn from deaths of patients in their care, the National Quality Board (NQB) published National Guidance on Learning from Deaths. This had the expressed purpose of supporting the development of a standardised approach across organisations and in particular focussing on involving bereaved families in helping NHS Trusts to improve the way in which deaths are reviewed and investigated and how families and carers are involved in this process.

In response to this Portsmouth Hospitals Trust has implemented a number of actions in response to these requirements which include:

Mortality Review Panel (MRP)

The panel is made up of senior clinical staff, with a minimum of one consultant and one senior nurse/therapist attending. Cases are presented by a member of the medical team who cared for the patient, usually but not always, a junior doctor. The aim of the meeting is to identify any learning from the deaths, both in terms of areas where care or treatment could have been improved but also where things went particularly well. In addition the panel ensures that the Death Certification is completed accurately and that comorbidities are recorded in an accurate and comprehensive manner. This enables better epidemiological understanding of the disease patterns and case mix of Trust patients.

The roll out of this process is now complete and all adult inpatient specialties are now included.

Child deaths continue to be reviewed in line with the national guidance 'Working together to Safeguard Children' and include a multi-agency, multi-disciplinary panel convened by the Local Safeguarding Children Board.

Mortality Review Group

This group, established August 2017 and chaired by the Medical Director, has been set up provide direction and formally report on progress against the key work-streams relating to mortality and learning from deaths across the Trust. In particular, the group will support the drive to reduce avoidable mortality and demonstrate clear and measurable outcomes benchmarked against peer providers and the national picture. A standardised approach to respond to any mortality anomalies, identified through Dr Foster reports, MRP or SIRI investigations has been agreed and implemented.

Learning from Deaths Policy

The above policy was published in September 2017 and details the case review process in place within the Trust. A review of the policy was undertaken in early 2018 and it has been updated and revalidated.

Data Collection

The Trust has implemented an electronic Mortality Review Tool on which specific details of all adult inpatient deaths are recorded. Additional

information on cases that have had a more in depth review, such as presentation at Morbidity and Mortality meeting, or Structured Judgement Review can also be added.

Structured Judgement Review Process

As part of the national focus on Learning from Deaths, the Royal Collage of Physicians were commissioned to develop a standardised approach to the review of cases identified as needing a more in depth evaluation. They produced the Structured Judgement Review (SJR) which provides a standard methodology for review of these cases. The Trust has a core group of clinicians who have been trained in the use of this tool and can cascade this training to other staff. A series of training events have been held with further sessions to continue in 2018 / 2019.

Themes and issues identified through review and investigation

The following are the key themes identified from MRP and M&M reviews which are largely unchanged from the last quarter.

- Significant number of cases where appropriate and timely anticipatory care planning could have enabled the patient to receive end of life care in a non hospital setting.
- Delays in decision making regarding ceiling of care and end of life care.
- Issues relating to transfer of patients, and handover of care, at end of life.
- Difficulty in achieving timely discharge for patients approaching end of life (fast track process).
- Patients who are medically fit for discharge for a length of time but deteriorate whilst awaiting discharge.
- Continued significant reduction in inappropriate referrals to HM Coroner.
- Continued reduction in total coroners post mortem examinations.
- Improved speed of completion of bereavement documentation, improving families' experience.
- Improved quality of Death certification and comorbidity coding.
- Positive learning opportunity for junior doctors.
- Increased positive feedback to clinical staff/teams.

SEPSIS

IMPROVED 1ST DOSE ANTIBIOTICS AND 3 DAY REVIEW OF ANTIBIOTIC PRESCPRIOS, TO MEET THE NATIONAL REQUIREMENT ✖

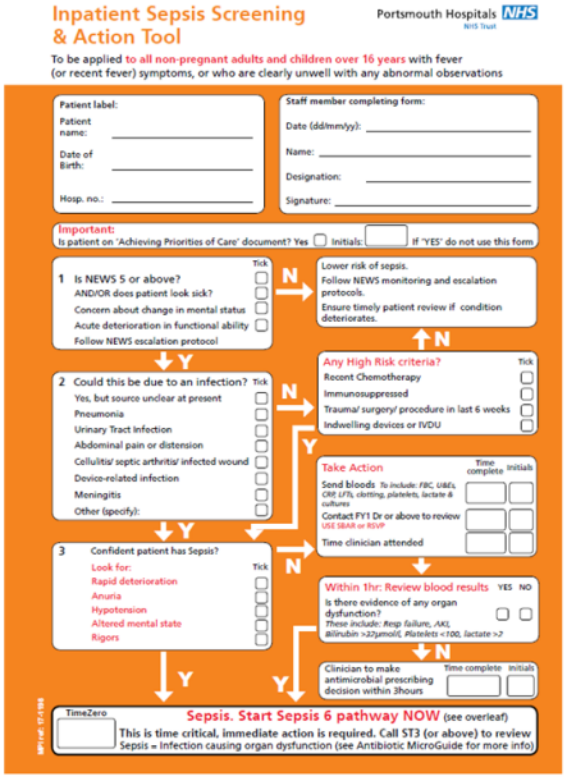
Sepsis is a potentially life-threatening condition, triggered by an infection or injury; without quick treatment, sepsis can lead to multiple organ failure and death.

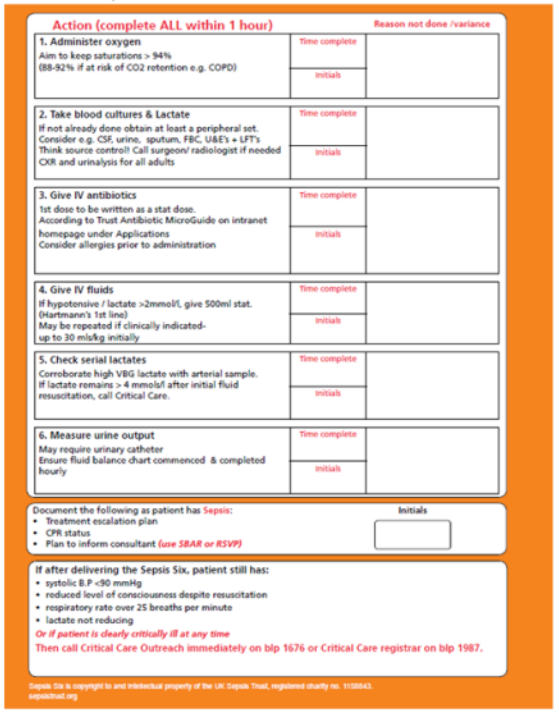
National guidance suggests that treatment should be started within 1 hour of sepsis being suspected; the National CQUIN focusses on the screening for sepsis for all patients for whom sepsis screening is appropriate, and to initiate intravenous antibiotics within 1 hour of presentation, for those patients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

The Sepsis CQUIN has not been achieved, although improvements have been made.

Actions to support the delivery of the CQUIN include:

- Amalgamation of the Sepsis and Deteriorating Patient workstreams to streamline processes and prevent duplication of effort.
- The sepsis pathway has been launched as has the deteriorating patient proforma.
- A business case for a dedicated Sepsis nurse has been written and is awaiting sign off.





Sepsis screening

Sepsis screening %	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
ED & Admit Patients	135	134	103	149	123	90	98	85	64
ED & Admit screened	132	132	102	148	123	88	97	85	59
Inpat Patients	40	27	22	41	17	15	44	29	22
Inpat Screened	38	25	22	40	16	15	42	26	20
ED & Admit Compliance	*98%*	*99%*	*99%*	*99%*	*100%*	*98%*	*99%*	*100%*	*92%*
Inpat compliance	*95%*	*93%*	*100%*	*98%*	*94%*	*100%*	*95%*	*90%*	*91%*
Overall compliance		*98%*			*99%*			*96%*	

Sepsis treatment within 1 hour

Antibiotics within 1 hour%	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
ED/Admit Antibiotics	131	131	102	145	122	84	97	84	64
1-hour compliance	104	98	79	113	90	75	80	68	49
Inpat Antibiotics	33	21	21	38	12	14	36	25	17
1-hour compliance	14	10	7	15	4	6	15	12	7
ED & Admit Compliance	*79%*	*75%*	*77%*	*78%*	*74%*	*89%*	*82%*	*81%*	*77%*
Inpat compliance	*42%*	*48%*	*33%*	*39%*	*33%*	*43%*	*42%*	*48%*	*41%*
Overall compliance		*71%*			*73%*			*72%*	

Q4 results are due to be published on 15 May.

DISCHARGE MEDICATION

REDUCED NUMBER OF INCIDENTS REPORTED AND DECREASED COMPLAINTS/EXTERNAL FEEDBACK REGARDING MEDICATION TO TAKE HOME (TTOs) ✖

Work to reduce errors and complaints relating to discharge medication has not delivered any significant change although the number of complaints has reduced slightly.

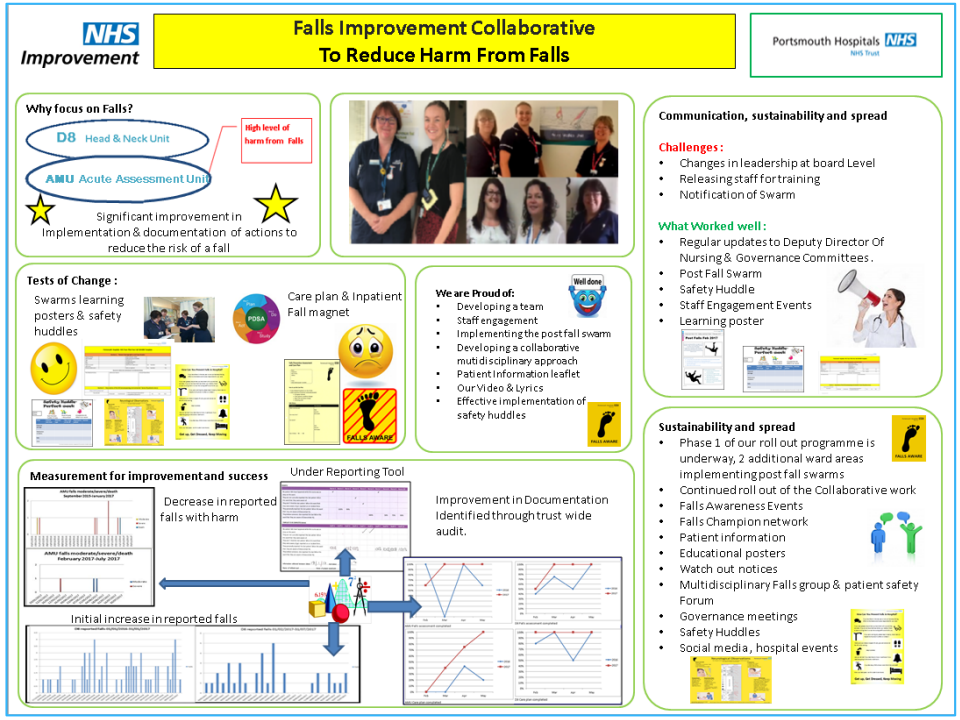
The Trust has remained under significant challenges with bed capacity, requiring the use of escalation areas and continual pressure to discharge patients quickly all of which have known impact on the prescribing and checking of medications and the information given to patients.

	Quarter 1	*Quarter 2*	*Quarter 3*	*Quarter 4*
Incidents reported internally	*41*	*60*	*51*	*60*
External providers	*7*	*6*	*14*	*6*
Complaints	*4*	*2*	*1*	*1*
Total	***52***	***68***	***66***	***67***

FALLS INCIDENTS

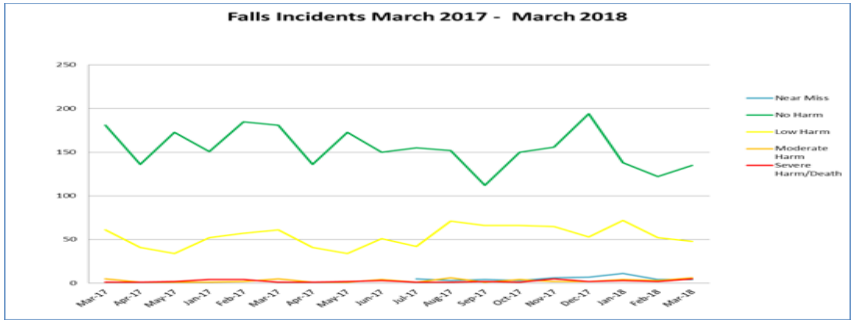
Patient falls are one of the leading causes of incidents in hospital and can lead to injury and prolonged hospital stays. Falls can also have a long term physiological effect on patients as they can lead to a loss in confidence and a fear of falling again.

The Trusts participated in NHS Improvement Falls Collaborative in early 2017 and on completion of this initiative has continued to implement improvement work using the NHSI methodology. Work that has been undertaken includes:



The current year-to-date position is 43 confirmed falls incidents, 34 resulting in severe harm and 9 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, 3 and 4 therefore, achieving the required target.

- Use of simulation training to improve staff awareness and response.
- Intensive training in falls assessment and care planning, including prevention strategies.
- Use of post fall review (SWARM) to identify modifiable risk factors and learning.
- Review and revision of falls assessment and care plan.
- Roll-out of falls collaborative approach more widely across the Trust.
- Revision of Bedrails assessment (currently being piloted).



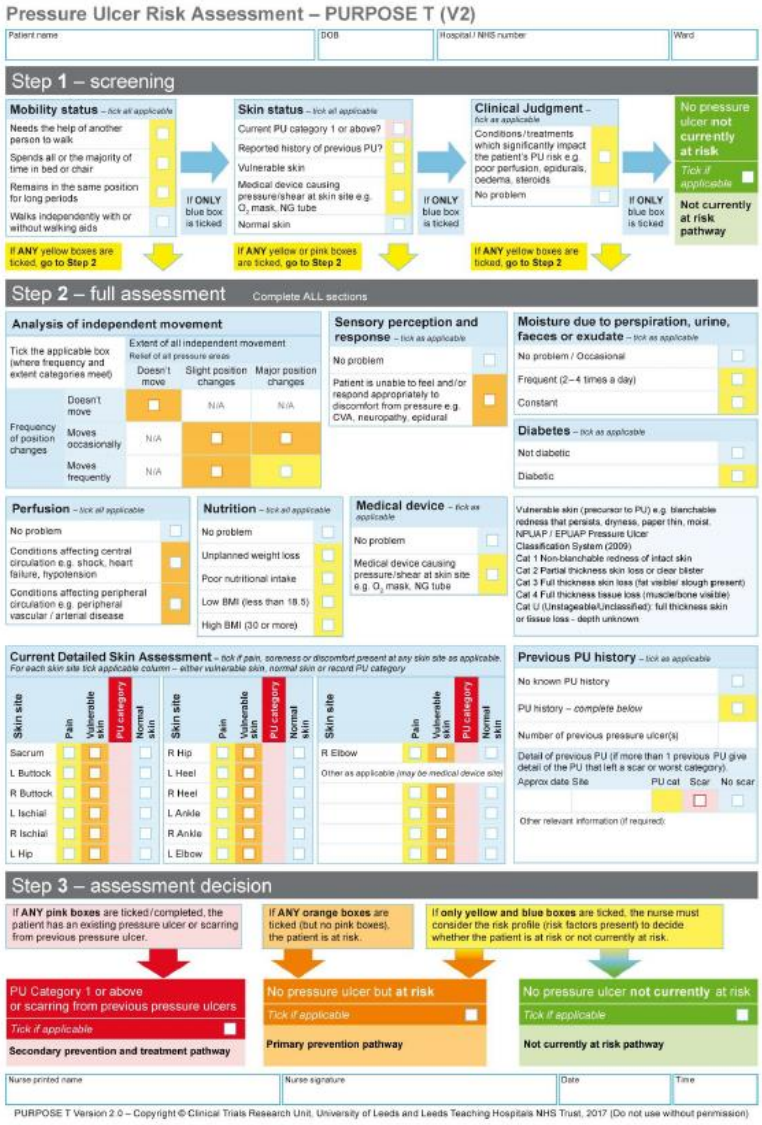
PRESSURE ULCERS

Pressure ulcers represent a major burden of sickness and reduced quality of life for individuals, their carers and families. The impact of PUs is psychologically, physically and clinically challenging for both patients and healthcare workers. They are frequently painful, can interrupt the return to full function; can cause a delay in discharge as well as an increased risk of secondary infection and mortality (Lyder, 2011; Sullivan, 2013). PUs are considered to be mainly preventable if evidence-based guidelines are used (VanGilder et al, 2010).

The Trust has implemented the following improvement actions during the year:

- Change from Braden to Purpose T risk assessment tool, successfully piloted in G1 and now implemented across the Trust.
- A number of education days with large numbers of staff attending.
- Development of the Tissue Viability team to include Military Staff.
- Leg Ulcer Specialist working with staff educating them whilst reviewing their patients.
- Introduction of and staff training in use of new Topical Negative Pressure pumps to improve wound healing.

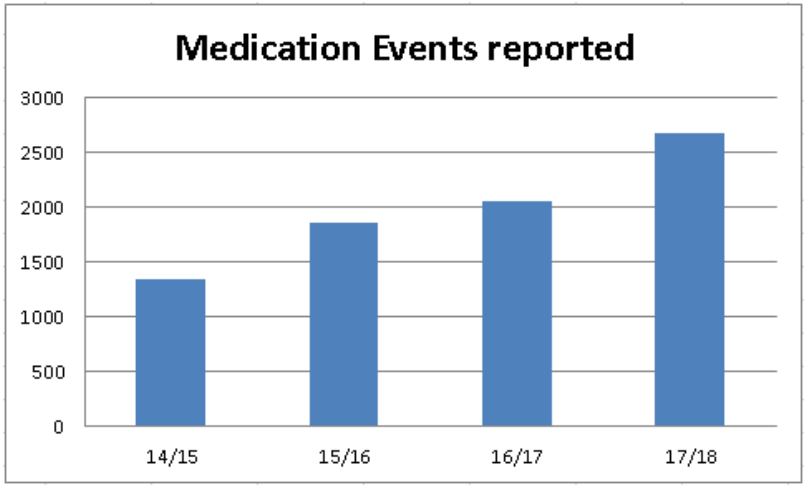
The current year-to-date position is 21 avoidable grade 3 Pressure Ulcers and 0 (zero) grade 4.

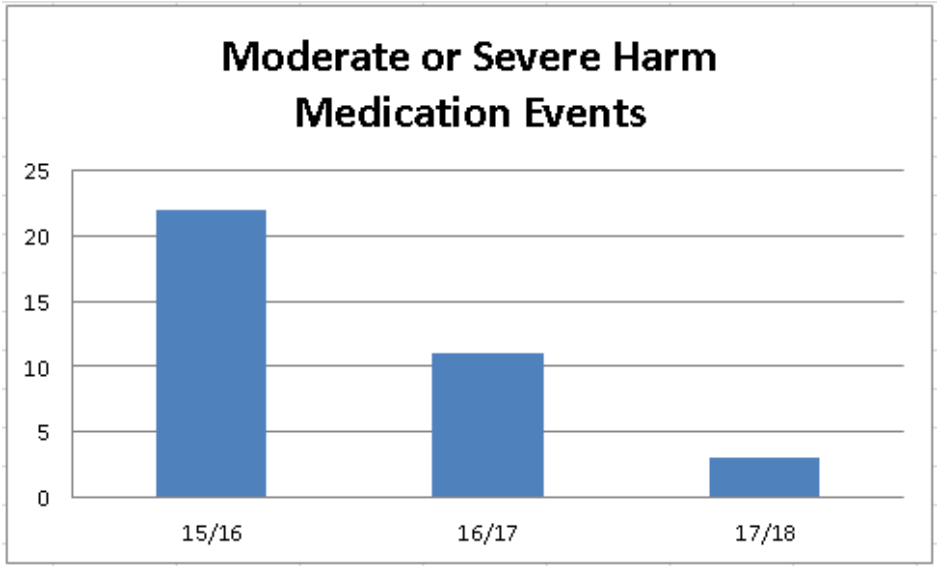


MEDICATION INCIDENTS

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 30% increase in reporting of medication safety learning events has been achieved during 2017/2018, with a total of 2,673 incidents being reported in 2017/18 demonstrating sustained improvement in reporting.





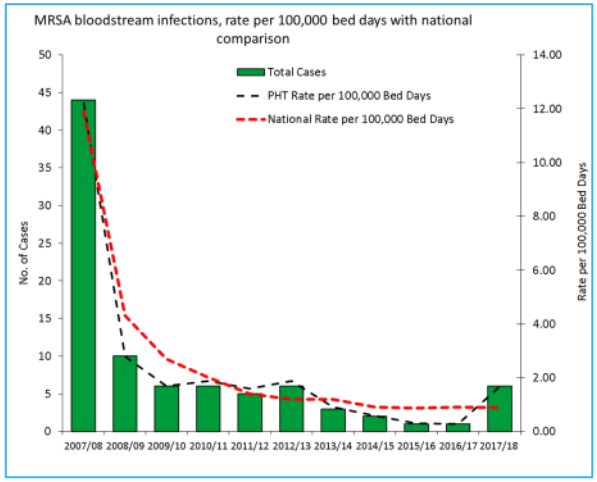
Whilst there has been an increase in reporting overall, there has been a further reduction in moderate harm incidents compared to last two years, with only 3 confirmed moderate harm incidents to date all of which occurred in quarter 1 compared to 11 last year.

HEALTHCARE ASSOCIATED INFECTIONS

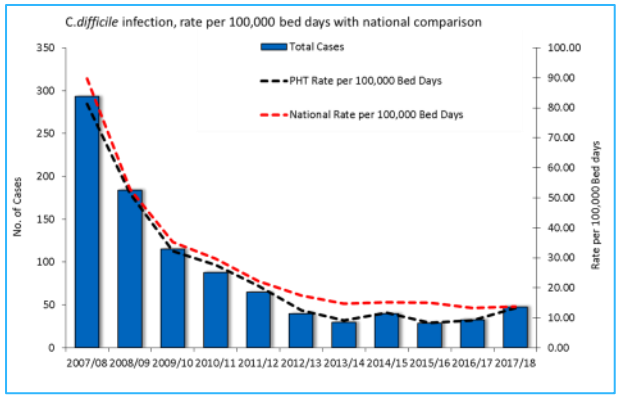
MRSA Objective: 0 (zero) cases – Exceeded

C. Difficile Objective: no more than 40 cases- Exceeded

Healthcare associated infections (HCAI) are infections associated with the delivery of healthcare interventions. The three main infections which are reported as HCAI are MRSA (bloodstream infections only), Clostridium Difficile (hospital acquired cases) and more recently blood stream infections caused by gram- negative infections such as E.Coli. In addition, seasonal influenza and other outbreaks of infection (e.g. viral gastroenteritis), are reported under the HCAI umbrella. The main aim of the infection prevention agenda is to prevent the transmission and acquisition of HCAI within the local healthcare economy. Hence the team works closely with external partners e.g. SCAS and the CCG to minimise the incidence of these infections.

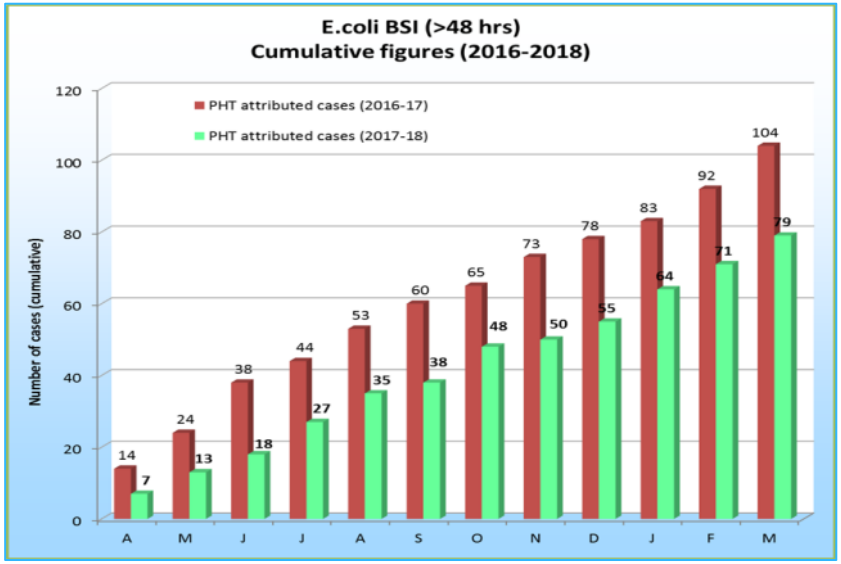


MRSA Blood stream infections: The Trust investigated 19 cases of MRSA blood stream infection. These investigations are multidisciplinary and include external partners involved in the patients' care. The investigations are designed to identify the root causes and learning behind each case and to attribute the case to the relevant organisation's objective (the latter process will stop in 18/19, meaning that all positive cultures taken after in excess of 48 hours from admission will automatically be attributed to the Trust). In 17/18, 6 cases were attributed to the PHT objective (4 unavoidable cases and 2 avoidable cases). The rest of the cases where attributed to the CCG or third party organisations. For the first time since 2012/13, the PHT MRSA bacteraemia rate has exceeded the national average rate. The actions required to embed learning associated with the avoidable cases is monitored through the Infection Prevention Management Committee.

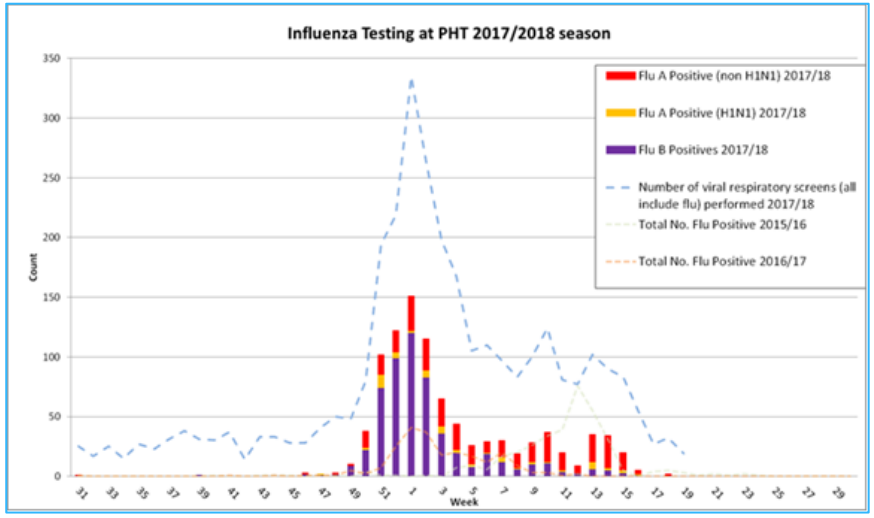


C. Difficile: The Trust reported 49 hospital acquired cases of C.Difficile against an objective of 40 cases. Although the PHT rate of infection remains below the national average, there has been a substantial increase in the number of cases seen within the Trust. Thankfully there is little evidence of cross transmission of cases or the predominance of a single strain; the increase in numbers is most likely to reflect the increasing numbers of acquisitions in the community setting with 2 distinct clusters of cases in the Portsmouth area.

E.Coli blood stream infections: In 2017 the Trust was benchmarked by PHE having one of the highest rates of E.coli bacteria in England, ranking 135th out of 153 Acute Trusts. Data for 2017/18 indicates that number of E.Coli bacteraemias has dropped by 16%, making PHT one of the 59 acute Trusts who have successfully reduced their rates by more than 10%. The monthly rate of E.coli bacteraemias remains erratic with local CCGs ranked as having an above average rate of E.coli bacteraemias.



Influenza: In the winter of 2017/18 the Trust recorded an unprecedented high number of flu cases. Between 31st July 2017 (Week 31) up until 13/05/18 (Week 19) the total number of Influenza cases identified at PHT is as follows: 336 Influenza A / non-H1N1, 58 Influenza A / H1N1 and 557 cases of Influenza B, making the Portsmouth area one of the highest incidence areas in the country, with one of the highest rates of hospitalisation for flu. The use of trivalent vaccines to immunise both staff and patients resulted in a predominance of the flu B strain which was not covered in this year's trivalent vaccine.

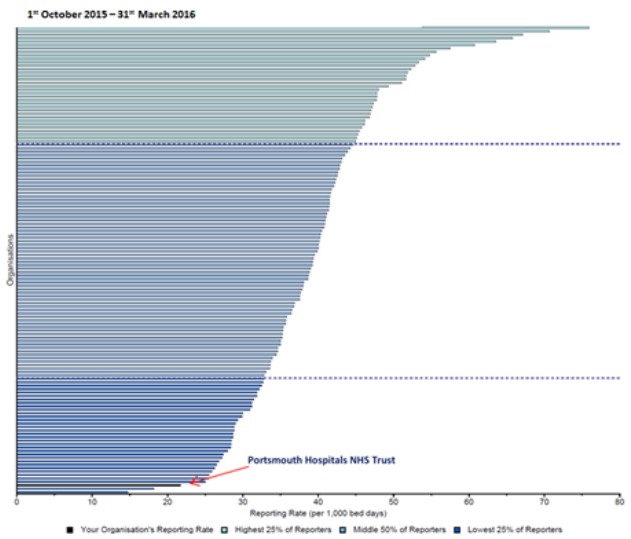


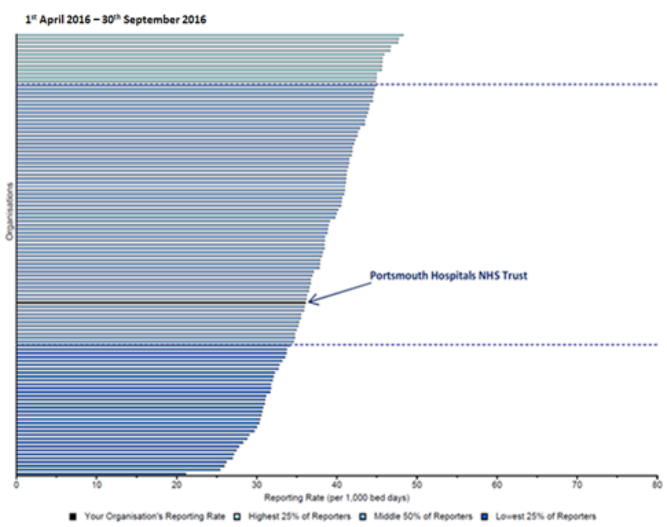
Patient Safety Learning Events

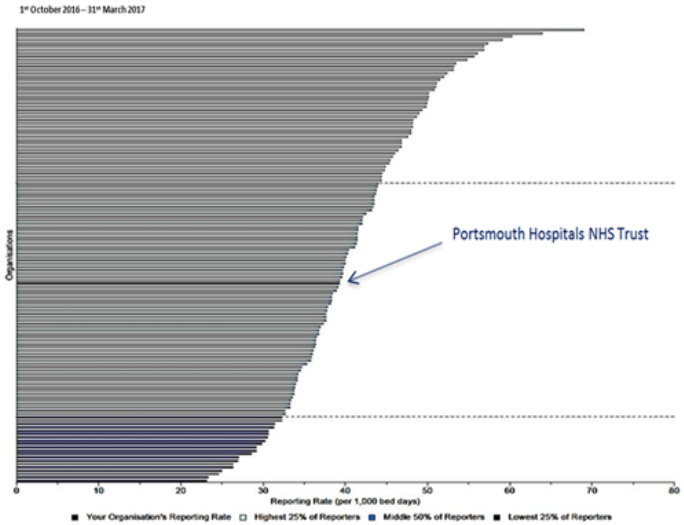
In 2015 the Trust undertook a formal review of incident reporting, due, in part to the low rate of reporting per 1000 bed days within the organisation. At that time the Trust was 3rd from bottom of all acute trusts in it's reporting of patient safety incidents (chart 1).

Following the review the Local Incident Reporting System (LIRS), provided by Datix, was relaunched with significant changes implemented to both the reporting forms and the process for closure. In addition the Trust held numerous events to promote a positive reporting culture, emphasising openness and involvement of staff.

Following the changes the reporting of patient safety incidents has increased. The most recent data shows the Trust is now in the mid range of all acute Trusts (chart 3) with continued increases in the number of Safety Learning Event forms completed by staff.







Clinical Effectiveness / Outcomes

Quality Account Priorities 2017 / 2018

CLINICAL EFFECTIVENESS

How did we do?

- **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 avoidablility 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. ✓

Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI)

TO MONITOR THE TRUST HSMR AND SHMI RATE MONTHLY ✓

INVESTIGATE ANY OUTLYING DATA WITH THE AIM TO REDUCE OVERALL RATES ✓

The HSMR and SHMI trend continues to be monitored and validated through the Mortality Review Group and reported to the Trust Board on a monthly basis.

All mortality alerts raised by Dr Foster in response to the data submitted for HSMR calculation are investigated using a standard methodology contained within the Trust's Learning from Deaths policy.

HSMR

For the 12 months, to December 2017, the Trust's HSMR is 108.2 (confidence interval of 103.4-113.2). This sits within a confidence interval of 103.4 – 113.2 and is statistically higher than expected.

The Trust has undertaken a review of all factors potentially contributing to the raised HSMR. Following which a number of coding practices have changed to correct identified issues including admission source. These changes have started to have an effect on the monthly HSMR, see graph. It is anticipated that the rolling HSMR will continue to reduce over time.

SHMI

The Trust SHMI for July 2016 to June 2017 is 109.13; showing an increase from the previous reported quarter's figure of 108.89. Whilst this figure is above the National Average of 100, it is within the official control limits.

SHMI: July 2016 to June 2017
- SHMI: 109.13 (within expected range)
- Adjusted for palliative care: 112.2 (within expected range)
- In-hospital deaths: 109.16 (within expected range)
- HSMR for the same period: 115.15 (within expected range)

Figure 4.0: HSMR 12-month trend Jan17 to Dec 17

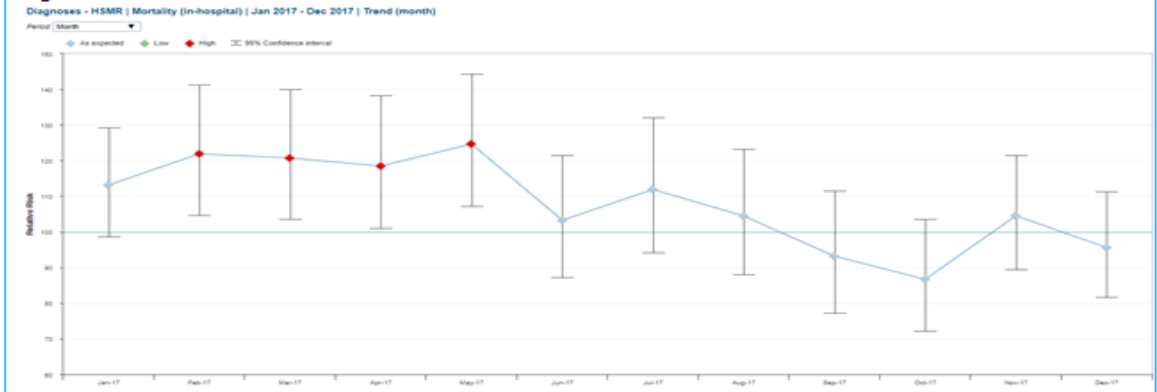
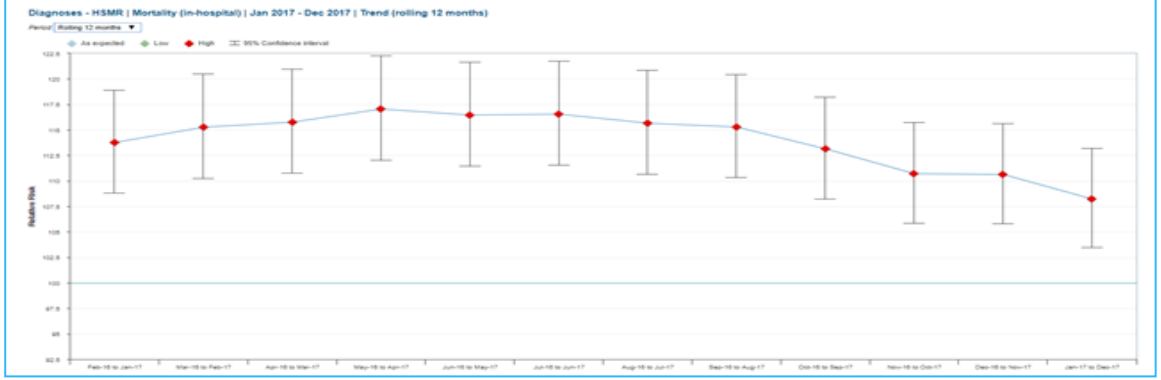


Figure 5.0: HSMR rolling 12-month Trend



Learning from in-patient deaths

TRUST-WIDE ROLL OUT OF THE MORTALITY REVIEW PANEL ✓
STRUCTURED JUDGEMENT REVIEWS ✓

Trust-wide roll out of the mortality review panel, ensuring avoidability of death is recorded and to ensure learning is applied Trust-wide.

Please refer to the information within the Mortality Review Patient Safety section.

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.

Please refer to the information within the Mortality Review Patient Safety section.

ACUTELY UNWELL AND DETERORIATING PATIENTS

SAMBA – Society of Acute Medicine Benchmarking Audit

Acute Medicine is concerned with the immediate and early specialist management of adults experiencing a wide range of medical conditions that require urgent or emergency care. Acute medical care in the United Kingdom is not delivered solely by Acute Medicine teams, and this is also true for the Trust. Therefore collaborative working between all those providing care to acute medical patients is essential.

During the past year the Trust has implemented several changes to practice to improve the care experienced by this group of patients:

- Introduction of 'Pit Stop' in the Emergency Department
- Recruitment and training of AMU Advanced Care Practitioners and Acute Medical Technicians
- Introduction of a new AMU clerking document including 'initial assessment' front page to ensure prompt first assessment of the patient
- Development and introduction of an electronic 'take list' so that it is clear which patient is to be seen next and their location within the Emergency Department
- Increased Specialist Consultant support working in a general role on the AMU

The SAMBA audit provides a snapshot of the care received by acutely unwell medical patients in the United Kingdom. The 2017 audit 'Against the Clock – Time for Patients' collected data from 110 Acute Medical Units over a 24 hour time period in June 2017.

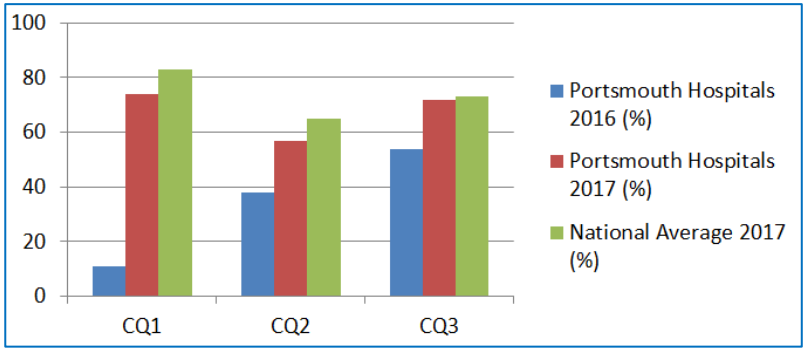
It highlighted that, despite not meeting national averages, the Trust has made significant improvements against the Clinical Quality Indicators (CQI).

CQ1 – *All patients admitted to AMU should have an early warning score measured upon arrival.*

CQ2 - *All patients should be seen by a competent clinical decision maker within 4 hours* of arrival on AMU who will perform a full assessment and instigate an appropriate management plan.*

CQ3 - *All patients should be reviewed by the admitting consultant physician or an appropriate specialty consultant physician within 14 hours of arrival on AMU.*

CQ4 - *All AMUs should collect the following data: Hospital mortality rates for all patients admitted via AMU; Proportion of admitted patients who are discharged directly from AMU; Proportion of patients discharged from AMU and readmitted within 7 days of discharge.*

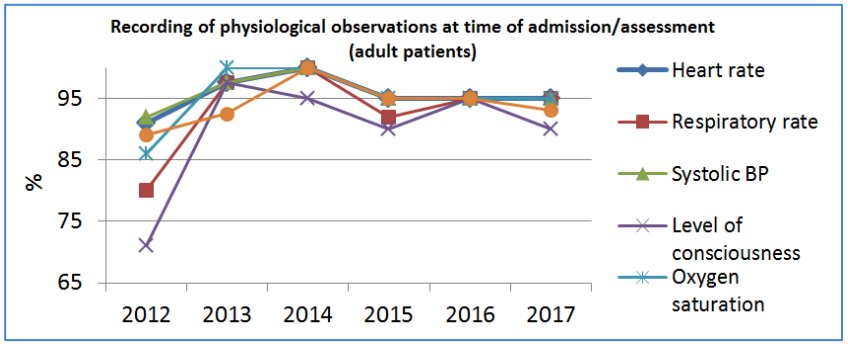


CQ4 - The Trust has good systems in place for mortality data (both via mortality review panels and how that links in with departmental M&M). Corporate reporting portal is developing in collecting real time data for the AMU, and reporting back to the AMU Clinical Director.

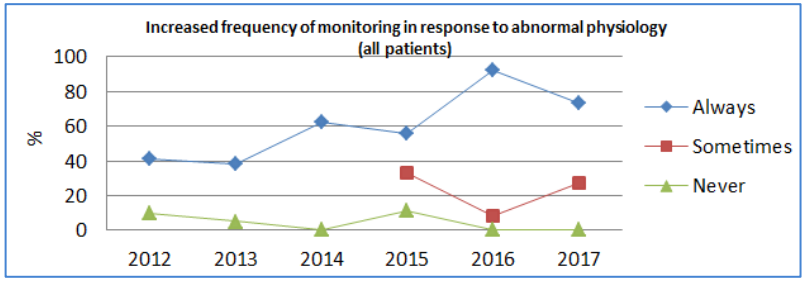
Acutely ill adults in hospital: recognising and responding to deterioration (NICE Guideline CG50)

Acutely unwell patients admitted to hospital, and their families/carers, need to feel confident that they are in the best place for prompt and effective treatment and that any deterioration in their condition will be recognised and managed quickly and appropriately. This guideline sets out recommendations for the care of this patient group.

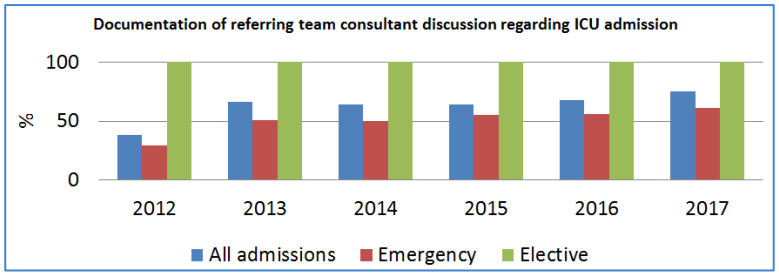
The Trust completes an annual clinical audit against this guideline; the results are shared and monitored by the Deteriorating Patient Group, Patient Safety Forum, Clinical Effectiveness Steering Group, and Critical Care Strategy Group. The Trust is currently partially compliant with the recommendations within the guidance, however is working towards full compliance.



All in-patient areas (adult, paediatric and obstetric) are using a physiological track and trigger system. There has been gradual improvement with increased frequency of monitoring in response to abnormal physiology using a track and trigger system.



There has been gradual improvement in the documentation of the referring team consultant being involved in the decision to admit to the Intensive Care Unit.



An action plan is in place to address any areas highlighted for improvement by the audit. This includes the launch of the Time to ACT initiative and the introduction of a new Deteriorating Patient pro forma; this has been designed to support the escalation and response to deteriorating patients.

Initially introduced on the respiratory wards (E6, E7 and E8) in December 2017, it has since been rolled out to other wards across the Trust. By July 2018 over 80% of adult in-patient areas will be using the pro forma.

IMPROVE THE SAFETY, EXPERIENCE AND EFFECTIVENESS OF CARE FOR OUR MOST VULNERABLE PATIENTS

Quality Account Priorities 2017 / 2018

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

VULNERABLE PATIENTS

Safeguarding including Mental Capacity Act and Deprivation of Liberty Safeguards	Mental Health	Dementia

Through a structured education programme focussed on:

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

- Portsmouth Quality Bundle Vulnerable patient module was launched 26th June 2017. This quality improvement programme involved ward areas and focused on privacy and dignity, safeguarding, dementia, Enhanced Care Observations, Mental Health, Adolescence, learning difficulties, chemical and physical restraint, Interpreting, covert medication and carers. The module started with a questionnaire and at a mid point review a 10% increase was seen. Along with the questionnaire training was provided and a focus was given on each component. A detailed report will follow.
- A total of 87% of clinical staff have been training in Enhanced MCA and DoLS.
- The Pocket guide for staff has been circulated along with the promotion of the use of NHS Safeguarding App.
- The Trust acknowledges that there is further work required in relation to dementia care.

PATIENT EXPERIENCE

Patient feedback

The Trust is committed to the delivery of safe, effective and a positive experience of care. To achieve this we need to have a comprehensive understanding of what we do well, and what our patients tell we could do better. We have made significant changes to the way we seek and gain feedback to achieve this, increasing the opportunities for formal feedback using for example national and local surveys and the Friends and Family Test, but also more inclusive systems such as Facebook and Twitter. We have moved beyond only seeking direct feedback from current or recent patients, to working closely with our local community to develop our knowledge of peoples lived experience of hospital care. We believe every part of the services we provide can and should be shaped and improved by involving those who use them. We have moved from simply understanding what matters most to patients, to a greater responsiveness and collaboration. We know use the asset of knowledge and experience that patients and our local community provide to ensure engagement, involvement and improvement are part of our everyday business.

Quality Account Priorities 2017 / 2018

PATIENT EXPERIENCE

How did we do?

- **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. ✓

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 ✓

At any one time about 1/3 of our hospital patients will have a specialist mental health need.

Key Developments 2017-18

1. Awareness raising sessions provided by:

    - The Good Mental Health Cooperative "Human Library" People living with specialist mental health needs spoke about personal experiences of being stigmatized because of reasons as varied as age, sexuality, mental illness.
    - University of Southampton Mental Health Team
    - PHT Simulation Team, in partnership with Southern Health, specialist mental health providers.
    - University of Bournemouth, focus on management of specialist mental health needs in the Emergency Care setting

2. Break away training provided to support staff in the management of behaviours that challenge.

3. Service user membership of the Mental Health Board. Solent Mind has supported service user membership of the Mental Health Board, enabling patient stories to be shared face to face, informing the further development of local policy and practice.

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 ✓

Understanding families experience at the end of life of a patient is important to ensure that we can support and care for them appropriately at what can be the most challenging time.

Key Developments 2017-18

- An evaluation of the survey which was implemented in 2016-17 has been completed. Bereaved families told us that some of the process for involving them in the survey needed to be improved and the wording of some questions changed. This has been completed.

- Since the amendment of the the amendment of the survey in July 2017, 223 people have responded. 83% (182) reported that they were appropriately supported in the final 2 days of the friend/relatives life.

- 11% (25) of bereaved relatives said hospital was not the right place for the patient to die. Work is being undertaken with partner organisations across health, social care and the third sector work to improve discharge and access to hospice beds for those people who do not wish to die in hospital.

- A review of written comments in which relatives are asked to provide additional information that they feel would benefit, established a need to improve communication. Sage and Thyme (specialist communication training) has been commissioned to increase staff skills.

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 HOSPITAL, COMMUNITY AND SOCIAL CARE SERVICES ✓

Unpaid family carers provide support to people who without that support would not cope. They provide essential care and make a major contribution to the health and wellbeing to people they care for. Early identification and support of carers is important to ensure they are adequately supported in their role.

Working in partnership with local care organisations the Trust has continued to develop different and creative ways to ensure carers are supported.

Key developments in 2017-18 include:

Carers Café

The Carers Café was designed to provide a quiet, supportive place for family carers to have some time out, or seek advice and information. One carer who wrote to us, told us about how the café had helped him.

QAH Carers

Brian told us.....

"Given the pressure that the NHS is under at the moment, I was amazed how many services are available to the general public. I say this as a man of 70 years of age, who in the last 6 months has become the career of his wife who has lung cancer. We have had 30 wonderful years of marriage and then our life's hit the buffers. I became very depressed and isolated until I walked through the doors of the Carers Cafe in QA Hospital. It was a light bulb moment. I was greeted with friendship, sympathy and understanding. After several cups of tea I relaxed and started to talk to the other Carers that were there, which made me realise I was not alone being a carer but the most important thing I got out of the morning was information, which enabled me to access all the services that are available when you are in this situation. So to sum up the Carers cafe is a life saver and I would encourage anyone in a similar situation to attend."

Happy to Chat Volunteering Team

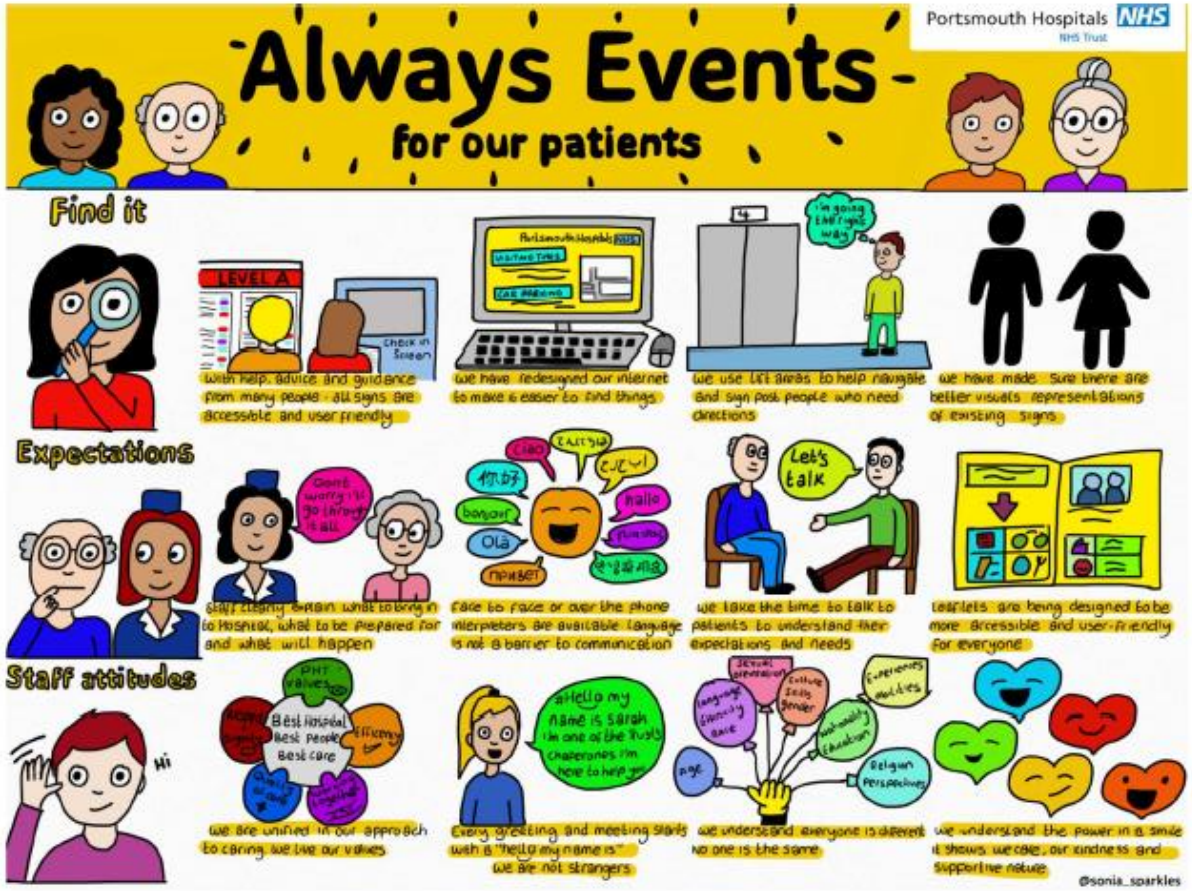
The team was developed in response to two concerns:

- Feedback from family carers that they didn't always know who and what was out there to help them, and they sometimes struggled in supporting the person they care for.
- An increasing number of people telling us they fell lonely and sometimes isolated in the hospital, often the most vulnerable of our patients.

They visit wards and departments, work with clinical teams to identify family carers and offer them support.

Always Events Programme

Family carers of people with additional needs told us that they didn't always get the support they needed so we signed up to the NHS England Always Event Programme. This innovative programme is developed and co-designed by service users and aims to identify an improvement that would like to see always happen. We approached outpatients as our pilot area and held a number of workshops with the local community to understand what mattered most to them. During this, the following three themes were identified as the priorities to work on: finding your way around the hospital, what to expect during an appointment or hospital stay and the need for friendly and welcoming staff.



LEARNING DISABILITIES

DEVELOP AND IMPLEMENT SYSTEMS FOR THE ACTIVE PARTICIPATION OF PEOPLE WITH A LEARNING DISABILITY TO DRIVE LOCAL IMPROVEMENTS. ✓

People with a learning disability are at an increased risk of developing specialist health care needs but have historically reported poorer experience of acute hospital services and poorer outcomes. To address this national concern, the trust works with Solent NHS Trust, providers of specialist learning disability services to provide a Learning Disability Liaison Service. This service supports patients with a learning disability and their family members and carers.

Key developments during 2016-17 include:

1. Learning Disability Service Users from the Kestrel Centre, Portsmouth, were partners in the Trust experience and engagement conference, December 2017. They provided staff with an insight into the lived experience of someone with a learning disability when using hospital services. Plans are being developed to introduce a rolling programme of service user led training events.
2. A programme of Makaton training for staff to support and improve communication with people with a learning disability.
3. The appointment of an "Autism Ambassador", a person living with autism, to:
   - support patients prior to and during their hospital stay
   - increase staff awareness of the specialist needs of a person on the autistic spectrum.

   This programme will extend to include staff who are supporting other staff with autism in 2018/19.
4. The successful application to the Wessex patient Safety Collaborative for the purchase of a portable sensory support system for people with a learning disability. Sensory support for people with cognitive impairment has been indicated to have a positive physiological, cognitive and behavioural outcome, reducing anxiety and agitation levels. The use of light and touch, helps keep people with communication difficulties at ease, distracted and more likely to be able to undergo the examination or treatment. This portable system allows for a standard waiting or inpatient area to be converted into a sensory environment enabling support to be provided in a wide range of areas in the Trust.

Wessex Academic Health Science Network

Discharge from hospital

Bedview

We are continuing to support the Urgent Care workstream with new developments in Bedview (electronic system supporting clinical staff to manage patient's care, bed allocation and discharges) the 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 key transformational pieces that we are working on at the moment are:

- Visibility of the Electronic Discharge Summary /TTOs (take home medication) from ICE in Bedview
- Inbound feed to PAS allowing users to Transfer and Discharge patients within Bedview
- Patient Placement including Performance dashboard and decision tool for management of patients

There is always work in flight around enhancing the existing capabilities within Bedview, current work items include:

- The current "frailty screen positive" flag is re-applied at each admission; a permanent flag will be applied, meaning this indicator appears at each admission
- Standardisation of mobility data; currently this field is free text. We are moving to a list selection with an additional free-text option. Once this is in place we can use mobility data to feed other systems or forms
- Identification of infectious patients on the AMU bed state report; this report is used to allocate patients to receiving wards within the hospital
- Enhancement to the Medicines Reconciliation process, allowing Pharmacy to identify the wards/patients without a medicines reconciliation.

We aim to release a new version of Bedview each quarter.

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.

Integrated Discharge Service

The Integrated Discharge Service consisting of Health and Social Care Teams across primary and secondary care organisations 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. In support of this the IDS have been working with external partners in rolling out a range of initiatives and ideas within the eight high impact changes model. This was introduced by the Association of Adult Social Services. This model identifies eight system changes that will have the highest impact on reducing delayed discharge. The IDS will have a new Director of Integrated Care commencing in the coming months who will continue to lead the ongoing work within the IDS. Six new Discharge Planning Assistants have been recruited to support ward teams with discharge planning for patients.

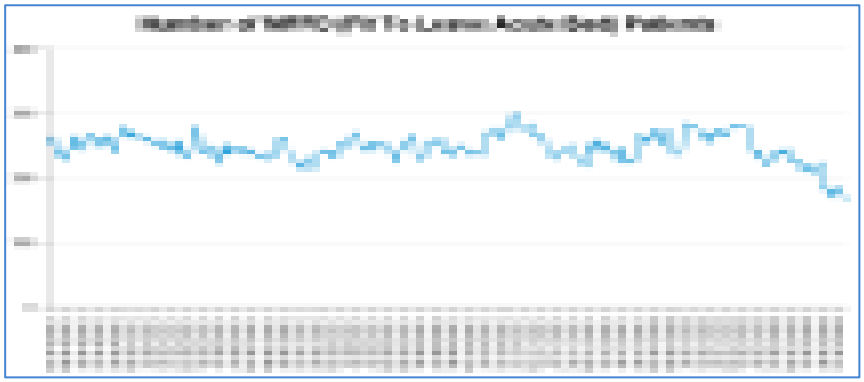
Discharge survey

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. Meetings have taken place with system partners to identify key themes to improve the patient and relative experience. In addition we have promoted the use of voluntary services eg Red Cross and Royal Voluntary services to support patients discharge.

Patients who are Medically Fit for Discharge

The Trust has seen a dramatic decrease in the number of patients who are declared Medically Fit for Discharge (MFFD). In order to continue to work towards reducing this number further work has been undertaken to achieve this as follows:



Multi Agency Discharge Events (MADE) have been carried out within the Trust. These bring together the local health system to:

- support improved patient flow across the system
- recognise and unblock delays
- challenge, improve and simplify complex discharge processes.

Weekly Super Stranded meetings are held and review every patient who has been on hospital over 21 days. Such has been the success, this has been reduced to reviewing all patients over 14 days.

Valuing Patient Time Initiatives

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 2 GREEN

Red 2 Green has been re-energised following a review of all MDT ward rounds by the Associate Medical Director and Associate Chief Nurse (Operations) in February and March 2018. Overall there was great team working displayed to be proud of as an organisation. One of the key questions asked of teams was whether **Red2Green** was adding value for the teams and patients and how its potential contribution could be improved. Themes for improvement were identified to make **Red2Green** meaningful for ward teams.

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

As a result **Red2Green** was a key focus as part of the Urgent Care Easter Sprint projects with the key question for the project team being: ***how can we take ownership of Red2Green as a clinical workforce to ensure that it adds value for our patients and staff going forwards?***

Key work streams were :

- In MDT board rounds we need to ask the question: ***What action will add value for each individual patient today?***
- Having defined those actions we should then ***set ourselves the challenge as an MDT to complete the action for each patient wherever possible during the course of the working day***, gaining support from CSC Silvers and others as needed to do so.
- ***Between 3 and 5pm we should routinely undertake another short board round*** with representatives of the MDT ***to confirm whether we've completed the action for each patient during the day or not***.
- ***Completed actions will allow us to convert a Red day to a Green day.***
- As well as generating data relating to internal and external delays this process is starting to demonstrate how effective teams and the Trust are at converting Red days to Green acting as a motivational feedback loop for ward teams.
- **Red2Green** should become the banner under which we as ward teams champion our patients and challenge delays to their inpatient journeys.
- With the **Last 1000 Days Campaign** , we want the MDT to imagine that the patient is looking over their shoulder as we discuss their case at our morning board handovers asking us the question ***'what action will you complete today that will add value to my journey and get me home sooner?'***
- At our afternoon handovers we should again try to imagine that each patient is there with us as we review their case so that we can celebrate with them when actions have been completed and explain the reason for delays to them when they have not.

The **Red2Green** project will continue long after the Easter sprint has finished. The challenge for us all is how we can make **Red2Green** a core motivational tool for us as individuals, teams and as a Trust. ***The ultimate goal from all of this is to get our patients home sooner.*** Reducing length of stay for our patients will protect them from deconditioning and the risk of harm associated with falls and hospital acquired infections. Reducing length of stay for our patients will also give us a fighting chance of functioning more safely and sustainably within the finite capacity we have available to us to deliver our services.

The Red2Green - Group Mailbox is now open. Please do mail Red2Green@porthosp.nhs.uk with your feedback and ideas for how we can deliver this project in a meaningful way that will sustainably add value for our patients and staff.

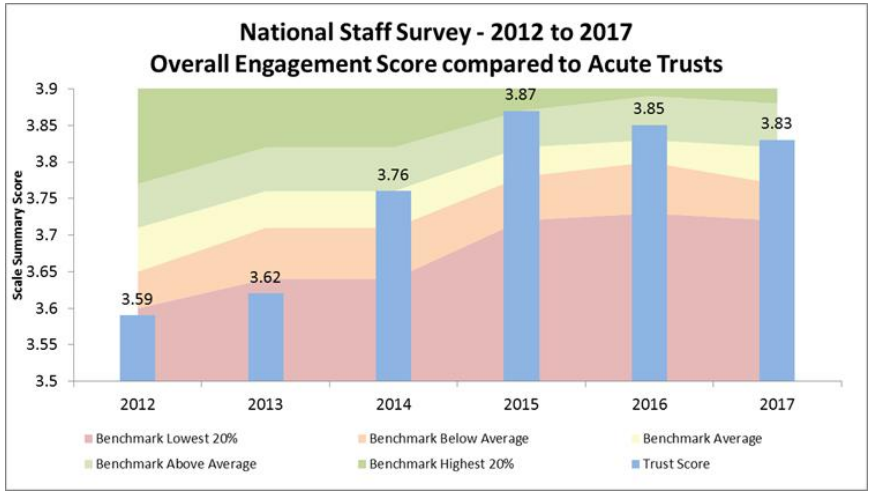
Staff feedback

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 2017 National NHS Staff Survey conducted in the Trust between September and December 2017 can be found below.

Between September and December 2017, 4210 staff took the opportunity to complete and return a survey, representing a 59% response rate which is in the highest 20% for acute trusts in England and compares with 58% in 2016. Of this 79% were female, 19% male and 1% preferred not to say; 90% specified as white and 10% as black and minority ethnic. 83% specified as not disabled and 17% specified as disabled.

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 and 2017 with a scale summary score of 3.83 (a slight decline of 0.02 from 2016).



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 2016 survey. When comparing the Key Findings to the 2016 survey:

- 2 KF's have had a positive change since 2016
- 8 KF's have had a negative change since 2016
- 19 KF's are better than average when compared with all acute trusts
  - Of these 10 are in the best 20%
- 5 KF's are worse than average when compared with all acute trusts
  - Of this 3 are in the worst 20%

Where the Trust compares most favourably with other acute trusts in England:

- KF16: % of staff working extra hours (65% compared to 72% a lower score is better)
- KF17: % of staff feeling unwell due to work related stress (33% compared to 36% a lower score is better)
- KF10: Support from immediate managers (3.85 compared to 3.74)
- KF21: % of staff believing the organisation provides equal opportunities for career progression/promotion (89% compared to 85%)
- KF6: % of staff reporting good communication between senior management and staff (40% compared to 33%)

Where the Trust compares least favourably with other acute trusts in England:

- KF28: % of staff witnessing potentially harmful errors, near misses or incidents in the last month (34% compared to 31% a lower score is better)
- KF22: % of staff experiencing physical violence from patients, relatives or the public in last 12 months (18% compared to 15% a lower score is better)
- KF25: % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months (31% compared to 28% a lower score is better)
- KF20: % of staff experiencing discrimination at work in the last 12 months (14% compared to 12%)
- KF18: % of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, work colleagues or themselves (53% compared to 52%)

Largest changes since the 2016 survey where staff experience has improved:

- KF27: % of staff/colleagues reporting most recent experience of harassment, bullying or abuse (up to 49% from 42%)
- KF24: % of staff/colleagues reporting most recent experience of violence (up to 73% from 67%)

Largest changes since the 2016 survey where staff experience has deteriorated:

- KF20: % of staff experiencing discrimination at work in the last 12 months (increased from 10% to 14%)
- KF13: Quality of non-mandatory training, learning or development (decreased from 4.10 to 4.05)
- KF14: Staff satisfaction with resourcing and support (decreased from 3.40 to 3.30)
- KF18: % of staff attending work in the last 3 months despite feeling unwell because they felt pressure from the manager, work colleagues or themselves (decreased from 50% to 53% a lower score is better)
- KF12: Quality of appraisals (decreased from 3.28 to 3.20)

The full report of the 2017 National; NHS Staff Survey was presented to the Trust Board in April 2018 which is within the 30 day requirement for reporting. Trust Board will agree the actions that will be taken forward for the following 12 months in relation to the survey results. It is anticipated that we will concentrate on the specific key findings that have declined from the previous year with an inch wide mile deep analysis of each.

Workforce

Equality Delivery System and Workforce Race Equality Standard

The Trust meets the requirements of 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 meets quarterly.
- The Trust has reviewed the equality and diversity policy and is now called the equality, diversity and inclusion policy.
- Equality impact assessments are completed on corporate and clinical policies. This has been updated to mirror the 9 protected characteristics.
- All Clinical Service Centres will work towards achieving the Gold Award of the Equality Standard.
- The current Equality and Diversity strategy is coming to an end and a new 5 year strategy is currently under review and will be ratified at the Workforce and Organisational Development sub-committee of the Board in the spring 2018. The strategy will include an integrated improvement plan with key indicators, targets and timeframes that will cover the Trusts priority requirements under the various Equality and Diversity standards and schemes (WRES, EDS2 and WDES) as well as the results from the National NHS Staff Survey.
- The WRES is published on the Trust website in line with national requirements (1 July 2017).
- 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 Black Asian Minority Staff Network relaunched in January 2018 and the first network meeting will take place March 2018.
- The Trust appointed a replacement Lead for Inclusion, Equality and Diversity in September 2017.
- The Trust has applied for the NHS Employers Partners programme for 2018-19. We will know in May 2018 if successful.

Future actions 2017/18:

- 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.
- Identification of the 3 or 4 key staff and patient priorities that the Trust will focus on for the next 12 months with agreed improvement targets.
- To explore the demand and need for LGBT+ and Disabled staff networks.
- Conduct a deep dive into our WRES data and identify any hotspots and areas of concern focusing on indicators 7, 8 and 9.
- Placing more effort on the development of specific positive action measures to address areas of under-representation or disadvantage i.e. recruitment, learning and development programmes for promotion.
- Promote our values and associated behaviours through training, development and communications to progress and encourage an appreciation of an inclusive workplace.
- Further promotion of inclusivity through the Patient Collaborative and links with local minority communities.
- Collaborative working with third party such as Stonewall and KROMA and disability community networks.

Workforce Race Equality Standard – Staff Survey

The data presented is drawn from the National Staff Survey 2017, 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 2017 30% of white staff agreed with this statement, which is 3% (27%) higher than the acute trust average and 1% (29%) higher than the 2016 score.
- In 2017 39% of BME staff agreed with this statement, which is 11% (28%) higher than the acute trust average and 5% (34%) higher than the 2016 score.
- 9% more BME staff felt that they had experienced harassment, bullying or abuse from patients, relatives or the public than white staff in 2017.

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

- In 2017 24% of white staff agreed with this statement, which is 1% (25%) lower than other acute trusts nationally and the same as 2016.
- In 2017 29% of BME staff agreed with this statement, which is 2% (27%) higher than acute trusts nationally and 5% (24%) higher than 2016.
- 5% more BME staff felt that they had experience harassment, bullying or abuse from staff than white staff in 2017.

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

- In 2017 91% of white staff agreed with this statement, which is 4% (87%) higher than the acute trust average and the same as 2016.
- In 2017 74% of BME staff agreed with this statement which is 1% (75%) lower than the acute average for acute trusts and 4% (78%) lower than 2016.
- 17% fewer BME staff feel that there are equal opportunities for progression or promotion than white staff in 2017.

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 2017 8% of white staff agreed with this statement, which is 1% (7%) higher than the acute trust average and 3% higher than 2016.
- In 2017 15% of BME staff agreed with this statement, which is the same as the acute trusts average and 3% higher than 2016.
- 7% more BME staff personally experienced discrimination at work than white staff in 2017.

Learning and Development

We continue to promote apprenticeships, encouraging new staff into the Trust and developing existing staff to further their careers in the NHS. The Trust is currently supporting 133 members of staff to complete apprenticeships in a range of clinical and non-clinical programmes and have started to explore higher apprenticeships to enable staff to develop to degree level, a small number will begin this training in 2018/19. We have also maintained our direct claim status for L3 in Pathology Support and L3 Award in Assessing Competence, with very positive feedback from the external Standard Verifier.

The department has supported 44 international nurses and 9 associate practitioners to transition into the workforce. We have provided adapted induction/preceptorship programmes and education for undertaking the Observed Structured Clinical Examination (OSCE) and English tests required for registration with the Nursing and Midwifery Council.

All newly appointed Healthcare Support Workers continue to undertake the Care Certificate. In 2017-18 173 passed this assessment of competence and a further 134 are being supported to do so.

The Learning and Development Department has been involved in the patient quality and safety agenda working with clinical teams to support initiatives such as End PJ Paralysis and Time to Act and provide in-situ training as part of our simulated learning approach.

Other achievements

Research and Innovation

Research at the Trust has grown exponentially over recent years with over five thousand patients recruited into trials in 2016/17 and again in 2017/18, demonstrating a significant step change in activity. Over 200 active studies are open to recruitment at any one time and the trust maintains a strong position (consistently in the top 10) within the league of acute trusts. Recent data published in August 2017 by the NIHR ranked the Trust in the top ten acute trusts reporting the biggest increase of research activity, with an overall ranking of twenty one in the national league table.

Over 30 specialties are research active within the Trust and the number of staff involved in research continues to grow. The fixed workforce equates to 88 WTE while the number of consultants involved in research has increased year on year; currently there are over 160 Principal Investigators listed as research study leads.

Research priorities are closely aligned with those of the Trust; for example, the award-winning respiratory research Mission clinics provide a model to transform services, reduce emergency admissions and provide care closer to home. Much of the endoscopy research at PHT is focused on early cancer detection and removal while renal research is looking at the potential benefits and impact of home dialysis.

At the Research & Innovation Annual Conference held in May 2017, a research patient, spoke movingly about the life-changing treatment he received as part of a clinical trial for a long standing skin condition; importantly the Trust was the first Trust to offer him an innovative approach to manage his condition.

The department continues to be competitive at a national level and attract awards and grants from national funders. The academic impact of the department is also significant with over 60 peer reviewed journal papers published by PHT staff this year; in addition, Portsmouth researchers were awarded the BMJ paper of the year 2017 for their work an antibiotic usage.

We have an excellent Research and Innovation office that supports the design, set up and delivery of studies. We also continue to develop clinical academic training pathways for nurses, midwives and junior doctors who are trained in the design and conduct of high quality research.

Defence Medical Group South (DMGS)

2017/18 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 high quality, effective and professional care to patients in a safe environment.

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. 2017/18 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)

Minestrone

The Minestrone system was developed by PHT IT and designed by junior and senior Trust doctors in collaboration with the Trust's Pathology department. The initial Trust-wide release in November 2017 delivered a 'Pathology Viewer' function. This provides a view of all the pathology results for a patient in one system, together with the ability to acknowledge those results and request add-on tests. This improves efficiency and increases the visibility of test results. The response from clinicians has been overwhelmingly positive and work is underway to add further capabilities to Minestrone. These capabilities include a 'Radiology Viewer' and ability to track the viewing and acknowledgement of test results, linked with an automated escalation process.

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)

Critical care:

- Digital maturity, use of raspberry pi technology for cost effective IT improvements to healthcare.
- Innovative approach to managing workforce pressures–Advanced Critical Care Practitioners (ACCP) programme, pilot resident on-call Consultant.
- Creation of an overseas nurses group to help support and integrate.
- Watch out notices now used across organisation and many plaudits and requests to use this work nationally and internationally.
- Humanising ICU environment with sound ears and work on light intensity http://journals.sagepub.com/doi/full/10.1177/1751143717748095
- Debrief sessions run by Critical care Consultant and TRIM - debriefing session following critical incidents to identify staff at risk
- Appointment of a Band 7 dietician and a Band 4 physio technician to promote rehabilitation.
- Bleeps introduced for relatives so that they can leave the Unit and be called back.
- Introduction of 'Happy App' to monitor staff well-being and satisfaction.

Anaesthetics:

- One of the first departments in the country to achieve the prestigious Anaesthesia Clinical Services Accreditation (ACSA).
- Development of perioperative medicine with the 'surgery school' project.
- Standard Operating Procedures for patients with learning difficulties - including ensuring that they are first on the operating list.
- Continue to be at the cutting edge of services provided, by being ahead of the game of any innovations/national changes .

Theatres:

- Participation in National NHS benchmarking and are recognised as being in the top decile for performance and efficiency.
- Activity Tracker introduced to follow patient through their theatre journey.
- Bedview and Vitalpac introduced in recovery allowing recording of observations and assessments.
- Funding awarded for development of 2 additional operating theatres.
- Different coloured hats introduce to theatres to aid with identification of roles.

HSDU:

- First HSDU in the country to create Apprenticeships to meet workforce needs.
- Staff undertaking and completing Technical certification level 3.
- Achievement of ISO13485:16 BSI Accreditation.

CLINICAL SUPPORT SERVICES

- Blood Sciences has been assessing the suitability of a high sensitivity troponin assay which has the potential to significantly reduce the wait to diagnose myocardial infarctions using the blood test, improving the urgent care pathway.
- Histopathology has been supporting the RCPath/IBMS Advanced Specialist Diploma (ASD) in Histopathology Reporting programme for Gynaecological Pathology to train one of the first Biomedical Scientists in the UK who can independently report cases, supporting the department during the present shortage of Histopathologists.
- Histopathology workforce development: The department has been developing staff to take on roles traditionally associated with consultants. Currently over 80% of routine dissection is carried out by BMS/Clinical Scientist staff which supports freeing consultant time for reporting helping to improve turnaround times for diagnostic reporting of histological samples.
- Patient Portal introduced in October 2017. Patients now receive Outpatient Appointments details directly to their smartphones with the ability to confirm, decline and rebook.
- Radiotherapy Physics, with oncology and urology departments, have received a research grant from EU Interreg 2 Seas funding body, in collaboration with several other international partners, to develop a robotic biopsy and brachytherapy treatment device.
- Implementation of Macmillan Dietician Service Review questionnaire, which aims to examine the service from the patients' perspective, to ensure the service is meeting patient expectations, to allow the tailoring of the service to meet user needs, to ensure patient involvement in the shaping of the service and to identify any gaps in the service to allow future planning.
- Upper GI surgical dietitian proposed a service development which has been well received by the surgical teams and is now being incorporated into clinical practice. This enables out-patient management of commencing feeding rather than the previously required inpatient admission. It also enables feeding to be commenced before complications of malnutrition develop as there is no delay whilst admission and theatre time are being arranged.
- One of the renal dietitians has worked in partnership with a consultant nephrologist to develop a food frequency questionnaire to identify dietary phosphate sources. This has been incorporated into the My Renal Care App which is being trialled as a shared care management tool between dialysis patients and renal staff.
- Community dietitians have been involved in a one stop COPD clinic along with respiratory team which is taking the service to GP practices to prevent patients having to travel to hospital.
- New leaflets developed in Neurophysiology based on standardised designs to update patient information, tests and make them more specific to test procedures (i.e. specific sections for children or disease specific tests). This will hopefully improve patient preparation for tests and improve the information patients receive regarding neurophysiological tests.
- Therapist working within the neurology and stroke pathways have developed a treatment pathway for the upper limb. This includes an integrated assessment that can be used by both occupational therapists and physiotherapists and a treatment algorithm (supported by detailed intervention guides). The pathway is evidence based and is currently being shared as an innovative project with therapy teams in Southampton. The project has benefited patients in several ways, by ensuring continuity and a

shared standard of treatment across the therapy pathway as well as supporting efficiency and clear communication.

- Stroke Wellbeing Group: The occupational therapy service and psychology service have developed a fortnightly group to support patients emotional wellbeing after stroke. Low mood has been shown to be a common experience after stroke and this group seeks to provide information and support for patients that are struggling with mood problems.
- Pharmacy: Development of Medicines Reconciliation tool for Frailty patients - implemented in MAU and Medicine for Older People (HEE Frailty Fellowship work), this work also includes a bid for an innovative MCP Interface-Frailty Pharmacist. Development of a patient information booklet for the newer direct acting oral anti-coagulants, this NHSE supported patient safety initiative attracted 'Patient Safety First' funding and won a local innovation prize - the booklet has been shared and used by other NHS Trusts in the UK.
- The CT department trialled the use of a CT Colonography (CTC) pre-assessment clinic (either in person or via telephone) prior to the examination to provide an explanation of procedure , advice on taking the preparation, and answer any questions the patients may have. Trial showed that the number of wasted slots was halved, all patients that attended had taken the correct prep, and patients that were inappropriately referred for the scan received the most appropriate scan.

EMERGENCY DEPARTMENT (ED) AND ACUTE MEDICINE

Emergency Department

- Development and implementation of a Navigator role for patients who walk into the Emergency Department. Following advice from NHSI and ECIP, the Nationally recognised Luton and Dunstable Trust streaming process was adapted for PHT ED. Since May there has been a senior nurse placed within the waiting room to meet patients on arrival and deliver a focussed assessment to stream the patients to the correct care pathway. While the model is designed to increase the number of patients streamed to the Urgent Care Centre, the benefit is that all patients are seen quicker and time critical diagnoses are identified and treatment implemented. The new model replaces the system where patients waited to be booked in and only had an clinical assessment after the wait for being booked onto the system. There is clear evidence of a marked reduction in the identification of myocardial infarct and stroke patients.
- Establishment of the ED observation into its new role as an Emergency Decision Unit. Patients are now booked into the EDU for assessment by the mental health team, Frailty Intervention Team and to await test results. Frees up clinical space to allow better flow.
- Urgent Care Treatment Centre only operated from 10 am to 10 pm 7 days a week. Following a visit by Pauline Philip, the ED submitted a business case for delivering a co-located UCC and this was achieved. Work continues to deliver the new model but as a result of the review of the UCC and the focus on the new streaming model, it now opens from 8 am to 11 pm and mirrors best practice elsewhere in country.
- Following the CQC inspection in May, after the report was received, the ED developed new mental health assessment documents and extended opening hours for the Mental Health Liaison Team. Where before patients did not robustly have a proper risk assessment and the performance of this was 40% , since the changes this now sits routinely above 95%.
- ED has and continues to deliver an effective Advance Care Practitioner training programme and the department is now seeing increased numbers of ACPs on the workforce.

- Departmental intranet page has been re-launched and now contains a large number of clinical and SOP policies that deliver consistent and robust patient care.

Acute Medical Unit (AMU)

- National benchmarking as part of Society for Acute Medicine Benchmarking Audit (SAMBA) showed a marked improvement in patients being reviewed by the medical team within 4h and by a consultant within 14h of referral (38% to 57% and 54% to 72% respectively).
- Significant changes to the organisation of the medical team in AMU including a dedicated daily admissions team and improved arrangements for the review and handover of overnight admissions.
- Improvements to how we assess patients referred by their GP through development of our Acute Medical Technician role and changes to the organisation of the medical and nursing teams.
- AMU nursing team have led development of system for non-verbal handover of patients to wards as a way to improve timeliness of transfers to medical wards from AMU.
- Recruitment of two trainee Advanced Clinical Practitioners who will become part of the medical team.
- Ongoing work with falls collaborative.
- Ongoing work to improve the care of vulnerable patients through Mental Capacity Act and DoLS training and daily safety huddles.
- Improvement to local governance processes to improve learning from incidents including engagement with trust Mortality Review Panels.
- Launched the first “Schwarz Rounds” at PHT – a type of group reflective practice shown to improve staff wellbeing and patient care.
- Multi-professional team awarded HEE Quality Improvement Fellowship through which we aim to improve the care and experience of patients referred to AMU by their GP and develop use of quality improvement techniques on AMU generally.
- Ongoing development of departmental research portfolio – our research lead has co-authored six published peer reviewed articles in 2017 and continues to work looking at identification of patients who deteriorate in hospital and patient with sepsis.

Priorities for 2018-2019

- Further improvement to timeliness of medical assessment (aiming for >95% of patients seen within 4h of referral by medical team and >95% seen within 14h of referral by consultant).
- Further development of alternative medical workforce to support sustainable medical staffing.
- Improving use of data to improve patient safety and experience.
- Work to understand reasons for unplanned patient readmissions via AMU.
- Ongoing development of Ambulatory Emergency Care.
- Keep building departmental research portfolio.

HEAD AND NECK

- New Matron to the service to support the quality and safety elements of the CSC.
- Training of Nurses to undertake aural- micro suction to further develop nurse led clinics and support the patient pathway for emergencies.
- Development of B6 nurse injectors in Ophthalmology.
- Cancer Nurse opportunities .
- Career pathway for band 4's for internal and oversees staff.

Opthalomology research

- Awareness of outcomes in glaucoma surgery enabling to offer surgery with more confidence.
- Increased use of lens extraction for Acute Closed Angle Glaucoma using an evidence base.
- Awareness of the risks of cataract surgery in short eyes.
- Increased use of Preservative Free drops in appropriate patients.
- Use of Steroid intra-ocular implant for Diabetic Macular oedema.
- Successfully conducted Research awareness day for patients and staff on National Eye Health week in collaboration with PRA team.
- PHT Best Research Impact Award 2017.
- Best recruiter award for Somnus/sleep study (Oxford University hospital).
- Nationally 3rd position for recruitment.
- Top recruiter for 3 research studies.
- Over recruitment for all current studies.
- PHT Ophthalmology team in process of starting 2 own studies.
- Recruited and trained a new Band 4 Research Assistant / Photographer.
- Team got nominated for CRN Wessex Outstanding Research Team awards.
- Rise in number of clinicians doing clinical trial

MEDICINE

- Retained Joint Advisory Group (JAG) accreditation for the QA Endoscopy Unit and gained JAG accreditation for the Gosport War Memorial Endoscopy Unit.
- Implementation of a ward round assistant within gastroenterology, with second about to commence in post.
- Fast Access Chest Pain Clinic - review of provision and the appointment of a Advanced clinical Practitioner to lead a redesign the service.
- Introduction of COPD Admission and Discharge Pathways.
- Development of an electronic flag to identify patients with acute exacerbation of COPD.This facilitates specialist review of AECOPD patients within first 24hours of admission.
- Gastroenterology - Alcohol Service nationally recognised and is used as example to other trusts wishing to set up a similar service. All patients offered health education on discharge in relation to smoking/alcohol consumption/diet
- Hepatology – Following the NCEPOD 2013 regarding the management of patient with ascites, the Hepatology service sought funding to build a dedicated area to provide specialist Hepatology nurse and consultant care

for this patient group. The building project completed in 2017, training of staff will be commencing in March 2018.

Actions from patient feedback

- Respiratory day ward: Patients fed back that were waiting too long for their procedures. As a result we have changed our practice thereby reducing the patient wait time.
- Acute Asthma Service.
- introduced a pre-clinic appointment to provide a full asthma workup for new asthma referrals, which gives us the opportunity to pre-screen inhaler technique and some measurement parameters (especially FENO)., Reducing the number of appointments they need to attend and has led to improved management, better control and earlier discharge.
- Biological treatment in Asthma.
- Patients fed back that they did not like being reviewed as a group prior to commencing treatment. A nurse-led clinic has been set up and patients are now reviewed individually.
- Lung Cancer Service.
- Our nurse contact card was changed to prompt patients to call if they hadn't received an appointment.
- TB Service.
- Telephone consultation service as patients reported they could not afford to keep coming to appointments or take time off work. Patients can now also collect their medication directly from pharmacy.
- Diabetes and Endocrine annual conference, agenda shaped by patients.
- Development of a patient information leaflet for Non-invasive ventilation (IV) by Respiratory High Care.

MEDICINE FOR OLDER PEOPLE, REHABILITATION AND STROKE

- Frailty and Interface Team, a multiagency admission avoidance team based in ED, is now fully embedded and managing to prevent up to 13 admissions per day.
- G4 was converted to a Frailty Short Stay Unit in October 2017, and has an enriched multidisciplinary to case manage patient discharges and reduce LOS. The average LOS for the ward is 6 days.
- MOPRS LOS has reduced over the past 12 months, from 23 days in April 2017 to 16.6 days, in March 2018. This is a great success story, linked to all the MOPRS work around managing complex discharges and the focus on frailty short stay.
- The Stroke service have achieved SSNAP level C for Aug to Nov 17, and are hoping to reach level B, with continued focus on 4 hour admission performance, and 4 hour swallow screening.
- Thrombolysis service at QA is now performing at 91.7% within 1 hour, which is exemplary.
- The Hospital Palliative Care team are working with the Rowen's Hospice to develop wider system wide thinking
- MOPRS were proud that the Frailty and Interface Team and a Senior Sister from F2 were awarded Highly Commended at the Best People Awards in November 2017.

- Portsmouth Enablement Centre is one of the 9 nationally recognised Murrison Centres, serving the needs of veterans, providing prosthetic limbs.

TRAUMA, ORTHOPAEDICS, RHEUMATOLOGY AND PAIN (MSK)

- New virtual clinics are in place lead by a Consultant and attended by community physiotherapists where community patients are discussed to ensure treatments are appropriate and that only patients who require a surgical opinion are referred to the Trust
- Orthopaedics have a "ring fenced" elective area for their patients which will help reduce the risk of infection particularly in patients who have undergone hip and knee replacement surgery. This was a recommendation from the "getting it right first time" lead Professor Briggs.
- D6 continue to lead the way nationally in the treatment of patients who have suffered from a fractured hip.
- Rheumatology are examining the prescription of biologic drugs for their patients saving the health economy in excess of £0.5 Million.

RENAL AND TRANSPLANTATION

- Establishment of a new inpatient renal service at UHS which delivers renal expertise to inpatients thereby improving their care and reducing the need for transfer to PHT.
- A new Acute Assessment Unit has been set up in the renal department. This avoids the need for renal patients to attend ED and provided renal-specific care to patients throughout Wessex. It is run by a specialist triage nurse thus reducing demands on the Junior Doctor on call.
- Ward review clinics have been set up to allow recently-discharged patients to be reviewed within a few days by a consultant. This has led to earlier discharge of patients and efficient bed usage.
- A new Haemodialysis service has been started in ICU at UHS with plans to roll this out to the rest of UHS over the next year.
- A new advanced practitioner has been appointed to deliver expert inpatient care in the renal department. This fills the shortfall in junior doctors and improves the quality of renal expert opinion. Further similar appointments are planned.
- A mobile app has been developed within our CSC to deliver patient-activated personalised care to patients receiving home haemodialysis. This will be extended to transplant and peritoneal dialysis patients in the next year.
- Consultant working patterns have been overhauled to deliver a daily consultant presence at board-rounds and ward-rounds and throughout the working day. Job plans have been changed to ensure that consultants rostered for ward duties do not attend off-site clinics.
- A new operating system for the renal department IT system has been purchased which will facilitate communication with renal clinics throughout Wessex and enable efficient audit.
- New outpatient clinics have been set up in Southampton (Adelaide Centre) and Fareham (Fareham Hospital) to bring care close to patients.

- A new Home Therapies department has been commissioned and financed at Fareham Hospital. Building works will commence shortly.
- A new transplant network has been set up with Dorset Hospitals. This will provide 10-20 transplants for Dorset and save patients from travelling to Bristol (where these transplants would otherwise have been done).

SURGERY AND CANCER

- Our Radiotherapy department retained their ISO9001:2015 accreditation this year. The certification acknowledges the quality standard of care delivered to the patients undergoing radiotherapy at PHT.
- There has been a successful business case through for additional staffing to expand our radiographer- led on- treatment review clinic service from 3 days per week to 5 days per week.
- The Combined Haematology & Oncology Unit (CHOC, F5, 6 & 7) wards and the Macmillan Information Centre were awarded the Macmillan Quality Environmental Mark (MQEM). The MQEM assesses whether cancer care environments meet the standards required by people living with cancer.
- The Haematology ward nurses (based on CHOC) received their 1st Autologous Transplant (stem cell treatment for certain types of cancer) patient in August 2017 and have now seen 16 patients coming back to Portsmouth following primary treatment in Southampton. The team had a JACIE (Joint Accreditation Committee) visit at the end of 2017 and successfully received accreditation for the service.
- The CSC has worked alongside Macmillan to appoint a Macmillan Clinical Psychologist to support cancer patients, families and carers through treatment and beyond.
- The Urology team have launched their 'Enhanced Recovery Pathway' for a number of elective major surgery pathways. Enhanced recovery is a modern evidence-based approach that helps people recover more quickly after having major surgery. This is already having a positive impact for Robotic Prostatectomies and Cystectomies.
- The Urology team won the 'Best Team Award' at the annual Trust Awards event.
- Reduction of Urology Outpatient Waiting List backlog by 73% (March 2017 575, March 2018 157)
- In response to Deanery request a robotic-theatre assistant was appointed.
- The CSC is supporting the implementation of 'My Medical Record' in association with the Living with and Beyond Cancer Transformation Fund. My Medical Record is an online tool which will allow patients to self-manage parts of their follow up pathway following cancer treatment, reducing the number of out-patient visits.
- Using Bed-View there has been SAU take-list development and implementation. This will give Trust visibility on the Surgical Ambulatory and Emergency take position. This will give auditable data which will assist in ensuring that first consultant contact is within 14 hours.
- 99.9% All new referrals via Choose and Book incl. 2WW (Breast &Urology)
- Successful re-accreditation of Breast Oncoplastic Training Centre (1 of 12 centres nationally).
- Successful re-accreditation of Oncoplastic Training Centre (1 of 12 centres nationally).

- Increase CNS by 2WTE: Incl. appointment of metastatic Breast care Nurse (1 of only 20% of Trusts to have this position as recommended by national clinical reference group).

WOMEN AND CHILDREN

NICU

- Peer Review –excellent feedback. Waiting final report still.

Paeds:

- Ambulatory Clinics in Children's OPD.
- Surgical familiarisation -The Trust and the University of Portsmouth are running a fun activity, filled Surgical Familiarisation drop in event to help Children and Young People and parents to know and get used to some of the areas and experiences they will experience at the time of the child's surgery.
- Harvey's Gang (School holidays). Children and Young People are visiting labs to look at the processes their blood sample goes through and meeting staff. It is hoped this innovation will improve patient experience for patients with long term conditions and improve communication with the lab staff.

Gynae:

- The Word catheter was introduced October 2016 and was recommended in NICE guidance. It provides treatment for Bartholin's cyst/abscess under local anaesthetic in an ambulatory/ward setting. Since introduction, admissions and use of the CEPOD theatre for treatment of Bartholin's under general anaesthetic has decreased significantly. This led to more efficient use of staff and theatre time. A recent spot patient questionnaire has shown 100% satisfaction rate. Staff are also very satisfied with the procedure as it allows a one-stop assessment/treatment. Department now has a guideline and dedicated patient leaflet.

Maternity Unit:

- Band 4 associate practice development of a maternity support worker. Leading on maternity support worker competency and completion of the Care Certificate competencies with the practice education team.
- Band 1-4 Maternity support worker project; development of support workers delivering support and care to women following competency based training. This includes elective caesarean section pathway.
- Local maternity system (LMS); includes the development of the academy which is a multi disciplinary training project using safety money from the DoH across the local health economy area. This work also includes the development of the acute observation unit training for midwives.
- Development of the 'my maternity' app; supporting the choice and personalisation project and follows on from the development of the 'My Birthplace' app.
- Development of the clinical effectiveness team. This includes development of the pods (multi disciplinary teams) leading on review of guidelines, audit, education, research and investigation.
- Continued development of the triage and day assessment area into a maternity assessment area.

- Increased surveillance using Wessex antenatal pathways and Saving Babies Lives care bundle guidance resulting in a reduction in stillbirth rates.
- Development of the Emotional Maternal Wellbeing website to support perinatal mental health signposting for women. This was created using Safety funding.
- First wave of the Maternity Neonatal and Safety collaborative. The project identified the need to review the provision of scanning capacity to support the Saving Babies Lives agenda. This has resulted in an increase of 1500 scans over the year leading to increased fetal surveilance and reduction in stillbirths.
- Diabetes pregnancy service - are a small dedicated team of doctors, midwives and diabetes nurses. Nationally stillbirth rates in diabetic mothers are more than twice those without diabetes, however the total number of stillbirths among the patients looked after by our team in 2017/18 was zero. In a service which last year saw over 450 mothers with a diabetes related pregnancy this is a huge achievement with enormous benefits to expectant mothers across our local area, and is testament to the fantastic team effort within the service.

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

Jeremy Poole

Date: 07 June 2018 Chairman

Date: 07 June 2018 Chief Executive

CCG COMMENTARY ON PORTSMOUTH HOSPITALS NHS TRUST (PHT) QUALITY ACCOUNTS 2017/2018

NHS
South Eastern Hampshire
Clinical Commissioning Group

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25 June 2018

Mark Cubbon
Chief Execuitve
Portsmouth Hospitals NHS Trust
Queen Alexandra hospital
Southwick Hill Road,
Cosham, Portsmouth,
PO6 3LY

By email

Dear Mark,

Trust Quality Account 2017/18: Supporting Commissioner Statement

Thank you for the opportunity to comment on the trust's quality account for 2017/18. I am responding on behalf of NHS South Eastern Hampshire Clinical Commissioning Group (CCG), NHS Fareham & Gosport CCG, NHS Portsmouth CCG and the various Hampshire and the Isle of Wight associate commissioners, whose views on the trust's quality achievements and challenges in 2017/18, and on the priorities set for 2018/19 are reflected in this joint commissioner statement.

Areas of quality achievement in 2017/18
Commissioners have been pleased to note that the Trust continues to strengthen its learning culture, clinical leadership and governance structures to support the delivery of consistently high quality patient care. Despite an extremely challenging year operationally, quality improvements have been progressed as follows:

- **National awards obtained** for patient, carer and volunteer engagement
- **Friends & family test** responses have been consistently positive
- **A *Carers Café* and "*Happy to Chat*"** volunteer team has been launched supporting carers with advice and information.
- **Training for staff** on learning disabilities, autism and mental capacity act
- **The anaesthetic department** achieved the Anaesthesia Clinical Services accreditation
- **Risk assessments for patients with mental health needs** presenting to the emergency department have been consistently achieved. PHT have played a key part in the establishment of the system wide mental health and mental capacity board.
- **Continued improvement in reporting of safety learning events**

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South Eastern Hampshire
Clinical Commissioning Group

- The total number of **unreported emergency department plain x rays** shows a decreasing trend and the agreed backlog has been cleared.
- **A quality improvement plan** has been developed following the Care Quality Commission (CQC) enforcement notices, and this overarching plan is reviewed monthly and remains the driving focus for quality improvements throughout the organisation.
- **The *Learning from Deaths* programme** has progressed well within the year with every in-patient death undergoing robust review.
- **Duty of Candour** application has improved, with evidence of more patient and family engagement in the serious incident investigation process.

Quality challenges in 2017/18

2017/18 was a challenging year for the trust operationally and for a number of CQC regulatory actions which include:

- **Three section 31 enforcement notices (HSCA, 2013)** in place for:

  1. **Care in the acute medical unit;** issued 3rd March 2017 with 4 conditions around staffing levels, skill mix and GP triage area. The trust report ongoing workforce challenges which are partially mitigated through temporary workforce.

  2. **Mental health care in the emergency decision unit and oversight of vulnerable patients across the organisation;** issued 12 May 2017 with 6 conditions. Sustained progress has made in risk assessments, improved access to psychiatric liaison services, staffing levels and the establishment of a PSEH system mental health board.

  3. **Diagnostic and screening procedures related to the backlog of radiology reporting;** issued 28th July 2017. The trust delivered the CQC established trajectory to clear the backlog. A retrospective review of unreported x rays was undertaken which indicated some patients had suffered significant harm and an independent review was undertaken which reported improvements had been made in governance.

In addition, a CQC **section 29a warning notice** was issued 4th July 2017, covering fundamentals of care, safeguarding, culture and governance and management of vulnerable patients, with an ongoing requirement notice under **regulation 17** issued in 2016. Positive progress has been made on improving governance, restructuring of committees and monitoring of quality through aligning the strategic objectives with the board assurance framework. The trust launched a *Portsmouth Quality Bundle* vulnerable patient module in June 2017, which focusses on improving fundamental standards of care.

- **Urgent and emergency care pathway**
  The trust was unable to deliver constitutional standards and other key performance and quality measures across the urgent and emergency care pathway. This resulted in some significant quality challenges including:
  - A high number of days where the trust declared Opel 4 or critical incident escalation, which impacted on elective care and some partner organisation services.
  - 307 breaches of the 12-hour decision to admit threshold
  - A high number of ambulances held at the department
  - High numbers of patients 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
- Cancelled operations and appointments

Commissioners are delighted to note the improving position for all aspects of urgent and emergency care during April and May 2018. We recognise that the commitment of the trust's front line staff and leaders both operationally and in the commitment to work together has delivered effective internal trust and system-wide solutions. The trust has taken forward a range of quality interventions to support safety in urgent care services, including the nurse navigator role for early patient triage, improving timeliness of senior medical review, extended access to mental health liaison team, introducing mental health assessment documentation and increased medical cover and nurse leadership. In addition, the friends & family test positive responses for the emergency department and trust as a whole remain above national average.

- **Elective Care**
  The trust has continued to experience challenges in delivering the constitutional targets for elective care and there are inconsistencies with managing the waiting lists and delays in follow ups. This has led to delays in assessment and treatment with significant patient safety incidents reported. A system wide elective care board, has been established to drive improvements.

- **Nursing workforce vacancy rate remains challenging specifically** across medicine and medicine for older persons & rehabilitation services, despite the trust's proactive recruitment campaign.. The trust's culture and leadership programme has been launched in year to support staff development.

- **Seven never events** were reported in 2017/18 and the trust is working towards strengthening the serious incident management process and embedding procedures for both national and local safety standards for invasive procedures. NHS Improvement is supporting the trust with improvements.

- **Serious Incidents:** The number of serious incidents in 2017/18 has increased compared to 2016/17, principally due to the number of "decision to admit breaches" which until January 2018 were reported at Sis. There have also been higher than usual SI completion delays. It is noted that the *National Reporting & Learning System* dataset (April 2017 – September 2017) rated the trust as having a higher number of safety incidents resulting in severe harm or death per 1,000 bed days). A review of the serious incident management process has progressed in-year and improvements are anticipated for 2018/19.

- **Dementia screening** remains below trajectory and the trust has established a dementia board and identified new roles to support improvement.

- **Learning from Deaths**: The trust hospital standardised mortality ratio (HSMR) is statistically higher than expected, although the rolling average is reducing. Commissioners are assured the trust has robust processes in place to support more accurate coding and learning.

- **Safeguarding Adults and Children:** The trust has produced an overarching improvement plan incorporating recommendations from the seven safeguarding inspection reviews undertaken in-year. The delivery of this is monitored externally through the local authority *Safeguarding Improvement Board*.

NHS
South Eastern Hampshire
Clinical Commissioning Group

- **Patient Safety Metrics**: there continues to be scope for improvement in harm related falls, avoidable pressure ulcers, medicines management, sepsis management and health care associated infections and commissioners are fully briefed on the trust work programmes against each of these.

- **Maternity Services**: improvements in relation to maternity services are being driven through the newly established trust maternity board, and assurance received through CCG engagement in internal trust assurance processes. The CCG anticipate this will include improvements as indicated through national audits and confidential enquiries.

- **Health Care Associated Infections**: the trust reports both methicillin-resistant staphylococcus aureus (MRSA) and C.Dificile targets have not been met in-year. An unprecedented number of flu cases were observed in quarter 4. The trust exceeded its targets for a very successful staff flu vaccination programme. The CCG are members of the infection control committee to support driving forward improvements across the local system.

- **Mixed sex accommodation breaches:** a higher number were reported, which is reflective of both operational pressures and improvements in the reporting culture.

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 2018/19
The quality account demonstrates that in setting 2018/19 quality priorities, the trust has considered both internal and external intelligence and local and national requirements.

Commissioners note that some priorities have a similar focus to those prioritised in previous years. However, the priorities do reflect what commissioners understand to be continued quality challenges. Some priorities now have a quantifiable outcome measure, for example HSMR ratio and reduction in rate of avoidable pressure injury. It is also noted that a significant number of work programmes are progressing through the overarching quality improvement plan.

Patient Safety

Commissioners are supportive of the trust setting a priority to improve the timeliness of completion of serious incident and never event investigations. The trust is making improvements in patient and family engagement in the serious incident process and applying the duty of candour principles. The trust has set an aspiration to reduce the number of serious incidents per 1,000 occupied bed days. This could be more clearly described as a rate rather than a number. Commissioners suggest that the baseline for reducing the number/rate of serious incidents be adjusted to account for "decision to admit breaches" no longer being reported as serious incidents.

Supporting staff through structured judgement review and root cause analysis training is welcome, and this may be measured through the improved quality of investigations and robustness of action plans.

The trust has set an ongoing improvement priority for sepsis management and recognition and management of the deteriorating patient. This is particularly relevant when patients are cared for in clinical settings outside their admitting speciality or who have been subject to non-clinical moves. It would be advisable to support this priority with outcome measures and commissioners look forward to reviewing the evidence of improvement through the "*Time to Act*" programme and the delivery of the national Commissioning for Quality & Innovation (CQUIN) sepsis targets, which were not met in full in 2017/18.

Commissioners recognise the work programmes which are in place to support continued reduction in injurious falls and pressure injury.

Commissioner quality priorities for trust consideration

In addition to the above priorities, commissioners note the delay in the full implementation of the electronic tracking system for assuring diagnostic test results are reviewed and acted upon. A number of patient safety incidents have been reported and commissioners have received assurance that this electronic system will be operational across all in-patient settings from June 2018.

As the trust has been unable to deliver all of the referral to treatment (RTT) constitutional targets across its specialities, it would have been good to see a priority to improve safe management of patients who have experienced delays in assessment and treatment within both the elective and urgent care pathways. This could include internal assurance processes for consistent application of clinical triage, on-going clinical prioritisation and defining harm at speciality level. Commissioners are engaged in programmes of work through the elective care board to support reducing risk associated with delays.

In addition, commissioners are aware there is a specific work programme to improve medication management, a need highlighted by the CQC, and commissioners anticipate this will include "discharge medication" which was an unmet quality priority for 2017/18 with 253 items of intelligence in year and "higher risk" medications such as insulin, controlled medication and 02 administration.

A quality priority for healthcare associated infection would have been welcomed as this would reflect the challenges listed in part 3 of the account.

Clinical Effectiveness / Outcomes

Commissioners acknowledge the priorities set for clinical effectiveness and note the trust has not yet been able to achieve dementia screening requirements set for 2017/18. Stroke indicators have been variable in-year, and sustained improvement challenged through operational urgent care pressures and a high nursing vacancy rate. Commissioners are fully supportive of improving stroke performance.

A suggested outcome measure for cancelled operations would be a reduction in cancelled on the day operations as a percentage of all operations, as this will allow for annual fluctuation in activity.

Patient Experience

Commissioners commend the trust on its patient engagement work, which has resulted in two national awards. The priorities set will reflect the programmes of work identified in the quality

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South Eastern Hampshire
Clinical Commissioning Group

improvement plan. Commissioners suggest the use of data from the wealth of surveys and quantifiable patient experience data available in order to inform improvement trajectories.

Achievements reported against 2017/18 priorities and overall quality performance

The trust sets out a useful summary of achievement against the 2017/18 priorities in part one of the quality account. This is supplemented by a more in-depth review of quality performance in part three.

It is encouraging to note the delivery of mortality review priorities and the identification of the factors affecting the HSMR, the reduction in coroner post mortem inappropriate referrals and examinations. Commissioners are encouraged to note that families' experience of bereavement support is more timely. Commissioners look forward to seeing the impact of this work in sustainably reducing the HSMR and are committed to supporting the Trust to achieve timely discharge of patients following their acute episode of care.

The point of transition between acute and community care affects the continuity of care and has been subject to concerns raised by system partners and via patient safety incidents. It was concerning to note that the discharge medication priority was not achieved and whilst commissioners are fully cognisant of the sustained pressure experienced in the trust and across the system in respect of capacity and demand on services, they feel this should remain a priority. It is also anticipated that outcome measures will be included in the medication safety work programme.

The trust is to be congratulated on the patient experience work which has progressed in year which has supported the engagement of carers and patients who support the trust in their internal quality monitoring processes. The 2017/18 pledge to "*improve the safety, experience and effectiveness of care for the most vulnerable patients*" through staff education of safeguarding mental capacity management, mental health and supporting patients with dementia remains an improvement requirement.

Data Quality

Commissioners note the slight variance on performance against national average for patient NHS number for inpatient and outpatient services and the 100% achievement for General Medical Practice code. The trust has continued to be awarded a "satisfactory" grading for its information governance assessment.

Clinical Audit and Research

The clinical audit section demonstrates that the trust participated in 100% of eligible national clinical audits and confidential enquiries (with a range of percentages for submitted cases).

It is positive to see the continued good performance in the *National Falls and Fragility Fracture* audit programme, with the trust being the only one to achieve top quartile in all rated assessment domains. In addition, it is noted that the trust is one of 8% of trusts to achieve above average in all key indicators in the *Inpatient Falls* audit. Likewise the trust provides a useful summary of achievements for each service division. It would be good to see progress in the challenges identified through the *National Diabetes* audit for resources to support improvements in medication errors, especially insulin and continue the education programme to support ward based staff. It is noted that the trust has set quality priorities for the *National Lung Cancer* audit and *National Stroke* audit. There is clear evidence of research participation.

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Commissioner Assessment Summary

The trust has demonstrated some really positive quality improvements in 2017/18, despite a significantly challenging year operationally across the urgent and unscheduled care pathway and for elective care. These challenges have resulted in regulatory notices being applied, enhanced external scrutiny and development support through NHSI, NHSE, CQC and commissioning networks. The trust has developed an overarching quality improvement plan and placed governance, leadership as the focus to enable the delivery of improvement. It was disappointing to read the outcome of the CQC inspection report published on 4th May 2018; however, there is strong commitment to support sustainable improvements. The trust continues to work collaboratively with commissioning and system partners to address challenges of capacity and demand, and there is early evidence (April and May 2018) that urgent care pressures are significantly improved.

Commissioners have welcomed and appreciated the trust's increasingly open and transparent approach, as well as the opportunities for full engagement in your internal quality assurance committees and joint work programmes under the aligned incentives contract. Commissioners are committed to supporting the trust in building on this approach to ensure that the current risks associated with specific service delays are mitigated.

We look forward to continuing to work with you and the trust's teams in 2018/19.

Yours sincerely,

Julia Barton

Julia Barton
Director of Quality & Nursing
South Eastern Hampshire Clinical Commissioning Group

CC: **Maggie MacIsaac**, Accountable Officer, Hampshire Commissioning Partnership
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

7

HAMPSHIRE HEALTH AND ADULT SOCIAL CARE SELECT COMMITTEE COMMENTARY ON PORTSMOUTH HOSPITALS NHS TRUST (PHT) QUALITY ACCOUNTS 2017/2018

No comment received.

PORTSMOUTH HEALTH OVERVIEW AND SCRUTINY PANEL COMMENTARY ON PORTSMOUTH HOSPITALS NHS TRUST (PHT) QUALITY ACCOUNTS 2017/2018

Portsmouth HOSP do not wish to comment on quality accounts of organisations.

HEALTH WATCH HAMPSHIRE COMMENTARY ON PORTSMOUTH HOSPITALS NHS TRUST (PHT) QUALITY ACCOUNTS 2017/2018

healthwatch Hampshire

Healthwatch Hampshire response to Portsmouth Hospitals NHS Trust Quality Account

As the independent voice for patients, Healthwatch Hampshire is committed to ensuring local people are involved in the improvement and development of health and social care services.

Each year, we are asked to comment on seven Quality Accounts from NHS Trusts. In the past, we have allocated scarce time to read drafts and give guidance on how they could be improved to make them meaningful for the public.

We recognise that this process is imposed on Trusts. However, as the format has largely continued to remain inaccessible to the public, we have concluded that it is not a process that benefits patients or family and friend carers unless the format is changed. So we will no longer comment on Quality Accounts individually.

This will release time for us to use our resources to challenge the system with integrity, so we can create more opportunities for local people and communities to co-producing service change. For example, this year, we are again running our 'Community Cash Fund' to offer local organisation and charities the opportunity to carry out projects that help people to stay well both now and in the future. We are currently accepting applications until the end of May.

If you have not already done so, we would ask you to look at the guidance on involvement from Wessex Voices (www.wessexvoices.org.uk) which aims to make sure local people are involved in designing and commissioning health services. Five Local Healthwatch alongside NHS England (Wessex) have produced a Wessex Voices toolkit to support patient and public involvement in commissioning. You can use this to ensure that your quality processes are in line with patients' views, and with the guidance from NICE (www.nice.org.uk/guidance/ng44) and Healthwatch England. (www.healthwatch.co.uk/reports/5-things-communities-should-expect-getting-involved)

If we can help you in planning co-design and participation in future activities, we'd be pleased to hear from you. We will continue to provide feedback to the Trust through a variety of channels to improve the quality, experience and safety of its patients.

Thank you for inviting us to comment

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LIMITED ASSURANCE REPORT

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

This report is produced in accordance with the terms of our engagement letter dated 14 July 2018 for the purpose of reporting to the Directors of Portsmouth Hospitals NHS Trust (the 'Trust') in connection with the Quality Account for the year ended 31 March 2018 ("the Quality Account").

This report is made solely to the Trust's Directors, as a body, in accordance with our engagement letter dated 14 July 2018. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018 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 permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Directors as a body, for our examination, for this report, or for the opinions we have formed.

Our work has been undertaken so that we might report to the Directors those matters that we have agreed to state to them in this report and for no other purpose. Our report must not be recited or referred to in whole or in part in any other document nor made available, copied or recited to any other party, in any circumstances, without our express prior written permission. This engagement is separate to, and distinct from, our appointment as the auditors to the Trust.

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, the National Health Service (Quality Account) Amendment Regulations 2012 and the National Health Service (Quality Account) Amendment Regulations 2017 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the following indicators:

- Percentage of patients risk-assessed for venous thromboembolism (VTE); and
- Percentage of patient safety incidents resulting in severe harm or death.

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

Respective responsibilities of Directors and Ernst & Young LLP

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 the other information sources detailed in the 'NHS Quality Accounts Auditor Guidance 2014-15'. These are:

- Board minutes for the period April 2017 to June 2018;
- papers relating to quality reported to the Board over the period April 2017 to June 2018;
- feedback from the Commissioners dated 25 June 2018;
- feedback from Local Healthwatch;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, for 2016/17;
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the latest national patient survey;
- the latest national staff survey;
- the Head of Internal Audit's annual opinion over the trust's control environment dated May 2018;
- the annual governance statement dated May 2018; 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.

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

Assurance work performed

We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included, but were not limited to:

- 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.

The objective of a limited assurance engagement is to perform such procedures as to obtain information and explanations in order to provide us with sufficient appropriate evidence to express a negative conclusion on the Quality Account. The procedures performed in a limited assurance engagement vary in nature and timing from, and are less in extent than for, a reasonable assurance engagement. Consequently the level of assurance obtained in a limited assurance engagement is substantially lower than the assurance that would have been obtained had a reasonable assurance engagement been performed.

Inherent 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 2018:

- 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.

Ernst & Young LLP
Southampton
27 June 2018

Notes:

1. The maintenance and integrity of the Portsmouth Hospitals NHS Trust web site is the responsibility of the directors; the work carried out by Ernst & Young LLP does not involve consideration of these matters and, accordingly, Ernst & Young LLP accept no responsibility for any changes that may have occurred to the Quality Account since it was initially presented on the web site.

2. Legislation in the United Kingdom governing the preparation and dissemination of financial statements 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.

Term	Description
	Source: NHS Choices
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.

4

APPENDIX A - NATIONAL CLINICAL AUDIT: ACTIONS TO IMPROVE QUALITY

NATIONAL CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES THAT PORTSMOUTH HOSPITALS NHS TRUST PARTICIPATED IN DURING 2017/2018	
Audit Title	**Outcome/Actions to improve quality of healthcare**
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	The Trust is in it's sixth year of providing a 24/7 primary angioplasty service for patients with a diagnosis of ST-elevation myocardial infarction (STEMI), from Portsmouth and South East Hants, West Sussex, and Isle of Wight. The Trust is the largest provider of primary Percutaneous Coronary Interventions (PCI) service in the Wessex region (Heart attack centre). The Trust has achieved excellent results for STEMI patients in terms of achieving targets for time to treatment. The Trust is currently improving its data capture process to increase the number of Non-ST-elevation myocardial infarctions submitted to the national audit.
BAUS Cystectomy Audit	Awaiting publication of the national report/results.
BAUS Nephrectomy Audit	Awaiting publication of the national report/results.
BAUS Percutaneous Nephrolithotomy (PCNL)	Awaiting publication of the national report/results.
BAUS Radical Prostatectomy Audit	Awaiting publication of the national report/results.
BAUS Urethroplasty	Awaiting publication of the national report/results.
BAUS Stress Urinary Incontinence Audit	Awaiting publication of the national report/results.
Bowel Cancer	The National Audit report published in January 2018 is currently being reviewed by the Trust; an action plan will be developed to address any areas highlighted for improvement. The previous National Audit report highlighted that the Trust attempts a significantly higher number of laparoscopic surgeries (84%) in patients having major resection compared to the national average of 61%. The 2 year mortality rate for this patient group is significantly lower than the national and network averages. The 18 month stoma rate for rectal cancer patients is better than the national and network averages.
Cardiac Rhythm Management	The Trust submitted 100% of the required data (all implants carried out) to this national audit. These results confirm that the Trust is supplying a quality service for the implantation of pacemakers, implantable cardioverter defibrillator (ICD) and cardiac resynchronisation therapy (CRT) devices showing comparable results with peers and the national averages. The Trust will continue to carry out local audits alongside the national audit confirming the Trust's compliance with relevant NICE guidelines. The Specialty has highlighted the current TOMCAT IT system, where implant data is collected and stored, is outdated and is under review to improve the quality of data captured.
Case Mix Programme (CMP) – Intensive Care National Audit and Research Centre (ICNARC)	The results highlight that the mean ICNARC illness severity score is slightly higher than similar units, which means our patient cohort is sicker than similar units. The number of high risk sepsis admissions, admitted to the Intensive Care Unit (ICU) from the wards, is highlighted as much higher than similar units. This indicates that the Trust is managing generally sicker patients. The Trust Standardised Mortality Rate is 0.98 which is a reduction from the previous reporting period (1.06) and compares favourably with regional comparator units. The Trust will continue to monitor this through regular Mortality & Morbidity (M&M) meetings and Governance meetings. The Trust is an outlier for delayed discharges; this has been included on the Trust risk register, and a new pathway has been introduced to escalate delayed discharges at day 3 to the Chief Operating Officer.

4

NATIONAL CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES THAT PORTSMOUTH HOSPITALS NHS TRUST PARTICIPATED IN DURING 2017/2018	
Audit Title	**Outcome/Actions to improve quality of healthcare**
Coronary Angioplasty – Percutaneous Coronary Intervention (PCI)	The national audit on percutaneous coronary interventions (PCI) confirms that the PCI service provided by the Trust is a modern, comprehensive service with excellent outcomes. All our operators have results within or better than the expected range. Whilst the Trust provides a timely service for patients with Acute coronary syndromes, elective waiting lists are of greatest concern.
Diabetes – Paediatric (NPDA)	The Trust Paediatric Diabetes team are achieving a median HbA1c (haemoglobin A1c blood test) better than the national average, have more patients with good control, and fewer patients with poor control. However the Trust continues to need to improve the number of patients who receive a complete care process. This will be achieved by putting in place systems and checklists to ensure that the 4 care processes that require improvement (Foot examination, Urine sample for ACR (albumin/creatinine ratio), Blood Pressure (BP), and Retinal Screening) are being achieved and are a focus at clinic visits.
Elective Surgery Patient Reported Outcome Measures (PROMS)	***Hip and Knee*** - There were 1,481 eligible hospital episodes with 844 pre-operative questionnaires returned; a participation rate of 57% (90.5% in England), which is an improvement on the previous reporting period. Of the 777 post-operative questionnaires distributed, 595 have been returned, a response rate of 76.6%, compared to a national average of 71.1%. ***Groin Hernia and Varicose Vein*** - There were 675 eligible hospital episodes with 83 pre-operative questionnaires returned; a participation rate of 12.3% (50.6% in England). Of the 83 post-operative questionnaires distributed, 59 have been returned, a response rate of 71.1%, compared to a national average of 59.3%.
Endocrine and Thyroid National Audit	Awaiting publication of the national report/results.
Falls and Fragility Fracture Audit Programme	***Fracture Liaison Service Database (FLS-DB)*** - The general results were good for the Trust FLS service, especially from diagnosis to assessment to DEXA (bone density) scan. The new database created by the Trust has improved the collection of data; this should be evident in the future reports. At this moment in time the Trust FLS service does not provide falls referrals; these are being met by other parts of the local health service. ***National Hip Fracture Database (NHFD)*** – The report highlighted that the Trust has seen an increase in hip fracture patients (749 compared to 692 in 2015), making the Trust the 6th highest nationally for hip fracture patients. The Trust are in the top quartile for 5 out of 7 of the rated outcome domains, with two other Trusts in England similarly rated and one in Ireland who achieved 6 out of 7. The two domains where the Trust did not achieve this relate to length of stay, with an acute length of stay of 17.3 days, compared to 16.2 days in 2015, nationally 16.6 days; this puts the Trust in the 3rd quartile. The Trust is the only trust this year to achieve top quartile in all rated assessment domains. The Trust continues to demonstrate a consistent high level of performance which is a reflection of the collaboration between all of the professional groups that input to the management of this frail, complex group of patients that have sustained a hip fracture. The Trust will continue to strive for further improvement and maintain vigilance over our performance. ***Inpatient Falls Audit (NAIF)*** - Although some areas of the audit have seen a small deterioration from 2015, the Trust must be commended for achieving such a satisfactory outcome from the report. The Trust is one of 8 % of trusts to achieve above average in all of the key indicators identified by the audit. This indicates that best practice is being followed with all appropriate assessments being incorporated in our routine documentation. It should be acknowledged that whilst there are improvements to be made, the report identifies the Trust as one of a small minority, achieving a multifactorial approach to falls prevention. It should be noted that at the time of the 2015 audit the Trust was part of the Fall Safe Project, with a dedicated project team.

4

NATIONAL CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES THAT PORTSMOUTH HOSPITALS NHS TRUST PARTICIPATED IN DURING 2017/2018	
Audit Title	**Outcome/Actions to improve quality of healthcare**
Head and Neck Cancer Audit (HANA)	Awaiting publication of the national report/results.
Inflammatory Bowel Disease (IBD) Programme	Awaiting publication of the national report/results.
Learning Disability Mortality Review Programme (LeDeR)	Awaiting publication of the national report/results.
Major Trauma Audit - Trauma Audit and Research Network (TARN)	The National Audit report published in March 2018 is currently being reviewed by the Trust; an action plan will be developed to address any areas highlighted for improvement.
National Audit of Breast Cancer in Older People (NABCOP)	The NABCOP audit identifies ways of improving the treatment of older patients with breast cancer so that they are not denied beneficial treatment or subjected to unnecessary risk. The Trust has been highlighted as having the second highest number of new breast cancers diagnosed in the Hampshire and Isle of Wight region for the data collection period with 700 cases, second to Southampton University Hospitals NHS Trust with 800 cases. Areas of good practice highlighted included weekly review of Cancer Outcomes and Services Dataset (COSD) data, and the Trust having the highest number of dedicated breast cancer operating lists per week within the region. The Trust is working to address areas highlighted for improvement including liaising with the elderly medicine team to gain assistance from their experience in other surgical areas. An audit of all breast cancer patients over 70 is to be conducted using a fragility score to assess the number who might benefit from elderly medicine referral.
National Audit of Dementia	The results of the National Dementia Audit for the Trust highlighted a mixed picture in terms of performance. There are several areas that need improvement and they are included as part of the Trust Quality Improvement Plan. The areas that require improvement include embedding and auditing the use of the 'This is Me' document, providing improved support for staff to care effectively for patients with dementia with support from the Dementia Champions and the Lead Dementia Nurse, improving carers support and communication by using the volunteers programme 'Happy to Chat', and re-auditing the inclusion of patients and carers in discharge planning.
National Bariatric Surgery Register (NBSR)	Awaiting publication of the national report/results.
National Cardiac Arrest Audit (NCAA) - ICNARC	Awaiting publication of the national report/results.
National Chronic Obstructive Pulmonary Disease Audit Programme (COPD)	***Organisational*** - The organisational audit demonstrates the Trust has good Non Invasive Ventilation (NIV) and Intensive Care Unit (ICU) provision in an extremely busy unit. However, the results highlight that only 50% of 1299 patients with acute COPD were discharged from a specialist respiratory bed. Therefore changes in triage and bed management form part of the audit action plan. Since the audit, a specialist COPD team has been appointed which has improved specialist review within 24 hours of admission to 87% (Quarter 3, 17/18) and increased delivery of smoking cessation advice (97% COPD admissions, Q3). ***Secondary Care*** – The report published in March 2018 is currently being reviewed by the Trust; an action plan will be developed to address any areas highlighted for improvement. ***Pulmonary Rehabilitation*** – The recently published report is currently being reviewed by the Trust; a self assessment checklist will be completed against the report recommendations and an action plan will be developed to address any areas highlighted for improvement.
National Comparative Audit of Blood	***Audit of red cell and platelet transfusion in adult haematology patients*** – Awaiting publication of the national report/results.

4

NATIONAL CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES THAT PORTSMOUTH HOSPITALS NHS TRUST PARTICIPATED IN DURING 2017/2018	
Audit Title	**Outcome/Actions to improve quality of healthcare**
Transfusion Programme	***TACO Audit*** - Awaiting publication of the national report/results. ***Audit of O negative red cells*** – This audit has been delayed in design, there is currently no clear start date. The following reports were published during 2017/18, reporting on data submitted in the previous year: ***Repeat Audit of Patient Blood Management in Adults undergoing elective, scheduled surgery*** – The results highlight that within the Trust there is likely increased recognition amongst clinicians caring for surgical patients of the importance of Patient Blood Management (PBM), with consequent signals (though not definitive evidence) that individual practice is changing. However, there is yet limited application of PBM across surgical pathways and there remains considerable room for improvement.
National Diabetes Audit - Adults	***Transition*** - Awaiting publication of the national report/results. ***Diabetes in Pregnancy*** - The results highlight that the Trust compares favourably to national averages, but there needs to be continued development of strategies to raise awareness of the importance of pre-conceptual care, early referral to the pregnancy team, the use of folic acid 5mg, and improving achievement of safe glucose control in pregnancy. There is a need 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, particularly in women with type 2 diabetes. The Trust will continue to monitor and improve local performance against NICE Quality Standard 109 'Diabetes in Pregnancy' with the aim of improving outcomes for women with pre-existing diabetes. ***Inpatient Audit*** - The National Audit report published in March 2018 is currently being reviewed by the Trust; an action plan will be developed to address any areas highlighted for improvement. The 2016 report highlighted a necessity for regular and structured education for all clinical staff regarding the importance of timely, appropriate and safe prescribing, review and administration of insulin and other diabetes medications. Foot assessments and interventions continue to be a priority for the Trust given changes in vascular surgical staffing which may need to include a further uplift in specialist podiatry support for in-patients. Compared to other trusts locally, the Trust has a higher percentage of insulin using patients, a higher percentage of complex patients and a higher percentage of emergency admissions of patients with diabetes. However resources available to support the care of this group are lower than both surrounding trusts and the national average, and in particular nursing hours has fallen again compared to 2015. At a ward level, basic monitoring and patient experiences are good, this is the likely explanation for the Trust's lower than average levels of severe hypo in hospital through early detection. However, this audit again highlights the continuing trend of increased medication errors and insulin errors. This suggests a possible negative impact from hospital staffing changes at a time when diabetes specialty medical and nursing resources to train and support new staff has declined. Although on this "one-day snapshot" there were no examples of diabetes-related never events, the Trust know from incident reporting that such events can and do occur and have been on the increase. Root cause analysis of such events always identifies staff knowledge gaps (or confidence in acting on knowledge) as the key determinant of such events, reinforcing the importance of the need for an educational approach. It is anticipated that the change in working practices in our vascular colleagues will have an impact on the foot outcomes when the NaDIA results 2017 are published. ***Foot Care*** - The results of this audit highlight that the Trust has a reduced rate of amputations, and there has been a reduction to hospital admission rates with foot ulceration. However, healing of foot ulcers at 12 and 24 weeks remains an area of concern. A delay in time to being reviewed by the Multidisciplinary Diabetic Foot Clinic (MDFC) increases the risk of amputation occurring. A business case has been submitted

NATIONAL CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES THAT PORTSMOUTH HOSPITALS NHS TRUST PARTICIPATED IN DURING 2017/2018	
Audit Title	**Outcome/Actions to improve quality of healthcare**
	to increase the clinic volume of the MDFC.
National Emergency Laparotomy Audit (NELA)	Overall the Trust did well in this audit taking into account the Trust remains one of the busiest hospitals in the country with respect to the number of patients qualifying for this audit. The Trust is addressing several areas highlighted for improvement, with some areas noted as improved in the latest published quarterly report. Admission to critical care for high risk patients has improved. The Trust is working to further improve Computerised Tomography (CT) scan reporting pre-operatively, and with the peri-operative medicine team to ensure elderly medicine cover for patients.
National Heart Failure Audit	Approximately 900,000 people in the United Kingdom have Heart Failure; it causes or complicates about 5% of all emergency hospital admissions in adults. The report highlights that the Trust results are excellent and above the national average and higher than other local Trusts. Unfortunately the Trust submitted 69% of required data against a requirement of 70%; a business plan has been agreed and with extra specialist staffing it is expected the Trust will reach the requested target in the next report. An action plan is in place to address areas highlighted for improvement.
National Joint Registry (NJR)	The report highlights that the Trust has good data collection processes and results. Outcomes after Joint Replacement are all satisfactory, falling within the expected range for most factors except for Hip Revision rates at 10 years, which were better than the expected range.
National Lung Cancer Audit (NLCA)	The National Lung Cancer Audit collects and analyses data on all patients diagnosed with lung cancer, to improve care and clinical outcomes in the United Kingdom. The 12th annual report summarised the key findings for patients diagnosed with lung cancer who were first seen in 2015. The Trust data completeness rates, needed for reliability of results, were high. There were a few areas where the Trust results were below the national average. The Trust has appointed another Respiratory Consultant and a new Lung Clinical Nurse Specialist (CNS) to support the lung cancer service. A case note review is to be completed to determine why patients did not receive the needed therapy, including whether a second opinion was offered to borderline fit patients. The Trust intends to improve and reconfigure the patient pathway in accordance with the National Optimal Lung Pathway.
National Maternity and Perinatal Audit (NMPA)	This is the first national audit undertaken by the NMPA. Analysis of the results highlighted the Trust Maternity Service was an outlier in one category; for postpartum haemorrhage greater than 1500mls. The Trust has created an action plan to address areas highlighted for improvement; the Trust has also supported the request for 2016-17 data for analysis by the NMPA team. The Trust Maternity Services has been supported by the Business Intelligence team to submit the data as the maternity information system does not support the format required by NMPA.
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	The results highlight that the Trust meets or exceeds the target for the four agreed standards. Where there is no agreed standard, the Trust matches or exceeds the national level – with the exception of Bronchopulmonary Dysplasia (BPD). No action is required at present to improve the excellent care provided.
National Ophthalmology Audit	Awaiting publication of the national report/results.
Oesophago-Gastric Cancer (NAOGC)	The National Audit report published in December 2017 is currently being reviewed by the Trust; an action plan will be developed to address any areas highlighted for improvement.
Prostate Cancer	The Trust is performing well and providing an excellent service for our men with prostate cancer. The Trust is 'ahead of the curve' with regards to diagnostic techniques but this has and will continue to put a strain on radiology (MRI), theatres (targeted biopsies), and

NATIONAL CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES THAT PORTSMOUTH HOSPITALS NHS TRUST PARTICIPATED IN DURING 2017/2018	
Audit Title	**Outcome/Actions to improve quality of healthcare**
	histopathology. As one of the higher volume centres in the country with excellent outcomes, the Trust needs to ensure that these services are supported to enable continued provision of this level of care for patients.
Royal College of Emergency Medicine	***Fractured Neck of Femur*** - Awaiting publication of the national report/results. ***Pain in Children*** - Awaiting publication of the national report/results. ***Procedural Sedation in Adults (care in emergency departments)*** - Awaiting publication of the national report/results. The following reports were published during 2017/18, reporting on data submitted in January 2017: ***Asthma*** - The results of the audit highlight the immense pressures being faced by the Trust in achieving the standard. There is a drop in performance in certain measured variables; however this is reflective of a significant increase in demand on the service. There are clear delays to assessment and treatment, however recent measures such as focus on ambulance handover and early streaming of patients has lead to an earlier assessment process in asthma presentation and treatment. There is current evidence of good practice nationally which could form the basis of a Quality Improvement Project (QIP). ***Consultant Sign Off*** - The results of the audit have highlighted the difficulty of having enough consultant cover to directly address all 4 standards. However this has been shown to be a significant problem at a national level – and the College acknowledges this. The Trust has taken significant strides to provide early consultant initial assessment as well as highlighting to all staff (medical and nursing) which are the high risk patient groups. ***Sepsis*** - There are a number of achievable standards in sepsis management and each audit cycle highlights an improvement. With increased pressures and demand on the Trust Emergency Medicine service as a whole, the need for early sepsis recognition remains paramount and this will be the focus of management. Blood culture packs have been created with a separate triage screen and immediate assessment for suspected sepsis – this will automatically trigger treatments and record timings. There needs to be better information given to patients and this could be addressed with a patient information sheet, however as these patients are admitted into hospital this could be better administered on the wards. Education remains an ongoing process within the Emergency Department across medical and nursing teams.
Sentinel Stroke National Audit Programme (SNNAP)	Stroke care remains a challenging specialty nationally, with evidence for interventions in the hyper acute phase well established. Intra-arterial thrombectomy pathway development is gathering pace both nationally and regionally. The National Plan is to focus on thrombectomy, as well as rehabilitation and long-term care. The opportunities for improving outcomes and reducing morbidity and mortality are considerable; however, continued investment in the service will be necessary in order for the Trust to realise the benefits for the whole health and social care community. Recruitment across all disciplines remains an on-going challenge, particularly to nursing and medical teams, as is the retention of staff. The development of specialist skills and knowledge is also proving difficult to maintain due to staff turnover. The improved SSNAP score from a Level D to a Level C is welcomed, especially against a background of continuing unscheduled care pressures. Nationally the standard and expectations continue to rise in response to the Royal College of Physicians (RCP) 2016 (5th Edition) guidance. The Trust remains committed to maintaining and furthering this improvement in SSNAP performance, as it reflects the improvement in standards of care and outcomes for patients.
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	The Trust meets the majority of recommendations contained within the report. An action plan is in place to address the areas highlighted for improvement as appropriate, including updating the laboratory training as per the United Kingdom Accreditation Service (UKAS) guidelines.

4

NATIONAL CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES THAT PORTSMOUTH HOSPITALS NHS TRUST PARTICIPATED IN DURING 2017/2018	
Audit Title	**Outcome/Actions to improve quality of healthcare**
UK Parkinson's Audit	Awaiting publication of the national report/results.
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) – Maternal Infant and Perinatal Confidential Enquiry	***Maternal Mortality*** - MBRRACE- UK Maternal Mortality report published December 2017 has created recommendations around maternal health focussing on sepsis, epilepsy, postpartum haemorrhage, perinatal mental health, pre-existing medical and surgical issues, anaesthetic care and amniotic fluid embolus; the Trust Maternity Service has provided evidence of compliance with the recommendations contained within the report and is progressing work streams to provide the Trust with assurance that partially and not met standards are met. Two risk assessments have been highlighted as being required and are being written. ***Perinatal Mortality*** - The Trust Maternity Service is actively reviewing compliance against the national recommendations. Whilst the Trust is compliant with the majority of the recommendations and has planned actions in place, it is recognised that further assessment of compliance is required and this will form part of the clinical audit plan for 2018/19 and potentially onwards. The Trust is actively involved in the Wessex safety programmes and the multi-professional team are active within the Wessex fetal and maternal medicine programmes; along side the Wessex Intrapartum Forum. The Trust will continue to report babies who meet the criteria to Each Baby Counts Royal College of Gynaecology (RCOG) study; this includes intrapartum stillbirths and neonatal deaths which occur in the first week of life.
Child Health Clinical Outcome Review Programme – Chronic Neurodisability	The report published in March 2018 is currently being reviewed by the Trust; a self assessment gap analysis will be completed against the report recommendations and an action plan will be developed to address any areas highlighted for improvement.
Child Health Clinical Outcome Review Programme – Young Persons Mental Health	Awaiting publication of the national report/results.
Child Health Clinical Outcome Review Programme – Cancer in Children, Teens and Young Adults	Awaiting publication of the national report/results.
National Confidential Enquiry into Patient Outcomes and Death – Peri-operative Diabetes	This study is ongoing.
National Confidential Enquiry into Patient Outcomes and Death – Heart Failure	Awaiting publication of the national report/results.

4

APPENDIX B – LOCAL CLINICAL AUDIT: ACTIONS TO IMPROVE QUALITY

Examples of local audits and the actions Portsmouth Hospitals NHS Trust intends to take to improve the quality of healthcare provided:

LOCAL CLINICAL AUDITS	
Audit Title	**Comments and actions to improve quality of healthcare**
An audit of compliance with the Trust Methotrexate Policy	This local audit highlighted that there are training needs around this medication across the Trust. Staff knowledge about Methotrexate and accessing the Trust's policy was variable. The results of this audit were shared in the Clinical Audit Department newsletter distributed trust-wide.
Trust wide Antimicrobial prescribing audit	This local audit highlighted that just over one third of patients included in the audit were prescribed an antimicrobial in mid summer, with 94.4% of these prescriptions considered appropriate. Co-amoxiclav was highlighted as the most commonly prescribed antibiotic and accounted for the majority of inappropriate prescriptions. The results of this audit were shared in the Clinical Audit Department newsletter distributed trust-wide.
Is the OMFS department completing dementia assessments for all inpatients in accordance with Trust policy	This re-audit highlighted a significant improvement in compliance with dementia screening following implementation of changes – a checklist was added to the Senior House Officer (SHO) handover to ensure completion of dementia assessment, a designated member of staff being allocated to check assessments had been completed each shift, and a departmental meeting highlighting the importance of assessment completion was held. The initial audit cycle identified 16% compliance; the re-audit identified a significant improvement of 88% compliance.
Management of inpatients with acute Heart Failure at QAH	This local audit highlighted that the majority of heart failure patients were admitted under Cardiology and most were seen by the specialist cardiology team in a timely manner. The results identified that no BNP (Brain Natriuretic Peptide) measurements were completed in hospital, and that not all patients admitted with heart failure had an ECHO (Echocardiogram). Poor follow up rates were also identified. Improvement actions implemented following this audit included the introduction of BNP testing in hospital and the recruitment of more Heart Failure Specialist Nurses. The changes implemented will improve the provision of early diagnosis of heart failure (according to NICE Guidelines), and it is hoped by the provision of more heart failure nurses patients will receive better management and follow up, especially for those admitted to non-cardiology departments.

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