NHS
Solent
NHS Trust

Solent NHS Trust
Quality Account 2018/19

Contents

Part One: Statement on quality from the Chief Executive

Introduction

Each year all providers of NHS healthcare services are required to produce an annual Quality Account for publication. The Quality Account sets out our commitment to continuous quality improvement and shows what we have achieved in the past year. It reflects and demonstrates the importance our board and our staff place on quality.

This is our eighth Quality Account since the Trust was established in 2011 and it is divided into three sections:

- Part One contains introductory statements from myself the Chief Executive, the Chief Nurse and Chief Medical Officer
- Part Two contains a review of our progress in delivery of our quality priorities for 2018/19, we also set out our priorities for improvement for 2019/20, and mandated quality statements and indicators as detailed in the *'Detailed Requirements for Quality Reports 2018/19'* published by NHS Improvement in December 2018
- Part Three contains details of other quality initiatives not covered elsewhere in the report and includes examples of quality improvement projects and patient stories from across our clinical servies which show how we have made a difference to patients

I hope this report provides a useful insight into our approach to quality, our performance and achievements, and our plans and priorities for the year ahead.

The Solent Story

At Solent NHS Trust we all share an ambitious vision to make a difference by keeping more people healthy, safe and independent in, or close to, their own homes.

People, values and culture drive us. The best people, doing their best work, in pursuit of our vision. People dedicated to giving Great Care to our service users, and great value to our partners.
We aspire to be the partner of choice for other service providers. With them we will reach even more people, and care for them through even more stages of their lives. Ultimately it is the people we care for who will tell us if we are successful and who will help shape our future care.

We know our vision is ambitious, but we have excellent foundations. Our priorities are what we do all of the time, they are how we:

Deliver Great Care
- Involving service users in shaping care and always learning from their experiences
- Working closely with partners to join up care
- Treating people with respect, giving equal emphasis to physical and mental health
- Ensuring we provide quality services, which are safe and effective

Make Solent a great place to work
- Supporting people to look after their health and wellbeing
- Improving the workplace by listening to ideas and acting on feedback
- Developing leaders to support and empower people in making a difference

Deliver the best value for money
- Spending money wisely and by working with partners
- Involving people in decisions about spending money
- Enabling services to have more time to provide care

Quality Framework

We launched our new Quality Framework in September 2018; it supports our vision and focus on making a difference to patients and their families and brings together how the Trust delivers Great Care in a way that is clear to patients, staff and our stakeholders

At the centre of the Framework is a formula designed to be easy for patients and staff to remember and relate to: **SEE** (Safe, Effective, Experience).

The Framework sets out:
- what quality means to Solent, its patients and staff in terms of Safe, Effective and Experience (SEE)
- the pivotal role our staff play and how we support them to deliver Great Care
- how we check the quality and standards of care in our services
- how we use innovation, research and organisational learning to continually improve
- governance, risk management and leadership arrangements for quality
- how we talk about quality at all levels of the Trust

The Framework will help us ensure that providing Great Care is at the heart of everything we do and we will be doing more work to embed it in the coming year.

Care Quality Commission

We were pleased to welcome the Care Quality Commission (CQC) to the Trust this year. I am delighted and extremely proud that following their inspections the CQC have rated Solent as "Good" overall and providing "Outstanding" care. Our Primary Care Services were inspected separately and were also rated as "Good" overall.

Within their reports, CQC identified several areas of "Outstanding" practice including:
- Our vision and purpose was found to be clearly stated and understood by our staff
- We have a holistic approach to ensuring mental health is part of overall health and not separate
- We have a positive culture developing across the Trust in respect of Allied Health Professionals (AHPs)
- Our strong medical leadership for supervision and training, alongside a quality improvement culture
- Our rates of Information Governance compliance and awareness resulting in our ranking as second out of 55 Mental Health Trusts on the Information Governance Toolkit
- The way we learn and improve when things don't go as planned and when there are positive outcomes for patients
- Our success in research and our top position in the National Institute for Health Research's annual league tables
- Our approach to actively engaging in collaborative work with external partners, such as involvement with sustainability and transformation plans, and our proactive approach to system changes and integration being essential for the future and to manage resources
- Outstanding practice in the Children's and Young People core service including:

- o The take up for the National Child Monitoring Programme (97.1%. compared to the national average of 90%).
- o The way in which the services used methods, such as Solent Young Shapers and the 15 Steps Challenge process, to seek the views of children and young people who used the services to support development and improvements to the services

We are especially proud that CQC found that our managers across the Trust promoted a positive and patient centred culture that supported and valued staff, creating a sense of common purpose based on our shared values and vision to make a difference to patients.

These results are a tribute to everyone who works in Solent; those who work directly with patients and in back office teams, to give consistently give Great Care, create a great place to work and to keep people safe and well at, or close to, home. I'm especially proud that the CQC found we are "Outstanding" at providing caring services; this reinforces what I see and hear every day about our innovative and inspirational patient care.

We pride ourselves on being an organisation with improvement and learning at its heart, and the CQC's report is a testament to that. There will always be areas where we can do better and there are some areas where more work is required. We are committed to making these improvements and continuing to improve the quality of care for our patients.

Quality Improvement Priorities

We are extremely pleased with the progress we've made in delivering the priorities we set for last year.   These were framed around our corporate strategic goals and were designed to provide a foundation for future quality improvements. Many projects will continue in the coming year.

Our trust-wide priorities for 2019/20 take into account the findings from CQC inspections and Staff Opinion Survey and this year each of our clinical services have identified their own priorities; all our priorities reflect staff and patient feedback and as well as national and local drivers. The service-led priorities resonate strongly with our frontline staff and will make a real difference to patients and their families.

We're Listening

Listening to our patients, their families and carers, our staff, people who live in the communities we serve, and our partners and stakeholders, helps us make sure we are doing the right thing.

Our overall Trust Friends and Family Test (FFT) results have been very positive this year with above 95% of respondents saying they would recommend Solent and below 5% saying they would not recommend us; this means we are consistently achieving the targets we have set ourselves and we score more highly than the national averages.   We review every source of feedack we receive, even if it is positive, and our services provide feedback on changes and improvements they've made as a result using "You Said, We Did" posters and bulletins and there are examples in this report.

We are also especially proud of our Staff Opinion Survey results for 2018. Results show we are among the best when compared with other combined mental health and community trusts, we are one of the top performing Trusts in the country for six key themes, and above average across all ten. We maintained excellent results in some important areas, and I am thrilled our engagement score, which tells us how staff feel about their work, has increased for the third year in a row. There are some other significant improvements such as staff feeling more valued and recognised for the work they do, and a significant increase in the number of people who would recommend Solent as a place to work.

The survey continues to highlight some challenges for example, staff can find it hard to take care of their own wellbeing, so I want to make sure Solent becomes an organisation where we achieve a balance between looking after ourselves and our patients. We also need to make sure we provide an environment where staff are able to speak up when they see and/or experience something that isn't right. To reflect their importance these are two of our Trust-wide quality improvement priorities for this year.

The 2018 results tell me staff feedback is making a difference, and we really are creating a great place to work. My commitment is to ensure that leaders and managers keep listening and making changes to improve the Trust for everybody.

Working Together
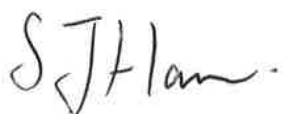
This year we developed our *Community Engagement Strategy* which will help us to address health inequalities, ensure we have meaningful involvement with our local communities and involve them in planning and decision-making. We held a very successful community engagement event before our Annual General Meeting in September which involved round-table discussions and a Q&A session between members of the Trust Board and a wide range of stakeholders. We plan to hold more events like this in future.

We have provided more opportunities for staff to talk directly to our leadership team such as CuriosiTEA events and Schwartz Rounds and have continued the *Solent Difference*, with many more staff taking the opportunity to share their story directly with colleagues through *The Difference* intranet page. These powerful stories shine a light on examples of great service and care that many people aren't aware of; it also encourages people to reflect on their own role and the many ways they make a difference to their colleagues or service users.

New for 2018/19

We are pleased to report on new aspects of our quality performance this year in relation to Speaking Up (whistleblowing), Doctors and Dentists in Training and Learning Disabilities Improvement Standards and in Part 3 of this report we provide insight into the various other ways we have improved quality over the past year.

I confirm that to the best of my knowledge the information in the Quality Account is accurate.

Sue Harriman
Chief Executive

Statement from Chief Nurse and Chief Medical Officer

Thank you for taking the time to read our Quality Account for 2018/19. It has been an incredibly busy and successful year when our focus has been to embed a culture of safety, continous improvement and learning, while we develop how we manage quality across the Trust. Below are some of the ways we have improved how we support our staff to deliver Great Care, made changes to our approach and the way we work, and how we plan to contine to improve in the year ahead.

Our new **Quality Framework** was developed and provides a clear blueprint to putting patient safety, clinical effectiveness and patient experience at the heart of everything we do.   We plan to further embed the Framework in 2019/20 by:

- reviewing our governance and assurance reporting arrangements to make sure the Quality Framework domains of Safety, Effective and Experience are reflected
- developing a communication plan to make the Framework more accessible to all of our staff
- evaluating the level of awareness and impact of the Framework at the end of next year

We are delighted our Primary Care services were rated "Good" following **CQC inspections** last year, and following inspection of other core services the Trust was rated "Good" overall and "Outstanding" in the caring domain. Achieving "Outstanding" in the caring domain reflects how well Solent NHS Trust involves and treats people with compassion, kindness, dignity and respect. The CQC repeatedly praised our staff for the commitment they show to patients, commenting that: "staff were kind, caring and treated patients with dignity and respect, and patients spoke of the positive care they received from staff". They said people "involved patients, and those close to them, in decisions about their care and treatment".

We have worked hard to ensure we have a strong quality improvement culture in the trust. The CQC were very complimentary of this culture, and said that people were proud to work for the Trust; "There was a positive organisational culture, which supported openness and transparency" and staff"spoke highly of their leaders".

The CQC's report identifies some areas where we need to make improvements and we will be adressing these in the coming year; some have been identified as **quality improvement priorities** alongside those developed by our clinical services. At a corporate level we have identified what we will do to support staff to deliver these priorities including:

- Developing the Ulysses system to improve the effectiveness of risk management and organisational learning from complaints, patient feedback and incident trends
- Implementing a consistent approach to developing new clinical roles across the Trust
- Developing and implementing an Organisational Safety Programme across our core clinical services
- Increasing access to research and improving the experience of being involved
- Continuing to foster a climate for learning, improvement and innovation across our organisation and community
- Strengthening patient and community involvement and engagement in improvement activity across the organisation

Our ambitous **Community Engagement Strategy** developed in 2018/19 sets out how we will build on the best engagement activities we undertake in Solent and ensure these are adoped widely across the organisation.   The Framework identifies how we will work more closely with our stakeholders including patients, families and carers, people who live in our communities, the voluntary sector and other public bodies. We are commited to improving the health and wellbeing of individuals by reducing health inequalities and seeking wider community involvement when setting our goals and vision, designing and delivering our clinical services, and evaluating services and making

improvements. We hope the shared culture and values, and ethos of collaboration and partnership with all of our stakeholders will become more embedded as we begin delivery of the strategy this year.

The **Solent Quality Improvement (QI) Programme** continues to grow in strength and impact, aiming to equip those that work with us (employees, patients and colleagues) with both the skills and confidence to identify, deliver and sustain improvements across our services. It has been extended this year to include 'Foundation Level' one day training to provide an introduction to QI methodology, as well as bespoke QI sessions within Trust leadership and development programmes. We have also delivered two cohorts (of 8 multidisciplinary teams) of our core programme which incorporates a facilitated QI project. A key part of the Foundation and Core programmes is the involvement of patients, service users and families in both identifying what could be improved and delivery and testing changes.

We have implemented our **Learning from Deaths** programme in line with the National Quality Board Guidance, with an emphasis on what we can learn to improve the care we provide to patients. The learning from deaths is shared at the monthly Learning from Deaths panel. If a mortality review indicates the need for a more thorough review or investigation then a strategy meeting is held and a decision taken as to the level of investigation required. All deaths which are investigated as a Serious Incident (SI) are presented to the same panel and the learning is recorded on the Verto learning log with review dates to ensure the change made has had a positive impact on the experience of patients, families and staff. In their recent inspection CQC commented that we have a very positive organisational learning culture, which supports openness and transparency and we are particularly proud of this achievement.

In response to the **Gosport War Memorial Independent Panel Report** we reviewed the findings and the Board received assurance that having completed an initial review, there were no risks identified which required immediate actions. However, we have put in place a plan to make improvements based on the findings in the report. In January 2019 the Trust Board received an update on progress against the improvement actions and a formal report was presented to Board in February 2019.

We developed our new **Learning Disabilities Strategy** this year which is an enabler to help us meet the Learning Disability Improvement Standards published in June 2018. In meeting these standards we will demonstrate we are delivering high quality services for people with learning disabilities, autism or both.   We have already made good progress and a summary of our current performance against each standard and improvement measures is in Section 3. Following approval by our Board we plan to launch the strategy at our nursing conference in May 2019.

We have now embedded **Accessible information** (AI) screening into all electronic patient record systems across the Trust. The screens have been designed to meet the requirements of the NHS England Accessible Information Standard (DCB1605 Accessible Information).

Looking ahead, providing Great Care remains remains our highest priority. Through this Quality Account we pledge our commitment to continue to support our staff to deliver the highest standards of quality across all the clinical services we provide, and in those clinical services where we work in partnership with others.

Jackie Ardley
Chief Nurse

Dan Meron
Chief Medical Officer

Part Two: Priorities for improvement and statements of assurance from the Board

2.1.1 Progress against Priorities for Improvement 2018-19

Our quality improvement priorities for 2018/19 were based on themes linked to our strategic corporate goals. The overarching aim of this approach was to create a sustainable dynamic framework of co-operative working which would deliver a shared vision and provide foundations for future improvement.

We are pleased to be able to report that significant progress has been made in the delivery of each priority and for the majority of these initiatives work will continue in 2019/20:

Priorities	Action/s to be taken	Progress
Theme 1: Involving People		
1.1 Embed a sustainable Community Engagement Strategy which is inclusive of patients, people who live in our communities, local partner organisations and external stakeholders.	• Development and delivery of a comprehensive action plan (Greater Together – Delivery Plan) to deliver the Community Engagement Strategy. • Development of Equality, Diversion and Inclusion (EDI) Strategy	• Delivery Plan complete and implementation led and monitored by new Community Engagement Committee which reports directly to Board. • Community Engagement data review is underway and due to report to Community Engagement Committeee in May 2019. The review is identifying gaps in the evidence base and providing an anlsysis that can be used to determine priorities to inform the Delivery Plan actions, so these are evidenced based. • External mapping of community and voluntary sector has been completed. This will be used to map engagement with the sector against relevent population group priorities (as evidenced in data review) against service line leads. • Engagement Communications Strategy in development to underpin the Delivery Plan and create a coherent narrative across business planning activities. • Business case developed for skills and competency work under the QI programme for community and service user enagement. • EDI Annual Report completed and discussed at Board. The new EDI Strategy is subject to further data analysis, which is being undertaken, in order to determine the Trust's equality objectives.
1.2 This will incorporate the use of assistive technology to successfully access "hard to reach" groups such as the frail, elderly and housebound in improving services.	• Use of AI to deliver the Community Engagement Strategy. • Research & Improvement (R&I) Team to use technology to support and learn how to engage	• Successful delivery of Community Engagement Event and Accessible Annual General Meeting (AGM) in September 2018 in line with Communication Access Standards. • Number of R&I projects that involve technology to increase access to

Priorities	Action/s to be taken	Progress
	with frail and elderly people receiving care in their home (housebound).	services and supported self-management. For example, Virtual Reality for mental health therapies, pedometers to improve physical health in mental health, and COPD; web-chat; and 'AI' for sexual health triage/ advice, particularly for high risk populations.
1.3 We will seek out and work with mental health patients and their families, and use them as subject-experts to ensure we meet their highly specific needs to make our environments as safe as possible for them. We will also be able to demonstrate learning from their experiences, and from the very precise knowledge patients can be enabled to share with us.	• We will develop a link role with Solent MIND; the post holder will work with patients and carers to ensure their views are sought and considered when we are developing our services. Members of our Patient Forum are invited to attend our Clinical Governance meeting and Solent MIND represent patients and their families at Solent other user groups and forums. • We will actively engage patients and their families in our forthcoming Quality Improvement Projects such as Older Peoples Care Planning, developing joint pathways with Southern Health, reducing violence and aggression on in-patient units and consulting with patients during ward remodelling about their preferences regarding furniture and art work • During the vanguard remodelling in our Substance Misuse service we plan to consult extensively with service users about their environmental preferences.	• Link role with Solent Mind has now been developed and recruited to. This post holder will bring patient and carers views to appropriate meetings and discussions. • Patients and carers have formed part of QI projects in varying degrees. Patients have also chosen art work and furniture in our inpatient wards. • Patients and carers have been consulted throughout as we have remodelled our Substance Misuse Service and we have taken their feedback into account when designing the new environment
1.4 We will increase our engagement with local Healthwatch groups, to ensure they are aware of our most up to date quality work. A measurable outcome will be held within records of these meetings and their opportunity to feedback real-time quality comments to further improve our relationship and functional work dynamic with our partners.	• Healthwatch to be invited to specific forums and events e.g. the Complaints Scrutiny Panel; the Annual General Meeting • Healthwatch to be involved in projects e.g. the complaints quality improvement project	• Healthwatch are active participants in the quarterly Complaints Scrutinty Panel. They were also active participants in the Annual General Meeting • A member of Healthwatch Portsmouth was a member of the QI project which worked on the local resolution process
Theme 2: Ensuring Safe Care		
2.1 Launch the Research and Improvement Academy. Using different learning	• Research Academy to be formally launched in July 2018.	• Academy of Research & Improvement launched in July 2018, including a new website.

Priorities	Action/s to be taken	Progress
approaches which our staff will be able to access at home or at work. The quality of care will improve as a direct result of staff working within an active learning culture, where the everyday norm is looking for improvement.	• Structured programme of learning opportunties to be introduced, including face to face, and through facilitated projects, workshops and masterclasses. Also to be made available as online materials	• Prospectus outlining support, opportunities and training events published, both in hard copy and online • Annual programme of learning events, and facilitated projects in place including extended scope for QI programme
2.2 Roll out the QI Leaders programme. This is aimed at all staff, both clinical and non clinical.	• Funding obtained from HEE Wessex to trial QI Leaders programme – cohort of 10 'leaders' recruited, to start their training in December 2018	• 8 QI leaders mid-way through a leadership programme. • This will form the first cohort of QI coaches that can support teams within services across the organisation. Second cohort to be advertised in Autumn 2019
2.3 Ensure patient safety is integrated and evidenced through documented one to one supervision conversations and pre-set personal outcomes for learning.	• Supervision policy to be reviewed and updated • Safety to be a focus of discussions with Professional leads and Matrons during Q3/2018 • Addendum to Clinical Supervision Policy to strengthen approach to 'eyes on practice' will be made emphasising link to safety and learning • Safety will be integrated into the Appraisal process and linked to personal development	• The Clinical Supervision and Safeguarding Supervision policies have been reveiwed and updated • Safe Staffing meetings have been introduced at which patient safety is considerd and discussed. Actions are taken when indicated. • Services across the Trust have introduced 'eyes on practice' through shadowing and some areas have introduced quality peer reviews
Theme 3: Learning and Improving		
3.1 Utilise the Learning from Deaths and Serious Incident Panels to learn, implement and disseminate positive change	• Learning when a change is identified that can be monitored, is tracked through "VERTO" and reviewed at future panels • Professional Leads to disseminate learning thorugh their service line governance structures • Different methods of dissmeninating learning to be piloted piloted e.g. Biteable videos • A shared learning page on the Quality and Professional Standards page to be developed • Establish good working relationships and links with the Research Academy teams-including clinical effectivemess and audit	• VERTO continues to be a successful process to monitor and track changes. The updates and progress, change outcomes continue to be monitored at panels • The Service Line Professional Leads use a variety of methods to disseminate learning, including local meetings and newsletters. • Other methods for dissemination continue to be piloted. A learning zone is under construction on the intranet to enable staff to access learning outcomes form a variety of sources • The Quality and Safety team held a joint meeting with the Research and Audit Team and continue to consider ways to collaborate and work together. The learning framework development work continues in collaboration
3.2 Launch a change and improvement database	• Establish the database/learning collection tool • Gather learning at SI and LfD panels • Allocate leads for each action and establish process for evidencing the improvements have been embedded in practice and shared across	• VERTO is now live, the action spreadsheet was transfered onto the live system in late December 2018 • Learning is noted for VERTO tracking at SI and LfD Panels. • Work continues to develop the learning zone. Once this is constructed extracts from VERTO can be added for all staff to access

Priorities	Action/s to be taken	Progress
	• the organisation • Make database accessible via SolNet	
3.3 Develop a toolkit for learning from excellence	• Reverse SI's carried out and learning shared • Favourable event reporting piloted and being implemented into trust wide reporting system. • Trust wide launch to happen early in 2019 • Materials on SolNet	• Appreciative enquiry carried out with 'reverse SIs' and shared via SI panel and Learning & Improvement Group • Learning Strategy & Framework developed with Delivery Plan in place for 2019 • Favourable Event reporting built into Ulysses system, with new branding, and paper copy to be made available • Materials available on SolNet with videos to share learning • Research & Improvement Conference 2019 themed around learning from excellence
3.4 Evidence the improvements as a result of learning and change	• Clinical Audit and Evaluation report templates to identify improvements rather than just completed actions to be put in place • QI projects to focus on outcomes and change (including skills development for teams)	• Improvements and learning captured in reporting templates, and reports to service line and Board committees – this applies to all Clinical Effectiveness and QI activity • Case studies now written for each project for easy to access summaries, to include outcomes and learning
	• Establish the use of "VERTO" to monitor and evidence change impact • Evidence of the learning to be reviewed at panels and the evidence of the product embedded and the value/change it has resulted in reviewed and discussed	See section 3.2 above
Theme 4: Sharing excellence		
4.1 Continue to present at local or national conferences on subjects of interest and expertise	• We will Increase the number of local and national conferences we present at. For instance, plans for 10 posters at the HEW Patient Safety and QI conference, including a prize winner; presentations at Health Services Research UK, R&D Forum – present jointly with patients; International Sexual Health Conference; International Quality Conference; National Falls and National Geriatric Society Conference; International SLT Conference	• Strong conference attendance, including presentations. Number of keynote talks given from Solent at national events, including NHSI patient experience conference
4.2 Work with system partners to ensure they are fully briefed on our most up to date improvement work	• QI programme to be open to external partners. • Training to be delivered to CCG in Hants, and joint teams in Soton and Portsmouth (eg Care Homes, PRRT, Autism Pathways)	• External partners, colleagues and patients are on the majority of QI teams. • Training completed

Priorities	Action/s to be taken	Progress
4.3 Work towards identifying all people with a learning disability and/or communication disability accessing any of our services and provide appropriate adjustments to support person centred planning	• Communication and information needs will continue to be collected via Accessible Information Screening available on all electronic patient records • Schedule analysis of contacts to investigate how services are meeting the specific communication and information needs of patients • Share best practice examples of Easy Read care plans and develop new templates to be made available on SolNet • Develop Easy Read / Accessible versions of Education Health & Care Plans	• Accessible Information screening embedded into all electronic patient records • Analysis of contacts as of February 2019, 11,646 discussions about communication and/or information needs have been recorded • Of these, 5,020 people went on to have a full accessible information screen completed. Through screening, 1,941 people with communication and/or information needs were identified, which equates to 39%. • There is a high proportion of people requesting information in a verbal format; provision of audiovisual information remains low
4.4 Replicate outstanding success factors from the learning disability service across other service lines	• Evaluate the impact of the Portsmouth CAMHS-LD accessible sleep help resources in relation to self-management and the teams productivity. • The Trust will develop a trust wide Learning Disability Strategy to be launched in Spring 2019. The Strategy will ensure the Trust meet its responsibilities within the Learning Disability Improvement Standards as set out by NHS Improvement in June 2018	• The 'Sleep Help' resources were launched in February 2019 and can be access via the Solent Healthier Together website: https://www.what0-18.nhs.uk/solent/camhs/sleep-help • Our new Learning Disabilities Strategy has been developed and approved by the Trust Board; the Strategy will be launched across the Trust in May 2019 • Section 3 of this Quality Account provides details of our progress in implementing the new national Learning Disabilities Improvement Standards
Theme 5: Supporting vulnerable people		
5.1 Further embed Mental Capacity Act (MCA) and Safeguarding training across our services	• Strengthen links with MCA lead for the Trust • Review MCA training offer and ensure people can access case based learning • Review Safeguarding trainng to maximise attendance	• The Trust has agreed to implement the national cometpency framework and the 4LSAB toolkit both of which will be rolled out across the Trust in 2019/20 • The Trust has invested in a MCA training role which will support implementation fo the cometpencies and toolkit as well as delivering scenario based training to all clincal staff. In 2018/19 we have seen significant improvements in compliance with MCA and safeguarding training
5.2 Develop our capabilities in the application of the MCA and safeguarding principles	• Consider adopting the National Competency Framework for staff across the Trust • Develop a scenario based trainng to support frontline practice • Work with colleagues across the 4LSAB's to learn from SAR's and embed learning in practice	• As above • Learning and actions as a result of SARs have been discussed at Safeguarding Steering Group

Priorities	Action/s to be taken	Progress
5.3 Ensure senior managers and the Executive Team attend MHA-specific training to use as a senior information resource for staff	• Work with MH Lead to develop trainng for senior managers and executives • Deliver training to senior managers and executives • Develop resource pack for senior managers to support decsion making and to enable high quality advice to staff	• The resource pack for senior managers will be delevoped when the newly appointed MHA lead is in post early in 2019/20
Theme 6: Looking after each other		
6.1 By promoting equality and diversity initiatives	• Establish forums to engage with diverse staff groups across the organisation such as LGBTQ and BAME • Launch of Commuity Engagement Strategy and EDI Strategy (see 1.1 above) • Creation of Carer's Staff Network	• LGBT+ Staff Network: survey monkey questionnaire completed by 29 respondents. Focus group held on 5th December and attended by 5 people. Terms of refrerence agreed. Date of next meeting to be confirmed in April. Launch of network planned for NHS National Equality, Diversity & Human Rights week commencing 13th May. • BAME Staff network: survey monkey questionnaire completed by 11 respondents. Focus group to plan next steps taking place on 24th April. • Staff Who are Carers network: survey monkey questionnaire completed by 28 respondents. Focus group took place on 12th February and attended by 6 people. Terms of Reference to be developed by small group and plan of meetings to be announced. • Launch of EDI strategy has fed into the launch of the Community Engagement Strategy
6.2 Supporting openness about mental health challenges	• Increasing participation and awareness of the work undertaken by the Health & Wellbeing Group incorporating OWLES agenda (Optimising, Wellbeing & Lived experience of staff)	• Health & Wellbeing Trust wide group meets bi-monthly and has delivered the 2018/19 associated H&WB Plan linked to H&WB CQUIN • Our OWLES membership (Optimising wellbeing and lived experience of staff with MH problems) continues to grow and supports staff with MH problems and encourages open conversations and support network
6.3 Developing our apprentices and reviewing their planned progression	• Career conversations with services and individuals regarding staff development and progression. Identification of staff that wish to progress thorough an apprenticeship and ensure they gain the correct entry requirements • Quarterly reviews with apprentices and their managers • Careers events promoting apprenticeships	• Career conversations with adult mental health bands 2 and 3 completed • Career conversations offered to all services and individuals • 80 apprenticeships started since 1/4/2018 • Increased uptake of functional skills in Maths and English for preparation of apprenticeship • Quarterly reviews on target for all apprenticeships • Attendance at career events at local schools for year 11 and at sixth form colleges
6.4 Increase health, well-being and resilience learning and development opportunities	• Shift Your Stress Online Programme focused on boosting resilience and managing workplace	• On-going development of self-help resources and support mechanism. • Solnet pages refreshed with a dedicated Mental Health page with

Priorities	Action/s to be taken	Progress
	stress • Mindful and Stress Buster workshops • Exploring Wellbeing in Practice workshops	resources and how to access help when needed • Proactive communications platforms have been available to include; regular staff briefings for employees and managers, social media , SolNet health & wellbeing pagers, newsletters, focused awareness campaigns, stress buster workshops, mindfulness workshops and online initiatives e.g. Shift your Stress, Kaido Wellbeing and Mindfulness online sessions
6.5 Creating internal and external opportunities for professional and personal development as part of on-going strengths based performance appraisal and talent management	• Following feedback from Exit Inteviews , review annual appraisal to develop more conversational approach which is focussed on career development • Development and delivery of new L&D Stragegy which includes expanision of Apprenticeship programme, launch of development tool to enable staff to map their career journey, creation of more CPD opportunities and leadership training delivery	• Annual appraisal has been refreshed and presentations have been provided to team meetings on how to get the most out of the appraisal. Career conversations have been provided to groups as requested by the Learning & Development Department • Draft Learning & Development Strategy has been endorsed by the People and Oganisational Development Committee and will be finalised by the end of March 2019 for launch in May 2019. • Interactive career tool continues to develop
6.6 Rewarding excellence in our people, by the use of nominations for national award schemes, internal awards and celebration events.	• Solent Conference including Research & Improvement Awards • 2 Celebration events a year for Research & Improvement projects	• Solent Awards event confirmed for 6th June 2019; will include Research and Improvement Awards. • Additional celebration events for Research and Improvement are planned

2.1.2 Priorities for Improvement 2019-20

This year in addition to identifying Trust-wide priorities, each of our clinical services have developed their own quality improvement priorities. These are framed around our Quality Framework domains of Safe, Effective and Experience and take into account local and national priorities, our business plan objectives and recent CQC inspections. Progress will be monitored through governance meetings in clinical services and the Trust's Quality Improvement & Risk Group and reported to our Assurance Committee and the Trust Board.

Trust-wide

SAFE, EFFECTIVE, EXPERIENCE			
Priority 1: Deliver the Learning Disability Strategy across all Trust services			
Why we chose this as a priority and what it means for patients:	Patients with a learning disability are more likely to have poorer health and die at a younger age than the general population. This is mainly due to unmet health needs due to difficulties identifying and addressing health concerns. We have developed our 3-year Learning Disability Strategy to enable us to build on existing good practice of providing support to this vulnerable group and to improve engagement and co-production. The Strategy is also an enabler to support delivery of the new national *Learning Disability Improvement Standards* and performance indicators introduced in June 2018.		
What we are planning to do:	In year 1 (2019/20) of the Strategy we will: - Run staff awareness sessions and Expert by Experience training - Update resources for all staff around "reasonable adjustments" with clearer access within SolNet and the introduction of "grab guides" for common issues - Review how clinical services are making their information accessible and explore the benefits of existing resources (e.g. Books beyond Words) - Explore how our electronic patient records can improve the "flagging" of patients with a learning disability that results in consideration of vulnerabilities and the need for reasonable adjustments - Make links to local external learning disability support networks with the support of Healthwatch - Develop, and trial, a system of "quality checking" that includes patients with a learning disability - Liaise with local external specialist services to explore voluntary work, paid work, or, apprentices for people with a learning disability in Solent - Recognise that many Solent staff will have family members and friends who have a learning disability and include "signposting" information within SolNet		
Performance measures:	**Proposed Measure:** Strategy Delivery Plan for Year 1	**Target:** - Finalise Year 1 Delivery Plan by 30th May 2019 - Deliver all Year 1 actions in 2019/20	**Reporting Cycle:** Report progress on Delivery Plan to Steering Group and QIR three times a year in July, November & March.

EXPERIENCE

Priority 1: Ensure all staff understand their responsibilities for Duty of Candour

Why we chose this as a priority and what it means for patients:	Duty of Candour is a legal responsibility for Trusts and healthcare professionals to be open and honest with patients when something that goes wrong with their treatment or care (moderate harm or above). From our own Serious Incident Panels we were aware that our staff had variable understanding of their responsibilities under the duty of candour requirements and this was highlighted in our CQC inspection report published in February 2019.
What we are planning to do:	• Revised *Being Open and Duty of Candour Policy* developed and to be approved in 2019. • The policy has been completely re-written to make clear Duty of Candour thresholds and requirements and distinguishes between these legal requirements and staff doing the right thing by saying sorry when things go wrong. • Develop and deliver general Duty of Candour training across the Trust to launch the policy • Update mandatory Duty of Candour training

Performance measures:	**Proposed Measure:**	**Target:**	**Reporting Cycle:**
	• Survey Monkey to assess staff level of understanding to be conducted before and after launch of new policy and training delivery • Monitor through Serious Incident Panels	• Survey Monkey to be repeated with target to show an improved understanding following policy launch and training roll-out • SI Panels to show increasing numbers of appropriate investigations have Duty of Candour requirements met	• Policy launch by June • Mid-year survey/ reporting in October 2019 • End of year survey/reporting in March 2020

Engagement and consultation:	Revised policy circulated to clinical services for comments

Priority 2: Ensure all staff are aware of and know how to access our Freedom to Speak Up Guardians

Why we chose this as a priority and what it means for patients:	*Freedom to Speak Up* is a national initiative to enable a more open and supportive culture that encourages staff to speak up about issues of patient care, quality or safety. Our CQC inspection report published in February 2019 stated that staff in some teams had limited understanding about the Freedom to Speak up Guardian role
What we are planning to do:	• Review the Freedom to Speak Up Communication Strategy to re-establish and refresh the identity of the Guardian role • Develop and implement a plan to deliver the FTSU Comms Strategy • Increase the FTSU Guardians visibility and accessibility by visiting services, attending Team Meetings, running workshops and drop-in sessions, etc.

Performance measures:	**Proposed Measure:**	**Target:**	**Reporting Cycle:**
	• Strategy completion • Strategy Delivery Plan established • No of contacts and referrals • Locations of cases	• Strategy to be refreshed by April 2020 • Strategy Delivery Plan to be in place by April 2020 • Sustained increase in referrals and contacts	Quarterly

Priority 3: Support our staff to maintain their on-going health and well-being			
Why we chose this as a priority and what it means for patients:	Staff health and well-being is important to patients because staff that are healthy and happy at work are better equipped to deliver the best care. There are national and local drivers for improving the health and well-being of staff including *Thriving At Work* which focuses on mental well-being, and contractual CQUIN targets and contractual service improvement requirements. Our 2018 Staff Survey results published in February 2019 have improved 3 years in a row; however results highlighted challenges some staff face finding the time to take care of their own health and well-being. Although this is an area which has shown improvement year-on-year we want to continue to ensure our staff are equipped to take care of themselves and have access to support when they need it.		
What we are planning to do:	• Develop service improvement plan to deliver *Thriving At Work* (mental well-being) • Deliver all elements of *National Health & Well-being Framework* including development of stress trigger tools, self-awareness guides and self-help tools as well as where to find help from the Trust and other sources • Explore use of national ("Britain's Healthiest Workplace") monitoring tool for use at organisational level		
Performance measures:	**Proposed Measure:** • Staff Survey • Staff Absence Rates • Staff Turnover • Employee Assistance Programme (EAP) Utilisation Reports – analysis of usage/ topics accessed • Britain's Healthiest Workplace (BHW) monitoring tool (if adopted)	**Target:** • Overall Health & Well-being score in Staff Survey is 6.5 in 2018 – continual improvement against this score • Absence and staff turnover rates to be maintained or reduced • EAP – decreasing access to work-related stress/ well-being topics • Britain's Healthiest Workplace monitoring tool (if adopted) - continual improvements against benchmark	**Reporting Cycle:** Staff Survey – annual Absence & Turnover – monthly EAP – quarterly BHW tool - TBC

Adults Services Portsmouth

SAFE	
Priority 1: To improve the dressings process in Portsmouth	
Why we chose this as a priority and what it means for patients:	We want to improve patient's access to the most economical effective dressing and reduce delays in ordering processes. It is not unusual for there to be delays of up to 6 weeks in dressing's processes and historically we have had a high number of incidents due to dressing's delays and prescribing processes were lengthy. In order to raise standards we have implemented sign-in and sign-out processes for dressings. We have sought pharmacy advice to work with community nurses to ensure the stock list is as economical as possible and effective. We have worked with services and GPs to pilot electronic processes to speed up prescription request. We now have the capability to order using System1 tasks and the S1 function links directly with pharmacy. A pilot with two GP practices and one pharmacy has been successful.
What we are planning to do:	We plan to roll out the new systems and processes developed in the pilot across the city in April 2019.

Performance measures:	**Proposed Measures:** • Reduction in delays in dressings • Reduction in complaints about dressings.	**Target:** Dressings to be available within 2 days of prescription.	**Reporting Cycle:** It will be audited October 2019 & March 2020.
Engagement and consultation:	We have listened to feedback from our patients from PALS and complaints.		
Priority 2: To improve the NEWS2 process in Portsmouth			
Why we chose this as a priority and what it means for patients:	NEWS2 is a standardised approach to recognise and care for any patients who may deteriorate in our care. On 3rd September 2018 NEWS2 was launched across the Trust. Prior to launch community nurses and support staff were trained via the National NEWS2 E-Learning module and face to face training sessions, supported by podcasts and other eLearning resources including access to an accredited App that informed and supported learning. Training included what's changed from the original NEWS assessment tool, situational and scenario based training and practical sessions on completing a NEWS2 assessment. Escalation guidance was also provided. Since the launch date NEWS2 has been used in community nursing when assessing patients who are suspected to have or be at of risk of deteriorating.		
What we are planning to do:	• Continue to update and support learning regarding NEWS2 to all staff - new and existing • All clinical staff are required to revisit and refresh competencies yearly, on return from long term leave or if practice issues occur		
Performance measures:	**Proposed Measures:** • Daily review of incidents	**Target:** • NEWS2 to remain embedded in clinical practice • Daily review of all incidents and the use of the NEWS2 assessment and any actions taken: Escalation if any and appropriateness of escalation responses • Incident management will measure all actions and the	**Reporting Cycle:** It will be audited October 2019 & March 2020.

	benefit to patients is timely assessment, appropriate response and care	
Engagement and consultation:	We have listened to feedback from our patients from PALS and complaints.	

EFFECTIVE

Priority 1: To set up a pilot long-term conditions hub in Portsmouth

Why we chose this as a priority and what it means for patients:	We will pilot a central hub in Portsmouth between Primary Care and Solent NHS Trust where patients with respiratory conditions and diabetes will be seen. The hub will have improved access to psychological therapies offering holistic streamlined care to patients and improved clinical outcomes which will be measured. We chose this priority as a business objective in Portsmouth as part of a system wide delivery governed by the Multispecialty Community Provider (MCP).		
What we are planning to do:	The LTC hub will address issues of duplication and variation in care, as activities traditionally conducted in general practice would transfer to the remit of the LTC Hub under the leadership of a Multi-Disciplinary Team (MDT) following a standardised, evidence-based approach to care management. In order to harbour an environment for improved multi-disciplinary working, staff from primary, secondary, and community care will pool together in the LTC Hub, enabling opportunities for individuals to bring learning and best practice back to their host organisations. In order to address the issues outlined above regarding patients' involvement in their care, the model includes patients being assessed for both their clinical and wellbeing needs and a holistic care plan being developed, with easy referral to a range of support organisations, statutory and non- statutory. This is in line with national and local strategies, *Portsmouth Blueprint for Heath and Care,* which include a focus on improving the management of LTCs. The service objectives for the Hub are outlined as delivery of: • Reduced variation in care, through standardised pathways (which enables personalised care) • Enhanced MDT support and more comprehensive care planning, improving outcomes • Increased levels of self-management and patients engaged in education • Reduced chance of patients reaching crisis • Improved diagnostic accuracy • Increased appointment availability and choice, with the aim of reducing DNA rates, at early stages of the disease. In addition, there are a series of other non –patient benefits, including: • Reduced training burden on individual GP practices • Up-skilling of primary care workforce through rotational input into the Hub • Reduced isolation of community staff through MDT support • Reduced clinical risk through all staff accessing full medical records • Real time updates of the clinical record		
Performance measures:	**Proposed Outcome Measures:** KPIS to be agreed by	**Targets:** To achieve key project milestones in year 1: pilot start date: April 2019, for an 18 month period with a 9 monthly review and a	**Reporting Cycle:** Quarterly

	28/02/19 and include: • Quality measures • Outcome activity • Patient activation measures • Data collection will be built into IT system • Patient questionnaires further 6 months to finalise recommendations and/or plan for exit or extension.
Engagement and consultation:	The Communications and Engagement Strategy due in March 2019 will include patient leaflets and engagement with Health Watch.

Priority 2: To pilot a leg ulcer hub in Portsmouth

Why we chose this as a priority and what it means for patients:	Chosen as a system piece of work in order to rationalise and provide cost effective care in one place for patients with leg ulcers. The hub will also enable skills transference between practice nurses and community nurses. It will make it easier for staff to sign off their competencies and will enable practice nurses and community nurses to see more patients as they will be brought to the hub.
What we are planning to do:	We will pilot the hub in May 2019. The hub will be evaluated and rolled out at scale following the evaluation.

Performance measures:	**Proposed Measure:** • Reduction dressing costs • Improve learning/ training and competency and mentorship • Reduce recurrence rates • Reduce need for secondary care • Reduce appointment times	**Target:** • Reductions against all proposed measures • Adherence to Solent Leg Ulcer SOP 2017	**Reporting Cycle:** Via MCP evaluation. Will be audited September 2019

Engagement and consultation:	The pilot will include a full evaluation of service user experience and stakeholder feedback.

EXPERIENCE

Priority 1: To pilot an intermediate care practitioner role and crisis GP within PRRT (Portsmouth Rehabilitation and Re-ablement team)

Why we chose this as a priority and what it means for patients:	We chose to do this pilot in response to system pressures within the Portsmouth system.
What we are planning to do:	We are going to pilot the implementation of an intermediate care practitioner and crisis GP role within PRRT. This will enable the team to deal with patients with higher acuity which will relieve system pressures and enable patients to receive timely care.

Performance measures:	Proposed Outcome Measures: • Prevention of unnecessary hospital admissions • Enable more frail elderly patients to be nursed in the community	Pilot Targets: To be determined once data baseline established in July 2019	Reporting Cycle: Via MCP evaluation starting in September 2019
Engagement and consultation:	MCP project as a pilot. Once pilot has completed there will be a comms plan from the MCP. The evaluation will include service user and stakeholder feedback.		

Priority 2: To reduce discharge delays in Jubilee House

Why we chose this as a priority and what it means for patients:	We have a number of discharge delays in our inpatient units and we wish to reduce these in order to achieve timely discharges for all our patients irrespective of final destination. This will ensure the patient, carer and staff experience is enhanced and the discharge is safe for the patient.		
What we are planning to do:	1. Establish data regarding the length of stay broken down into patient groups in Jubilee House • End of life • Continuing Health Care Assessment • Bridging patients (admitted from PHT and community) 2. Confirm project lead 3. Review all internal processes from admission to discharge including; • Admission criteria and local policy • Information provided to patients and relatives • Managing expectations of all concerned • Referral & triage process 4. Review external processes and national standards within which we are required to work including ; • Continuing Health Care process • Fast track and end of life contracted resource • Social service support for those patients who do not meet the above • Greater understanding of support services such as PRRT, community nursing and community nursing support service (CNSS) previously known as 'Blue team'		
Performance measures:	Proposed Measures: • Length of stay • FFT • Complaints • 28 day CHC tracker	Target: To be determined once data baseline established.	Reporting Cycle: Monthly internal
Engagement and consultation:	Contact will be made with all appropriate external partners as required.		

Adults Services Southampton

SAFE			
Priority 1: Red and Green Days at Royal South Hants Hospital			
Why we chose this as a priority and what it means for patients:	Red and Green Bed Days' are a visual management system to assist in the identification of wasted time in a Patient's journey. This approach is used to reduce internal and external delays as part of the SAFER patient flow bundle. At the centre of the system is the person receiving acute care whose experience should be one of involvement and personal control, with an expectation of what will be happening. It links flow, safety and reliability and has a pro-active escalation process.		
What we are planning to do:	To reduce the length of stay to 20 days or under in our Royal South Hants Hospital wards, Fanshawe and Lower Brambles, by implementing a community bed adapted safer patient bundle and red and green days. This is supported by Discharge to Assess care packages to prevent delayed transfers of care. This will then support flow through the wider healthcare system.		
Performance measures:	**Proposed Measure:** Daily electronic reporting tool completed 5 days a week (Mon-Fri) with identified associated escalation processes in place.	**Target:** - To collect data to set baseline of red days April 2019 to support identifying agreed % target - The target will be a 10% reduction in red days over the year - In reducing reasons for internal red days, aim to pre-empt external red days to support patient flow.	**Reporting Cycle:** Quarterly reporting
Engagement and consultation:	Multi professional engagement required including social services. Launch meeting held in September 2018. Requirement of success to have data retrieval - to enable set support setting % targets - with transformation.		
Priority 2: Chronic Obstructive Pulmonary Disease (COPD) , Pulmonary Rehabilitation (PR) Audit			
Why we chose this as a priority and what it means for patients:	We know patients who complete PR have less exacerbation, improved Health Related Quality of Life (HRQOL), reduction in risk of admission and the associated complications of this. If patient are referred for assessment for PR they are assessed by a specialist service and optimised, further improving their care. One area that has been reported by us to be below the national average is primary care referrals. The national average is 51 % and the referrals to the team were 38 %. We will engage in the COPD national Pulmonary Rehabilitation (PR) audit which commences in March 2019. We had previously participated in sporadic tri-yearly audits; this is now continuous data collection which should deliver QI initiatives and practical implementation outcomes to improve patient care and safety. This will help to give an overview of many aspects of our interventions and collate key performance indicators (KPIs). This will help with service evaluation in-line with clinical guidelines and best practice to optimise patient safety.		
What we are planning to do:	Complete the COPD national Pulmonary Rehabilitation (PR) continuous audit which commences March 2019		
Performance measures:	**Proposed Measure:** Look at % of patient referred to PR from GP practices (GP or Practice Nurse)	**Target:** Increase this by 15%	**Reporting Cycle:** Every other month

EFFECTIVE	
Priority 1: Project to assess and manage pain on Snowdon Ward	
Why we chose this as a priority and what it means for patients:	We chose this priority as it has been highlighted from a documentation review and structured interviews with staff and patients that there is a requirement for a more robust conversations/ assessment around identification, recording and managing of patient's pain. This can be especially challenging when patients have communication and cognitive impairments. We chose this so we can up skill all staff to feel confident to discuss and assess pain with patients, which will lead to more effective pain management for patients.
What we are planning to do:	Under take a QI project to clearly define the current position and address issues identified through use of QI tools and staff training.

Performance measures:	**Proposed Measure:** Documentation audit to check patients have an appropriate pain assessment and management plan.	**Target:** 85% of patients reporting pain will have a full assessment and plan of care to support pain management.	**Reporting Cycle:** Documentation audit at start and finish of project – months 1 and 6 to 9
Engagement and consultation:	Engagement with patients and staff at all levels, senior managers, matrons, Clinical Director and Professional Lead.		
Priority 2: The Women's Health Project			
Why we chose this as a priority and what it means for patients:	1 in 3 women experience stress urinary incontinence and 1 in 10 will experience overactive bladder symptoms. 1 in 2 postmenopausal women will experience prolapse symptoms. Conservative management is the first line treatment prior to secondary care and can help in up to 70% of cases avoiding surgery and consultant management. It allows women in Southampton to self-refer/GP refer and receive first line treatment to help improve their quality of life and reduce symptoms.		
What we are planning to do:	• A physiotherapist will be in post to assist with managing and treating women experiencing Bladder and Bowel symptoms. • Deliver in-service training and arrange regular company representative updates to ensure service provision remains up to date with new treatments. • Reporting outcomes to interventions to measure effectiveness with baseline and post treatment ICIQ (International Consultation on Incontinence Questionnaire) scores.		
Performance measures:	**Proposed Measure:** Measure the effect of the women's health service for bladder and bowel conditions through utilisation of a Quality of Life measure.	**Target:** 50% improvement in quality of life measures over a one year period starting Nov 18-19	**Reporting Cycle:** Jan 2019 April 2019 July 2019 October 2019 Jan 2020
Engagement and consultation:	We have engaged frontline staff to ensure they are aware of the outcome measures we need recorded. We have spoken to operational staff as we have to supply quarterly reports with performance outcomes on. Consultation with Southampton CCG occurred to get gain funding the new physiotherapy service.		

EXPERIENCE			
Priority 1: Implementation of My Medical Record (MMR)			
Why we chose this as a priority and what it means for patients:	Supporting self-management of long term neurological conditions is a key national and local priority. Solent is working in partnership with University Hospitals Southampton to deliver a digital platform called "My Medical Record". The platform has been developed in partnership with staff and patients and My Medical Record sites are live for multiple sclerosis, motor neurone disease, Parkinson's Disease, epilepsy and Huntington's Disease. Patients are be able to: • see their clinical documents • see their upcoming appointments • see their test results • send secure messages to their clinical teams • read condition specific information • see information on clinical trials and find out how to take part • complete health outcomes questionnaires • complete online health diaries to share with their clinical teams • co produce online care plans to document patient centred goals and outcomes		
What we are planning to do:	Roll out the platform to a wider number of patients. Increase the interaction between patients and staff on MMR		
Performance measures:	**Proposed Measure:** Increased number of patients accessing MMR (current uptake 70)	**Target:** In partnership with UHS, 250 patients will be registered on MMR to support their ability to self-management by end March 2020.	**Reporting Cycle:** Quarterly reports from UHS.
Engagement and consultation:	Solent staff, UHS staff, Patients across SNRS and UHS services.		
Priority 2: Improved Pathway for City patients into CR2/CR3			
Why we chose this as a priority and what it means for patients:	Percutaneous Cardiac Intervention patients should be seen within 2 weeks of a referral being received. This wasn't happening as the CR2 clinics which were often booked up in advance so patients were waiting longer to be seen and start cardiac rehabilitation. Seeing patients within the correct time frame enables us to pick up any problems earlier, answer any questions they may have about their cardiac event, help them maintain their overall health and wellbeing, start returning to life prior to their event and may reduce hospital admissions		
What we are planning to do:	Move the assessment to a community cardiac rehabilitation venue where a class is taking place as we have more staff available due to patient numbers to undertake the assessment.		
Performance measures:	**Proposed Measure:** Number of patients seen within 14 days of referral measured on City KPI. 100% for months 9 & 10 2018/19.	**Target:** Increase in the KPI for this measure	**Reporting Cycle:** Monthly
Engagement and consultation:	Staff within service and patient feedback through current patient experience format.		

Child & Family Services

SAFE	
Priority 1: To ensure assurance tools and governance processes are in place to ensure those at risk of Childhood Sexual Exploitation (CSE) are identified and appropriate interventions put in place	
Why we chose this as a priority and what it means for patients:	Young people under the age of 18 can be at risk of childhood sexual exploitation and therefore it is important that a risk assessment is completed at each visit as this can highlight concerns.
What we are planning to do:	We would want to ensure all children seen by our services over the age of 13 are screened using the CSE tool and appropriate referrals are completed if risks are identified.

Performance measures:	**Proposed Measure:** Overall number of completed CSE assessments in 18/19 as a baseline and then quarterly in 19/20	**Target:** Sustained improvement in documentation and completion of assessment tools	**Reporting Cycle:** Quarterly to performance meetings
Engagement and consultation:	This has been identified through recent Serious Incidents requiring investigation		

Priority 2: To improve young people's access to and understanding of their health care plan (Looked After Children) and Care plans within the CCN team including special schools			
Why we chose this as a priority and what it means for patients:	It is imperative that children and Young People (YP) are engaged in the care planning process to ensure that health needs are assessed and children and YP are engaged in how to improve their health. This also includes working with partner organisations to ensure that care plans are used within health and education settings. This was identified as an area of improvement within our CQC report of 2019.		
What we are planning to do:	Improve the engagement of young people in writing care plans to ensure they are meaningful and useful to them. This would be through a user engagement forum.		
Performance measures:	**Proposed Measure:** • Audit how many care plans are undertaken jointly with young people and/or education. • Deep Dive Q2 and Q4 for care plans (10 CCN and 10 LAC east and west each quarter)	**Target:** Sustained improvement	**Reporting Cycle:** Twice yearly through the audit group
Engagement and consultation:	YP engagement forum.		

EFFECTIVE

Priority 1: To develop a career pathway in the child and family service line for Advanced Clinical Practice (ACP)

Why we chose this as a priority and what it means for patients:	At present there is no career pathway for ACP; as we transform our services over the next four years we need to ensure that changes to service delivery are made safely and staff receive adequate training and supervision. This will ensure safe and effective service delivery. This relates to our business plan in terms transforming services to ensure we have the right staff in the right roles to deliver the right care.
What we are planning to do:	This will be managed as a formal Project for 4 years; the milestones will include a clear plan of what the workforce will look like in 4 years including a forecast of how many ACP positions will need to be in post and the training that will be required to meet the competencies.

Performance measures:	**Proposed Measure:** Effective delivery of key project milestones for year 1	**Target:** Delivery of Year 1 key milestones	**Reporting Cycle:** Quarterly to Service Line Governance

Priority 2: To improve the pathway for children and young people with depression.

Why we chose this as a priority and what it means for patients:	As a service we need to ensure we are following the national guidance for safe and effective care for children and young people with depression. There is draft national NICE guidance in place at present due to be ratified in Spring 2019 which we must implement. The improvement will make a difference through a clear pathway for children and young people that is shared with partner organisations in the local authorities, acute sector and voluntary agencies. This links to the CAMHS business plan regarding transforming services to better enable access and outcomes for children
What we are planning to do:	Assess our service delivery against the NICE guidance and remodel service delivery as appropriate.

Performance measures:	**Proposed Measure:** Benchmarking practice -audit care plans to check that the depression pathway is followed	**Target:** 90% of care plans audited included consideration of depression triggers	**Reporting Cycle:** Quarterly to Service Line governance

Engagement and consultation:	Through sharing pathways with the young people's engagement groups in East and West

EXPERIENCE

Priority 1: To develop the offer for children and families service delivery to include Remote Consultation (Skype), telephone and texts and use of translation services as required.

Why we chose this as a priority and what it means for patients:	Young people and families report through engagement meetings that they would like our services to be more user friendly and accessible. This links into our business plan around transforming the role of business support and particularly making best use of digital and business platforms to improve services. This was also identified as an area of improvement within our 2019 CQC report for CYP.
What we are planning to do:	Deliver some consultations through other means other than face to face. This will need to be completed as part of a risk assessed service

Performance measures:	Proposed Measure: • Effective delivery of key project milestones for year 1 which will include the sign off of the process and risk assessment.	Target • Delivery of all Year 1 Project Milestones • Feedback from patients and families indicates higher levels of satisfaction with accessibility and user-friendliness of services	Reporting Cycle: Quarterly to Service Line governance
Engagement and consultation:	Through Young Shapers forums		

Priority 2: To develop client involvement in their treatment plan, developing choice within the pathway of care delivery.

Why we chose this as a priority and what it means for patients:	Engagement with parent forums has highlighted that parents would like to be involved in the best way to meet their child's needs be that through seeing a consultant or having a course of 6 therapy sessions. This will increase patient engagement and is hoped will reduce complaints and non-attendance (was not brought) to appointments. This quality priority will improve the overall quality of the clinical model/care being offered and therefore will help address this poorly scoring area of the quality of care within our staff survey		
What we are planning to do:	Using evidence based practice have clear pathways in place with identified outcomes including choice of service delivery		
Performance measures:	Proposed Measure: • Effective delivery of key project milestones for Yr. 1 • Patient feedback on new approach.	Target: • Delivery of Project Plan key milestones for Year 1 • Higher levels of patient/parent satisfaction	Reporting Cycle: Quarterly to Service Line Governance meeting
Engagement and consultation:	Parent Forums, Young Shapers Meetings.		

Specialist Dental Services

SAFE			
Priority 1: Aligning General Anaesthetic (GA) pathway on the Isle of Wight (IOW) and Hampshire			
Why we chose this as a priority and what it means for patients:	The Dental Service has recently commenced delivery of Special Care Dentistry on the Isle of Wight. It has been noted that there is an absence of clear protocols for provision of dental care under General Anaesthesia. There is inconsistent availability of patient records (electronic/paper) in theatre. This has the potential to adversely affect Patient Safety and Quality of Care.		
What we are planning to do:	1.To incorporate the GA list on the St Mary's site into the Solent Specialist Dental Service GA Procedures Document 2.Produce updated care pathway for patients requiring Dental Care under General Anaesthesia 3.Introduce checklists to ensure that patient information is appropriately recorded and transferred to the GA session 4.Improve numbers of clinicians trained to operate at St Mary's by provision of honorary contracts and providing training via a shadowing programme 5. Ensure availability of a Second operating Dentist where a patient having treatment under General Anaesthesia lacks capacity to consent.		
Performance measures:	**Proposed Measure:** Audit the use of the GA procedures document by measuring completion of the GA checklists	**Target:** To align Procedures with those on the mainland (using existing GA pathway as a standard).	**Reporting Cycle:** July 2019 – **50% complete** December 2019 – **70% complete** March 2020 – **100%**
Engagement and consultation:	The clinician providing GA services on the IOW has been consulted and contributed to the GA procedures document review in Dec 2018. Members of staff on the Isle of Wight to be trained in the GA procedures document and the use of checklists. GA training Day to be organised on the Isle of Wight involving members of staff from Hampshire and the IOW GA teams to improve awareness and improve treatment planning for GA patients and to allow staff to ask questions about the procedures and pathway.		
Priority 2: Introduction of Intraoral Radiography into Dental General Anaesthetic (GA) Sessions			
Why we chose this as a priority and what it means for patients:	Radiographs are a valuable diagnostic tool to diagnose dental pathology. The facility to take intraoral radiographs in theatre is not currently available at all GA sites. The exception is Poswillo where radiographs can be taken. Some patients with special needs are unable to tolerate intraoral radiographs routinely. Where dental care for this group of patients is provided under general anaesthesia, the availability of radiographs would enhance treatment planning and improve the quality of patient care. In addition to caries diagnosis, information from diagnostic radiographs would provide important detail about root morphology and adjacent structures which inform decisions based on need for treatment balanced against the risks of complications. Radiographs also form an important part of the clinical records and provide important evidence for medico-legal reasons. This has been on the service risk register for a period of time.		
What we are planning to do:	To introduce digital radiography into each of our general anaesthetic sites. Currently this is only available at our own site (Poswillo) and not at sites where we are hosted by other hospital providers.		

	This will require
	1. Achieving funding for equipment
	2. Securing IT access in theatre at each site
	3. Purchasing equipment
	4. Liaising with hospital sites to carry out works required
	5. Preparing Local rules and procedure documents
	6. Training staff

Performance measures:	Proposed Measure:	Target:	Reporting Cycle:
	Audit: To record availability/unavailability of intraoral radiography at Dental GA sites	To implement intraoral radiography in theatre at all external GA sites (North Hampshire Hospital, Royal Hampshire County Hospital, SGH, St Mary's)	September **2019 – 50%** December **2019 – 70%** March 2020 – **100% of sites**
Engagement and consultation:	Consultation with hospital teams will be key to ensure that equipment can be appropriately stored. Support from IT services in Solent and within other provider organisations will be essential to secure the required access to systems.		

EFFECTIVE

Priority 1: Introduction of Inhalation Sedation (IS) Service for Patients on the Isle of Wight (IOW) to facilitate dental treatment under conscious sedation as opposed to a general anaesthetic (GA)

Why we chose this as a priority and what it means for patients:	**Inhalation Sedation:** The General Dental Council states that "patients' dental pain and anxiety should be managed appropriately". As a dental service providing specialised dental care to patients, such as those with physical, intellectual and/or medical impairments or disabilities, these needs should be met. Thus, forms of conscious sedation should be available to allow the delivery of a high standard of patient care. The provision of this service on the Isle of Wight would also act to reduce the General Anaesthetic waiting list and hence waiting time for patients – as well as offering an alternative approach with fewer risks than a general anaesthetic. Finally by offering the service of conscious sedation it will ensure an equality of access for patients on the IOW, as well as the mainland.
What we are planning to do:	• Arrange accredited in-house training for dental team to include supervised cases • Ensure suitability of environment and correct equipment available for IS e.g. scavenging • Arrange for staff members on IOW to shadow sedation clinic on the mainland • To implement the same protocol and procedures used on the mainland to the IOW • Show all staff relevant sedation SOPs and guidance on R drive • Ensure checklist being used on IOW is consistent with mainland • Create sedation folder for IOW to replicate mainland copy • Commence sedation for patients under guidance of sedation leads • Provide training updates as required • Ensure opportunity for case reflection and appraisal

Performance measures:	Proposed Measure: 1. Audit clinical notes for IS – to ensure compliance with sedation policy 2. Ensure IS pre- and post- op machine checks being completed for 100% of cases 3. Audit use of IS checklist and clinical note keeping for 100% of cases 4. Review any sedation related incidents and share learning at Sedation Network 5. Case reflection and discussion with sedation leads 6. Record patient feedback around sedation for 100% of cases	Target: • Monitor introduction of sedation service against agreed timeline • Compliance on IOW with mainland sedation policy and procedures	Reporting Cycle: June 2019 -**30%** September 2019 – **50%** December 2019 – **70%** March 2020 – **100% completed**
Engagement and consultation:	Encourage networking between members of staff on the IOW and those providing sedation on the mainland Invite IOW staff to Sedation Network meetings. Arranged clinical supervision visits to IOW and for staff on IOW to visit sedation clinics on mainland. Review of audit – repeat to ensure correct standards being maintained – with any recommendations to improve standards from IOW or mainland staff members. Discussion of sedation cases, incidents and patient feedback with sedation leads and at Sedation Network		
Priority 2: Introduction of an Intravenous Sedation (IS) Service for patients on the Isle of Wight (IOW) as an alternative option for some patients who would otherwise only be able to access dental treatment under general anaesthesia			
Why we chose this as a priority and what it means for patients:	**Intravenous Sedation:** The General Dental Council states that "patients' dental pain and anxiety should be managed appropriately". As a dental service providing specialised dental care to patients, such as those with physical, intellectual and/or medical impairments or disabilities, these needs should be met. Thus, forms of conscious sedation should be available to allow the delivery of a high standard of patient care. The provision of this service on the Isle of Wight would also act to reduce the General Anaesthetic waiting list and hence waiting time for patients – as well as offering an alternative approach with fewer risks than a general anaesthetic. Finally by offering the service of conscious sedation it will ensure an equality of access for patients on the IOW, as well as the mainland.		
What we are planning to do:	• Arrange accredited training for dental team to include supervised cases • Assess sedation related training and CPD for new member of staff • Ensure suitability of environment and correct equipment available for IVS • Arrange for staff members on IOW to shadow sedation clinic on the mainland • To implement the same protocol and procedures used on the mainland to the IOW – Show all staff relevant sedation SOPs and guidance on R drive • Ensure checklist being used on IOW is consistent with mainland • Create sedation folder for IOW to replicate mainland copy • Arrange shadowing/mentorship program until confident to provide sedation independently • Commence sedation for patients under guidance of sedation leads		

	• Invite clinicians to Sedation Network meeting • Provide training updates as required • Ensure opportunity for case reflection and appraisal

Performance measures:	**Proposed Measure:**	**Target:**	**Reporting Cycle:**
	1. Audit clinical notes for IV sedation – to ensure compliance with sedation policy. 1. Audit use of IV checklist and clinical note keeping for 100% of cases. 2. Review controlled drugs record book for 100% of cases 3. Review any sedation related incidents and share learning at Sedation Network 4. Case reflection and discussion with sedation leads 5. Record patient feedback around sedation for 100% of cases	Monitor introduction of sedation service against agreed timeline Compliance on IOW with mainland sedation policy and procedures	June 2019 -**30%** Sept 2019 – **50%** December 2019 – **70%** March 2020 – **100% completed**

Engagement and consultation:	Encourage networking between members of staff on the IOW and those providing sedation on the mainland. Invite IOW staff to Sedation Network meetings. Arranged clinical supervision visits to IOW and for staff on IOW to visit sedation clinics on mainland. Review of audit – repeat to ensure correct standards being maintained – with any recommendations to improve standards from IOW or mainland staff members .Discussion of sedation cases, incidents and patient feedback with sedation leads and at Sedation Network

EXPERIENCE

Priority 1: Introduction of a training package for oral health care and carer training for use in nursing and residential care homes

Why we chose this as a priority and what it means for patients:	Following NICE guidelines, the NHS 10 year plan and feedback from special care dental staff who deliver regular domiciliary dental care in nursing and care homes, there is an obvious need to deliver Oral Health carer training and provide a training package, including a workbook and face to face training sessions. Oral health is as important for vulnerable adults in the latter stages of life, as it is for children in the early years of life. Poor oral health has found to be linked with heart disease, diabetes, sepsis, etc. and can be extremely debilitating, especially when unable to communicate feelings of pain, diet, oral function and self-esteem.
What we are planning to do:	Pilot carer training in designated carer/ nursing homes with the aim to implement the use of oral health assessment forms and daily mouth care plans for each resident.

Performance measures:	Proposed Measure: **Audit:** Number of practitioners working with vulnerable adults and old people in care homes who have received OHP training.	Target: 100% of patients in one care home have an oral care plan.	Reporting Cycle: August 2019 – **40%** January 2020 – **60%** March 2020 – **100%**
Engagement and consultation:	Care home staff, residents, family members of residents, commissioners as required and Solent staff.		

Priority 2: Development of Accessible Information (AI) Champions at each Service Locality

Why we chose this as a priority and what it means for patients:	Research found that 12-30% of the population have a communication need. The Accessible information Standard was set in 2016. This legislation means that NHS organisations and public services must: Ask, document, share and support service users/carers/parents with communication needs. Attending health care appointments can be overwhelming. The health sector often use medical terms 'jargon'. At the end of the appointment some patients may have left feeling confused and agreed to something they don't really understand so imagine how difficult it is for someone with learning difficulties, learning disability, and visual or hearing impairment. The new legislation will mean that these service users will now have support by highlighting their needs.		
What we are planning to do:	- To have in place AI Champions at each Service locality: North, West, East and Isle of Wight. - To support new and existing members of staff to comply with the AI Standard – Assess/Record/Support needs of our Service Users. - Identify the communication needs of all our Service users – Using the Toolkit Guide - Record needs in their dental records, AI recording format and highlighting using the AI. An AI icon will be on their records. It highlights and identifies that the patient have a communication need and may require additional support.		
Performance measures:	Proposed Measure: 1. AI Champions will be identified, trained and can train and support members of staff 2. Communication needs are recorded and highlighted on R4 dental system and monitored for completion 3. Dental records will be monitored every 3 months	Target: 1. On going 2. End of year 40-50% of patient records will have documented AI needs and increase by 20% over the following years 3. To start monitoring records quarterly (Audit). 10 patient records per clinician assessed over a set week for completion.	Reporting Cycle: April 2019 – **30%** July 2019 – **50%** October 2019 – **70%** January 2020 – **90%** March 2020 – **100%**
Engagement and consultation:	Staff will be informed at locality meetings and supported by AI champions to complete records for all patients.		

Mental Health Services

SAFE			
Priority 1: Physical Health Monitoring in Substance Misuses Services (SMS)			
Why we chose this as a priority and what it means for patients:	Within our Substance Misuse Services we do not at this time routinely undertake physical health care monitoring. This client group is vulnerable to ill health and may not be accessing their GP due to complications such as homelessness, lack of funds to get to the surgery, or lack of relationship with these services.		
What we are planning to do:	• We will train Solent staff within the service to undertake physical health care monitoring and use NEWS2 • We will offer this to service users who will be attending for a pre alcohol detox with one of the registered nurses within the service		
Performance measures:	**Proposed Measure:** Offering of physical health monitoring within the substance misuse assessment.	**Target:** 90% of patients offered	**Reporting Cycle:** Quarterly
Engagement and consultation:	Discussed with relevant staff within the service and with SSJ as an integrated partner.		
Priority 2: High Dose Antipsychotic Treatment (HDAT) monitoring			
Why we chose this as a priority and what it means for patients:	Some patients in mental health services require high dose antipsychotic treatment (HDAT). For some patients this is short term at the point of a crisis, but for others this is a longer term treatment. There are risks for HDAT which need to be considered and monitored to ensure patient safety. The CQC stated in their visit in 2018 *the trust must ensure Medication Management is safe for all patients (Regulation 12). Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment.*		
What we are planning to do:	We have developed a HDAT monitoring form which will be part of Systm1. We plan for all Patients who are prescribed HDAT to have a HDAT form in place.		
Performance measures:	**Proposed Measure:** Eligible patients have a HDAT form in place on system 1.	**Target: 90%**	**Reporting Cycle:** Q2 and Q4
Engagement and consultation:	Discussed with the medical staff, nursing and system 1 colleagues.		
EFFECTIVE			
Priority 1: Patients within our rehabilitation service achieving their recovery goals			
Why we chose this as a priority and what it means for patients:	We are in the process of reviewing our rehabilitation offer, moving this from an inpatient service to a community service. Monitoring of the Patient Recovery Outcome Measure (PROM), of which Dialog is used within the service, will enable us to ensure we are continuing to be an effective service, and meeting the patient's goals and priorities.		
What we are planning to do:	At the start of the patients engagement with the rehabilitation team a Dialog questionnaire will be used to agree the patient's recovery goal. At the point of discharge the questionnaire will be undertaken again to determine whether the patient feels an improvement has been made.		
Performance measures:	**Proposed Measure:** There is an improvement for patients self-rating following engagement with the rehabilitation services.	**Target:** 90%	**Reporting Cycle:** Quarterly audit

Priority 2: Did Not Attend (DNA) rates in A2i			
Why we chose this as a priority and what it means for patients:	Currently the A2i service has a DNA rate on average of 20%. This is a service in high demand with an average of 155 referrals each month and this DNA rate is equivalent to 31 patients a month. Each new patient assessment will take 2 hours (including write up) meaning on average 62 hours of lost activity each month. This 20% DNA rate is therefore wasted time that would be better used in a patient facing activity.		
What we are planning to do:	The service will seek to understand why the DNA rate is high and look to reduce this. In order to do so the service will establish a task and finish group to obtain feedback from service users who DNA to ascertain the reason for their non-attendance, we will analyse these results and put measure in place to improve attendance.		
Performance measures:	**Proposed Measure:** **Q1-** task and finish group is established and service user feedback tool agreed. **Q2-** Feedback obtained from patients who DNA on reasons for this DNA. Feedback analysed and actions agreed. **Q3**- Actions/ changes embedded in practice. **Q4**- reduction in DNA rates.	**Target:** Minimum of 5% reduction in DNA rates within the service.	**Reporting Cycle:** Quarterly
Priority 3: Psychology input into OPMH inpatients			
Why we chose this as a priority and what it means for patients:	The CQC stated in their visit in 2018 *the trust should ensure they continue to develop psychological treatments to meet patients' needs*.		
What we are planning to do:	Develop a pathway for psychological therapies access for older persons which include psychological therapies access within the ward setting.		
Performance measures:	**Proposed Measure:** Q1- • Baseline figures obtained for older adults access to psychological therapies within the ward setting • Pathway developed for both primary (IAPT) and secondary care access for older persons Q2- Pathway agreed through appropriate governance routes and put into place Q3- reporting on the whole of Q3 to be submitted in Q4	**Target:** An increase in baseline figures for ward psychological therapies.	**Reporting Cycle:** Report for Q3 to be submitted in Q4.
Engagement and consultation:	Patients and staff will be consulted as part of the pathway development work.		

EXPERIENCE

Priority 1: Care planning in community services.

Why we chose this as a priority and what it means for patients:	The mental health in-patient services went through a programme of improvement in care planning last year to ensure that care plans were meaningful for our patients. The outcome of this is that the care planning process is simpler for both the patient and the service, and is led by the needs of the individual. We now wish to extend this improvement to our mental health community services.
What we are planning to do:	A task and finish group will be set up to review the current care planning processes in the community services. This group will determine whether the changes made to care planning in the in-patient setting are appropriate for the community services or whether further changes are required. This will then be built on Systm1 and all staff appropriately trained to complete this. Practice will be embedded with the service with all patients having a new community care plan by Q4.

Performance measures:	**Proposed Measure:** Q4 would see all patients for whom we are providing care in community services having a "new" community care plan.	**Target:** 90% of patients with a new community care plan in Q4.	**Reporting Cycle:** Q4
Engagement and consultation:	Community services staff and managers.		

Priority 2: Carer's engagement with OPMH inpatient service (Brooker)

Why we chose this as a priority and what it means for patients:	Carers are able to provide invaluable information and support to both the services and the service users. This is particularly important within our older person's wards when we are caring for persons with dementia or memory problems. Whilst the service has taken steps to improve this through the introduction of "this is me", there have been some complaints in the past 12 months whereby carers have not felt appropriately engaged in their loved ones care.
What we are planning to do:	The service will undertake a Quality Improvement (QI) project starting in May (Q1) to look at how engagement with carers can be improved within Brooker. Within Q2 the service will be engaging with carers and staff to understand the needs of both and any barriers to this currently. Q3 will focus on making changes to improve engagement with carers, reviewing these changes and amending as required. Q4 should see the changes embedded and improvements measurable.

Performance measures:	**Proposed Measure:** To be established through the quality improvement project.	**Target:** QI project undertaken by the service which is able to demonstrate and improvement in the services engagement of carers.	**Reporting Cycle:** Q4
Engagement and consultation:	QI team has been established and has begun to engage with the Solent QI team. Further engagement will take place as part of the QI project.		

Primary Care Services

SAFE		
Priority 1: Developing "multi chair" Podiatry Clinics		
Why we chose this as a priority and what it means for patients:	We believe that developing "multi chair" clinics within our podiatry service will promote a positive and safe environment for both staff and patients. This development will aim to reduce lone worker/isolated clinics therefore improving support for staff with a complex and challenging cohort of patients. We believe this approach will support retention of junior podiatrists by creating a positive learning environment, providing opportunities to observe, escalate and provide/receive mentorship. The benefit for patients is that staff will be able to escalate, receive advice and guidance promptly with the potential to reduce appointments.	
What we are planning to do:	Develop hubs with "multi chair" clinics at strategic sites across the geographical area and reduce lone working. This will enable junior and senior staff to work alongside each other and provide the ability to give clinical support, education, training and escalation promptly to enhance the patient and staff experience.	
Performance measures:	**Proposed Measure:** Improved percentage of B5/B6 and B6/B7 multi chair clinics	**Target:** Increase multi chair clinics by 75%	**Reporting Cycle:** Via Podiatry operational meetings and Governance meetings to monitor impact on staff and patients experience
Engagement and consultation:	This will be an informal consultation with staff and due to the reduction of sites will require consultation with our commissioners and patients. It is anticipated that this will evolve over a two year period. Year 1 will involve the review and consultation period with the development of the clinics with latter quarter year 1 / year 2.	
Priority 2: Rationalisation of podiatry clinic locations		
Why we chose this as a priority and what it means for patients:	We have chosen this priority as it has multi-facetted benefits. The rationalisation of sites supports our vision to develop multi chair clinics (above) and enables the service to consolidate the estate provision across the geographical area reducing expenditure and providing value for money. It is recognised that reducing sites has the potential to impact on patient experience (due to preferred location) however the benefits of delivering specialist quality care do provide the opportunity to improve outcomes for patients.	
What we are planning to do:	We aim to reduce our podiatry estate to key "hub" locations. This will be dependent on Estates and Facilities Team support regarding the development of St Marys (Block B) and Adelaide Health Centre.	
Performance measures:	**Proposed Measure:** The number of current sites	**Target:** To reduce the number of Podiatry sites by 50%.	**Reporting Cycle:** Via Podiatry operational meetings and Governance meetings to monitor impact on staff and patients experience
Engagement and consultation:	The project will evolve over 2 years and will require consultation with Estates and Facilities Team, commissioners, staff and patients. Year 1 will see the redevelopment of key sites to support the project, year 2 will seek to complete and embed transition	

EFFECTIVE

Priority 1: Increase patient and public engagement to support improved patient outcomes

Why we chose this as a priority and what it means for patients:	We recognise that we have vulnerable patient groups within our service line; in particular pain management and homeless health. Often the patients are challenged to attend consultations and at times do not consider the supportive programme/ onward referrals to be of benefit. The project aims to improve engagement of patients through patient advocacy.
What we are planning to do:	1) Within pain management team the aim is to initiate Follow on Groups (FOG). Often patients participate in a programme of support and upon conclusion of the programme feel that they need continued support (which cannot be offered within the service). It is proposed that patients are invited to participate in an on-going programme that is facilitated by the service but lead by the patients themselves. 2) Within Homeless Health patients often require secondary care for the management of acute and chronic conditions however often will disengage due predominately to a chaotic lifestyle. The aim is to utilise participates in a supportive role to encourage patients to attend secondary care appointments, help with issues with transport, accommodation etc.

Performance measures:	**Proposed Measure:** 1) To monitor the impact of FOGs upon the re-referral to pain management services. 2) To monitor the conversion of patients who attend secondary care appointments (for specific condition)	**Target:** 1) To reduce re-referral to pain management service by 25% 2) To improve attendance at secondary care appointment by 20%	**Reporting Cycle:** 6 monthly report to governance

Engagement and consultation:	This will be a two year programme for both projects. Year 1 to establish cost benefit analysis of schemes and if applicable identify funding support. Year 2 to facilitate and embed in practice.

Priority 2: To review the workflow management across the service line

Why we chose this as a priority and what it means for patients:	Within the service line we receive and send data in multiple formats. It is imperative we deal with this in a safe and effective way ensuring we maintain information governance standards and are as "stream lined" as possible. We aim to utilise technology to support the management of this to improve the experience for staff (both clinical and administration) and improve effective communication to patients and healthcare professionals.
What we are planning to do:	To undertake a full review of our current processes both person and technology focused with regards to the management of information "in and out" of the service to reduce the administrative burden

Performance measures:	**Proposed Measure:** Audit	**Target:** • To reduce the workflow burden and improve the efficiency of workflow management. • To reduce information governance errors by 50 %	**Reporting Cycle:** Audit – frequency to be confirmed

Engagement and consultation:	Two year project in liaison with IT and our administration leads.

EXPERIENCE

Priority 1: Solent GP Surgery Transformation

Why we chose this as a priority and what it means for patients:	In 2016 our three independent GP Surgeries merged to form Solent GP Surgery. Since its formation we have been challenged to standardise our processes and work cohesively as one surgery and realise the benefits this provides from a workflow and professional perspective. The aim is the transformation project will benefit the surgery from a patient and staff perspective but also will provide financial efficiencies and enable us to consider our estate requirements, alternative workforce provision (taking into account reduced numbers of GP availability), staff retention, and development of clinical and administration staff.
What we are planning to do:	Undertake a transformation project over a two year period of our GP Surgery

Performance measures:	**Proposed Measure:** Delivery of identified project mile stones	**Target:** To potentially reduce number of premises and improve efficiencies within workforce and workflow	**Reporting Cycle:** Monthly via Project initiation document within operational and governance forums

Engagement and consultation:	This will require engagement with staff, patients, Trust (Estates & Facilities, Finance and Contracts) and SC CCG.

Priority 2: Development of   web site & digital platforms within MPP

Why we chose this as a priority and what it means for patients:	We aim to optimise the Solent MSK Website and other digital platforms to provide effective MSK guidance prior to accessing the MSK Service
What we are planning to do:	Improve our patient's pathway ensuring patients are seen at the right time & right place by the right clinician. The aim is to ensure our website offers advice and guidance supporting patients to make decisions regarding self-referral and signposting.

Performance measures:	**Proposed Measure:** The number of patients who appropriately self-refer following visit to web site.	**Target:** To have 50 % of appropriate referrals	**Reporting Cycle:** Quarterly audit of self-referrals

Engagement and consultation:	This will be a two-year project with year one reviewing the current website and digital platform and redesign with year two ensuring web site in place with processes in place to ensure the platforms remain current and relevant,

Sexual Health

SAFE			
Priority 1: To implement a monthly patient safety quality assurance process			
Why we chose this as a priority and what it means for patients:	We chose this priority because we want to be able to provide assurances that all mandated checks are being completed within the service to ensure we are providing safe care.		
What we are planning to do:	We are going to develop a process to provide monthly assurance to the clinical governance service line meeting that the following tasks are being carried out: • Fridge and drug room temperature checks • Completion of cleaning schedules • Checking of resuscitation equipment • PAT testing • Changing of patient curtains • Correct signage of waste bins • Sharps bins are being closed appropriately		
Performance measures:	**Proposed Measure:** Completion of the above tasks	**Target:** Sustained improvement in completion of the above tasks	**Reporting Cycle:** Reported monthly to service line clinical governance meeting
Engagement/consultation:	This has been identified as an area for improvement during quality visits		
Priority 2: To ensure that 95% of patients under the age of 18 have a Risk Assessment Tool (RAT) completed			
Why we chose this as a priority and what it means for patients:	Young people under the age of 18 are at risk of criminal sexual exploitation and therefore it is important that a risk assessment is completed at each visit as this can highlight concerns. At the end of QRT 3 2018/19 the completion rate was 98.9% in Hampshire, 98.5% in Portsmouth and 100% in Southampton. The service wants to maintain this high completion rate to ensure that young people who are vulnerable and at risk are identified and referred to relevant agencies.		
What we are planning to do:	Every month the notes of patients under the age of 18 are reviewed to ensure that a RAT has been completed. If a RAT has not been completed it is discussed with the staff member concerned and any lessons learnt shared with the team. Throughout 2018 risk assessment training was provided to staff, as well reminders in the staff newsletter to improve the amount of risk assessments completed. This notes review will continue monthly to ensure that completion rates remain high; the results will be shared at the monthly service line clinical governance meetings.		
Performance measures:	**Proposed Measure:** Overall number of RAT completed in under 18 year olds	**Target:** Sustained improvement of completion of RAT	**Reporting Cycle:** Bi-monthly at the performance meeting
Engagement and consultation:	This has been identified by our commissioners as a key performance indictor. We have consulted with our staff about the importance of completing RAT and extra training has been provided		

EFFECTIVE

Priority 1: To improvement the treatment pathway for non-complex Chlamydia treatments by introducing treatment by post

Why we chose this as a priority and what it means for patients:	We chose this priority to reduce the time is takes for patient to receive their Chlamydia treatment by developing a treatment by post scheme. A patient survey showed this was the preferred method to receive treatment. It will also increase access into the service for other more complex patients.		
What we are planning to do:	To develop and implement a treatment by post pathway.		
Performance measures:	**Proposed Measure:** Implementation of treatment by post	**Target:** Delivery of plans to implement the treatment by post	**Reporting Cycle:** Stage 1 - Create patient health record due to go live 30/06/19 Stage 2 – Self-managed partner notification due to go live 30/09/19 Stage 3 – Treatment by post due to go live 01/11/19
Engagement and consultation:	A patient survey was completed in 2018 asking patients how acceptable it would be for them to receive their treatment by post, pharmacy or in clinic. The majority of patients wanted to receive their treatment by post.		

Priority 2: To develop an online platform for partner notification

Why we chose this as a priority and what it means for patients:	We want to improve the uptake of treatment for partners, to reduce re-infection and complications related to untreated infection by introducing an online platform for patient notification.		
What we are planning to do:	We are working with our IT provider to develop an online system for partner notification so patients can enter their partner details anonymously.		
Performance measures:	**Proposed Measure:** Implementation of the online partner notification platform	**Target:** Delivery of plans to implement the online partner notification platform	**Reporting Cycle:** Stage 1 - Create patient health record due to go live 30/06/19 Stage 2 – Self-managed partner notification due to go live 30/09/19
Engagement and consultation:	IT provider and staff working on the project		

EXPERIENCE

Priority 1: To develop a patient portal

Why we chose this as a priority and what it means for patients:	We want to improve the way patients can access appointments, receive their results and request online testing. The current online booking service requires patients to enter their details each time they book an appointment and we have had feedback from patients that this is cumbersome.
What we are planning to do:	We will work with our electronic patient record (EPR) provider INFORM, to develop a patient portal that allows patients to log in to their EPR to receive results, book appointments and request online tests.

Performance measures:	Proposed Measure: Implementation of the patient portal	Target: Delivery of plans to implement the patient portal		Reporting Cycle: Stage 1 - Create patient health record due to go live 30/06/19
Engagement and consultation:	We have listened to feedback from our patients via FFT, service concerns and complaints			
Priority 2: To improve the referral pathway between Sexual Assault Referral Centre (SARC) and Sexual Health (SH)				
Why we chose this as a priority and what it means for patients:	Patients that are a victim of a sexual assault should be followed up in Sexual Health for screening, post exposure prophylaxis for sexual exposure to HIV follow-up and on-going contraception. The referral process has just been updated to improve the patient pathway and support vulnerable patient to attend Sexual Health services			
What we are planning to do:	We will be completing an audit to see how effective our referral pathway is by reviewing how many people that are referred from SARC attend Sexual Health services.			
Performance measures:	Proposed Measure: Number of patients that attend SH compared to the number that are referred by SARC baseline audit to be completed by the end of May.	Target: To see a sustained increase in the number of patient referred from SARC attending sexual health		Reporting Cycle: This is a service evaluation on the 19/20 audit plan. To be presented in December 2019 CG
Engagement and consultation:	This has been identified by staff in both SH and SARC as an area for improvement. We have consulted with our staff so they are aware of the new referral pathway.			

2.2 Statements relating to quality of NHS services provided

The statements and wording in this section are mandated by NHS regulations and enable patients, the public and stakeholders to compare performance and data across health care providers. We cannot change these statements but we have added further information to provide context where appropriate.

Review of services

During 2018/19 Solent NHS Trust provided and/or sub-contracted 153 relevant health services.

Solent NHS Trust has reviewed all the data available to them on the quality of care in 153 (100%) of these relevant health services. Data relating to the quality of care in our services is reviewed at Service Line governance and business meetings, Service Line and Care Group Performance Review Meetings, at Quality Improvement & Risk Group, Assurance Committee and the Trust Board.

The income generated by the relevant health services reviewed in 2018/19 represents 89% of the total income generated from the provision of relevant health services by Solent NHS Trust for 2018/19.

Participation in local and national clinical audits and national confidential enquiries

National Audits

During 2018/19, 14 national clinical audits and 2 national confidential enquiries covered relevant health services that Solent NHS Trust provides.

During that period, Solent NHS Trust participated in 93% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The table below shows:
- the national clinical audits and national confidential enquiries that Solent NHS Trust was eligible to participate in during 2018/19
- those it did participate in
- 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

| National Clinical Audits & Confidential Enquiries that Solent NHS Trust was eligible to participate in during 2018/19 are as follows:	Did Solent participate?	Number of cases submitted to each audit or enquiry (as a % of no required or * if not applicable)
National Clinical Audits		
Prescribing Observatory for Mental Health Quality Improvement Programme: 6d - Assessment of the side effects of depot antipsychotics	Yes	180 (100%)
Prescribing Observatory for Mental Health Quality Improvement Programme: 7f - Monitoring of patients prescribed lithium	Yes	90 (100%)
National Clinical Audit of Anxiety and Depression (NCAAD)	Yes	30 (100%)
National Clinical Audit of Anxiety and Depression (NCAAD):	Yes	30 (100%)

National Clinical Audits & Confidential Enquiries that Solent NHS Trust was eligible to participate in during 2018/19 are as follows:	Did Solent participate?	Number of cases submitted to each audit or enquiry (as a % of no required or * if not applicable)
Psychological Therapies spotlight audit		
National Clinical Audit of Psychosis (NCAP): Early Intervention in Psychosis (EIP) spotlight audit	Yes	49
Falls and Fragility Fractures Audit Programme: National inpatient falls audit (NAIF) organisational audit	Yes	Submitted as required*
National Audit of Cardiac Rehabilitation	Yes	431 (100%)
National Audit of Care at the End of Life (NACEL)	Yes	24 (100%)
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12):	Yes	Submitted as required*
National Diabetes Audit – Adults: National Core Diabetes Audit	Yes	845
National Diabetes Audit - Adults: National Foot Care Audit	Yes	79
Sentinel Stroke National Audit Programme (SSNAP)	Yes	328
Learning Disability Mortality Review Programme (LeDeR)	Yes	Submitted as required*
National Audit of Intermediate Care	No	
National Confidential Enquiries		
Mental Health: Suicide, Homicide & Sudden Unexplained Death	Yes	3/3 (100%)
Maternal (& New-born / Infant): Maternal morbidity and mortality confidential enquiry (including psychiatric morbidity)	Yes	No submissions required

The reports of 100% national clinical audits were reviewed by the provider in 2018/19 and examples of actions Solent NHS Trust intends to take to improve the quality of healthcare provided are below:

- National audit reports were distributed on publication to the relevant service line and local audit leads along with a summary of recommendations and an action tracker to measure compliance. National audit reports are also highlighted at the trust Learning and Improvement Group to promote cross service learning for improvement

- In one example of a repeated national audit, the National Clinical Audit of Psychosis, we submitted 88 cases and shared results across the trust in a range of formats including video and info-graphics. The info-graphic below shows key findings and actions for improvement
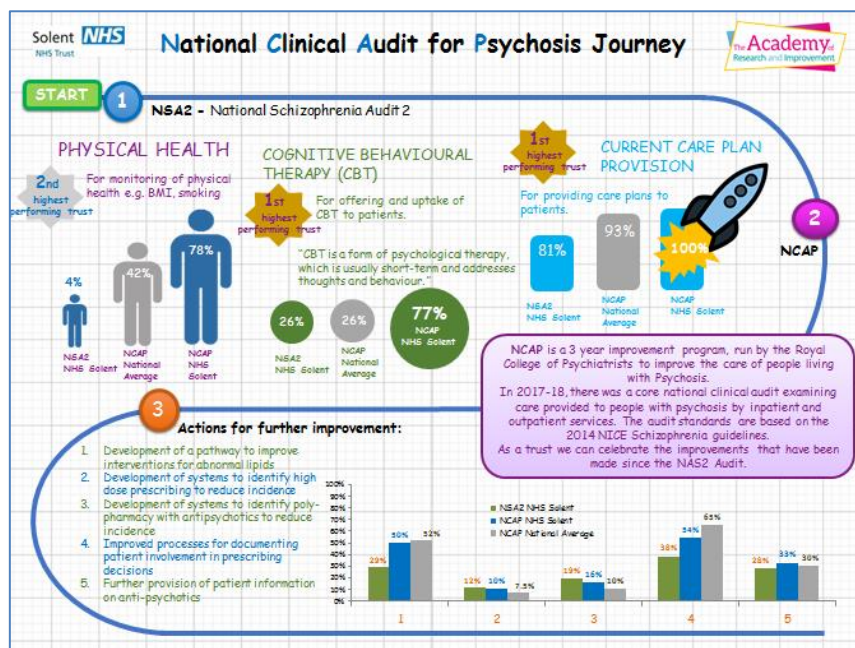
Local Audits and Service Evaluations

The reports of 124 local clinical audits were reviewed by the provider in 2018/19 and Solent NHS Trust intends to take the actions set out in the table below to improve the quality of healthcare provided.

These projects are determined by each service, based on their priorities, and are as a result of patient and staff feedback, business plans, complaints investigations, serious and high-risk incident investigations, as a means of measuring compliance with NICE guidance and as a baseline measure for Quality Improvement projects. At the start of each year, all service lines meet to develop and share ideas for projects in a trust wide improvement planning event.

Audit plans and actions are reviewed at service line audit groups with key learning and improvements shared at the trust learning and improvement group. Audit and evaluation action planning for improvement is increasingly integrated into the trust Quality Improvement programme. Specific training on audit and evaluation has had a high uptake.

Examples of some of the improvement outcomes achieved and actions planned as a result of local audits and service evaluations are detailed in the tables below:

Audit title	Improvement as a result of audit
(Adult services) Wound assessments	158 patients with wound care plans were audited of which 137 had a wound assessment (87%) which exceeded requirements and showed an improvement from 80% in the last audit, and 65% in the audit prior to that
(Adult Services) Nutritional screening	100% (37) of patients were screened for malnutrition status within 24 hours of admission - this was an 18% improvement from 2017-18; 92% overall had this repeated weekly
(Mental Health) Cardio metabolic monitoring	In this and the previous audit 100% of patients had their blood pressure screened. There were improvements in all other screening factors and both glucose and lipid were 100% compliant. The range of percentage improvement for the 5 areas that improved was between 7% and 25% (mean 13%)
(Mental Health) Completion of individualised care plans	Four audits were completed between January to June 2018. Between the first and last audit there was improvement in all areas measured: • Care Plan in place - 30% improvement • Care Plan current and in date - 60% improvement • Relevant to episode of care - 40% improvement • Documentation of capacity - 60% improvement • Documentation of consent - 40% improvement
(Podiatry) Post-op complications following nail surgery	The number of patients lost to follow up before wound healing improved by 3.7% to 13.3%. Post-operative infection rates improved by 19% to 13.3% whilst delayed wound healing improved by 6% to 33% patients
(Primary Care) Liver fibrosis markers in non-alcoholic fatty liver disease (NAFLD)	Coding of NAFLD has increased from 61 to 75 cases which may be due to increased awareness of this condition amongst clinicians since the initial audit. The percentage of patients with NAFLD who have been screened for liver fibrosis has increased from 20% to 43%
(Sexual Health) HIV History taking	Improvements on the previous audit were: from 50% to 75% in having a 6 monthly sexual history documented; from 85% to 94% for those appropriately offered any STI screening
(Sexual Health) Complication rates of vasectomies	Occurrence of complications has been overestimated - when coded complications were checked, only 12 out of 31 coded were appropriately coded according to definitions of complications (infection and haematoma). This gave an overall complication rate for Solent vasectomy department of 0.79% (12/1525 operations) which is within the limits quoted in the evidence and an improvement on the previous audit rate of 5.8%
(Sexual Health) Partner notification (PN)	Since implementation of an operating procedure, the Trust has improved on 2 of the 3 primary outcome measures. PN discussions are occurring in a timely manner

Audit title	Improvement as a result of audit
and testing of contacts of new HIV patients	with almost half done on the same day as diagnosis. The longest time to PN discussion was 11 days which is still within the 4-week target. The percentage of partners tested (86%) has increased since the procedure was introduced.
(Specialist Dentistry) Recording parental consent	The compliance reported in this audit (87%) shows continued improvement since the previous audit (83%). General anaesthetic sessions and assessment clinics had a compliance of 93%. This is an improvement since the last audit from 85%
(Specialist Dentistry) Recording of patient risk assessment	66 adult examinations were reviewed, compliance was Caries Risk - 47/66 (71%); Periodontal Risk 45/66 (68%); Oral Cancer Risk 33/66 (65%). These results indicate a significant improvement in recording of adults' risk (previously 31%, 26% and 16% respectively)
(Child and Family) Consent for comparative genomic hybridisation (CGH) blood test	Since the last audit, a consent form and CGH array pack has been introduced, leading to an improvement in the documentation of discussion around this investigation. In 2015, provision of an information leaflet had dropped to 31%. In this audit 46% were fully informed and consented, with a further 34% receiving information and/or being consented in a less clearly documented way
(Child and Family) Transition of young person to adult	There was an improvement from 42% in 2014 to 62% for plan of transition starting at appropriate age. Information in health care plan had also significantly improved with, for example, young person views increasing from 47% to 55% and list of professionals increasing from 33% to 100%

Audit/Evaluation title	Example actions planned as a result of audits and evaluations
(Adult services) Audit of patient wristbands	Implement an additional safety measure to support nurses: include a photo with prescription cards that have the patient's DOB & NHS number
(Mental Health) Audit of individualised care plans	Copies of care plans where appropriate will be sent to the patient with the patient's assessment letter. It will be documented in the electronic record whether a patient was offered a copy of their care plan, and whether it was accepted, given or declined
(MSK) Evaluation of Lower limb rehabilitation classes	Implement a patient resource pack; review and formalise class structure to complete a standard operating procedure; remind clinicians leading the class to discuss, agree and record SMART goals with patients; agree outcome measures and inclusion criteria for the programme; agree on class DNA / follow-up policy
(Primary Care) Re-audit of patients taking Spironolactone and Ace Inhibitor/Angiotensin receptor Antagonist – Risk of Hyperkalaemia	Initiate a monthly batch report to identify patients who are due a blood test & send the report to the medicines manager each month; put pop up prompts on electronic records when prescribing spironolactone; educate clinicians by emailing all clinicians via the coffee break MHRA update
(Sexual Health) Audit of complication rates following vasectomy	Remind staff to encourage men to contact the service if they experience complications and fill in & return the 4 month post op questionnaire along with their semen sample. Post-op, code complications according to agreed criteria. Remind lab that received questionnaires should be sent to service to be analysed
(Specialist Dental) Audit of recording of patient risk factors	Inform dentists of the re-audit results by a presentation and discuss area for improvement with them; provide links for clinicians to the documents Good Practice Guidelines (FGDP, NICE recall and SCDEP OHAR); encourage and monitor the use of templates on electronic records that include a risk factor assessment prompt
(Child and Family) Evaluation of GP and Health visiting liaison	Clarify with every GP practice how information is communicated and shared with the service/duty HV; introduce process to have a spread-sheet to record GP Liaison, provide an HV Service Update at GP training Day; meet with CCG Safeguarding Lead to discuss effective ways to promote GP/HV liaison and improved information sharing

Quality Improvement Programme

Solent's Quality Improvement (QI) Programme, launched in July 2016, is designed to support individuals and teams to develop the skills and capability to successfully identify and implement QI projects within their workplace. The growing success of the initial offer of a six monthly QI training programme for teams of staff has resulted in the successful launch this year of a stepped QI training programme comprising:

1. Introduction to QI: this short introductory session provides teams with a brief overview of QI.
2. Foundation day: this day long training provides an introduction to key QI methods. It is available to staff, patients and others using our services and includes support to carry out small scale QI projects within the workplace.
3. QI Practitioner: This is a team based training programme, bringing together staff and patients to build upon skills and knowledge in QI and use these to deliver improvement projects in their workplace.
4. QI Leaders: this year long programme is open to staff who have experience of successfully delivering QI projects and who want to develop their ability to lead QI activities across the Trust. The programme provides 4 externally facilitated training days, individual support with personal development and QI project delivery, and funding to support, for example, external site visits and project dissemination at conference.

This year approximately 350 staff and patients have participated in QI training.

Eleven Foundation Days have been delivered, 21 Foundation Day projects have successfully completed and 15 projects are underway. Examples of successful Foundation Day projects include:

- A team in our Special Care Dental Service has implemented a standardised process for follow up of patients who either did not attend or were not brought to their appointment. This resulted in a 50% increase in the number of patients seen after missing an appointment. Following implementation of the new process staff also reported increased confidence that patients who missed appointments were now being followed up appropriately

- A Specialist Community Nursing team increased the number of care plans completed by their staff from 28% to 100%. They also worked with their patients to co-design a Home Health Monitoring Care Plan

- A Community Therapy team identified that their current urgent waiting list was growing. The team identified that a new triaging system could help manage the urgent waiting list. This reduced the waiting time on the Urgent List from 13 weeks to 3 weeks and 3 days

Twelve teams also participated in two QI Practitioner programmes, 8 QI Practitioner projects have successfully completed and twelve projects are underway. Staff attending the training report better knowledge and increased confidence on how to make improvements; Charts 1 and 2 show outcomes for the most recent QI Practitioner cohort.

Chart 1: Results of Cohort 7 QI Practitioner participant evaluation of QI knowledge and skills
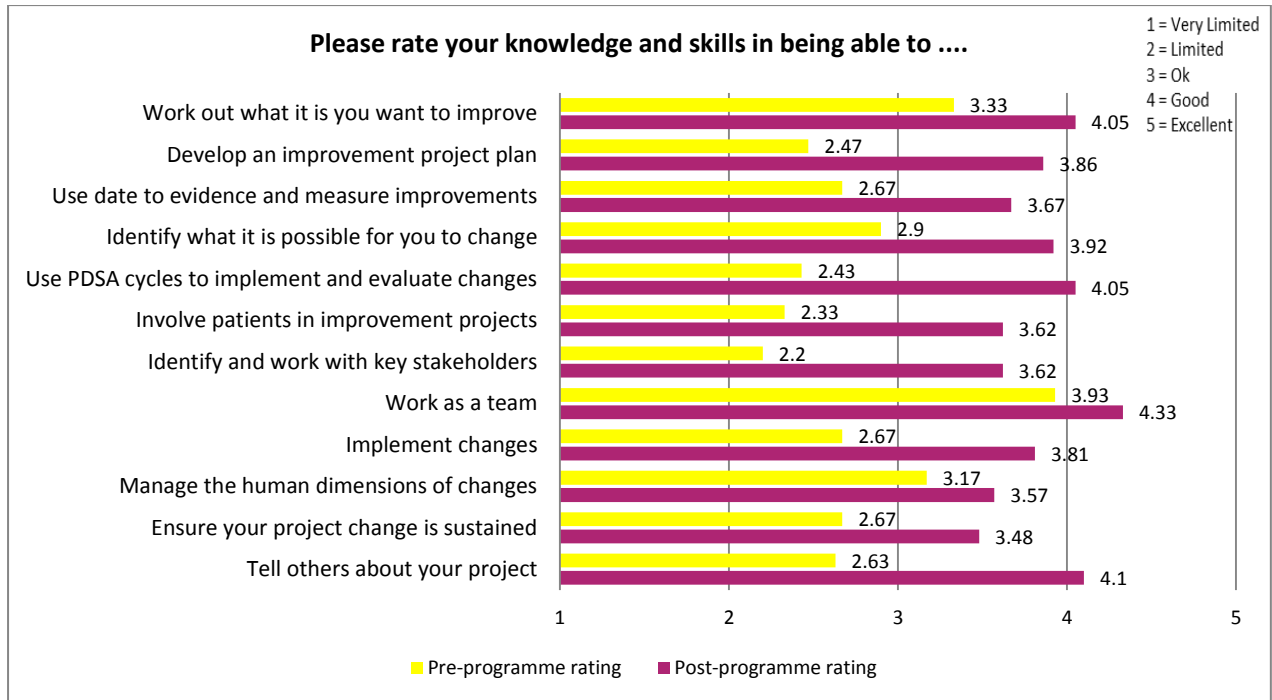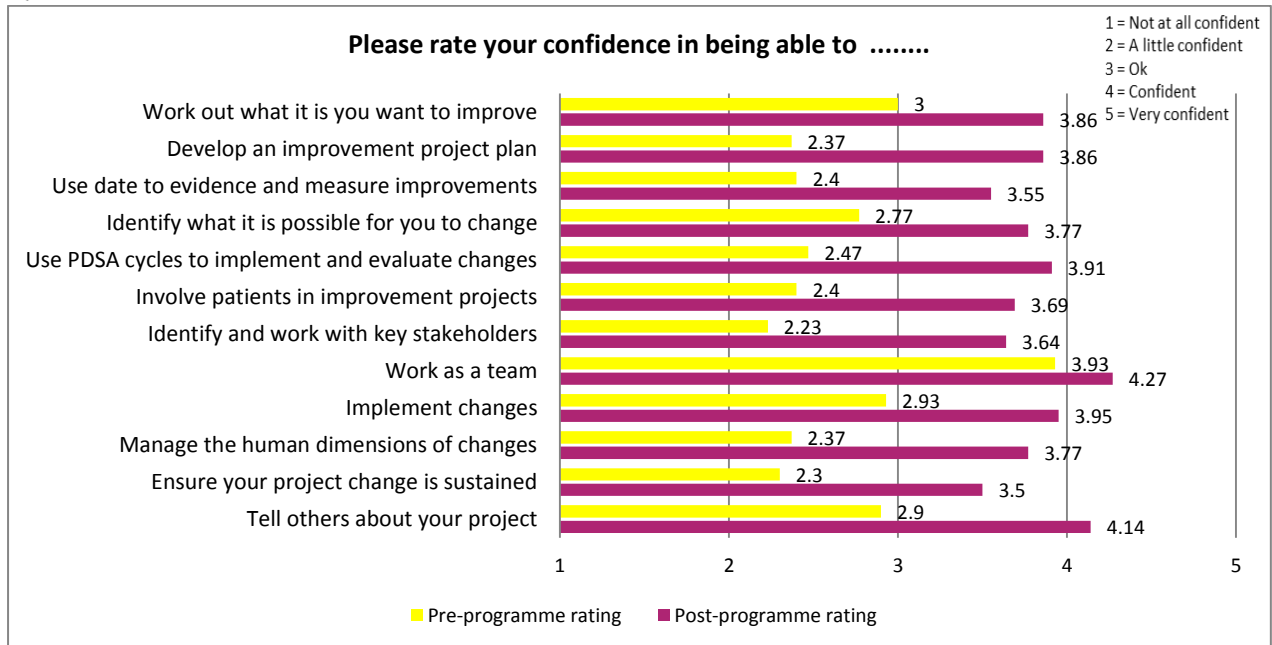
Please rate your knowledge and skills in being able to ....

1 = Very Limited
2 = Limited
3 = Ok
4 = Good
5 = Excellent

Category	Pre-programme rating	Post-programme rating
Work out what it is you want to improve	3.33	4.05
Develop an improvement project plan	2.47	3.86
Use date to evidence and measure improvements	2.67	3.67
Identify what it is possible for you to change	2.9	3.92
Use PDSA cycles to implement and evaluate changes	2.43	4.05
Involve patients in improvement projects	2.33	3.62
Identify and work with key stakeholders	2.2	3.62
Work as a team	3.93	4.33
Implement changes	2.67	3.81
Manage the human dimensions of changes	3.17	3.57
Ensure your project change is sustained	2.67	3.48
Tell others about your project	2.63	4.1

■ Pre-programme rating ■ Post-programme rating

Chart 2: Results of Cohort 7 QI Practitioner participant evaluation of confidence in ability to deliver QI activities

Please rate your confidence in being able to ....

1 = Not at all confident
2 = A little confident
3 = Ok
4 = Confident
5 = Very confident

Category	Pre-programme rating	Post-programme rating
Work out what it is you want to improve	3	3.86
Develop an improvement project plan	2.37	3.86
Use date to evidence and measure improvements	2.4	3.55
Identify what it is possible for you to change	2.77	3.77
Use PDSA cycles to implement and evaluate changes	2.47	3.91
Involve patients in improvement projects	2.4	3.69
Identify and work with key stakeholders	2.23	3.64
Work as a team	3.93	4.27
Implement changes	2.93	3.95
Manage the human dimensions of changes	2.37	3.77
Ensure your project change is sustained	2.3	3.5
Tell others about your project	2.9	4.14

■ Pre-programme rating ■ Post-programme rating

Examples of successful QI Practitioner projects include:

- A podiatry service worked to ensure their emergency appointment slots were no longer being booked for planned appointments. Following extensive data analysis, routine and follow up waiting lists across clinics were pooled, the number of daily emergency slots was adjusted, the length of each slot was increased and telephone triage to confirm the need for an emergency slot was introduced

- The Portsmouth Children's Healthy Weight team worked with two schools to increase engagement between the school and school nurse team with parents/carers of children identified as obese at their year R National Child Measurement Programme screening. Changes implemented, following consultation with parents, included timely distribution of the pre-measurement letter, text messaging reminders to parents the day before the measurement, promoting the role of the school nurse and translation of information into other languages

- The Sexual Health Services project ensured specimen logging and labeling errors were reduced and that when errors were made they were identified and rectified prior to samples being sent for laboratory processing. Changes made included implementation of a new process and standard operating policy, introduction of new logging sheets, display of flow charts in specimen logging areas and a programme of staff training. These changes have been spread Trust wide

Research

The number of patients receiving relevant health services provided or subcontracted by Solent NHS Trust in 2018/19, that were recruited during that period to participate in research approved by a research ethics committee is 2,849.

Solent NHS Trust continues to grow its research activity, with nearly 3,000 participants being involved in 50 studies over the past year. Solent was named as the most research active Care Trust in the National Institute for Health's most recent national league tables.

Number of participants recruited to research by year

Year	Participants
2016/17	1513
2017/18	2415
2018/19	2849
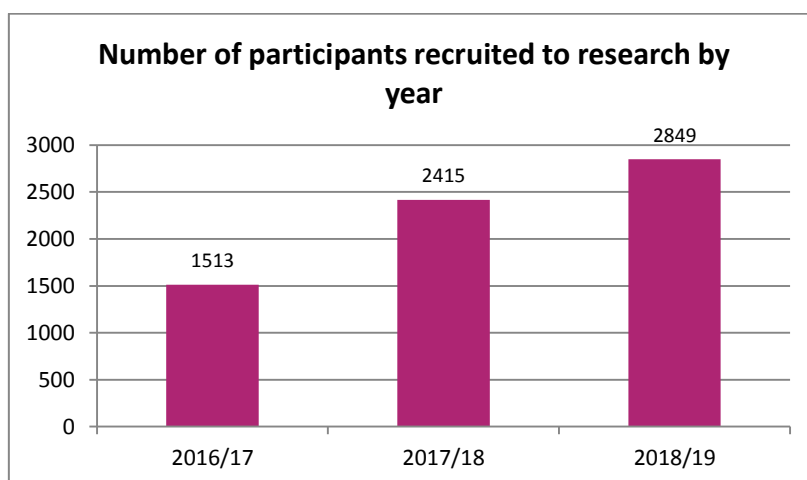
Solent NHS Trust conducts community-based health and social care research across a range of specialty areas including infection, neurology and stroke, musculoskeletal, mental health and ageing. We host grants and lead trials as well as contributing to research studies being led by other NHS trusts and universities.

We are working with a team at the University of Southampton to support research into antibiotic resistance, and carriage rates for infection. We take samples from people of all ages from the community. This enables the research team to determine community carriage levels of common respiratory pathogens and the prevalence of antibiotic resistance. To date we have recruited over 2,000 participants, across the full spectrum of age groups.

The PrEP Impact study is funded by NHS England and is taking place across the UK. It is testing medication to reduce the risk of contracting HIV. Solent NHS Trust offers participation in this trial at our three Sexual Health Service hubs. Interest in the trial has been high and, to date, we have recruited 146 participants. Our role includes regular follow up visits and collection of samples to determine successful avoidance of infection.

The Vision in Parkinson's disease study (led by University College London) investigates how, when and where visual processing breaks down for patients. Solent recruited 16 participants to this study who will be followed up over a four year period. Long-term this study will increase understanding of visual breakdown and contribute to the development of effective treatment.

The Ankle Recovery Trial (ART) compares two methods of managing ankle fractures after surgery using either a plaster cast or removable boot. This study was conducted in conjunction with a local orthopedic surgery department at Portsmouth Hospital Trust. Solent NHS Trust's research team co-ordinated the study, recruited 19 participants and provided the physiotherapy intervention. Formal results are awaited and will be used to guide future management of this patient group.

The CAP-MEM study (led by Northumberland, Tyne & Wear NHS Trust) explores the cause and prevalence of memory problems in mental health. It assesses self-reported concentration and memory problems amongst people with a clinical diagnosis of a psychiatric disorder and a comparison group of healthy controls. To date, Solent NHS Trust has recruited 263 participants to the study. This initial study will be used to establish the feasibility of conducting similar research amongst larger numbers of individuals in the future. Ultimately, findings will enable researchers to better understand the relationships between psychiatric diagnoses and memory and concentration problems, taking into account factors such as medication type and dosage.

The SCIMITAR study (led by the University of York) involved a bespoke intervention to support individuals with serious mental illness to stop smoking. Smoking cessation is often particularly difficult for this population cohort, and comorbid physical health problems are widespread. Solent NHS Trust recruited participants and delivered the intervention. Results of this study have recently been published in The Lancet demonstrating high rates of quitting in the intervention group compared to the usual care control group.

Our full Academy of Research and Improvement Annual Report is included in Appendix C of this report.

Commissioning for Quality and Innovation (CQUIN)

A proportion of Solent NHS Trust income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between Solent NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

This table shows the number of CQUINSs schemes in place for 2018-2019 and the number of schemes achieved:

Chart 1: Number of CQUIN schemes in place 2018-2019

Care Group / Service Line	Scheme	Commissioner	Q1		Q2		Q3		Q4	
			Due	Achieved	Due	Achieved	Due	Achieved	Due	Achieved
Portsmouth Care Group	#1 – Improving Staff Health and Wellbeing	Portsmouth							3	3
Southampton Care Group	#1 – Improving Staff Health and Wellbeing	Southampton							3	1
Adults Mental Health	#3 – Improving Physical Health for people with Severe Mental Illness	Portsmouth	4	4	1	1	1	1	6	6
Adults Mental Health	#4 - Improving services for people with Mental Health needs who present to A&E	Portsmouth	1	1			1	1	5	5
Childrens East	#5 – Transitions out of Children and Young People's Mental Health Services (CYPMH)	Portsmouth	1	1	4	4			4	4
Childrens West	#5 – Transitions out of Children and Young People's Mental Health Services (CYPMH)	Southampton	1	1	4	4			4	4
Adults Portsmouth	#8b – Supporting proactive and safe discharges - Community	Portsmouth							1	1
Adults Southampton	#8b – Supporting proactive and safe discharges - Community	Southampton							1	1
Portsmouth Care Group	#9 – Preventing ill health by risky behaviours – alcohol and tobacco	Portsmouth	5	5	5	5	5	5	5	5
Primary Care	#9 – Preventing ill health by risky behaviours – alcohol and tobacco	Southampton	5	0	5	0	5	0	5	0
Adults Portsmouth	#10 – Improving of Wounds Assessment	Portsmouth			1	1			1	1
Adults Southampton	#10 – Improving of Wounds Assessment	Southampton			1	1			1	1
Sexual Health Service	#1.1 – Activation System for Patients with Long Term Conditions (LTCs)	NHS England	1	1	1	1	1	1	1	1
		Total	18	13	22	17	13	8	40	33
			72%		77%		62%		83%	

Care Quality Commission (CQC)

Solent NHS Trust is required to register with the Care Quality Commission and the Trust is registered with no conditions.

The Care Quality Commission has not taken enforcement action against Solent NHS Trust during 2018/19.

Solent NHS Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Solent NHS Trust underwent a comprehensive core services inspection of all 15 core services in June 2016. The overall rating at that time was "Requires Improvement" with Mental Health and Learning Disabilities service given an "Outstanding" rating.

Our Primary Care services at Adelaide Health Centre (Solent GP Surgery) were inspected early in October 2018 and services were rated "Good" across all population groups with Primary Care rated "Good" overall.

Later in October 2018 we welcomed back the CQC to undertake a core services inspection of all services that previously had a 2016 "Requires Improvement" rating. The CQC inspected eight core services:
- Adults Community Services
- Children and Families
- Mental Health Psychiatric Intensive Care Units
- Older Peoples Mental Health Inpatient Ward
- Older Peoples Mental Health Community Services
- Mental Health Rehabilitation Integrated Practice Unit
- Mental Health Crisis 136 Suite

In November 2018, CQC returned to undertake a Well-Led inspection. This involved 31 interviews, mainly of the Board and senior leadership teams, plus two focus groups over a 2 ½ day period.

All inspections were announced, and no NHS Improvements "Use of Resources" inspection was deemed required at this time.

On February 27 2019, the final inspection report was published, and the Trust was given an overall rating of "Good". Our Older Peoples Mental Health (OPMH) in-patient unit was awarded a rating of "Outstanding" in the caring domain following the submission of additional information by the Trust. This had the benefit of raising the whole Trust rating to "Outstanding" in caring, which we believe is well-deserved recognition of our exceptional care.   Every core service inspected in 2018 was rated "Good" or "Outstanding" overall.

Our CQC ratings are now as follows:

Figure 1: Overall Trust Ratings

Overall rating for this trust	Good ●
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Outstanding ☆
Are services responsive?	Good ●
Are services well-led?	Good ●

Figure 2: Ratings for Primary Care services by population group

Older people	Good ●
People with long-term conditions	Good ●
Families, children and young people	Good ●
Working age people (including those recently retired and students)	Good ●
People whose circumstances may make them vulnerable	Good ●
People experiencing poor mental health (including people with dementia)	Good ●

Figure 3: Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good ↑ Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019
Community health services for children and young people	Good ↑ Feb 2019	Good ↑ Feb 2019	Good →← Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019
Community health inpatient services	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Community end of life care	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Overall*	Good ↑ Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019

Figure 4: Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019
Long-stay or rehabilitation mental health wards for working age adults	Good ↑ Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019
Wards for older people with mental health problems	Good ↑ Feb 2019	Good ↑ Feb 2019	Outstanding ↑ Feb 2019	Good →← Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019
Community-based mental health services for adults of working age	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Mental health crisis services and health-based places of safety	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good →← Feb 2019	Good ↑ Feb 2019	Good →← Feb 2019
Specialist community mental health services for children and young people	Good Sept 2017	Good Sept 2017	Outstanding Sept 2017	Requires improvement Sept 2017	Good Sept 2017	Good Sept 2017
Community-based mental health services for older people	Good ↑ Feb 2019	Good ↑ Feb 2019	Good Feb 2019	Good →← Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019
Community mental health services for people with a learning disability or autism	Good Nov 2016	Outstanding Nov 2016	Outstanding Nov 2016	Outstanding Nov 2016	Outstanding Nov 2016	Outstanding Nov 2016
Substance misuse services	Good Sept 2017	Good Sept 2017	Good Sept 2017	Good Sept 2017	Good Sept 2017	Good Sept 2017
Overall	Good ↑ Feb 2019	Good ↑ Feb 2019	Outstanding ↑ Feb 2019	Good →← Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019

We were advised of 36 minor breaches of regulations; these areas for improvement are spread across the trust and clinical services. While action is not mandated, the findings will positively

influence us to deliver best practice and the time frame we have set to make improvements is 6-12 months.

We were issued with one Requirement Notice for a breach of *Regulation 12(2) (g): the proper and safe management of medicines* in our Adult Mental Health services. This breach was found in one location only, was not system-wide and we have submitted a comprehensive action plan to CQC which addresses the regulatory requirements. The actions are already well underway and will be tracked and maintenance monitored through service-level governance meetings, the Quality Improvement & Risk Group and monitored by the Assurance Committee and Trust Board.

Two other reviews of services have been undertaken by the Mental Health Act Review team, resulting in two positive reports.

Our Specialist Dental Services and Sexual Health were not inspected in 2018 and we look forward to welcoming CQC back to review these services.

Information Governance

The Solent NHS Trust *Data Security and Protection Toolkit for 2018/19* was submitted on 27 March 2019 as Standards Met; meaning all mandatory requirements have been achieved.

Payment by Results (PbR) Clinical Coding

Solent NHS Trust was not subject to the Payment by Results clinical coding audit by the Audit Commission during 2018/19.

Data Quality

During 2018/19 we developed our internal data quality tools, giving services simple, near real-time access to their information, including waiting lists and appointment outcomes, in order to validate and correct any data entry issues. As a result, the number of reported 52 week breaches and the number of reported 18-51 week waiters has dramatically reduced giving a clearer and more accurate position for the Trust.

The Data Quality Team has received additional investment during 2018/19 to expand the resource available to work collaboratively with our services to validate data including waiting time performance indicators, continue to systemically review all service users on waiting lists to ensure they are accurate and appropriately recorded, and to investigate and resolve data quality issues as they arise. Regular automated reporting will be extended and oversight shared with services and senior management to ensure validations and outcomes are being recorded correctly and the quality of our data continues to improve.

An internal audit report on Clinical Data Quality was published in May 2018, assessing both the governance and implementation of data quality processes in order to establish adherence to national and internal guidelines. The main issue identified in the audit report was that reporting on clinical data was hindered by inaccurate and often delayed data entry by clinical service staff. The developments within the data quality function over the past year have aimed to address these issues and the additional resource should further help to alleviate this into 2019/20.

Learning from Deaths

During 2018/19 1867 people who have been in receipt of services provided by Solent NHS Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 383 in the first quarter;
- 458 in the second quarter;
- 505 in the third quarter;
- 521 in the fourth quarter.

By end of year, 751 case record reviews and 14 serious incident investigations have been carried out in relation to 1867 of the deaths included above

In 14 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 223 in the first quarter;
- 204 in the second quarter;
- 190 in the third quarter;
- 168 in the fourth quarter.

Our current process does not identify how many patient deaths scrutinised by case record review during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. However, where concerns were noted an incident review meeting was held to determine whether a serious incident investigation was required. From April 2019, the Trust will record on the mortality dashboard how many deaths were identified with concerns relating to quality of care and or deaths that were noted as more likely than not to be attributed to the care provided by our organisation. This will be discussed at the monthly Learning from Deaths panel where all service lines are represented.

The Trust continues to develop its Learning from Deaths Framework and was one of the first community Trusts in the country to adopt the Structured Judgement Tool Reviews before the expectation that all Trusts would adopt this methodology (it was originally piloted for acute Trusts only).

The inclusion criteria in our current policy, results in a high number of reviews being undertaken when our organisation was not the main provider of care (for example, where we provided dental or podiatry services). We continue to review and update our criteria for review as we strive to ensure that reviews are meaningful and supportive of identifying lessons and improvements. This is reflected in the quarterly data which shows a decreasing number of cases reviewed over the year.

When learning is identified this is added to the Trust Learning Framework Database; changes and outcomes are monitored at the monthly Learning from Deaths panel.

To date, on review of our care provided we have not identified any deaths relating to our care provision which were thought to be avoidable. We have also not identified any deaths in which the quality of care was noted to have been a contributing factor in the patient's death. Had this been identified, a serious incident would have been declared.

In cases when we have attended the Coroners court we have not received any Prevention of Future Deaths Notifications or been notified that any other actions need to be undertaken. In cases where a serious incident has been completed, the Coroner has been satisfied with the recommendations and actions the Trust has already agreed or implemented. In all cases, it was confirmed that had

these actions been undertaken, it would not have resulted in a different outcome for the patient (i.e. prevented their death).

Below is a summary of the learning we have identified by undertaking reviews of deaths, and the subsequent actions taken. Delivery of actions has been monitored through the Trust Learning Database:

Service	Learning and Improvements
Children's and Families	The team has reviewed all safe sleeping information and introduced standardised paperwork including leaflets to ensure staff members always confirm where a baby is sleeping
Children's and Families	A training programme has been introduced for staff relating to the management of pre-term babies
Children's and Families	We are now working with acute providers to strengthen the pathway for managing babies with identified risk factors when discharging to the community nurses
Children's and Families	We can now link a child's records to the father/significant other on the electronic recording system. Previously it was only possible to link with the mother's records
Adults Portsmouth	Nurses are now able (after training) to verify deaths when a patient's death is expected in an end of life care setting to avoid distressing delays for families out of hours
Adults Portsmouth	Safeguarding guidance and the referral process has been updated on the Trust intranet to support staff in their decision making
Adult Mental Health	Guidance has been introduced to guide staff on the referral and management processes between the Hampshire Liaison and Diversion Service (HLDS) and the Police
Adult Mental Health	Guidance has been updated and implemented for staff to follow when agreeing informal leave for patients who are not detained under the Mental Health Capacity Act
Adult Mental Health	Training sessions and simulation exercises have been completed (and continue) across the service to improve staff competency and confidence in immediate life support and airway management in an emergency situation
Adult Southampton	A decision making tool has been rolled out to support pain assessments to improve end of life care in non-end of life care settings and is available on the electronic patient record system
Adult Mental Health, Adults Southampton and Adults Portsmouth	The service is developing collaborative guidance for preadmission assessments and referral processes to ensure that we transfer patients safely to the correct environment according to their needs
Adult Mental Health	We have written a clear process and guidance for staff advising when to repeat VTE assessment when a patient's condition
Adult Mental Health	We have developed a process to highlight a list of most "at risk of suicide" patients who are then discussed in depth at the multi-disciplinary team meetings by those present
Children's and Families	We have implemented an SOP to provide guidance to staff on how to complete an assessment and when and how to escalate concerns relating to child sexual exploitation
Children's and Families	We have implemented an SOP on the process and requirements needed when transferring a patients care to another provider to ensure that the safety of the patient is consistently maintained
Children's and Families	The process for the support of staff involved with a child who dies unexpectedly has been developed and improved upon. This is now provided in the form of debriefs and supervision and since the implementation of this there have not been any further reported issues regarding this
Children's and Families	Guidance has been introduced for staff on when and how to refer patients to the pharmacy technician for review of patient medications. This will include concerns regarding safeguarding and compliance
Adult Southampton	The Trust Mental Capacity Tool is now easily available on the clinical tree within the electronic patient record to enable staff to complete the assessment as required
Adult Southampton	An audit has been completed to demonstrate the impact of change relating to the

Service	Learning and Improvements
	development of a pain tool on the electronic record system –this related to the management of end of life care for patients on wards that rarely provide this form of care. Staff had varied knowledge and experience of the tool and the service has committed to continue to promote the knowledge and use of this tool and will now monitor at service level

There were 16 case record reviews and 0 investigations completed after 31 March 2018 which related to deaths which took place before the start of the reporting period 2018/19.

None of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

None of the patient deaths during 2018/19 are judged to be more likely than not to have been due to problems in the care provided to the patient.

As stated above, during this period the Trust did not have a process in place identify how many patient deaths scrutinised by case record review during the reporting period were judged to be more likely than not to have been due to problems in the care provided to the patient. A process has been introduced from April 2019.

Speaking Up (New for 2018/19)

In its response to the Gosport Independent Panel Report, the Government committed to legislation requiring all NHS trusts and NHS foundation trusts in England to report annually on staff who speak up (including whistle blowers).

Since the introduction of Freedom to Speak Up in 2015 and as a consequence of recommendations made by Sir Robert Francis, we have implemented processes within the Trust to ensure our staff are able to easily raise concerns and seek confidential advice and support.

We have an Independent Freedom to Speak up (FTSU) Lead Guardian who is supported by 5 Guardians working across our services. Staff can speak up on any issue using a variety of communication mechanisms; Freedom To Speak Up Guardian (FTSUG) inbox, email FTSUG individually, face to face meetings, telephone call, video call. Feedback is requested verbally and recorded quarterly using our data return log to the National Guardian Office.

Our Quarterly Freedom to Speak Up (FTSU) Steering Group is chaired by a Non-Executive Director (Chair of the Audit & Risk Committee) and is attended by the Chief Executive, Chief People Officer, Chief Nurse and our Independent Lead FTSU Guardian. At the meeting, the Independent FTSU Lead Guardian and Executives provide assurance to the Lead Non-Executive Director for FTSU on behalf of the Board that issues raised are dealt with promptly and appropriately by the Trust. The FTSU Independent Lead Guardian briefs colleagues on:
- current cases and actions taken taking into account confidentiality and anonymity
- regulatory/national requirements from the National Guardian Office

The Chief Nurse and Chief People Officer brief members and provide assurance that appropriate actions are being taken where any matters concern patient and staff safety and /or wellbeing.

The Group also oversees work programmes associated with FTSU including the development of the strategy and associated implementation plan, the completion of the National Board Self- Assessment and ensuring appropriate promotion and engagement to support an open culture of raising concerns, continuous learning and organisational development.

As of 14th Feb 2019 the Trust has had 35 logged of Freedom to Speak Up cases. Three themes have been identified in 2018/19:

- Bullying & Harassment
- Systems and processes
- Behaviours & relationships

As a result of these cases the Trust has reviewed and assessed its Freedom to Speak Up processes by:

- Carrying out deep dives into specific service areas which have involved analysis of local data, listening exercises with staff groups and onsite assessments
- Engaged in consultative & collaborative working with senior managers to improve service areas and working culture relationships
- The Trust Board also led on the appointment of an independent, impartial Lead Freedom to Speak Up Guardian in December 2018

Doctors and Dentists in Training (New for 2018/19)

The Trust produces quarterly and annual Guardian of Safe Working Reports and these indicate we are doing well in ensuring all the provisions and Terms & Conditions from the 2016 Juniors' Contract are being followed.

Gaps are mainly evident in two rotas, both of which are held jointly with other Trusts and the longer term management of the rotas will involve wider systems including other Trusts, CCGs, especially for the Child & Adolescent Mental Health Services (CAMHS) rota as well as Sustainability & Transformation Partnerships (STP) systems.

Actions being taken to address gaps in the two rotas include:

- Child and Adolescent Mental Health (CAMHS) Rota – gaps are being filled by offering them as locums to trainees with all the Educational Supervisors, Guardian of Safe Working and Director of Medical Education ensuring there is no adverse impact on education and training. The use of locums may need to follow the Trust's 'acting down' Policy for gaps that can't be filled by trainee locums and as a results consultants may need to 'act down' (we have a number of gaps this year due to the coincidental completion and graduation from the rotation of 5 Specialty Trainees). The gaps will eventually be filled as trainees are recruited nationally. The CAMHS Service has also taken a longer term view regarding recruitment and retention, and the Director of Medical Education has worked with Health Education Wessex and Health Education England (HEE) to ensure the Trust will participate in the national CAP (Child & Adolescent Psychiatry) run-through training pilot

- Mental Health Junior Doctor Rota – this rota is shared between Southern Health NHS Foundation NHS Trust and Solent. The unfilled shifts/ gaps are currently covered by locums and occasionally by Specialist Trainees 'acting down'. There are on-going discussions between the two Trusts and Wessex Deanery to find a more sustainable way forward and this will involve other systems including STP, and HEE national recruitment

2.3 Reporting against Core Indicators

NHS Trusts are required to report performance against a core set of mandated indicators using data made available to the Trust by NHS Digital.   Target thresholds for indicators 1 to 3 are being met. The target threshold for indicator 4 is not being met and a summary of actions to be taken is provided. There are no target thresholds for indicator 5.

Indicator 1: The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period

Measure:	Numbers of Service Users followed up within 7 days of discharge from inpatient care (Omnibus collection by Information Centre)											
	Threshold	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
Month	95%	100%	100%	100%	100%	98%	100%	100%	97%	100%	100%	100%	100%
YTD	95%	100%	100%	100%	100%	100%	100%	100%	99%	99%	99%	100%	100%

Indicator 2: The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period

Measure:	Percentage of Admission Gate Kept by CRHT (Including MHA assessments)											
	Threshold	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
Month	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
YTD	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Indicator 3: The percentage of patients aged (i) 0 to 15 and (ii) 16 or over re-admitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period

Measure:	Percentage of patients aged 0 to 15 re-admitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust											
	Threshold	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
Month	5%	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL
YTD	5%	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL	NIL

Measure:	Percentage of patients aged 16 or over re-admitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust											
	Threshold	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
Month	5%	0%	3%	2%	4%	3%	3%	2%	2%	3%	2%	3%	1%
YTD	5%	0%	1%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%

Indicator 4: The trust's 'Patient experience of community mental health services' indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period

Measure: % of Patients Extremely Likely or Likely to Recommend Solent Services													
	Threshold	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
Month	95%	75%	71%	88%	89%	86%	100%	91%	91%	88%	85%	91%	92%
YTD	95%	75%	73%	78%	81%	81%	83%	84%	85%	86%	86%	87%	87%

Data is shown in red as target thresholds have not been met however this is consistent with the national trend for Friends and Family Test (FFT) in Mental Health services. We continue to work hard to increase FFT feedback so the data is more representative and the service has improved results by 10% over the past 12 months using iPads in some areas. We aim to continue this improvement in the next 12 months and are currently exploring other ways of obtaining feedback.

Indicator 5: The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death

Indicator	2017-18		2018-19	
	Number	Percentage	Number	Percentage
Patient safety incidents reported	4452	N/A	4415*	N/A
Patient safety incidents resulting in severe harm or death	6	0.13%	2**	0.45%

*NRLS data is published every six months and the last published data was to the end of February 2019
** The number of severe harm or death incidents does not directly equate to the number of serious incidents (Learning from Deaths section). Many of the Trust's serious incidents are moderate harm incidents and are sometimes downgraded following investigation.

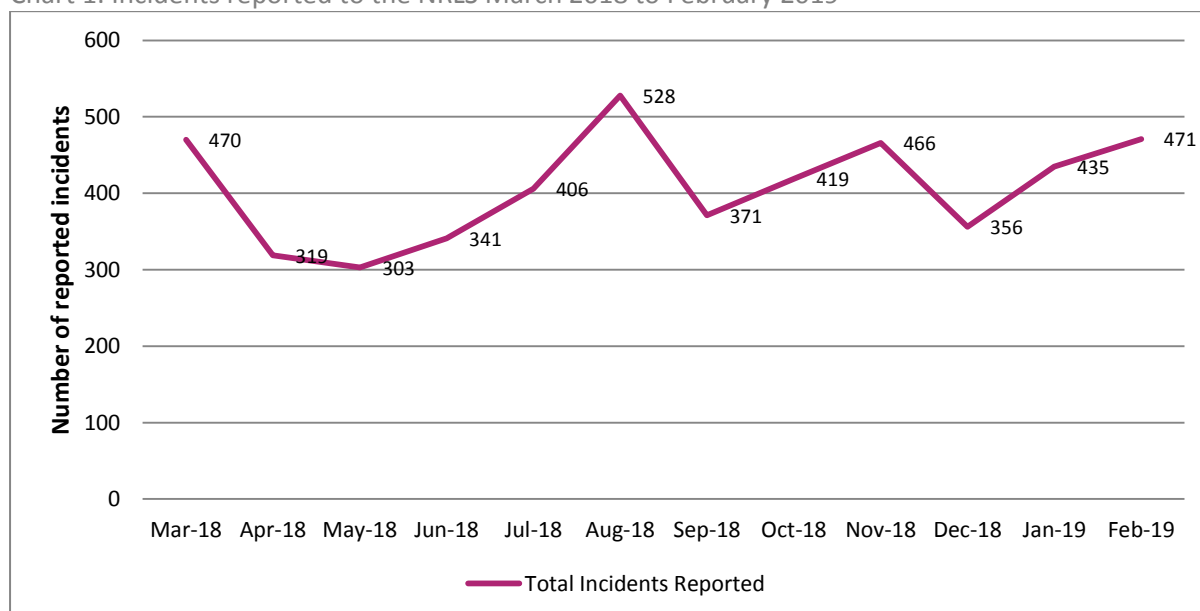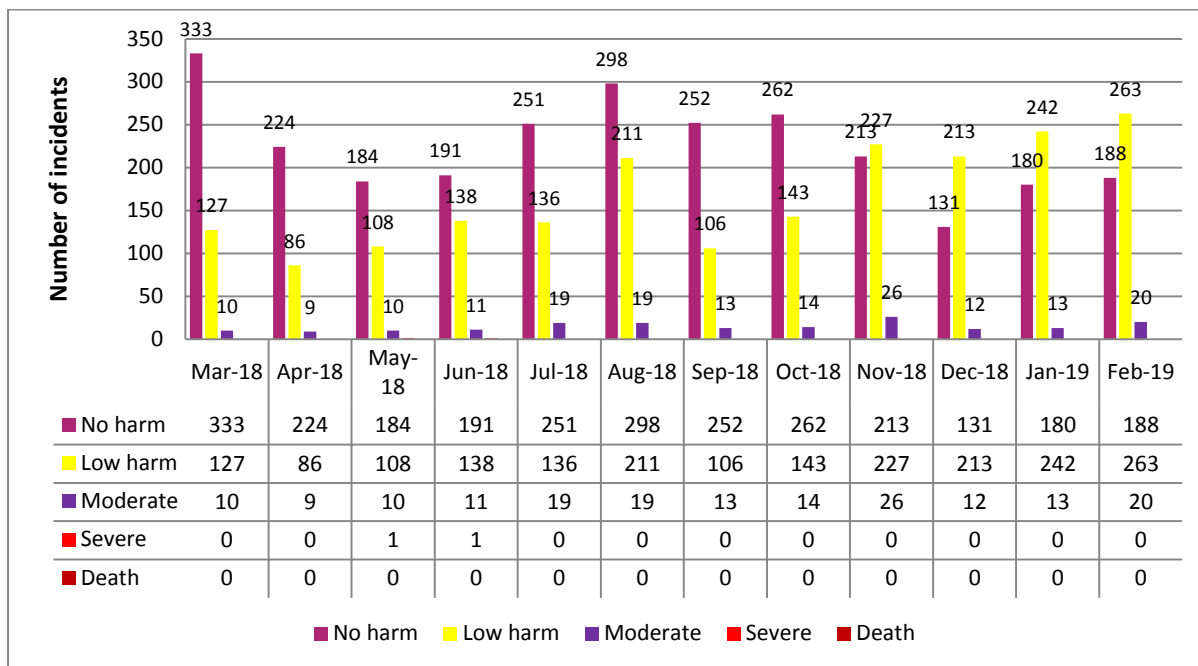Chart 1: Incidents reported to the NRLS March 2018 to February 2019

Chart 2: Degree of harm of NRLS reported incidents from March 2018 to February 2019

	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
No harm	333	224	184	191	251	298	252	262	213	131	180	188
Low harm	127	86	108	138	136	211	106	143	227	213	242	263
Moderate	10	9	10	11	19	19	13	14	26	12	13	20
Severe	0	0	1	1	0	0	0	0	0	0	0	0
Death	0	0	0	0	0	0	0	0	0	0	0	0

Solent NHS Trust considers this data is as described for the following reasons;

- The number of moderate incidents relates mainly to category 3 and 4 pressure ulcers which were acquired in the care of the Trust.
- Of the two severe incidents, one relates to a patient causing major damage to the ward area which resulted in the evacuation of all patients on the ward. Several patients had to be relocated to other health care providers. The other relates to a patient who fractured their neck of femur while an inpatient.

Reducing Patient Harm

The figures highlight that the majority of incidents reported result in "no harm" or are "near misses". There is a positive culture in reporting and staff are encouraged to report incidents and where an increase is seen it is seen as a positive increase in no or low harm incidents (none have been identified as severe harm).

Incidents are reviewed alongside other data such as compliance with assessments. Analysis is undertaken monthly to identify if there are any themes or trends and if identified this is highlighted to service leads and escalated via Quality Improvement and Risk (QIR) Group for future actions to be monitored.

Training is provided for incident reporters and reviewers which has improved the quality of data reporting and management. The Trust continues to work with staff to improve the reporting processes and make improvements to the electronic reporting system.

Duty of Candour

The Trust has implemented the statutory requirements of Duty of Candour and provides mandatory training and local guidance as per the Trust policy. When staff complete an incident form using the online reporting system, if Moderate harm or above is indicated the system prompts the reporter to consider if Duty of Candour applies. If a serious incident is declared, again the service is prompted to consider if Duty of Candour applies.

In their inspection last year, CQC identified that some staff were unsure of their obligations in relation to Duty of Candour and one of our quality improvement priorities for 2019/20 is to address this; in quarter 1 2019/20 the Trust will launch the updated "Being Open and Duty of Candour" policy which will enhance staff awareness of the importance of Being Open, in addition to how to meet the statutory requirements of Duty of Candour and when it applies.

Training packages and resources are being developed to support this as the Trust recognises that getting this right at first point of contact is crucial in supporting our patients and families/carers to ensure we embrace our Trust values and culture of "honesty" and "everyone counts" and seek to identify opportunities for learning when things have not gone the way we intended.

Family Liaison

In November 2018 the Trust recruited to the role of Family Liaison Manager (FLM), following recognition of the need for support of our bereaved families, at a time of great emotional distress. The aim of the FLM role is to ensure the Trust provides a consistent, autonomous person who will give unconstrained and appropriate support to bereaved families and carers, also assisting the Trust in consulting with and involving affected families.

The FLM fully walks through the processes, whatever they may be, with the family and supports them both at the time of the incident and during investigation, and in the future, should they need this.

The FLM encourages families to speak up and to be involved in investigations, to provide key information that may assist in a more rounded and holistic view/outcome of an investigation, as well as ensuring that staff are confidently and actively involving families and with regard to Duty of Candour.

The FLM is involved from the outset, starting at the Incident Review Meeting, where the FLM can input about support for the family and brings to that meeting the voice of the family.

Signposting for relevant services, counselling and FLM support is offered to all families and carers, by way of this role when a bereavement or serious incident happens and it is identified that there may be a role for FLM.

The FLM is also on hand to guide families through the Inquest process and also other health and social care systems as required.

Part Three: Other information

3.1 Quality Initiatives

This section provides information about other quality improvements and initiatives not covered elsewhere in this report.

Accessible Information (AI)

Identifying patients and carers communication and/or information needs

Accessible information (AI) screening has now been embedded into all electronic patient record systems across the Trust. The screens have been designed to meet the requirements of the NHS England Accessible Information Standard (DCB1605 Accessible Information).

11,646 Communication Discussed

5,020 AI screens completed

Accessible Information (AI) screening includes four key questions - how the person communicates; if they require any communication support; what format they need their information; and their preferred contact method.

As of February 2019, **11,646** discussions about communication and/or information needs have been recorded. Of these, **5,020** people went on to have a full accessible information screen completed. Through screening, **1,941** people with communication and/or information needs were identified, which equates to 39%.

To further understand the nature and prevalence of communication and/or information needs across our local population, additional data is presented in the tables below.
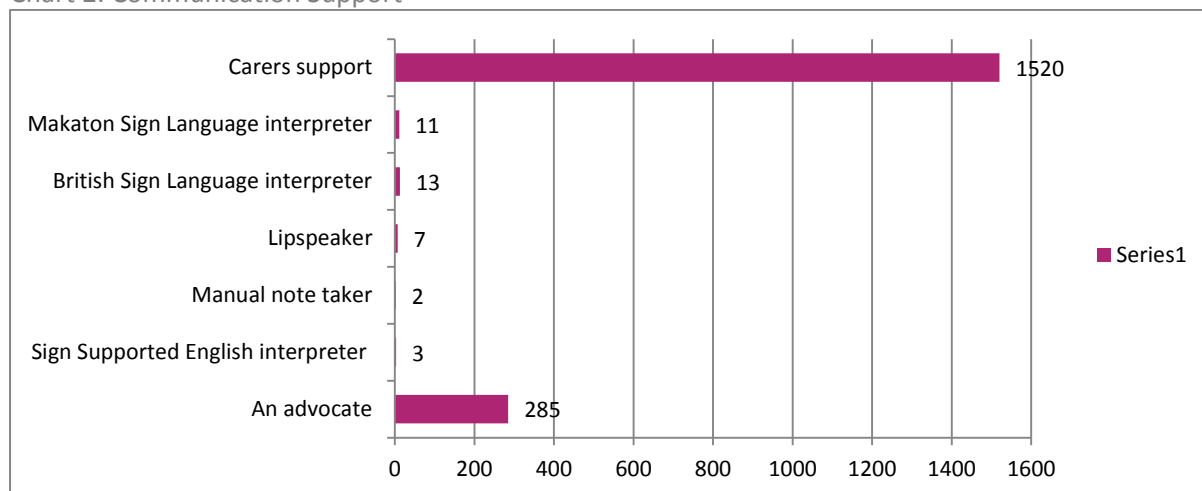
Chart 1 highlights the wide range of communication methods used by our patients and carers and the skills needed by our staff to support and facilitate inclusive communication approaches.

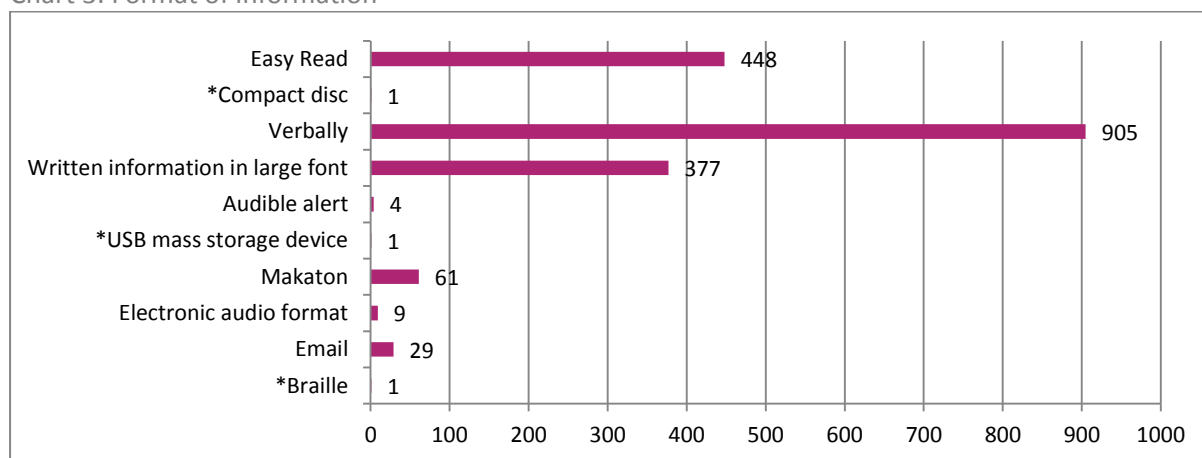Chart 1: Patient/Carer method of communication
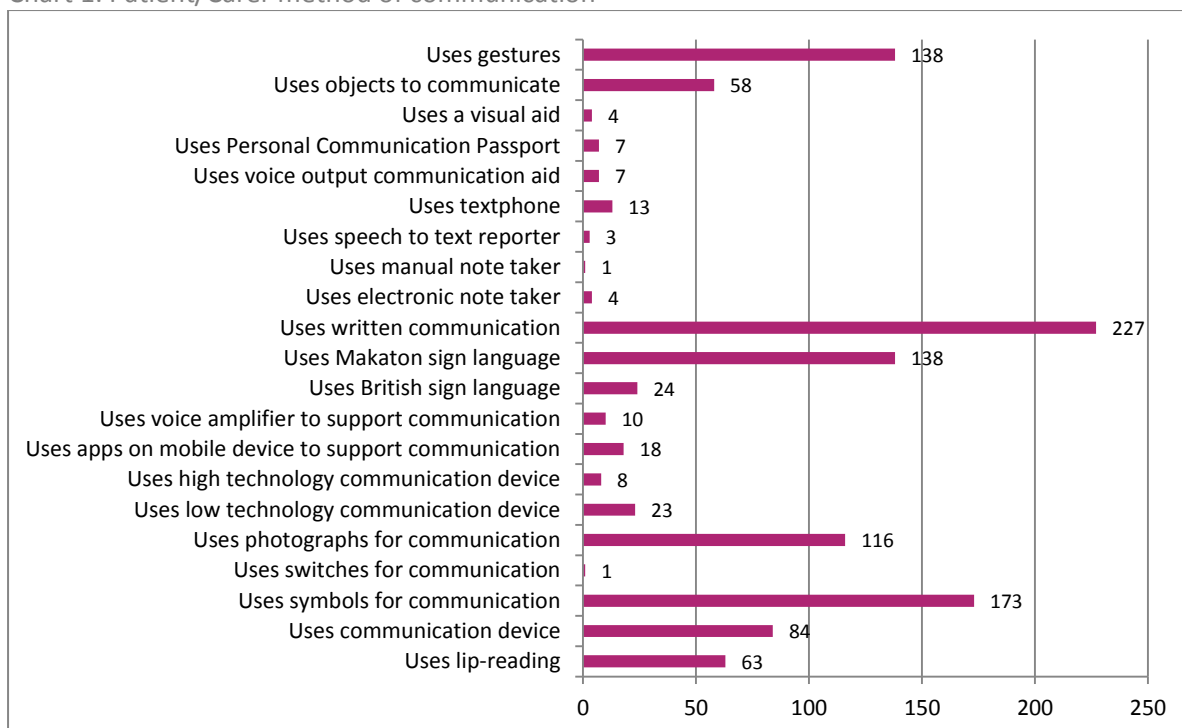
In addition to the information presented above, **1,114** people were recorded as using a hearing aid.

Chart 2: Communication Support

Category	Value
Carers support	1520
Makaton Sign Language interpreter	11
British Sign Language interpreter	13
Lipspeaker	7
Manual note taker	2
Sign Supported English interpreter	3
An advocate	285

(Series1, axis 0 – 1600)

The information presented in Chart 2 illustrates that of those screened, 83% required the support of a paid or unpaid carer to support their communication and 15% required an advocate. Data on the number of people requiring a paid communication specialist e.g. a British Sign Language (BSL) interpreter remains low at only 3%. However, through our procurement records we know that a higher number of BSL interpreters have been commissioned; indicating that some services are still not recording this need within the AI screen.
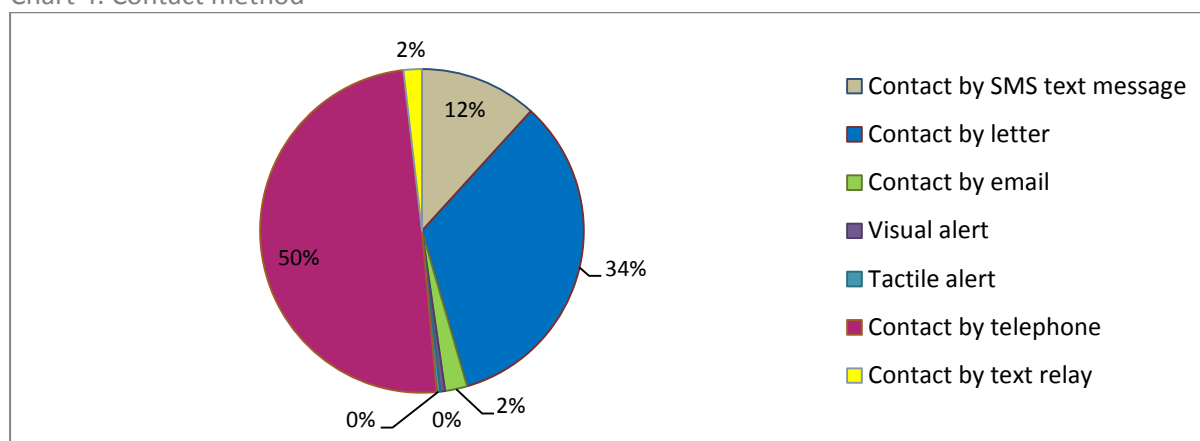
Chart 3: Format of information

Category	Value
Easy Read	448
*Compact disc	1
Verbally	905
Written information in large font	377
Audible alert	4
*USB mass storage device	1
Makaton	61
Electronic audio format	9
Email	29
*Braille	1

(axis 0 – 1000)

*= only 1 person identified.

Of those screened, 900 people requested to have their information verbally, however this raises a concern about the person's ability to accurately retain and act on the health information given. The next highest requested formats were Easy Read and large font, both of which can be produced in-house.

Chart 4: Contact method

Pie chart segments:
- 2% (Contact by text relay, yellow, top)
- 12% Contact by SMS text message
- 34% Contact by letter
- 2% Contact by email
- 0% Visual alert
- 0% Tactile alert
- 50% Contact by telephone

Legend:
- Contact by SMS text message
- Contact by letter
- Contact by email
- Visual alert
- Tactile alert
- Contact by telephone
- Contact by text relay

Of those screened, most people are still requesting contact via the traditional methods such as by telephone, letter, email and SMS text message (98% collectively). Only 2% of those screened required a more specialist contact method as illustrated above.

In-house communication training and support

Throughout 2018/19, 35 additional members of staff from 22 services across the Trust have completed the one-day AI workshop delivered by the Accessible Information Team. The workshop has been updated to include the Communication Access Symbol UK (see below) and is now co-delivered by a patient-lead that has first-hand experience of living with communication and information needs. Some staff supporting patients with complex communication needs have also been trained in Talking Mats™. The Trust has one accredited trainer for Talking Mats™ who delivers the training across the Trust bi-annually.

There is an established AI champion network, with over 50 members, that meets bi-monthly to lead change and share learning beyond the training. AI practice is further supported by a comprehensive AI SolNet page that hosts a range of tools to support the production accessible resources, ready to use Easy Read resources and information to support self-directed learning.

Communication Access Symbol UK – early adopters

Following a two-year national project run by the Royal College of Speech and Language Therapists (RCSLT), 2018 saw the launch of the new Communication Access Symbol UK. The symbol (pictured on the left) will be used to demonstrate that the service/team can support the communication access standards. Good communication benefits everyone and effective communication access for all is achievable through awareness, education and training.

Solent NHS Trust was proud to be selected as the first community and mental health NHS Trust nationally to register as an early adopter of the Communication Access Symbol. On the 8 March 2019, key staff from the Trust headquarters received the training and Highpoint become our first communication accessible location. As part of the early adopter phase it is hoped our in-house AI workshop will be Communication Access accredited which will support local implementation.

Co-produced accessible self-help guides for children with learning disability and mental distress

A collaborative quality improvement project was led by the Accessible Information Team to develop and evaluate accessible resources to support and promote self-management whilst families await

specialist interventions. Engagement events were conducted with parents, children and siblings who had lived experience of managing mental distress within the home environment. Baseline data from the Child and Adolescent Mental Health Service - Learning Disabilities (CAMHS-LD) was reviewed in relation to the range, frequency, intensity and cost of their interventions. A co-production model was then utilised to develop the accessible self-help guides.

Sleep was identified as the key topic for the on-line prototype. Parents wanted a demonstration video, which included professional guidance alongside stories from families with lived experience, as well as Easy Read documents. The impact on siblings and the need for a child friendly resource was highlighted. A range of children worked with the team in designing an animation to support good sleep strategies.

The 'Sleep Help' resources were launched in February 2019 and can be access via the Solent Healthier Together website: https://www.what0-18.nhs.uk/solent/camhs/sleep-help. The impact of the accessible sleep self-help resources will be fully evaluated over a 12 month period, through service user feedback and a review of CAMHS-LD activity data.

Inclusive Community Engagement Event and Accessible Annual General Meeting (September 2018)

For the 2018 Annual General Meeting (AGM) a number of steps were taken to ensure the meeting and event beforehand supported communication access. A summary of the action taken is presented below;

- Promotional resources about the event and AGM included an Easy Read leaflet/poster and sign-up form
- People were encouraged to register for the event. The online registration included four key questions about communication and information needs (aligned to the Accessible Information Standard) so the right support could be planned ahead of the event
- There was a registration desk where people were welcomed and their support needs checked.
- Rather than a traditional health fair, there was an interactive community engagement event that enabled people to explore our services through their senses. This led to a more shared experience, accessible to all
- Everyone received an accessible resource pack that will include a range of resources to support understanding including a dual format agenda, a visual floor plan to guide people through the event, a large print version of the Directors poster etc.
- To maximise the accessibility of the AGM presentation, there were BSL interpreters who signed alongside the Chairman's welcome and the review of the year by the Chief Executive, Chief Finance Officer and Chief Nurse. There was also an Easy Read summary of the presentation in the packs
- The open question and answer session was replaced by small group discussions. There was a table host and a communication facilitator on each table. A range of total communication tools were available to support the discussion and the facilitators ensured that everyone was listened to and had an equal voice. Key points from each table will be shared with the larger group and collated in an action plan

We plan to build on the success and feedback received when we hold our 2019 Annual General Meeting later this year.

Future Developments

In 2019/20 the focus will be on rollout of Communication Access Symbol UK across a range of clinical bases and further development of centralised advice and support for meeting patients and carers AI needs, including expanding our use of audiovisual information.

Following growing interest in our AI developments from other NHS Trust, we will scope the potential for national consultancy support to drive AI developments at scale.

Avoidable Healthcare Associated Infections (HCAI's)

Healthcare Associated Infections (HCAIs) can develop as a direct result of healthcare interventions or from being in contact with a healthcare facility. The term HCAI covers a wide range of infections including the most well-known such as Methicillin Resistant Staphylococcus Aurous (MRSA) and Clostridium Difficile Infection (CDI).

In line with the *Five Year Forward View* (NHS England 2014) the Trust has remained committed to a zero tolerance approach to any HCAI. If any such infections occur a full investigation takes place so that any learning can be shared and implemented. The following graph illustrates numbers of MRSA bloodstream infections (MRSA BSI) and cases of CDI that have occurred within the Trust since 2013 to the end of 2018/19.

Chart 1: MRSA and CDI infections 2013 - 2019
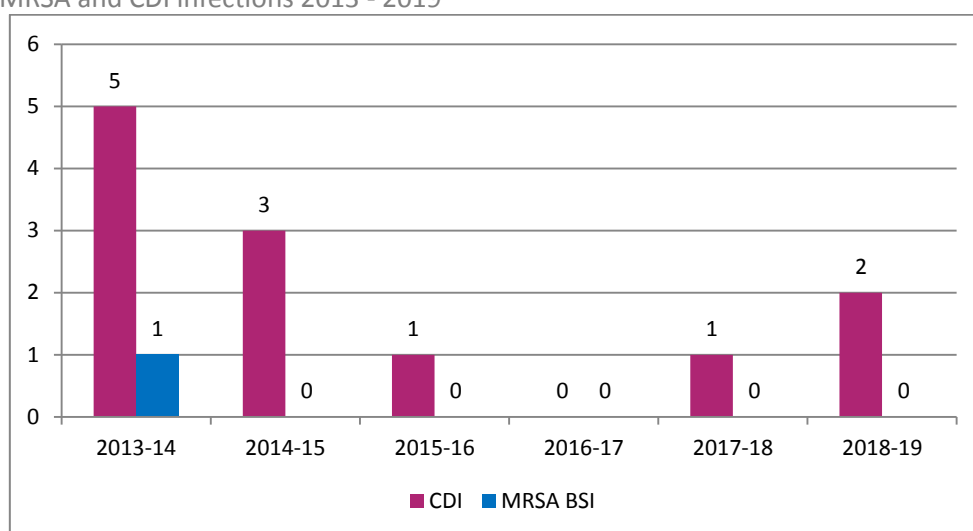
The numbers of reportable infections remain very low. In addition to this there have been no ward closures due to outbreaks of infection for in excess of two years.

Over the past few years a range of specialist infection prevention projects have been undertaken for three local Clinical Commissioning Groups (CCGs) by the Infection Prevention Team (IPT) through a service specification. This model of collaborative working has been recognised as a positive factor in the constant drive to reduce HCAI across the local and wider health economy.

The ability to access microbiological results in real time and disseminate these to the appropriate healthcare professionals and ensure timely actions are put in place demonstrates compliance with at least four areas within the NHS Outcomes Framework Domains and Indicators (Dec 2010). To date this year, in excess of 700 community infections have been detected early and actions put in place to ensure the correct treatment is commenced in a timely way. This aims to protect those individuals developing more serious infections such as sepsis and reduce the possibility of onward transmission to others.

The IPT will remain focused on quality improvement and use a variety of tools and measures to monitor compliance with the Health and Social Care Act (2008). To help us achieve this we have developed a valuable resource known as infection prevention link advisors (IPLA). The IPT strongly support the role of the IPLAs within all clinical areas with visits, additional training and workshops.

147 IPLAs currently work across our organisation completing spot checks within their service areas as well as keeping staff compliant with hand hygiene competencies. This year we have seen a 28% increase in attendance at the workshops as illustrated below.

Chart 2: Link Advisor Training Attendance 2017 - 2019

Number of Link Advisors attending Workshops

Year	Number
2017-18	89
2018-19	114
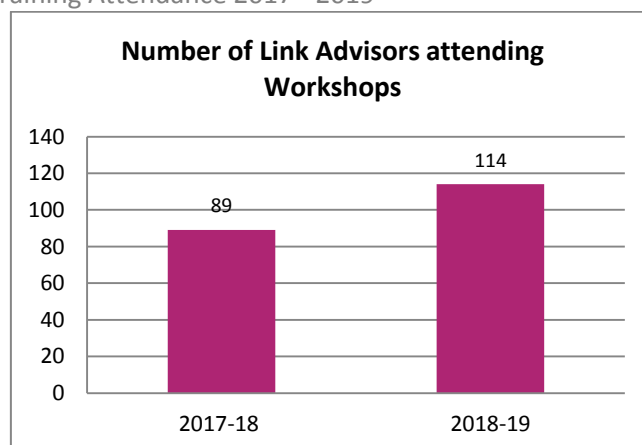
There are challenges with regards to the continued emergence of resistant bacteria and growing resistance to antibiotics so it continues to be more important than ever to reduce the spread of avoidable infection with good and safe practice within healthcare. We will continue to push the infection prevention agenda and enhance this by working collaboratively with neighbour organisations.

Complaints and Concerns

The Trust's approach to complaints handling is based on the principles published by the Parliamentary and Health Service Ombudsman (PHSO). Their principles outline the approach the PHSO believe public bodies should adopt when delivering good administration and customer service, and how to respond when things go wrong. These principles are:

- getting it right
- being customer focused
- being open and accountable
- acting fairly and proportionately
- putting things right
- seeking continuous improvement

Training is provided for staff on a regular basis to ensure that anyone making a complaint is supported; receives honest, timely communication; and is clear about the actions we are going to take next as a result of our learning from complaints. The Trust encourages the staff closest to the people receiving our services to, wherever possible and with the service user's consent, deal with concerns and problems at the local level, aiming to ensure that issues are resolved the earliest stage possible and in a way that is responsive to the service user's needs and circumstances.

Timely intervention can prevent an escalation of the issues raised and achieve a more satisfactory outcome for all concerned. However, if the complaint is initially dealt with as a service concern[1], it does not prevent the complaint being escalated formally should the patient remain dissatisfied with the initial outcome.

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1 We define service concerns as matters that can be resolved locally. A complaint follows a formal investigation process in order to gain resolution.

The following tables show the number of complaints we have received in the past 12 months, complaints received in comparison to previous years and categories of complaints:

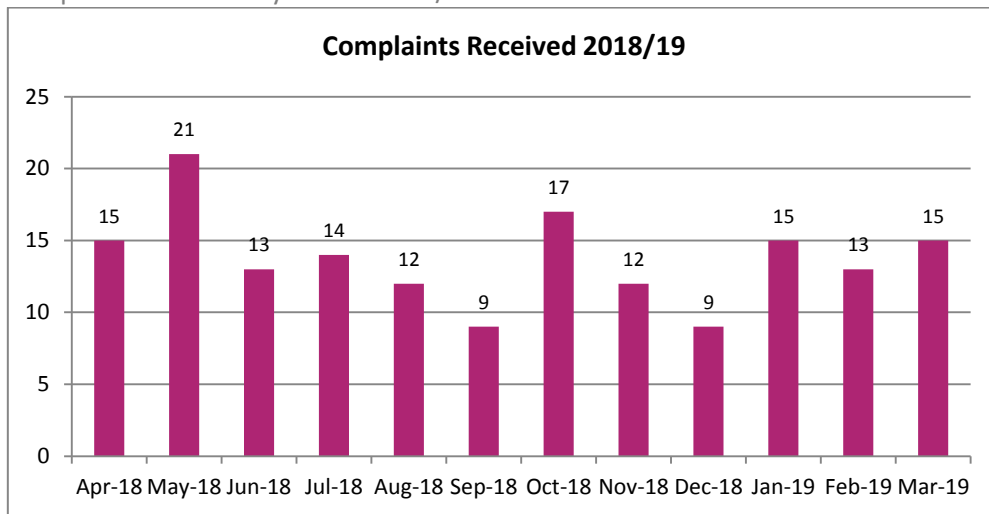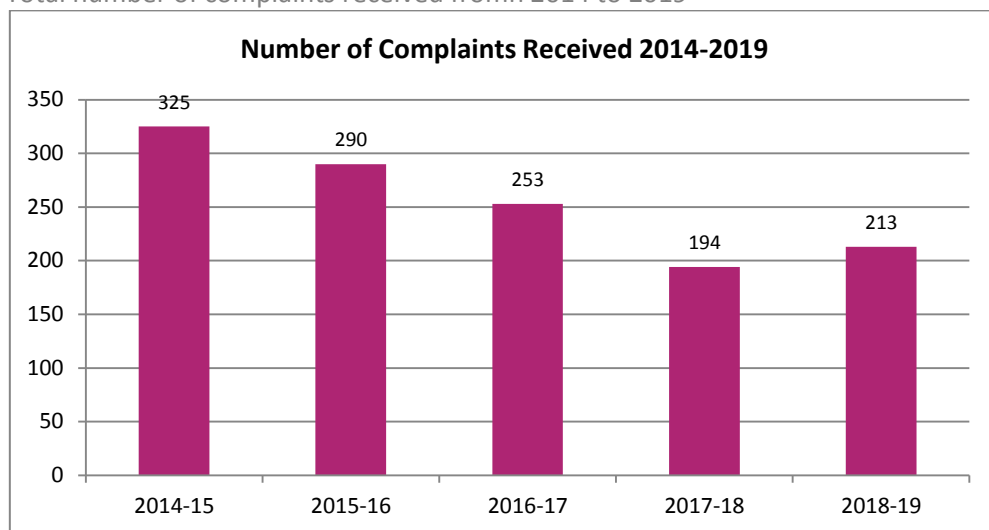Chart 1: Complaints received by month 2018/19

Complaints Received 2018/19

Month	Complaints
Apr-18	15
May-18	21
Jun-18	13
Jul-18	14
Aug-18	12
Sep-18	9
Oct-18	17
Nov-18	12
Dec-18	9
Jan-19	15
Feb-19	13
Mar-19	15

Chart 2: Total number of complaints received fromn 2014 to 2019

Number of Complaints Received 2014-2019

Year	Complaints
2014-15	325
2015-16	290
2016-17	253
2017-18	194
2018-19	213

There has been an increase in complaints this year which we believe is due to the introduction of the Quasar system by South East Hampshire CCG. Quasar has a module that allows Primary Care services to feedback directly regarding other community services, making it easier to report concerns etc.

The table below shows the formal complaints received by type of complaint:

Formal Complaints Received by Category of Complaint
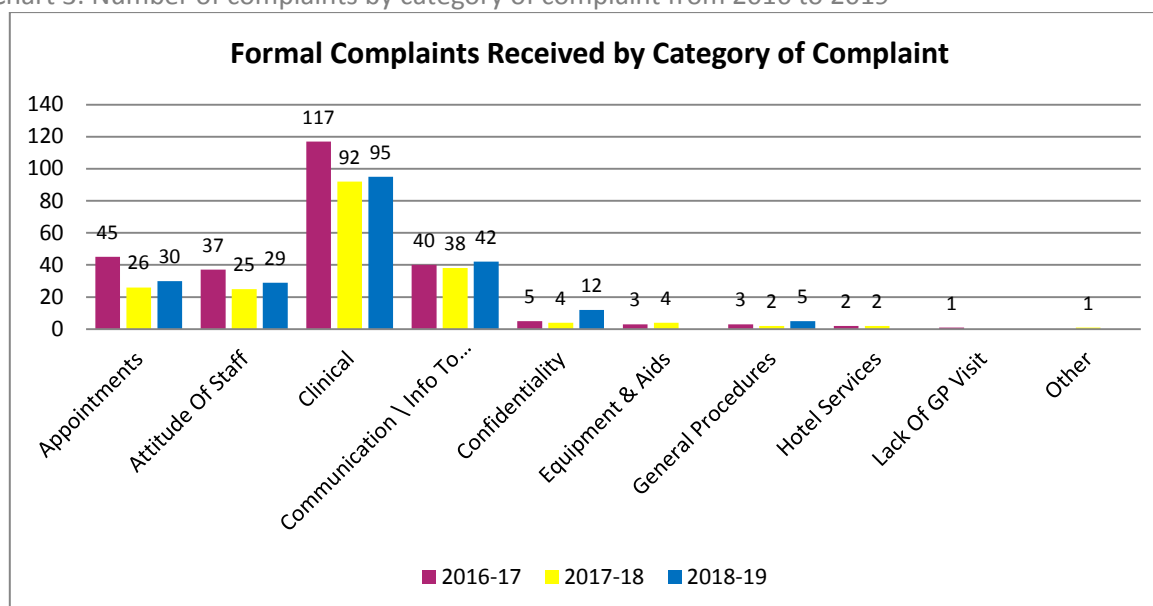
When a complaint is received, the team or individual it relates to are encouraged to consider learning and how to make improvements. These are discussed at a local governance level and any concerns regarding themes or trends are escalated. This will continue with the addition that changes can be tracked and monitored using the Trust Learning Framework and the electronic system which has now been fully implemented to manage complaints across the Trust. Below is a summary of learning and improvements identified to (March 2019):

Service	Learning and Improvements from Complaints
Primary Care	The Pain Team offer more advice and support to referring GPs to avoid inappropriate referrals
Primary Care	The service has updated the GP Surgeries website after it was identified that there was inaccurate information concerning new patient assessments
Primary Care	The Tip Toe team mobile number was provided to existing patients to enable communications when problems with the landline were identified
Primary Care	A new consultation room is being provided at one of the surgeries so there is greater access to a private space for patients
Sexual Health Service	The service is reviewing the appointments system in an attempt to improve access to the clinic after difficulties in access were highlighted
Sexual Health	The waiting time signage was improved to ensure patients are kept up to date and aware of delays
Sexual Health	Text message content was reviewed and now includes clinic dates and time so that patients can identify what the text relates to
Sexual Health	Test result management is under review and a new patient portal will be introduced in Q1 2019/20 to improve access to results
Adult Mental Health	Handover sheets are now printed on single sided paper to avoid future information governance breaches
Adult Mental Health	Reviewed the arrangements and process for clinical supervision.
Adult Mental Health	Reviewed and improved how they communicate with patients' who have difficulty articulating their needs and requirements
Adults Southampton	A direct referral pathway has been developed which ensures referrals are sent to the correct team
Adults Southampton	The Bladder and Bowel service have provided updated telephone numbers of another organisation to ensure that correct information is given to patients
Adults Portsmouth	The service provided additional information and training to GPs so there is a greater

Service	Learning and Improvements from Complaints
	awareness of what they can provide and avoid inappropriate referrals
Specialist Dental Service	Reviewed communication for patients' who do not meet criteria for treatment
Children and Families	Reviewed process when there is a delay between the appointment and a report being sent. Teams were reminded that if third party information is included in a report, consent must be given prior to sharing
Children's and Families	Processes introduced to ensure that when patients' are referred to other providers the demographics of the patient are correctly recorded
Children's and Families	Process and protocols have been reviewed for when consent is not provided for children to be entered into national programmes
Primary Care	The Podiatry Service now has full access to swab results, along with increased capacity, to review infected patients
Children and Families	Learning shared at a professional day to reduce delays in communication to families
Children and Families	Service currently reviewing the nasal flu spray parental consent form to make it clearer. Schools are being given follow up information about ensuring quiet rooms are provided for Nurses to undertake the triaging of consent forms
Sexual Health Service	Quality Improvement Project to be completed looking at access to the service. Outcomes will be reviewed once available
Sexual Health Service	Online booking process to undergo additional work and the introduction of an online, patient specific portal
Child and Family	Feedback given to teams regarding the importance of first contact with young people and families
Sexual Health Service	SMS text cancellation service to be implemented. Web chat facility for alternative signposting and advice for patients

As an organisation we are committed to learning from complaints to ensure that other service users do not have the same experience and we will continue to review this and if any themes or trends emerge, actions will be taken to address this and seek to understand why and if there is a need for a wider system and process review.

In 2019/20 the Trust will continue to develop and improve the Complaints process to support service users who complain. We are currently updating the Complaints Policy, which will introduce a change in approach by offering complainants an opportunity to meet with the service and discuss their concerns directly at the beginning of the process rather than the end. One service line has been successfully piloting this in 2018/19 and feedback has been positive. Complainants will continue to be offered a choice as to how they wish to progress, but it is anticipated that there will be a positive uptake on an earlier meeting and that complainants will find this a more satisfactory experience when things haven't gone as planned.

Community Engagement Strategy

In 2018/19 the Trust Board endorsed the Community Engagement Strategy including the establishment of a Community Engagement Committee to oversee its delivery. The Committee is chaired by Non-Executive Director and reports directly to Board. The aim of the strategy is to make community engagement a core part of how the Trust operates so that it becomes embedded in the culture and practice of the organisation at all levels.

By community engagement the Trust means the variety of ways in which it involves and works collaboratively with the full diversity of communities it serves, in order to improve the health and wellbeing of individuals from those communities. The Trust recognises there is no single way in which a community can be defined, it may include:

- characteristics - for example, identification with one of the protected characteristics[2] as defined by the Equality Act 2010
- location and place – for example, having a shared identity by virtue of living in a neighbourhood or area
- vulnerability and risk – for example, being homeless or lacking mental capacity
- socio-economic – for example, being unemployed or disadvantaged

All of the above may contribute to different individuals and communities experiencing health inequalities and other factors that can inhibit access to services, detract from the experience of using services and result in poorer health outcomes. Working with and involving different communities in the work of the Trust is a means to address these barriers and ensure that everyone who uses and needs the Trust's services, can fully access them and gain the benefits and health outcomes that they need.

Delivery of the Trust's community engagement strategy rests on four building blocks:
- Intelligent use of data and information
- Workforce and leadership development
- Fostering good relations with different community groups
- Involvement of community groups in service delivery, evaluation and development to improve health outcomes

These building blocks are designed to be developmental and will change and be revised as the delivery plan progresses. A Delivery Plan is in place and includes actions to ensure good governance and leadership so that the Community Engagement Strategy is aligned with other core functions of the Trust, for example equality, diversity and inclusion.

A data review to establish base line evidence is underway and due for completion in April 2019 with a report to the Community Engagement Committee in May 2019. The data review and evidence base, which covers patient experience, service utilisation and workforce will be used to inform the development of priorities for action under the Delivery Plan objectives.

Over the coming year the Community Engagement Committee will manage progress and reporting for the Community Engagement Strategy Delivery Plan. This will include prioritisation of community and service user groups for engagement; workforce development and leadership and building relations with the community and voluntary sector.

Dementia

The Trust has a Dementia Lead who works with Teams to ensure the needs of patients with dementia and related illnesses are considered and support the Trust in its delivery of the National Dementia Strategy. Achievements this year include:
- Provision of expert dementia advice on many estates and quality improvement projects which have enhanced patient experience for those with dementia
- Up-skilled teams to self-manage dementia developments in the future.
- Raised the Dementia profile in local services
- Implemented training and dementia champions, increasing knowledge and confidence in staff
- Established a Dementia Champion Network
- Trust presentation at the National Dementia Congress 2018

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2 Protected characteristics are defined under the Equality Act 2010 as: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex and sexual orientation

End of Life

The development of the Trust End of Life Policy and establishment of the End of Life Strategy Group has been a key focus for 2018/19. From the policy the Strategy Group has produced delivery framework and the strategy will be delivered in 2019/20 using a co-production methodology. An initial workshop has been held and further work involving local communities is planned for early 2019/20 to complete this work. The aim is to fulfill the six ambitions from the National End of Life Care Partnership.

The End of Life Strategy Group completed a review of the Gosport War Memorial Report and has commenced a programme of work to review current practice through staff survey and case note reviews. Good practice identified is shared across services and areas for improvement which have been identified to date and which will be a focus for 2019/20 are:

- Complete the review of the syringe driver checklist and guidance which is currently going through Trust governance processes
- Implement the 'ADIoS' software to support more proactive monitoring of controlled drug supply and usage
- Develop through the Matron's forum a toolkit of resources to facilitate improved professional assertiveness
- Continue to develop through our Learning Framework the sharing of learning and changes made as a result of learning from deaths

Learning Disabilities Improvement Standards (New for 2018/19)

People with learning disabilities, autism or both and their families and carers should expect high quality care across all services provided by the NHS. They should receive treatment, care and support that are safe and personalised; and have the same access to services and outcomes as their non-disabled peers. In June 2018 NHS Improvement published four standards and improvement measures NHS trusts need to meet; in meeting these standards we can demonstrate we are delivering high quality services for people with learning disabilities, autism or both.

A summary of our performance against each standard and improvement measure are below. The delivery of our new Learning Disability Strategy which includes achieving continual improvement against these standards is one of our quality improvement priorities for 2019/20:

Standard 1: Respecting and protecting rights All trusts must ensure that they meet their Equality Act Duties to people with learning disabilities, autism or both, and that the wider human rights of these people are respected and protected, as required by the Human Rights Act	
Improvement Measures	**Our Performance**
Trusts must demonstrate they have made reasonable adjustments to care pathways to ensure people with learning disabilities, autism or both can access highly personalised care and achieve equality of outcomes.	The Trust seeks engagement with people with a learning disability and their carers in a number of ways: it has a strategy for producing accessible information; it has an adapted patient feedback process; a number of services have developed adapted responses to this patient group (e.g. sexual health services have worked with our learning disability service to develop a special clinic); "Shield", for people with a learning disability; specialist dental services have developed a feedback group of people with a learning disability to help them improve their service response; the recent AGM had provision for people who use Makaton to engage; there is expert by experience training available; the learning disability service has a range of engagement

Standard 1: Respecting and protecting rights All trusts must ensure that they meet their Equality Act Duties to people with learning disabilities, autism or both, and that the wider human rights of these people are respected and protected, as required by the Human Rights Act	
	processes that can be supported across other services
Trusts must have mechanisms to identify and flag patients with learning disabilities, autism or both from the point of admission through to discharge; and where appropriate, share this information as people move through departments and between services.	There is a patient flagging option within the Trust's electronic patient record system. Working is progressing to ensure that this is fully utilised and linked to care planning promoting reasonable adjustments
Trusts must have processes to investigate the death of a person with learning disabilities, autism or both while using their services, and to learn lessons from the findings of these investigations.	A monthly Learning from Death's panel is held and chaired by the Chief Medical Officer. The panel discuss any deaths which were reported as Serious incidents (SI), learning from any Coroner's court cases and Mortality review papers for each clinical division. The Trust has developed a Mortality dashboard which covers all services with the exception of Special care Dentistry and Sexual Health services. Teams identify through their Mortality review process cases which are appropriate for a clinical judgement review (also known as structured clinical judgement tool). The Trust has developed a learning database which monitors and tracks specific changes that need to be implemented to improve future outcomes (this is separate from action plans). This includes cases where learning has been identified form deaths. In line with this the Trusts Specialist Learning Disability service are fully engaged with the Learning Disabilities Mortality Review (LeDeR) programme
Trusts must demonstrate that they vigilantly monitor any restrictions or deprivations of liberty associated with the delivery of care and treatment to people with learning disabilities, autism or both.	This is monitored through Mental Capacity Act (MCA) and Depravation of Liberty (DoLS) audit processes
Trusts must have measures to promote anti-discriminatory practice in relation to people with learning disabilities, autism or both.	The Trust promotes anti-discriminatory practice by providing reasonable adjustment options such as: - Providing accessible information to aid patient understanding - Providing staff with the appropriate skills and support to take an individualised approach to communicating with people - Involving family carers from pre-admission onwards - Involving family carers in care decisions as appropriate - Ensuring that staff have been trained in MCA and DoLS and know how to implement these policies - Ensuring there is a protocol in place which details when best interest decisions are required - Providing information for people with learning disabilities and family carers regarding their rights under the Mental Capacity Act - Having a flagging system highlighting a patient has a learning disability to help identify additional support may be required - Ensuring that reasonable adjustments are put in place regarding appointment times and length e.g. offers of first or last appointments of the day - Supporting staff to use Hospital Passports or

Standard 1: Respecting and protecting rights All trusts must ensure that they meet their Equality Act Duties to people with learning disabilities, autism or both, and that the wider human rights of these people are respected and protected, as required by the Human Rights Act

	- similar where these are in place - Ensuring staff know how individuals express pain and discomfort and act accordingly - Using good practice guidance on dysphagia and ensuring there is accessible information about food choices - Identify, analyse and learn from incidents involving people with learning disabilities

Standard 2: Inclusion and engagement Every trust must ensure all people with learning disabilities, autism or both and their families and carers are empowered to be partners in the care they receive

Improvement Measures	Our Performance
Trusts must demonstrate processes that ensure they work and engage with people receiving care, their families and carers, as set out in the NHS Constitution.	The Trust seeks engagement with people with a learning disability and their carers in a number of ways: it has a strategy for producing accessible information; it has an adapted patient feedback process; a number of services have developed adapted responses to this patient group (e.g. sexual health services have worked with our learning disability service to develop a special clinic); "Shield", for people with a learning disability; specialist dental services have developed a feedback group of people with a learning disability to help them improve their service response; the recent AGM had provision for people who use Makaton to engage; there is expert by experience training available; the learning disability service has a range of engagement processes that can be supported across other services
Trusts must demonstrate that their services are 'values-led'; for example, in service design/improvement, handling of complaints, investigations, training and development, and recruitment.	We ensure our clinical services have a strong focus on the Trust values through a number of processes such as: - Patient feedback - Analysis of complaints, concerns and compliments - Learning from adverse events - In its staff training and development opportunities - Within its governance structures - In its public engagement strategy
Trusts must demonstrate that they co-design relevant services with people with learning disabilities, autism or both and their families and carers.	The Trust's Learning Disability services facilitate a number of such forums related to both service developments and/or clinical pathways using experts by experience. It is an expectation that all service development activity has a clear engagement strategy
Trusts must demonstrate that they learn from complaints, investigations and mortality reviews, and that they engage with and involve people, families and carers throughout these processes.	Complaints, investigations, incidents and mortality reviewed are agenda items at all governance meetings which in turn report to the Quality Improvement & Risk Group and the Assurance Committee (Board sub-committee) There was 1 serious incident involving a person with a Learning Disability in 2018/19 which raised the following actions: Raised awareness within the Community Team to use the accessible information template on S1.

Standard 2: Inclusion and engagement Every trust must ensure all people with learning disabilities, autism or both and their families and carers are empowered to be partners in the care they receive	
	• All team members to complete the mental capacity act training; this will help them to document consideration of mental capacity when planning care

Standard 3: Workforce All trusts must have the skills and capacity to meet the needs of people with learning disabilities, autism or both by providing safe and sustainable staffing, with effective leadership at all levels	
Improvement Measures	**Our Performance**
Based on analysis of the needs of the local population, trusts ensure staff have the specialist knowledge and skills to meet the needs of people with learning disabilities, autism or both, as well as those who support them.	All clinical areas have a "Learning Disability Resource Pack" that supports staff to deliver effective care. More formal training is under development and will be shared across the local TCP (SHIP). Autism training is currently being explored
Staff must be trained and then routinely updated in how to deliver care to people with learning disabilities, autism or both who use their services, in a way that takes account of their rights, unique needs and health vulnerabilities; adjustments to how services are delivered are tailored to each person's individual needs.	The Trust is currently finalising a Learning Disability Strategy that reflects the Learning Disability national standards and directly addresses staff competence and confidence in supporting patients with a Learning Disability
Trusts must have workforce plans that manage and mitigate the impact of the growing, cross-system shortage of qualified practitioners with a professional specialism in learning disabilities.	Workforce plans are in place within the Trust's Specialist Learning Disability Services. This includes supporting apprenticeships, involvement in "return to practice" initiatives, review of skill mix, and, participation in the "Training Nurse Associates"
Trusts must demonstrate clinical and practice leadership and consideration of the needs of people with learning disabilities, autism or both, within local strategies to ensure safe and sustainable staffing.	A workforce plan is currently in place that reflects the clinical demands upon services

Standard 4: Specialist learning disability services Trusts that provide specialist learning disabilities services commissioned solely for the use of people with learning disabilities, autism or both must fulfill the objectives of national policy and strategy	
Improvement Measures	**Our Performance**
Trusts must have plans for the development of community-based intensive support, including treatment and support for people accessing mental health services and the criminal justice system.	The Trust's Specialist Learning Disability Service already has an Intensive Support Team which is effective in supporting those in crisis. A request has been made to the local CCG for funding of a focussed forensic practitioner role
Trusts use the care and treatment review (CTR) and care and education treatment review (CETR) to ensure a stringent assessment is made if admission is anticipated or requested, and that discharge arrangements ensure no individual stays longer than necessary.	The Trust's Specialist Learning Disability Service is actively involved in the CTR's/CETR's of its patients. It hosts regular meetings to review the care arrangements and discharge options of those patients
Trusts have processes to regularly review the medications prescribed to people with learning disabilities, autism or both. Specifically, prescribing of all psychotropic medication should be considered in line with NHS England's programme stopping over medication programme STOMP.	The Trust's Specialist Learning Disability Service have engaged with our Pharmacy service in the delivery of a STOMP initiative
Trusts providing inpatient services have clinical pathways that adhere to evidence-based assessment and treatment, time-limited interventions and measurable discharge processes to ensure inpatient episodes are as short as possible	The Trust has no specialist inpatient services

Standard 4: Specialist learning disability services Trusts that provide specialist learning disabilities services commissioned solely for the use of people with learning disabilities, autism or both must fulfill the objectives of national policy and strategy	
Trusts have governance processes for measuring the use of restraint and other restrictive practices, including detailed evidence-based recommendations to support the discontinuation of planned prone restraints and reduction in unwarranted variation in use of restrictive practices. They can demonstrate that alternative approaches are being deployed	The Trust has no specialist inpatient services

Patient Experience & Engagement

Patient Experience

Experience is one of the three domains in our Quality Framework and our experience goals for 2018/19 have been to ensure we learn from patient feedback and involve people in the development of our clinical services.

We bring together information from various sources including complaints and the Friends and Family Test (FFT), community engagement and patient, family and carer feedback to focus on learning and improvement and we showcase lessons we have learnt and improvements made in the form of 'You said, We did' posters, bulletins and newsletters.

Our FFT results throughout the year show a consistent positive level of satisfaction for the Trust overall with our internal targets of 95% and above who would recommend Solent services, and below 5% who would not recommend, being consistently met.

Chart 1: Aggregated results for Solent NHS Trust combined community and mental health services
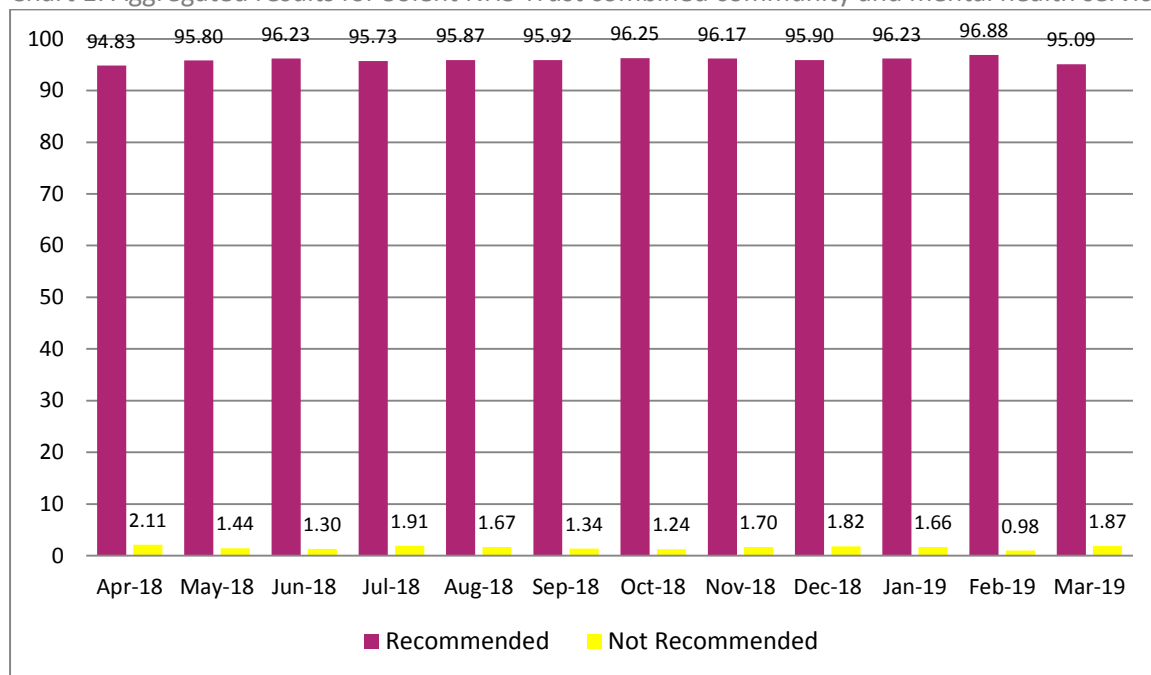
A total of 25,119 FFT responses were received by Solent in 2018/19 compared to 18,560 in 2017/18. This is an increase of 6,559 and is attributable to work in our clinical services to increase levels of patient feedback including:

- The Sexual Health Service and teams in Primary Care and Childrens Services have introduced

email to capture FFT responses
- The Childrens Service is currently piloting the use of Android phones for capturing patient feedback
- Adults Services Southampton, Adults Portsmouth and the Dental Service have enrolled volunteers to capture patient feedback with other service lines exploring the same method

Our results compare favourably with national FFT results which are reported separately for Community Health and Mental Health services:
- Community Health – 97.05% would recommend, 0.97% would not recommend
- Mental Health – 89.66% would recommend, 3.15% would not recommend

Each of our clinical services reviews their own FFT responses to enable as near real-time feedback as possible, action planning and learning. The table below provides a breakdown of responses by service. The proportion of respondents recommending Solent for care exceeds the Trust target in all service lines except Mental Health Services; however results are consistent with national levels for mental health trusts.

Chart 2: FFT responses broken down by Service Line

Area	SMS/Text/ Smartphone App	Electronic tablet/kiosk at point of discharge	Paper/Postcard given at point of contact	Paper survey, sent to the patients home	Telephone survey once patient is home	Online survey once patient is home	Other
Overall	55	213	23092	0	0	1759	0

Area	Recommend	Not Recommend	Total Responses	Extremely Likely	Likely	Neither Likely or Unlikely	Unlikely	Extremely Unlikely	Don't Know
Adults Portsmouth Services	97.69%	0.77%	1948	1517	386	27	8	7	3
Adults Southampton Services	96.93%	0.86%	4752	3532	1074	77	26	15	28
Childrens Services	96.44%	1.15%	4773	3756	847	70	33	22	45
Dental Services	98.28%	0.74%	1630	1334	268	10	6	6	6
Mental Health Services	84.88%	4.63%	800	446	233	61	20	17	23
Primary Care Services	93.40%	3.71%	3804	2923	630	78	54	87	32
Sexual Health Services	96.51%	1.23%	7412	5622	1531	137	47	44	31
Summary	95.94%	1.56%	25119	19130	4969	460	194	198	168

Although the quantitative FFT and survey results are encouraging it is free text comments from patients that provide the richest source of information. All free text comments are reviewed as even when quantitative results are positive and complimentary the comments may include suggestions of small changes that can be implemented to improve the experience of our patients. When we identify a change or improvement we feed this back to patients by displaying on Solent NHS Trust's website and by using the "You Said, We did" poster in patient areas such as wards, clinics and waiting areas.

Below are just a few examples of feedback from individual patients which has led to us reviewing our practice and making improvements:

You said: The chairs in the waiting room are scruffy and not appealing to sit down on.
We did: The League of Friends are to support us with the purchase of new chairs.

You said: The location is very far from home for us and would take one train, a bus and a walk by public transport, so we had to spend £30 on taxis.
We did: We currently offer clinics across the City and are in the process of developing a CAMHS leaflet which would indicate this was available to families accessing the service.

You said: I felt ill because of the heat in the surgery. It's far too hot to lie there having treatment. I have sweated so much. I don't know how staff work all day in that heat.
We did: Portable air conditioning units have been delivered to Gosport and an improvement in temperature has been reported. Our staff continue to monitor the temperature.

You said: Reception staff could be friendlier and more approachable. Medical staff I have seen have been great.
We did: All of our receptionists have now received training in Customer Care and we will be monitoring this through individual 1:1 meetings.

You said: The program is difficult to access. Our computer screen isn't suitable for using because it is too small for clarity. I felt that instructions were given too quickly and the sound was not clear, there was also no feedback on exercises i.e. to assess if I was doing them correctly.
We did: This patient felt they were not given enough time and in future we will ensure all patients on the face to face programme will be asked if they need any extra time to recover or undertake a particular exercise.

You said: I found the Physio to be too overpowering. She kept on at me and I said just go away.
We did: Following receipt of this feedback we carried out an internal investigation to understand exactly what happened. As a result our staff have been reminded of the need to flag difficult conversations they have had with patients in either team or individual supervision. The importance of this has been highlighted to enable the team to deal with potentially difficult situations in a timely way, but primarily to consider how care and treatment needs can be met if a patient declines treatment.

Demographic information

The data below provides a summary of the current diversity demographics for patient experience surveys. The data represents contacts rather than individuals.

Chart 1: Age of respondents

	Returns	0-17	18-24	25-40	41-60	61-75	76-85	86 or over	Prefer not to say
Total	21587	141	2,824	5,582	4,041	2,974	2,047	1,213	20

Chart 2: Sex of survey respondents

	Returns	Female	Male	Prefer not to say
Total	20830	13,555	7,234	41

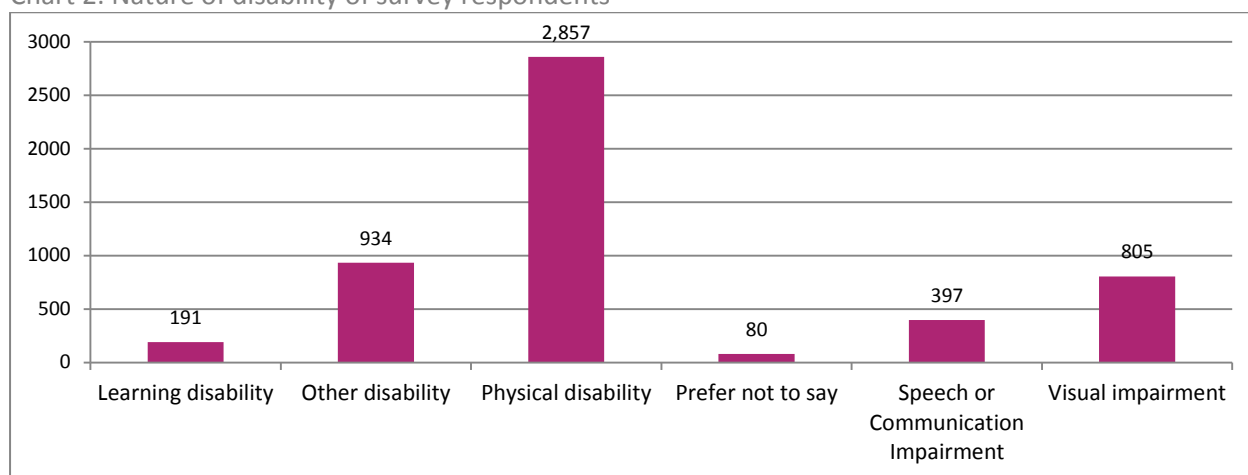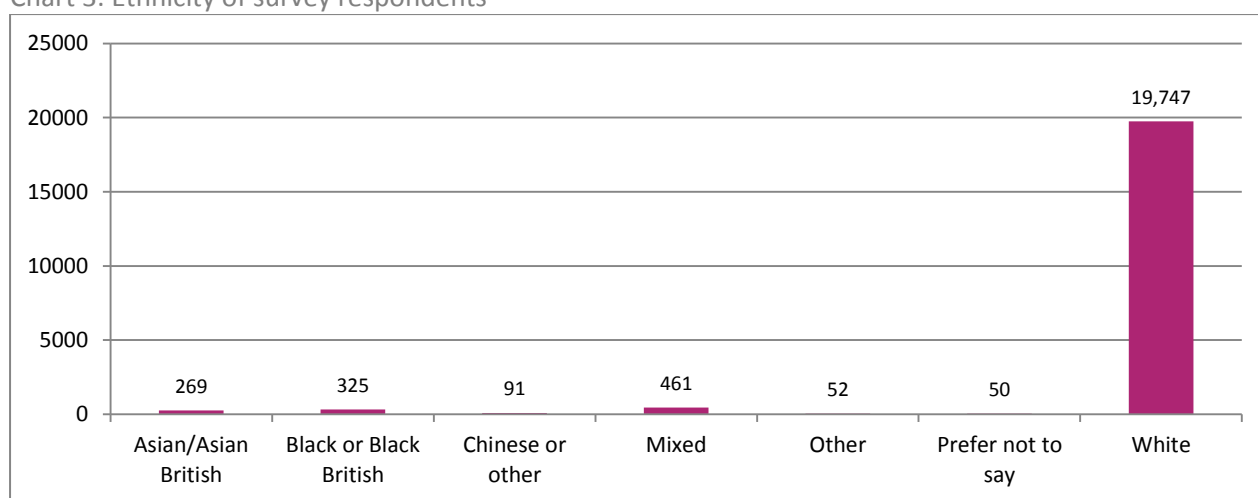Chart 2: Nature of disability of survey respondents

Chart 3: Ethnicity of survey respondents

Engagement

As part of our community engagement the following stories illustrate how engagement with patients and our wider communities has made a difference and provided many learning opportunities for us:

- The Side-By-Side group are a patient involvement group who are committed to working in partnership with the Academy of Research & Improvement. The group hosted coffee mornings in Portsmouth and Southampton as an opportunity to advertise and engage with the public about joining Side-by-Side. The coffee mornings were held at non NHS sites. Running small scale informal events at community (non NHS) venues is a good way to engage with patients and the public. The group found social media and internal communications to be useful ways to inform others of events, but we found that more importantly existing relationships and networks attracted people to attend. As a result more than 10 individuals have expressed interest in being part of Side-by-Side. The group is now looking at how it can make being involved as accessible as possible and support people to be engaged in a meaningful way. Through expanding and diversifying Side-by-Side the group anticipates that our patient population will be better represented in sharing a varied patient & public perspective

- The Family Nurse Partnership (FNP) Team wanted to establish if group sessions would be attended by the young mothers on their caseload, with an aim to decrease social isolation. The FNP Team distributed a survey to young mothers and held free engagement events at Non-NHS sites to enable informal discussion. The survey identified that young mothers and their children

were visiting public places such as parks and town centres but were not socialising with other people. Through the survey results and non-attendance at the engagement events, the FNP team learnt running group sessions is unlikely to decrease social isolation. The FNP Team are now aiming to look at different ways to engage with young mothers. Taking the time to hold patient engagement events has provided insight into what the young mothers do and do not want. Without this the Team could have wasted time and resources setting up a group which would not have been attended

- The Trust had received reports of negative comments relating to overhanging trees and potential harm/damage for residents opposite the St James Hospital site. We engaged with local residents through their Facebook page and were able to see where they may be experiencing problems that we could to act upon. As a result, the Estates team visited residents and offered to address their problems. In two cases, our gardening contractors removed trees overhanging a resident's property. This quick action and the resulting positive feedback ensured residents know where to come if they have concerns and that issues can be dealt with swiftly. This has had a positive impact on the Trust's relationship with the local residents

- Each year *Carer's Rights Day* brings organisations across the UK together to help carers know their rights and find out how to get the help and support they are entitled to. This year we wanted to raise the profile of informal carers with a focus on our staff who are carers. We did this by re-launching Solent's Staff Carers Pledge and we recognised that staff who are also carers may need additional support to maintain their health and well-being at work so we asked them to complete a survey. A network event took place in February 2019 to engage with staff who are informal carers to help us shape what support should be provided in the workplace (outcome of event to be updated in final version)
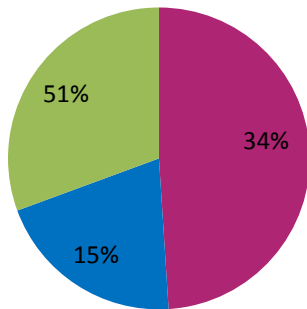
Volunteers

We recognise the important, and valuable, contribution volunteers make to our services, as well as enhancing patient care. Our Volunteer Service was developed to improve patient's experience of healthcare for the benefit of local people. As well as benefiting patients, many volunteers can gain vital volunteer work experience, it can also provide excellent opportunities to make new friends and be part of a team.

We advertise volunteer opportunities through our website including become a befriending volunteer to help people feel less lonely while in hospital, volunteer gardener, help guide patients and visitors around our hospitals/clinics/units as a meet and greeter, or there are 'volunteers by experience'. *Volunteers by experience* are volunteers who are recruited to share their own health / life experience to support others in a similar situation.

We currently have 146 volunteers enrolled with the Trust including 57 Solent volunteers and 89 League of Friends volunteers at St Mary's Community Campus. We collect demographic information about our volunteers to enable us to monitor inclusivity and diversity within volunteer roles. This information will continue to be monitored over the coming year to determine how closely our volunteer profile reflects our local population profile:
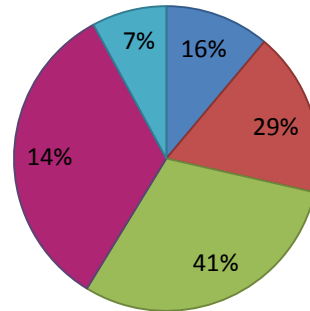
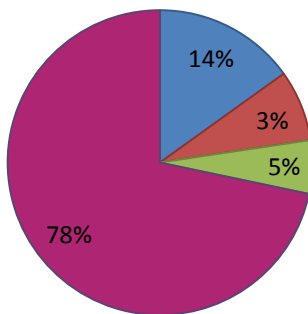## Solent Volunteer Activity

Enquiry ■ Progressing ■ Active ■

- Enquiry: 34%
- Progressing: 15%
- Active: 51%

Age of Volunteers

■ 16-21 ■ 22-30 ■ 31-50 ■ 51-75 ■ 76+

- 16-21: 16%
- 22-30: 29%
- 31-50: 41%
- 51-75: 14%
- 76+: 7%

Ethnic Origin of Volunteers

■ Asian ■ Black ■ Mixed ■ White

- Asian: 14%
- Black: 3%
- Mixed: 5%
- White: 78%

Do you have a disability?

■ Yes ■ No

- Yes: 24%
- No: 76%
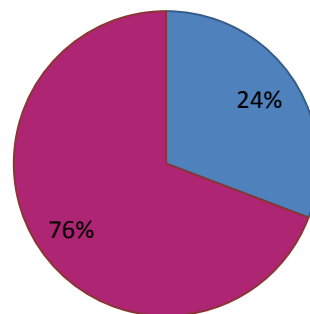
Examples of the great work our volunteers do are below:

- This year our Dental Service enrolled additional volunteers to help with meet & greet, talking to patients whilst they wait to be picked up by transport, assisting patients to fill in forms and encouraging patients to complete the Friends & Family Test (FFT) after their consultation, all of which enhance a patients experience of using our services

- The Patient Experience Volunteer supports with sorting, collating and bagging Friends & Family Test (FFT) and patient feedback. Volunteers also provide teams with the necessary information from Meridian

- A patient experience volunteer has recently joined Jubilee House to help staff capture feedback from patients and carers; they also identified a suitable area where *'You said, We did'* feedback could be displayed for patients, staff and visitors to view

- The Memory Café is an opportunity for carers of people with dementia to meet and socialise with others who understand their situation in an informal and friendly setting. Memory café volunteers help support the Admiral Nurses to provide such an environment

During December 2018 we signed up to the Helpforce/Daily Mail campaign. Helpforce is a charitable organisation that is committed to creating a better future in health and care through volunteering. The campaign asked people to pledge their time and give the NHS one day a month or three hours a week for six months. When the campaign closed at the beginning of 2019, 33,000 people had pledged. We are one of 160 Trusts who have come forward with volunteer opportunities and pledgers are in the process of being matched to Trusts opportunities. We look forward to welcoming new volunteers to the Trust in the months ahead.

Volunteers are valuable members of our team. Their contribution can make all the difference to the experience of a patient, and we thank all our volunteers for giving up their time to enhance other people's lives.

Patient Led Assessment of the Care Environment (PLACE)

The table below provides an overview of the scores achieved in the 2018 PLACE inspection and provides a comparison with national scores and the Trust scores for the previous year:

	Cleanliness %	Food Score %	Privacy, Dignity & Wellbeing %	Condition, Appearance and Maintenance score %	Dementia %	Disability %
National Average 2018	98.8	92.10	84.30	93.10	81.70	87.1
Solent NHS Trust 2018	95.2	93.5	75.1	91.1	75.3	83.2
Solent NHS Trust 2017	99	98	91	97	92	93

The decrease in overall scores was discussed at the PLACE feedback event hosted by the Trust and it was agreed the following had impacted negatively on our results:
- PLACE assessments are designed for acute Trusts therefore an appropriate response to some questions for many community services would be "not applicable". However, the only responses which can be entered are a yes or no or "pass" or "fail"; this results in some answers achieving a zero score on an area that is not relevant to the service
- The national Dementia Standards have been reviewed and updated and despite all actions being taken following recommendations made in the 2017 inspection, many Trusts reported a similar decrease in results
- The cleaning contract is under review nationally and following this inspection the Trust is considering other options to manage contract in future
- Some incorrect information had been reported by the assessors and which they did not highlight during the inspection. Therefore in some instances, this has resulted in negative recording

On a positive note, there is a higher than average score in the food category; our mental health sites achieved a higher than the national average for disability; an end of life care/rehabilitation site scored higher than average in the disability domain and privacy and dignity, and one site exceeded all national averages with the exception of the privacy and dignity domain.

We have made many improvements during the year and since the inspection including the following:
- Signage has been reviewed and updated
- Painting is to be updated to demonstrate a clear separation of the floor and wall

- Outstanding building/maintenance works for one area were escalated and resolved as a direct result of the PLACE inspection (in a non-Solent building).
- Orientation and dementia friendly clocks are in place
- Estates work including redecoration monies has been resourced
- A hearing loop system has been sourced to support a community clinic
- Alcohol dispensers have been placed in areas it was highlighted that they were absent
- Waste bins have been sourced to ensure all areas have the correct bins for general waste in addition to clinical waste
- Discussions have been held with the landlords of premises we are currently tenants in and the results shared. The Trust's estate teams will continue to review and monitor the progression of the action plans relating to premises concerns raised in the inspection

Clinical services monitor their progress on actions locally. Whilst some actions have been completed promptly, others require a more considered approach and in some cases the balance needs to be sought between patient safety and the environment. One example being our mental health wards where if they completed some of the actions the PLACE inspections recommended, it would create a ligature risk and hence impact on patient safety.

For the 2019 inspection, we will manage PLACE inspections in the same way we emulate CQC inspections. This will mean that a senior member of staff will accompany the PLACE assessors who are best placed to respond to any queries and support as required. It was also agreed at the feedback event that we would work collaboratively with Healthwatch to support the pre planning of the event.

Safeguarding

The Trust endorses everyone's human right to live their life free from abuse and harm.

Solent's Safeguarding team support the organisation to fulfill it's safeguarding duties and responsibilites, completing targetted work with specific clinical teams to embed safegaurding frameworks, such as making safeguarding personal.

The team provide expertise and promotes professional curiosity, challenge and collaboration. Staff are empowered to fulfil their safeguarding responsibilities through:

- Education
- Supervision
- Responsive and expert advice and support

Quarterly reports, demonstrating compliance with regulations, are submitted to the Safeguarding Steering Group, the Quality Improvement and Risk Group(QIR), Assurance Committee, the Board and the commissioners.

Solent NHS Trust is an active partner and is represented at the four Local Safeguarding Childrens Boards, (4LSCB), and four Local Safeguarding Adults Boards, (4LSAB), for Hampshire, Southampton, Portsmouth and the Isle of Wight and works collaboratively with partner agencies at a strategic and operational level.

Improvements during 2018/19

During this period the sSafeguarding team has implemented the following quality improvements:

- The provision of health navigators for the Portsmouth Multi-Agency Safeguarding Hub, (MASH). Intially this was for a fixed term contract but has now been extended and made into a substantive post
- The Trust Modern Slavery Statement, Referral to Social Care and Domestic Abuse pathways have been embedded in practice to suport and advise staff on the correct actions to take in these situations
- The Safeguarding Champions Forum with representation from all clinical services was established and works collaboratively to promote safeguarding within their clinical areas
- The Trust's Safeguarding Children and Adults policies have been reviewed and combined into a single Safeguarding Children, Young People and Adults at Risk Policy
- A Safeguarding Supervision Policy has been published to underpin newly stregthened safeguarding arrangements provided by the Safeguarding team. An electronic system for monitoring compliance with supervision standards was implemented in Q3
- A Safeguarding module has been introduced in the electronic patient record to ensure that safeguarding activity is recorded and easily accessible to all staff within the Trust
- Review of the Safeguarding Children and Young People - Roles and Competencies for Healthcare Staff (2019) and Adult Safeguarding - Roles and Competencies for Healthcare Staff, (2018), commenced to ensure all staff in the organisation are compliant with training requirements which will support improved safeguarding practices and improve outcomes for children, young people and adults at risk

The Safeguarding Adults – Roles and Competencies for HealthCare Staff, (2018) changed the requirements for staff who require Level 3 Safeguarding adults training, meaning an increase in the number of staff who required the training. This resulted in a drop in the training compliance for Level 3 Safeguarding Training which impacted on the Trust's overall compliance rate. A key priority for the Trust was to improve compliance with mandatory safeguarding training with a target of 90% at year end. The Trust's compliance rate has increased each quarter with a compliance rate of 87.72% at end of March 2019, the highest compliance since 2015.

Plaudits and Compliments

An independent author for a Safeguarding Children's review, (SCR), congratulated the Trust on the high standard of the internal management review the Safeguarding Team had submitted to inform the SCR process. The author commented that standard of objectivety and analysis was very effective and informative.   One of Solent's commissioners also thanked the Safeguarding Team for their hard work and support to partner agencies, subsequently the team received Solent's Directors Choice Award for services to the Trust.

Safeguarding Children and Adults Reviews

The Safeguarding Team have fulfilled all requests for Safeguarding Adult and Child reviews during the year. An unusually high number of safeguarding children reviews were supported, whilst the quality of the reports and development of action plans was maintained.

Learning from all cases is shared with the clinical services and examples of key learning include the introduction of standard protocols for safe sleeping advice, which was developed as an outcome of a Children's thematic review, and work to start the development of a Transitions Protocol which was the outcome of an adult safeguarding review.

A pathway for sharing learning from Safeguarding Case Reviews and Safeguarding Adult Enquiries is being developed to ensure that learning is disseminated and easily accessible to all staff across the Trust, with the aim of informing service improvements.

Safeguarding Priorities and Quality Improvements for 2019/20

Plans for 2019/20 to improve the quality of safeguarding practice and which are in line with the Safeguarding Children and Adult Boards priorities have been agreed as follows:

- The safeguarding team will respond to 90% of requests for advice with one working day
- The safeguarding team will revise and develop the mandatory safeguarding training program provided to staff
- Embed Making Safeguarding Personal within adult services to allow adults' voices to be heard and listened to within safeguarding activity
- To further strengthen the Whole Family Approach to Safeguarding so that silo working is reduced and collaborative working is achieved

To provide quality assurance and to inform service improvements in 2019/20 the following audits and service evaluations will be completed:

- The quality and responsiveness of the safeguarding advice provided to staff
- The quality and frequency of safeguarding supervision provided to staff
- Quality of MASH referrals completed by Solent NHS Trust staff
- Evidence that the Whole Family approach is embedded into practice
- Evidence that Making Safeguarding Personal is embedded into practice
- Additional audits will be completed as requested by the 4LSCB and 4 LSAB

Same Sex Accommodation Breaches

The Trust has not had any Same Sex Accommodation breaches in 2018/19.

Tissue Viability

In June 2018, NHS Improvement (NHSI) published a report 'Pressure Ulcers: Revised definition and Measurement'. To support a more consistent approach to the definition and measurement of pressure ulcers at both local and national levels across all trusts, NHSI have recommended the use of the following definitions which are in line with the EPUAP (2016) classification system of categories, these are;

- Categories 1,2,3,4,
- Unstageable
- Suspected deep tissue injury

It has been agreed that these categories will be adopted across the country by April 2019. In order to prepare the Trust for implementation, a gap analysis was carried out by the Tissue Viability and the Quality and Professional Standards teams. This identified a number of areas that would need to be altered as a result and an implementation plan has been delivered, a summary of the actions taken are as follows:

- In December 2018, a revised Tissue Viability training programme was delivered to staff across Solent sites including community nurses, inpatient staff, children's nurses and urgent response. This has included training presentation, Pressure Ulcer Reporting Flow Chart and Pressure Ulcer recognition poster. An online presentation is being developed
- Incident reporting on Ulysses has been amended to reflect the additional categories of recording, i.e., the addition of unstageable and also suspected deep tissue injury which was not previously recorded by the Trust
- The Tissue Viability Policy, Pressure Ulcer Standard Operating Procedure, pressure ulcer review paperwork and care plans have been updated to reflect the changes

In January 2019, Pressure Ulcer reporting in Solent switched from 4 categories to the recommended 6 categories. The period from January to 31 March 2019 is viewed as a transition period and it is expected the new recording will be consistently applied from 1 April 2019 in line with the NHSI requirement to fully implement changes from this date.

In addition to the changes to the categories to be recorded, NHSI recommended the terms avoidable and unavoidable will no longer be used and the focus will be on the learning. The result of this will be that all pressure ulcer incidents will be investigated to support organisational/system learning. Instead of focusing on if the pressure ulcer was avoidable, teams will be required to assess level of harm which will be consistent with other categories of patient safety incidents.

The changes described will enable the Trust to benchmark against other areas of a similar population, helping us to improve quality and provide better outcomes for patients. This will be a key focus for us in the coming year.

3.2 Making a Difference

In addition to the Trust-wide improvements and initiatives above, each of our clinical services continually identifies ways in which their services can be improved. This section provides just a few examples of how our teams have worked to make a difference for patients, their families and carers in the past 12 months.

Some of the stories relate to changes and improvements across whole teams and services which have made a difference to many patients, other stories relate to how our staff have made a difference to individual patients.

Adult Services in Portsmouth

In September 2018 the Trust launched NEWS2 a national tool to help identify patients whose conditions may be deteriorating. The tool is based on a simple combined scoring system and involves allocating a score to physiological measurements which are already recorded when patients present to, or are being monitored in a hospital community and community health setting. The combined score is allocated to each measure with the magnitude of the score reflecting how much the parameters vary from the patient's normal range. The score is then aggregated and uplifted by 2 points for people requiring supplemental oxygen to maintain their recommended oxygen saturation. This tool combined with the staff member's clinical judgement helps determine the appropriate level of response needed to access appropriate and timely treatment and support for the patient.

Since the tool was launched in Adults Services in Portsmouth one of our registered nurses in our community nursing team visited a patient for a routine planned nursing care visit and recognised the patient's condition had deteriorated. The nurse used the NEWS2 assessment tool and this identified that the patient required immediate conveyance to the emergency department for immediate treatment. Had the tool not been used the urgency of the patients condition could have been missed and they may not have received the treatment they needed in a timely way.

As one of our priorities in Portsmouth for the coming year, we plan to ensure all of our staff are trained to use the NEWS2 tool and to refresh their competencies annually.

Adult Services in Southampton

In October 2018 we introduced a new pathway for Southampton City percutaneous coronary intervention (PCI) patients who should be seen within 14 days of their referral being received. Originally they were seen either at Bitterne Health Centre or Adelaide Health Centre but often not within 14 days as the clinics were already fully booked and this resulted in a delay in them starting their cardiac rehabilitation exercise programme.

We decided to offer patients assessment appointments at the cardiac rehab venue nearest their home address instead of coming to Bitterne Health Centre or Adelaide Health Centre. The rationale being that there are more staff at the cardiac rehab venues due to the number of patients attending. However, once the exercise component is finished staff still needed to be at the venue but could be free to undertake assessments. It also meant patients were able to visit the venue they would be attending in future and see some of the class taking place. If the venue wasn't convenient patients could chose an alternative.

Since October 2018 all Southampton City PCI patients have been booked in this way. This has resulted in an increase in patients being seen within the 14 days and our performance indicators confirm this. Patients are starting their cardiac rehab programmes earlier as PCI patients are usually

only in hospital for one night at the most, this helps with the support and advice they may not have had time to receive as an inpatient.

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Over the last year we reviewed the maintenance programme in pulmonary rehabilitation (PR). Patients attended the sessions after completing PR and were offered in accordance with our arrangement with the Clinical Commissioning Group. It had been noted that classes had become suboptimal due to several factors:

- Some patients health had deteriorated due to other co-morbidities and were no longer able to attend and participate to the evidenced based level of exercise, so were not getting the benefits
- Patients were not very motivated to take responsibility for their own exercise and self-management
- Some patients had been attending the sessions for a long period of time and this had resulted in:
  - Difficulting integrating new patients with a high drop out rate for new patients
  - Sessions were oversubscribed with new patients finding the sessions difficult to access
  - The sessions not being valued as a medical treatment of exercise prescription by some long-standing patients
- Staff had become less aware of other exercise options and did not sign post patients to other providers

A structured meeting with all staff and COPD consultants was held where the positive aspects and challenges of the current model were discussed. Other models were also reviewed including what happens in other parts of Solent such as the Portsmouth area.

As a result new "Next Step" classes have been launched. Patients come for 16 weeks and there is now a flow of patients through the service. We have improved our links with third party providers and supported Active Nations to set up breathability classes that patients can graduate to, and also attend alongside Next Step; we have increased our communications with the Saints Foundations and they are liaising with us regarding their service developments and how it might compliment the needs of our client group.

Child and Family Services

Our Speech and Language Therapy Team in south west Hampshire received a referral from a paediatrician at Royal Hampshire County Hospital to provide an in-patient service to their neonatal ward. This was unusual as we are not commissioned to work on a hospital site and children who need to stay in hospital are usually seen in Southampton however the Royal Hampshire hospital did not feel this was feasible for this particular family.

The referral related to a premature baby who was born at 23 weeks and who had chronic lung disease and unilateral vocal cord palsy. The baby was nasogastric tube fed and was nil by mouth due to aspiration.

An honorary contract was organised and the therapist visited the child on the ward where they were able to discuss her care with the paediatrician and nurses, and instructed the ward to increase the amount the child could take orally to 5ml. The therapist visited the ward three more times to check their advice was being followed and monitor whether it was still relevant.

The child was due to be discharged home with an NG tube, and the therapist had arranged to see her in the community however, she was not well enough to be discharged. Previously this would have meant she would have had a longer period without access to a therapy service however, we

were able to introduce orally fed purees in the hospital which she has taken to well and she made steady improvements.

Once the child was discharged home from hospital the therapist was able to see her at home, having already made a relationship with parents at the hospital and and was able to start her on more solids, and reintroduce liquids. Through her visits to the hospital the therapist was already in touch with the childs dietician and paediatrician, and able to discuss potential changes to her care in advance of her visits.

The therapist did encouter some challenges as this was not a service that had been provided before. She had to fit into how an acute ward operated, linked with different staff members who were all under pressure to care for several premature babies. Paediatricians were keen to push the child on, and the therapist needed to be firm about how safe they felt that was. The high number of staff on the wards meant that handover did not always include the therapists plan and she needed to explain this to senior nurses and make sure the information was somewhere prominent.

However this approach has been a success; the child had no more periods of aspiration where she needed resuscitation, but was able to successfully take a small amount. This means that parents could experience feeding her orally, which the child enjoyed, but they knew how to do this safely and when to stop. She was also now safely taking small amounts of puree and a larger amount of liquids, whilst in a safe environment.

A few weeks later the child was taking three puree meals a day and had begun to have some small snacks. Her parents were happy to try new foods under the therapists guidance and over time increasing the amount the child could take orally, so the amount given through her tube was reduced. This has been done in conjunction with the paediatrician and the dietician.

The family received support in safe feeding before leaving the hospital, and received support from the same therapist when they were at home. Parents felt comfortable contacting the therapist to ask about small changes to food and drink, and knew that that the therapist knews the challenges of the child and the family. The therapsist has also been able to organise a joint visit with the physiotherapist and plan one with the occupational therapist, reducing the time spent in appointments for the family.

The therapist's knowledge about premature infants within a hospital environment has increased and she has gone on to link with other hospital speech and language therapists to access clinical supervision. She is also proud to be part of the the success of joined up hospital and community care.

Mental Health

In 2018 we reviewed our in-patient care planning process and found that:
- The process for completing patient care plans was not truly collaborative and did not always demonstrate an understanding of patient needs or preferences
- In-patient wards had a high volume of care plans (from 12 to 21) for each individual patient
- The high volume of care plans means that nursing staff are not using these in order to truly lead patient care and it was difficult to ensure that care plans remained live and represented the patient's current needs at all times
- Many care plans had been created as a way of evidencing an assessment or task undertaken, rather than from a patient identified need. This means that the care plan process was not meaningful for the patient, with many not being appropriate to the patient's individual needs
- Care plan standards were not the same across the three mental health in-patient services

In-patient services recognised that a change to its current care planning process was required and set up a group to review the process. This group was comprised of ward based staff, managers of the services and colleagues within patient systems.   The group wanted to ensure that:

- Every patient is fully engaged in both the assessment and care planning processes from the point of admission to the point of discharge
- Carers have an opportunity to engage formally in the care planning process and have their views recorded
- Assessments continue to be thoroughly undertaken and that this assessment continues to be demonstrated
- Care plans provide information that is easily understood by patients, carers and staff.
- Care plans are up to date to ensure that they truly lead the care provided to the patient
- At each point of change, the plan of care is agreed with the patient wherever possible. Where this plan of care cannot be agreed, this should be explained to both the patient and carer where appropriate
- Assessment and care plan standards must be the same across the mental health inpatient wards

The group then designed a care plan template which can be used with a patient and carer alongside the full assessment of the patient. The template includes:

- Inpatient Plan of Care
- Summary of Assessment
- Admission Objective and Patient Goals
- Staff Objectives
- Patient Objectives
- Interventions for my mental health recovery
- Interventions for my physical health wellbeing
- Interventions to manage my risk/safety
- Discharge planning requirements
- Patient Views
- Carers Views

For the patient this now means that:

- *I am spoken to about why I am in hospital and asked what matters to me and what would support me to be able to go home*
- *I am given information in a way that is succinct, makes sense to me and mirrors the reason I am in hospital.*
- *I am able to share this plan with my loved ones and it is clear to them why I am in hospital and what will change for me to be discharged home*
- *If I don't agree with any part the plan I am able to say so very clearly on the care plan.*
- *All of the staff on the ward know what support I need as they are able to easily assess this care plan*
- *The care plan is kept up to date as things change, which can be quite quickly in hospital, and both the staff and I know what those changes are at all times*

The outcome of this is that care planning process is simpler for both the patient and the service, and is led by the needs of the individual. The new care plans have been rolled-out in all of our in-patient areas and we have received positive feedback from patients and staff.

We now plan to extend this approach to our community services and this is one of our quality improvement priorities for 2019/20.

Primary Care Services

In September 2018 one of our podiatrists took part in a webinar organised and presented by Martin Fox a Vascular Specialist Podiatrist within the Manchester Leg Circulation Service. The webinar focused on the Academic Health Science Network North East and North Cumbria NHS (AHSN NENC) and the Northern England Clinical Networks Atrial Fibrillation programme "Diabetes Podiatry and Atrial Fibrillation (AF) – Save a Life, Stop a Stroke".   The study involved a three month pilot when 45 podiatrists from North Durham, Darlington and Durham Dales, Easington and Sedgefield CCGs were trained to spot heart irregularities when taking foot pulse readings of diabetic patients in their annual foot screening.   The study found that 1 new case of atrial fibrillationwas detected for every 500 people having their annual foot check and as a result it was recommended that podiatrists:
- Listen to the pulse with the Doppler for at least 30 seconds.
- Check the quality and regularity of the pulse
- If an irregular pulse is identified, explain clearly to the patient why you are referring them to their GP and that they will require further tests.

The Podiatrist reflected on learning from the webinar and put the study recommendations into practice. They began to feel and listen to the quality, rate and rhythm of the pulse, doing this for at least 30 seconds to 1 minute.

During a routine annual assessment of an 85 year old gentleman with no previous history of atrial fibrillation, the podiatrist identified an irregular pulse, they checked the patients medical history and questioned whether or not he had any symptoms; he did not. The podiatrist explained it was not for them to diagnose but that they had detected an irregularity that should be checked with the GP.

The podiatrist wrote to the GP explaining the findings of the assessment and asked the patient to book an appointment with the GP to follow this up which he. When the podiatrist saw the patient 6-8 weeks later he reported he had seen the GP who had arranged for an ECG and blood tests and subsequently diagnosed with atrial fibrilation. The patient has now been put on a beta-blocker and an anticoagulant and was most appreciative for the care and attention given to him.

Following this, the podiatrist gave a presentation to colleagues as part of the one of the Solent Podiatry Target (training) days. There was much positive feedback from the podiatry team after the presentation

Sexual Health Services

In September 2018 the service implemented "webchat" to support patients to self-manage their care, increase availability of appointments and to reduce number of concerns raised by patients about accessing the service.

The aim of webchat was to:
- Support patients to manage their own care
- To increase access for health promotion advice
- To increase availability of appointments for complex patients by reducing the number of low risk patients accessing appointments

The webchat starts with a number of electronic algorithms which aim to answer more general questions a patient may have about their sexual health. If this does not answer all of the patient's questions they can then access a nurse or health advisor via web chat to have a more in-depth discussion.

Since webchat went live in September 2018 we have seen a reduction in patient concerns regarding access; in quarter 2 there were 23 concerns and in quarter 2 after the introduction of webchat there were 12.

The Sexual Health service will continue to review the impact of webchat and in the coming year two of our improvement priorities aim to increae our our use of technology as a way of making our services more accessible by developing a new patient portal and an online platform for partner notification.

Special Care Dental Services

We have a 57 year old female patient who has been seen at one of our dental clinics since 2016. She is a bariatric wheelchair user and had previously attended in her own wheelchair which reclined to allow treatment to take place.   In 2018 her reclining wheelchair became unusable and she attended in a wheelchair which does not recline. Due to her weight of 160kg, the patient could not be hoisted into the dental chair for treatment as she exceeded the safe working weight limit for the dental chair.

The clinician who had been treating the patient liaised with the team at the Royal South Hants (RSH) Hospital to arrange care using the bariatric facilities at the RSH. An appointment was arranged and transport booked. Unfortunately when the Ambulance crew arrived to collect the patient they found that her wheelchair did not have anchor points, making it unsafe to transport her. The clinician who was due to treat the patient telephoned the patient and it transpired she was awaiting a double lower limb amputation and she needed her dental extractions to be carried out before her surgery could take place. The clinician discussed the options for treatment with the patient and a joint decision was made to refer the patient for dental care under general anaesthetic at the Queen Alexandra Hospital which is closer to the patient's home and has facilities for in patient care. An urgent referral was made and the patient received her dental treatment in time to enable her other treatments to go ahead as planned.

The specialist dental service often treat patients with exceptional circumstances and many of our patients have multiple physical and/or mental health needs in addition to their dental health needs.   The needs of this patient were particularly challenging and this case is a good example of how our staff maintain a patient-centred and quality focussed approach to coordinating and providing joined-up care which ensures the unique individual needs of every patient are met.

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Last year we designed an Accessible Information questionnaire for patients who attended the Paediatric Special Care General Anaesthetic list.   We designed storyboards (easy read/pictorial leaflets) to support patients through this procedure. This included the themes:
- Visit to the dentist (for the assessment clinic)
- At the hospital/Fasting instructions (for the general anaesthetic)
- Care after my hospital visit (post-operative instructions)

Over a three month period we asked patients/carers/parents, at their hospital visit, to complete a patient questionnaire. During this time we received 43 completed questionnaires with the following results:
33/43 – felt that these leaflets were helpful
36/43 – wanted more leaflets like these to support them at the dentist

Some of the comments made:

"My daughter has autism and we sign to her as words confuse her so the pictures were good and she can see what is going on. Thank you"

"Social story was really useful as being Autistic it is nice to know what is going to happen…"

"…excellent…really helped and reassured us all…"

Our Accessible Information Lead has provided mini videos for staff to access Makaton signs and symbols to support our patients and our service is encouraging staff to introduce themselves using Makaton: *#Hello my name is…* This has improved our communication with and helped us better to understand the needs of patients who have accessible information needs.

Annex 1: Statements from commissioners, Healthwatch and Overview and Scrutiny Panel

The NHS Improvement letter dated 17 December 2018 *"Quality Accounts: reporting arrangements for 2018/19"* stated that Quality Accounts should be shared with commissioners and local scrutineers including the local authority Overview & Scrutiny Committee and HealthWatch organisations.

The draft Quality Account was sent to the following stakeholders on 29th March 2019:

Portsmouth City CCG
Southampton City CCG
West Hampshire CCG
Portsmouth HealthWatch
Southampton HealthWatch
Hampshire HealthWatch
Southampton City Council Overview & Scrutiny Panel

Responses received from stakeholders are set out the following pages.

<u>Healthwatch Southampton Comments on Solent NHS trust Quality Account 2018/19</u>

Healthwatch Southampton welcomes the opportunity to make formal comment on the draft of Solent NHS Trust Quality Account 2018/19. In Southampton, Solent NHS Trust provide in-patient care at the Western and Royal South Hants hospitals as well as providing GP practice surgeries, Child and Adolescent Mental Health Services (CAMHS), outpatient clinics and community services.

Our overall comment is that the account is well laid out, easy to read and as far as we can judge is complete and accurate with no serious omissions relating to services delivered in Southampton.

The statement on quality from the Chief Executive and the statement from the chief Nurse and Chief Medical Officer are a good introduction to the quality account. They are well justified in their comments about the CQC report; the Trust and its staff are to be congratulated on the overall rating of 'good' and particularly for its 'outstanding' rating for care

Last year we commented that it was disappointing that the coming year' priorities were not put in the context of progress made in meeting the priorities for improvement set out for the previous year's quality account. We are delighted that this has been rectified this year and that this report has an early section dealing with the progress against priorities for improvement 2018-19. This sets the priorities for improvement for 2019-20 into context and makes the report easier and more meaningful to read.

Without commenting in detail on each of the priorities established for 2018-19, it is clear that the Trust has made good progress overall and has maintained a focus on improving quality. We are very pleased to read of the progress made to embed a sustainable Community Engagement Strategy. The annual general meeting held in September was a good example of encompassing the accessible information standard; it was a pleasure to attend a well-thought-out event. We can attest to efforts to liaise with local healthwatch which is very welcome.

The priorities for improvement for 2019-20 are well set out. The idea for each of the clinical services to develop their own quality improvement priorities as well as identifying Trust-wide priorities is very sensible and makes it easier for the public to understand the purpose. It is appropriate for the priorities to be set around the Quality Framework domains of Safe, Effective and Experience. The format of 'Why we chose this as a priority and what it means for patients'; 'What we are planning to do'; 'Performance measures' and 'Engagement and consultation' is a very good way of presenting the priority and will make monitoring progress much clearer. We are particularly pleased that the Trust intends to monitor progress against delivery of each priority through governance meetings in clinical services and the Trust's Quality Improvement & Risk Group.

The specific proposals for Adult Services Southampton, Child and Family Services, Primary Care Services and Sexual Health are all supported and if successful will be very beneficial to patients. However, no mention is made of encouraging, developing and making use of Patient Participation Group (PPG) especially under Primary Care. We are aware that the Trust has a PPG group and would expect it to have a part to play in engagement and consultation for Primary Care Services.

The Trust-wide priorities are clearly important. We are pleased that the Trust will concentrate on improving their interaction with those with learning difficulties as 'Patients with a learning disability are more likely to have poorer health and die at a younger age than the general population. Duty of Candour is a simple and important concept but is not fully understood by everyone in the health service; it is right that the Trust has this as a priority. Similarly, we are pleased to see 'Freedom to Speak Up' guardians identified as a subject

requiring priority. The final priority 'to support staff' is very important.   It is good that there has been continual improvement over the previous few years and we hope to see a further improvement in the coming year.

Part 3 of the quality account provides more detail and is helpful. The actions to implement the accessible information standard are welcomed. The Trust has made very significant progress with this important aspect. It is pleasing that the number of healthcare associated infections has remained very low. Learning from complaints is important and we are pleased to note that the Trust is offering patients an opportunity to discuss issues at an early stage of the process.

The PLACE feedback event demonstrated a commitment to improving the environment and we were pleased to be invited. Healthwatch Southampton has been involved for several years in the PLACE process in Southampton. It is very positive that the Trust has agreed to work collaboratively with Healthwatch to support the pre planning of the 2019 event.

We look forward to continuing an effective relationship with the Trust and will do what we can to help the trust achieve its objectives.

Harry F Dymond MBE   Steve Beale
Chair Healthwatch Southampton   Healthwatch Southampton

25 April 2019

By Email

25 April 2019

Sue Harriman
Chief Executive
Solent NHS Trust

Dear Sue,

We are pleased to be able to comment on the Trust's Quality Account for 2018/19.

Having reviewed the mandatory detail of the report we are satisfied that the Quality account incorporated the mandated elements based on available data.

We commend you on your CQC rating of good and outstanding for caring and consider this is well deserved recognition of your journey as a Trust over the last few years. The Trust recognises there are improvements that have to be made and we expect that you will be monitoring these areas closely over the next few months.

The Trust has made good progress on its 18/19 priorities. Of particular note is your QI programme, your approach to Learning from Deaths and Serious Incidents and that you remain a leader amongst Community Trusts in the area of research.

We were excited to see the launch of the Academy of Research and Improvement website but note that updates are no longer that current.

We welcome your bottom up approach from service lines to developing the 19/20 priorities and are pleased to see these are both smart and comprehensible to your staff. These priorities reflect a broad base of what is important for staff and patients and that service delivery and quality indicators are intrinsically linked. We look forward to seeing the progress on these areas in the coming year.

By implementing new ways of working between the Trust and the CCG we have been able to witness your quality assurance processes in action and look forward to working in partnership with you in 19/20 to ensure the best possible care for our patients.

Yours sincerely

Dr Linda Collie
Chief Clinical Officer & Clinical Leader, NHS Portsmouth CCG

26 April 2019

Sue Harriman
Chief Executive
Solent NHS Trust
Highpoint
Bursledon Road
Southampton
SO19 8BR

Dear Sue

Solent NHS Trust Quality Account 2018/19

As the lead commissioner Southampton City Clinical Commissioning Group (CCG) is pleased to comment on Solent NHS Trust's Quality Account for 2018/19. The CCG and the associate CCG of West Hampshire have continued to work with the Trust over the past year in monitoring the quality of care provided to the local populations and identifying areas for improvement.

The Quality Account is well presented and demonstrates the Trust's ambitious vision, values, and commitment to quality. It also shows the commitment to learning and making improvements where needed.

The CCG would like to congratulate the Trust on the positive results from both the national Staff Opinion Survey and patient Friends and Family Test. The CCG is pleased to note the overall rating by the Care Quality Commission (CQC) of 'good' and 'outstanding' given under the caring domain. It is also of note that the 2019/20 priorities have taken into account the findings from the CQC feedback and each clinical service has developed their own quality priorities with clear improvement measures.

The Quality Account provides details of progress made against the 2018/19 priorities and although they have not specifically been defined as 'achieved' or 'not achieved' within the report the updates on progress have been presented in a clear and understandable format. Further information on the impact of the initiatives on patients would be welcome. Details of engagement with key stakeholders including patients and staff is included, however the Quality Account would have been further strengthened through specific examples of patient stories.

The CCG is pleased to note that the Trust also continued with a number of other quality improvement activities during the year, which are to be commended.

Examples of note were:

- Improvements detailed as a result of local clinical audit initiatives
- Following recognition of the need for support for bereaved families the Trust's development of a Family Liaison Manager role
- Progress with implementation of requirements required to meet the NHS England Accessible Information Standard
- Details of learning and improvements in response to feedback from complaints and concerns.

The Quality Account continues to provide details of the Trust's learning from deaths reviews undertaken including areas identified for improvement. The Quality Account also includes the new

requirements for 2018/19 regarding details of ways in which staff can speak up and how they ensure staff who do speak up do not suffer detriment, as well as gaps in medical rotas.

The Trust should be congratulated on its successful community engagement event which involved discussions between members of the Trust Board and a wide range of stakeholders.

The CCG's opinion is that the Quality Account for 2018/19 meets the minimum national expected reporting requirements and provides details of levels of achievement.

Southampton City along with West Hampshire CCG look forward to continued close working over the coming year and the Trust ongoing commitment to work with system partners to further progress improvements in the quality of services and care provided to the people of Southampton and West Hampshire.

Yours sincerely

John Richards
Chief Executive Officer
Southampton CCG

CC: Stephanie Ramsey – Director of Quality and Integration / Chief Nurse
     Carol Alstrom – Associate Director of Quality / Deputy Chief Nurse

Healthwatch Hampshire response to Solent NHS Trust Quality Account 2018/19

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 several 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.

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.

23 May 2019

Annex 2: Statement of Directors' Responsibilities for the Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare a Quality Account for each financial year.

NHS Improvement has issued guidance to NHS trust boards on the form and content of annual quality accounts (which incorporate the above legal requirements) and on the arrangements that NHS trust boards should put in place to support the data quality for the preparation of the quality account.

In preparing the quality account, directors are required to take steps to satisfy themselves that:

• the content of the quality account meets the requirements set out in the *NHS Improvement Letter 'Quality Accounts: reporting arrangements for 18/19" dated 17 December 2018* and the *Detailed requirements for quality accounts 2018/19*

• the content of the quality account is not inconsistent with internal and external sources of information including:

> – board minutes and papers for the period 1 April 2018 to 24 May 2019

> – papers relating to quality accounted to the board over the period 1 April 2018 to 24 May 2019

> – feedback from Portsmouth, Southampton and West Hampshire Clinical Commissioning Groups dated 25 and 26 April 2019 respectively

> – feedback from Southampton Healthwatch dated 26 April 2019

> – the Trust Friends & Family Test results which are submitted to NHS England monthly and Staff Friends & Family Test results which are submitted quarterly

> – the 2018 NHS Staff Survey Results published in February 2019

> – the Head of Internal Audit's annual opinion of the trust's internal control environment dated 24 May 2019

> – CQC inspection report dated 27 February 2019

• the quality account presents a balanced picture of the NHS 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, is subject to appropriate scrutiny and review

• the quality account has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality account.
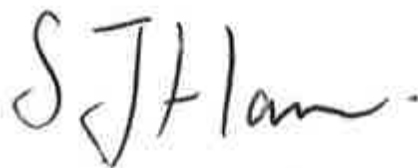
The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality account.

By order of the board

.......24th May 2019......................Date   Chairman

.......24th May 2019......................Date   Chief Executive

Academy of Research & Improvement: Annual Report 2018-19

Trust overview

Activity in numbers

Research	Quality Improvement	Dragon's Den	Audits and Evaluations	
50 studies 2855 participants	350 staff trained 11 foundation days 2 practitioner cohorts 20 projects underway	10 projects in progress	14 national audits 2 national confidential enquiries	124 local audits and evaluations

Artwork generated from Research and Improvement conference 2018
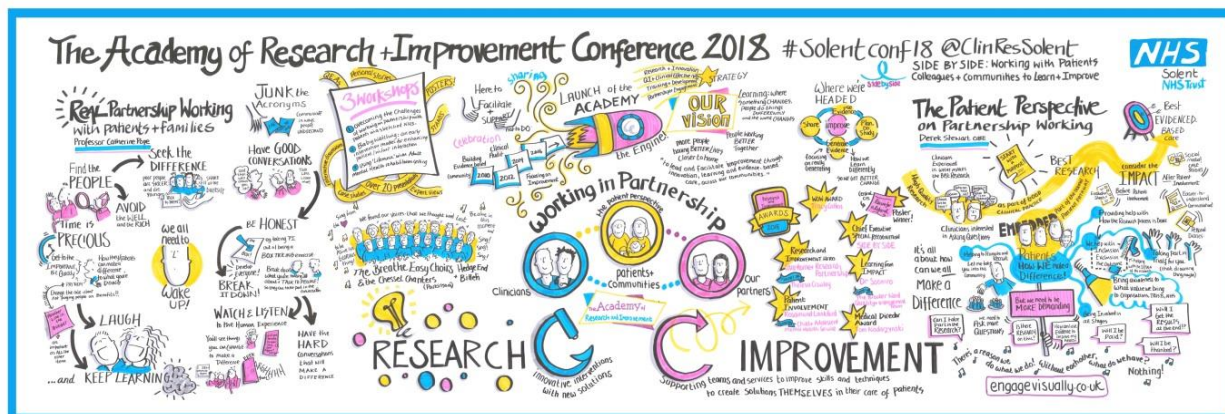
Solent Academy of Research and Improvement

The Solent Academy of Research & Improvement was officially launched in July 2018, with an accompanying Strategy and website (www.academy.solent. nhs.uk). It aims to support learning and ongoing improvement across the organisation.

As the Academy moves into its second year the benefits of our innovative integrated model, combining research, clinical audit and quality improvement are becoming increasingly apparent. The natural synergies between these key functions provide numerous opportunities for sharing of knowledge, learning and cross-pollination of ideas for how we, as a Trust, can continue to innovate and improve.

The Academy supports a spectrum of activities, supporting skills development for those that with for and with us. A selection of the projects that have been undertaken through the Academy in 2018-19 are detailed in this report. A full list is given in the Appendices.

Research	Audit	Evaluation	Outcomes	Quality Improvement
Patient and Community Engagement	Innovation (Dragon's Den)	Sharing Learning	Favourable Event Reporting	Schwartz Rounds

The Strategy was developed in partnership with staff, patients, our Side by Side group and colleagues in partner organisations. It has four key priorities:

Patient and community participation

Patients, families and others who touch our services should play a central role in our learning and improvement. Supporting teams and patients to work in partnership is one of the key strategic priorities for the Academy. The last 12 months has seen the way Solent works together with patients and communities gain considerable momentum, particularly with the launch of the Trust Community Engagement Strategy.

A Patient's Included Conference

The theme of the 2018 Solent Research & Improvement Conference was 'Working in Partnership'. For the second year, the event was accredited as 'Patient's Included' and was co-designed by our patient group – Side by Side. Derek Stewart, a patient leader for research gave the keynote talk, and a number of patients presented on the day alongside clinicians. The Side by Side group ran a workshop on barriers and facilitators for good partnership working.

Patients as partners in Quality Improvement

All those participating in the QI programme are required to include the patient voice in their improvement – and teams on the Practitioner training include patient or family representatives.

Patients and families are involved in improvement projects in a variety of ways. For example, a mother of a child with autism is working along side a QI team to look at the referral pathway into the Child and Adolescent Mental Health Service; an experience based design approach is being used in one physio service to view access to the service through patient's eyes, by literally walking through the process with them. Patients in a vocation rehabilitation service have co-designed an outcome measure to help track and plan their progress; patient's experience of the pain pathway is being used to streamline appointments.

A Health Foundation Grant was also secured to co-design a patient specific module within the QI programme – this project is currently underway and is being carried out in

collaboration with Southampton Children's Hospital.

Patients leading improvement projects

In addition to having patient and public participation in quality improvement, two projects were service user led.

One looked at the plates used on the Brooker ward, for those with acute Dementia. Evidence shows that the colour and composition of plates can affect eating and therefore nutrition. The project was carried out with residents, families and staff, and a blue lightweight set of plates is now in use.

Similarly, a past client of our mental health services has designed small 'pocket-therapy' aids to support recovery and participation in different types of therapies. The printing and distribution of these booklets was supported by Dragon's Den funding.

Improving Access to Research

In research, we secured funding from the Wessex Clinical Research Network to develop promotional materials, and hold engagement events to extend our Side-by-Side group.

We also carried out an audit on diversity in research, which demonstrated that although we know anecdotally that research is typically less accessible to some groups (older adults, those who don't have home internet access,

those who don't have English as a first language etc), we have limited evidence to demonstrate this. We are now collecting demographic data on all research participants and working with the national Health Research Authority (who approve all research studies in England) on widening inclusion criteria.

Valuing Lived Experience

Patients, with their lived experience, can support other patients in their health needs, through peer support or co-production of health services and health outcomes. A few services have peer support workers (for example the Recovery College in Mental Health and the Pain Service) and this is starting to extend. To support this aim, the *'Valuing Lived Experience'* network has been established for staff. This network supports managers and lead clinicians to share and learn from each other regarding the challenges and successes of involving patients through co-production or involving peer workers in delivering services.

The Academy of Research and Improvement

NHS Solent NHS Trust

Come and join us

sidebyside

Share your experience and make a difference by:

- Contributing to service improvement projects by helping us to see through your eyes.
- Designing health research to help make it patient friendly.
- Sharing and promoting your experience of being involved in research and improvement.

For more information contact Carl Adams and Rachael Brown:
Tel: **0300 123 3994** Email: **involvement@solent.nhs.uk**

Research

Solent NHS Trust continues to grow its research activity, recruiting 2855 participants into 50 studies in 2018/19. This is an increase of 18% on the previous year, making Solent the most research active Care Trust in the National Institute for Health Research annual league tables.

Participants recruited to research studies, by year

Year	Participants	Studies
2016/17	1509	48 studie
2017/18	2414	55 studie
2018/19	2855	50 studies
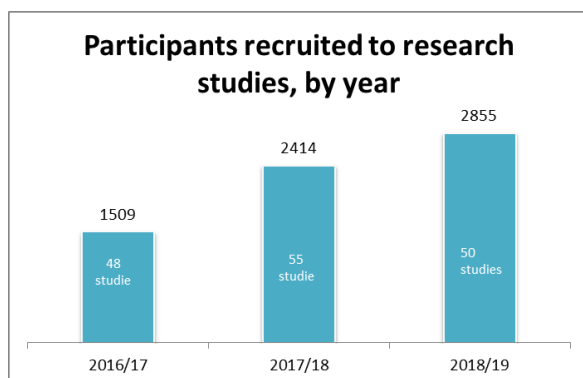
Solent NHS Trust conducts community-based health and social research across a range of specialty areas including infection, children, oral and dental health, mental health, dementia, genetics, musculoskeletal, health services, neurology, stroke and primary care. We host and lead trials as well as contributing to research studies being led by other NHS Trusts and Universities. This is important because there is a wealth of evidence that Trusts which are active in research have better patient outcomes and higher quality services. Research activity raises awareness of evidence-based practice, drives innovation and gives staff opportunities to learn new skills. It also often gives patients access to interventions, medications and treatment that might not otherwise be available to them.

A core component of our research is our community research partnership model, in which we work collaboratively with other care organisations to deliver studies. To date, we work with care homes (over 30), schools, colleges and community organisations. The care home research partnership was

recognised this year with Solent winning the Nursing Times Award for Clinical Research Impact.

The following pages outline a selection of the research studies we currently have in progress.

Trust-wide research

Carriage rates and antibiotic resistance

This winter saw the third year of Solent's involvement in the important SMART study. We recruit people of all ages from the community and take samples of bacteria from the upper respiratory tract. This enables the research team to determine community carriage levels of common respiratory pathogens and the prevalence of antibiotic resistance. To date we have recruited over 2000 participants, across the full spectrum of age groups. This is contributing to a national programme of work on Antimicrobial resistance.

Adults Service Research

Vision in Parkinson's Disease

As well as the recognised effects on movement, patients with Parkinson's disease suffer from visual disturbance, even at the earliest stages. Yet little is known about how and where visual processing breaks down in

patients with Parkinson's disease. Solent recruited 16 participants to this study. Participants took part in psychological testing, blood tests and computer based visual tasks. They will complete follow up, undertaking these tests once a year for 4 years. The long-term goal is to increase understanding of visual breakdown and inform the development of effective treatments.

Accessing medicines at end-of-life

This study involves an England-wide survey of health care professionals, to capture important details about current practice in providing patients with access to end-of-life medicines, and views on what facilitates and prevents good practice in this area. A cohort of Solent's community nurses completed a short survey. We are now in the process of setting up phase 2 of the study which will help shape policy and practice.

Musculoskeletal

Ankle Recovery Trial (ART)

The purpose of the ART study was to compare two methods of managing ankle fractures after surgery using either a plaster cast or removable boot. This study was conducted in conjunction with a local Orthopaedic surgery department. Solent NHS Trust's research team co-ordinated the study, recruited 19 participants and provided the physiotherapy intervention. Formal results are awaited and will be used to guide future management of this patient group.

Sedentary Behaviour and Physical Activity in Osteoarthritis (OA)

The aim of this study is to better understand why some individuals with OA make an effort to be physically active, whilst the majority are physically inactive. Part of the study involves body composition analysis which participants have found interesting and informative. To date, Solent has recruited 13 participants to the study. The results will be used to identify effective practices to help inactive people with OA become more active.

Ageing

Falls in Care Homes (FinCH)

Care home residents are susceptible to falls and these are often associated with negative health outcomes. The purpose of the FinCH study is to determine the clinical and cost effectiveness of the Guide to Action (GtACH) process for fall prevention in care homes compared to usual care. The study involves a randomised controlled trial to gauge the impact of GtACH training for care home staff on the number and severity of falls in care homes. Solent NHS Trust recruited 86 participants for this study. Ultimately, the goal

is to identify strategies to reduce the number and severity of falls in care homes.

Memory Service Professional Practice regarding Assistive Technology

Due to the increasing number of people in the UK living with dementia there has been a growing interest in supporting people with dementia to live independently. One way to help support independent living is the use of assistive technology. This study aims to determine current practice of professionals working in Memory Services regarding the provision of information on, and access to, assistive technology for families living with dementia. Solent NHS Trust recruited 23 participants to this study. The findings will be used to find ways to better support memory services to enable people with dementia and their families' timely access to assistive technology.

Sense Cog KAP

This study is designed to investigate the impact of sensory impairment on cognition in older people with dementia. It is being conducted within care/nursing home settings. Solent NHS Trust has played a key role in assessing feasibility and setting up of this study, tapping into our Care Home Research Partnership. To date, the team has recruited more than 20 care homes and over 200 participants to the study. This includes care home managers, paid carers and family carers. The study will provide insight into issues and strategies for the management of sensory impairment amongst care home residents.

Adult Mental Health

The CAP-MEM Study

This study explores the cause and prevalence of memory problems in mental health. It assesses self-reported concentration and memory problems amongst people with a clinical diagnosis of a psychiatric disorder and a comparison group of healthy controls. To date, Solent NHS Trust has recruited around 200 participants to the study. This initial study will be used to establish the feasibility of conducting similar research amongst larger numbers of individuals in the future. Ultimately, findings will enable researchers to better understand the relationships between psychiatric diagnoses and memory and concentration problems, taking into account factors such as medication type and dosage.

The LIGHTMind Study

This is the third phase of a study to compare the benefits of cognitive behavioural therapy (CBT) to mindfulness therapy amongst patients seeking treatment for depression. Patients are recruited from Solent NHS Trust's

Improved Access to Psychological Treatment centre in Portsmouth. The study aims to determine which therapeutic approach provides the greatest benefit in terms of reducing symptoms of depression and minimising the risk of relapse. The trial is ongoing and, to date, Solent has recruited 13 participants into the study.

Sexual Health

HIV Prevention Study

PrEP Impact is a high profile national trial looking at people who are at high risk of acquiring HIV and involves them taking medication to reduce their risk. Solent NHS Trust offers participation in this trial at our three sexual health service hubs. Interest in the trial has been high and, to date, we have recruited 146 participants. Our role includes regular follow up visits and collection of samples to determine successful avoidance of infection.

Accelerated Partner Therapy (APT) Chlamydia Trial

The LUSTRUM study is a randomised controlled trial to measure the effectiveness of APT to identify and treat the partners of patients diagnosed with chlamydia. Solent NHST Trust is recruiting patients from sexual health clinics in Southampton and Portsmouth. To date we have recruited 86 patients to the trial. Our sexual health nurses deliver the intervention and collect outcome measures. If the intervention is shown to be effective, it will help to reduce rates of chlamydia by reducing incidents of reinfection.

Research with Children

The E-SEE trial

In an attempt to combat the public health challenge presented by behavioural problems and mental illness this study examines a program designed to promote social and emotional wellbeing in young children. This study aims to investigate whether the Incredible Years programme is effective in enhancing children's wellbeing at 20 months of age compared to usual care. The Solent NHS Trust team recruited 83 participants to the study and provided 10 week block parenting courses. If the programme is found to be successful it has potential to benefit the long-term health of the families involved.

The Pre-Appt Study

Children accessing therapy services often have a variety of long-term conditions and rely on their parent's willingness to engage with services. Across the country, there are wide variations in content of materials sent to families ahead of their first appointment and it is unclear whether materials encourage families to engage with therapy services. This study aims to compare and contrast pre-appointment materials to determine whether they can be standardised in a way which improves parental engagement. The Solent NHS Trust research team liaised with 8 local children's therapy services and submitted

materials to be assessed for this study. The results will provide insight into current practice across England and guidance around the content, tone and look of materials to increase parents' willingness to engage with therapy services for their child.

Cost of Autism Diagnostic Assessment

Nationally, there has been a significant increase in referrals for possible Autistic Spectrum Disorder (ASD), and this is putting a strain in diagnostic services. This multi-centre observational study aims to find out the amount of clinician time taken to assess a child for possible ASD and from this calculate the resulting costs to the NHS. Solent NHS Trust recruited 72 participants for this study. It is hoped that by understanding the complexity of assessment and costs, this will inform appropriate resourcing of assessment services and improve patients' experience.

Quality Improvement (QI)

The Academy's Quality Improvement (QI) Programme, launched in July 2016, is designed to support individuals and teams to develop the skills and capability to successfully identify and implement QI projects within their workplace. The growing success of the initial offer of a six monthly QI training programme for teams of staff has resulted in the successful launch this year of a stepped QI training programme comprising of four key elements:

1. **Introduction to QI:** this short introductory session provides teams with a brief overview of QI.
2. **Foundation day:** this day long training provides an introduction to key QI methods. It is available to all staff and includes support to carry out small scale QI projects within the workplace.
3. **QI Practitioner:** this brings teams of staff and patients together to participate in learning days on key QI topics whilst they carry out improvement projects over 6-8 months. Teams also receive individual facilitation and support.
4. **QI Leaders:** newly launched in 2018, this year long programme is open to staff who have experience of successfully delivering QI projects and who want to develop their ability to lead QI activities across the Trust.

This year *over 350 staff, external partners and patients have participated in Solent's QI training*. Those attending the training report better knowledge and increased confidence on how to make improvements.
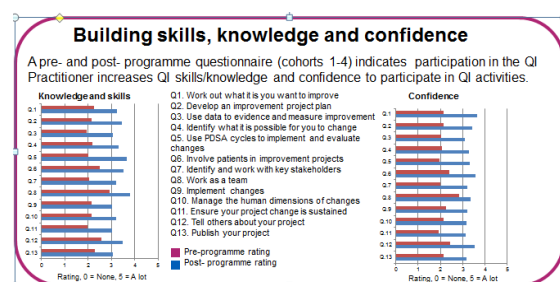
QI Programme Key Deliverables in 2018/19	
	11 foundation training days
	22 foundation day projects have successfully completed and 15 projects are underway
	2 Practioner courses, 12 teams
	8 QI Practitioner projects have successfully completed and 12 projects are underway
	8 members of staff recently joined the newly launched QI Leaders.
	Optional Master Classes delivered by external speakers and open to all Trust staff have been run regularly throughout the year

This year has also seen a number of projects presented at local and national conferences. Additional activity to support dissemination of project outcomes is planned. Increased patient engagement in QI projects is planned for 2019. This will be supported by a specific QI training programme for patients and the public; development of this programme is currently underway.

QI Foundation Projects

Examples of some of the QI Foundation projects which are underway or have been completed are:

"Safeguarding Vulnerable Patients" - Special Care Dental Services, project complete

Patients seen within the Special Care Dental Service who did not attend (DNA) or were not brought (WNB) to a dental appointment, may not be followed up adequately and 'fall between the cracks'. Aims for the project included:

1. For 100% of all WNB patients to be followed up with the re-engagement process.
2. To increase the awareness and engagement all staff members, within the dental team, with the WNB/DNA procedure and ensure they understand its relevance to safeguarding.
3. To standardise the WNB/DNA process across the East Area of Solent NHS dental service.

These aims were achieved by engaging both patients and staff in the development and adoption of a flow chart for missed appointments and disengagement.

Patients are now followed up in a standardised way across the East Area of the service, with 78% of staff using the new flow chart. The number of patients seen within 9 weeks of a missed appointment was increased by 50%. Dental nurses and receptionists, who book the majority of dental appointments, had little or no confidence that DNA/WNB patients were followed up in an appropriate

manner. Following the implementation of the new flow chart these confidence levels improved from 36% to 93% for the Nursing staff and 0% to 85% for the Receptionists.

"Standardising Microscopy" – Sexual health services, project complete

The aim of this project was to standardise an approach to microscopy which could be rolled out across all Sexual Health Services in Solent. Initial audit data and findings were shared at Education Days. A process was agreed and added to the Microscopy field of the IT system INFORM. A microscopy training tool was developed which included competency sign off.

"Standardising Community therapy provision for 0-4yr children with complex needs" - SW Hants Children Therapy Team, project complete

The team had identified that there was inequity in the access to therapy provision for children aged 0-4yrs with complex needs across the SW Hants area Children's Therapy services operates. The aim of the project was to ensure that 100% of children aged 0-4 Years would have the same access to therapy provision available to them. Patient and staff satisfaction relating to the current service provision was gathered across the SW Hants area. Information was gathered regarding what type of activities should be offered and this was used to review the service provided and identify possible improvements. Two new "6 weeks' groups" commenced in Eastleigh and Hedge End on the 11th September 2018, referrals were accepted from children across the whole of SW Hants. These groups were evaluated and the second round of "6 week groups" took place in January/February 2019. Staff who would be involved in the role out of the project across SW Hants was invited to attend training in preparation for the expansion of the project. In March 2019 two further groups start in Totton and Winchester/Andover. Development of a 'Handbook for group setup' is being created for staff to use when setting up a new group.

"Improving the management of the Urgent Waiting List" - Community Therapy Team East, project complete

The team highlighted that there was an issue with their current Urgent Waiting List and that this was increasing in number and causing stress and anxiety for staff. A patient questionnaire was developed to gain some patient views around the current waiting time for physiotherapy. The questionnaire also looked at the perception of "Urgent" need and how long patients were willing to wait. Staff opinions were sought to understand the problem measure the current level of stress and explore any ideas for improvement. The

team identified that a new triaging system could help manage the urgent waiting list and so developed a new set of triage questions. This has led to a reduced waiting time on the Urgent List from 13 weeks to 3 weeks and 3 days, a reduction of 73%, meaning that the project's aim has been achieved.

"Improving the confidence in staff to facilitate and lead ward activities for patients" - Oakdene Ward AMH, project complete

Oakdene Ward runs activities for patients to engage in throughout the day to aid their rehabilitation. Some staff were reluctant to facilitate or lead these activities due to lack of confidence. Despite a wide range of staff engagement activities the outcome from this project did not achieve the original aim set out. However there are clear learning points when a project does not go according to plan. The team have now identified that the problem highlighted is more complex, including staff opinion surrounding job roles and the possible overlap between historic "nursing roles" and "therapy roles." In order for the original aim to be achieved the team now realise further work will need to be completed to understand the barriers that are currently in place affecting staff willingness to lead and facilitate ward based activities. Engaging staff more fully in the original

"understanding the problem" could have improved the outcome of this project and the learning from this will be shared and used in future projects.

"Grow Your Own" - Central Community Independence Team, Project complete

The demand for a Comprehensive Geriatric Assessment (CGA) was greater than capacity available. This led to concerns that GP tasks were not being completed in a timely fashion thus impacting patient wait times for rehabilitation. There was little career progression for therapists in the Community Independence (CIS) team and this was seen to be impacting on staff recruitment & retention. The aim of the project was to develop a therapy role with extended skills within the CIS team to ensure 100% of medically referred patients receive the right care at the right time (CGA Within 2 weeks). Outcomes included an increase in the number of CGA's being completed, patients who have had a CGA, stay in hospital on average 7 days less than those who have not. Patients admitted to the acute trust by Central CIS had a reduction in bed days. There has been a decrease in the number of tasks being sent to GP's and 100% of tasks outlined by the therapist were completed showing that GP's recognised their expertise. Staff reports that patients' rehab was being affected whilst they

were waiting for a CGA has reduced from 45% of patients being affected to 7%.

QI Practitioner Projects

"Emergency appointments in podiatry" - Podiatry Service West

There are up to 50 emergency slots across the podiatry service each week. Due to clinical and staffing pressures these slots were frequently being booked for planned appointments, which was impacting on quality. The aim of this project was for 100% of emergency patients to be seen by the right clinician at the right time by January 2019. In order to understand the problem the team process mapped new patient and follow up appointment pathways, validated their list of clinics, identified all specialties and analysed the variation in their emergency appointment data using statistical control process charts. They then pooled their waiting lists for all routine and follow up appointment slots across all Southampton and West Hants clinics, adjusted the number of emergency appointments slots available per day to account for variation, introduced 7 day embargoed emergency slots, increased the length of each emergency appointment slot from 30 minutes to 45 minutes and introduced telephone triage slots to confirm the need for an emergency slot. Results show there has been a reduction in the number of times when emergency slots are booked for

planned appointments. For this project, understanding variation using statistical process control and reducing queues into the appointment system were critical factors in improving patient flow.

"Right patient, right results" - Sexual health services

The Sexual Health Services take many hundreds of specimens a year, which are sent to a laboratory for analysis. Staff were concerned that there had been a number of errors in the process of labelling and logging specimens. This could give rise to serious incidents in which patients may be given incorrect results. Therefore, the aim of this project was for 100% of patients to have their specimens labelled and logged correctly. The team mapped their process for labelling and logging specimens, conducted an observational walk through of the environment and worked with their wider team to identify potential causes of errors. Changes tested and adopted included implementation of a new process and Standard Operating Policy, new logging sheets, flow charts displayed in specimen logging areas, and a programme of staff training. The process has now been successfully spread service wide. Data show there have been fewer specimen labelling and logging errors and these have all been successfully identified and rectified prior to the specimens being sent to the laboratory.

The team are currently producing a podcast on the process to support a range of staff learning needs. Process standardisation and extensive testing using plan-do-study-act cycles has been a key to the success of the project.

"Changing health outcomes for overweight and obese children through better engagement with their families" - Children's healthy weight team,

This project sought to achieve by June 2018, an increase in engagement between the school and school nurse team with parents/carers of children identified as obese at their Year R National Child Measurement Programme (NCMP) screening.   A multi-agency project team focused on two schools in Portsmouth with the highest obesity rates. All parents of year R children at these schools were invited to attend a focus group to explore this issue. The findings of the focus groups, at which 12 parents attended, were that 30% of the parents had no understanding of the NCMP, 100% of the parents thought that childhood obesity was an important issue and understood the health implications associated with obesity, 83% of parents thought the NCMP post-measurement letter was easy to understand that that the language used and information the letter contained was clear. Changes implemented by schools and the school nurse team to support children and their families to

maintain a healthy weight included timely distribution of the pre-measurement letter; SMS reminders to be sent by the school to parents the day before the measurement, promoting the role of the School Nurse and translation of information into other languages.

"Improving complainant and staff experience of local resolution meetings" - Complaints team (corporate services)

Local Resolution Meetings (LRMs) are being encouraged as an early step in managing a complaint. This project sought to improve complaint and staff experience of LRMs. The team interviewed a number of complainants, staff and advocates, using an experience based design approach to understand their experience of participating in an LRM. They also reviewed the complaint investigation process and flow, and analysed data to identify the number of LRMs and time to completion. Changes made included revision of the Complaints Policy so that the complainant is routinely offered the choice to meet the service, staff training on holding LRMs is now provided and guidance for staff on LRMs has been developed and is available on the intranet.

"Improving missed medication doses reporting" - Adult Mental Health inpatient wards

Staff were concerned that there were occasions when medication cards showed that patients were missing medication doses. Missed medication doses can have a negative impact upon patient recovery and well-being. Therefore, a data collection sheet to capture the number of 'blank boxes' on medication charts was developed for us on the four inpatient wards.. The results showed how many medication administrations had not been recorded but there was no way of knowing if these were missed doses or not. In order to understand the problem and identify potential solutions the team consulted staff, shadowed medication rounds, raised awareness at team meetings and handovers, gathered feedback from patients and completed a fishbone cause and effect diagram with staff on each ward. Staff identified they wanted a second person to check the medication cards and this was tested and implemented on each ward. The team also held meetings with ward managers to agree standards for managing non-compliance with policy, leadership teams communicated with nursing staff about the issue of non- compliance, non-compliance and associated risks were escalated via the Mental Health Governance structure. Data showed that over a six month period some wards made significant sustained improvements whilst other wards had further work to do. Further feedback from staff indicated they felt there now needed to be "people management". A plan was agreed for handing this improvement activity over to services for embedding into practice and monitoring is continuing through a variety of forums.

"Reducing rates of non-concordance with home oxygen therapy for patients with Interstitial Lung Disease (ILD) and Chronic Obstructive Pulmonary Disease (COPD)" - Home Oxygen Therapy Service, Adults Portsmouth

The Home Oxygen Therapy team were concerned that under or over use of home oxygen was a common occurrence amongst their patient group. Such under or over use has potential to negatively impact upon patient quality of life. Data analysis showed that the greatest amount of non-concordance was in those patients with ILD and COPD. Therefore, this project aimed to reduce rates of non-concordance with home oxygen therapy for patients with ILD and COPD. Consultation with patients identified the current method of providing verbal information regarding their home oxygen therapy prescription didn't fully support their needs. Following this the team worked collaboratively with patients to develop a home oxygen therapy information leaflet which also included a prescription sheet for the clinician to complete with the patient. This is currently being tested with patients.

"Improving patient education on the risk of herniation" - Stoma Care Service, Adults Southampton

Patients with a stoma are at risk of developing a hernia as a complication of surgery. The Stoma Care Team realised they could influence outcomes through providing education to all patients undergoing surgery. Therefore, the project's aim was to improve the pre-operative information provided to patients on the potential risk of hernia formation and on the preventative steps they could take. The team developed a survey seeking feedback on the way information is currently given, the timing of its delivery and the preferred delivery method. Attendees at 2 stoma support groups participated in the

survey. Based on the feedback the team have designed a short patient education video which is currently being tested in clinic. The team are developing plans to use the video as part of their care pathway, potentially prior to discharge from hospital, as survey respondents identified this as an ideal time to reiterate the information. They are also exploring the feasibility of sharing the video on the Trust's intranet and internet and the Stoma Care Service's Facebook page to increase accessibility.

Clinical Effectiveness

Our clinical effectiveness activities include clinical audits, service evaluations, the development of clinical outcome measures and the dissemination and review of NICE guidance.

In all these activities we are looking to identify areas of concern and evidence of effectiveness, from which we make plans for improvement.

Planning for Improvement

We are required to produce an annual plan for our audits and evaluations. This has traditionally been done by service lines in isolation.

Last year, we launched a trust wide improvement planning together event which

we repeated, with improvements, in January this year. This year we included patient and public representatives meeting with teams from each of the service lines and corporate services.

Each team was provided with:

- results of a staff improvement ideas survey
- key themes from patient experience reports, incidents and complaints
- details of audits and evaluations marked for re-measurement

A video was also produced for this event to promote good practice and share examples of improvement from the previous year.

Draft plans from each team were discussed around the room to promote joint working.

One of the key themes identified, discussed and planned at this event was processes for maintaining standards by reviews of electronic patient records.

Clinical Outcome Measures

Last year we conducted a scoping survey to identify and build a database to track clinical outcome measures use in the trust.

Examples of projects to design and implement outcome measures into clinical service are:

- A co-designed (patient and clinician) set of outcome measures in the Vocational Rehab Service
- Roll out of an outcome measure for the physiotherapist service in Portsmouth
- Development of outcome measures with young people for the Child and Adolescent Mental Health Service
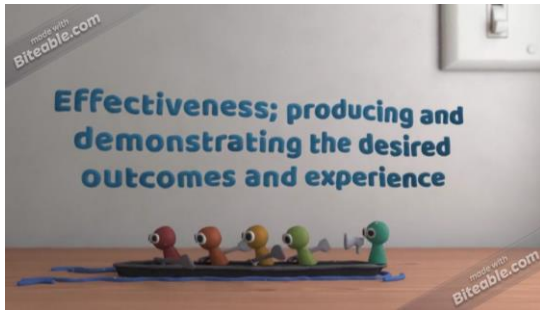
National Audits

During 2018-19 we participated in 16 national audits, submitting over 2,000 cases.

In one example of a repeated national audit, the National Clinical Audit of Psychosis, we submitted 88 cases and shared results across the trust in a range of formats including video and info-graphics. The info-graphic below shows key findings and actions for improvement.

Local Clinical Audits and Service Evaluations

During 2018-19 we conducted 124 local audits and evaluations.
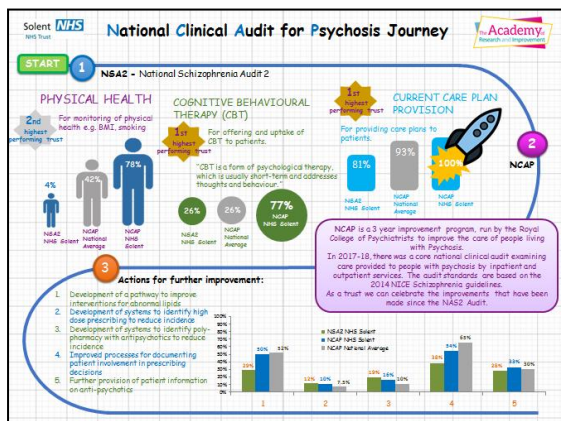
The examples of repeated audits and evaluations below show how the cycle of repeated measurement and action can lead to improvement.

Completion of care plans in mental health (re-audit).

Four audits were completed between January to June 2018. Between the first and last audit there was improvement in all areas measured:

Standard	Improvement
Care Plan in place	30%
Current and in date	60%
Relevant to episode of care	40%
Documentation of capacity	60%
Documentation of consent	40%

Recording parental consent in specialist dentistry (re-audit).

The compliance reported in this audit (87%) shows continued improvement since the previous audit (83%) and a run of improvement since the audit started in 2015.

	Dec 2018	Dec 2017	June 2017	Jan 2017	Dec 2015
Overall compliance	87%	83%	65%	44%	39%

Wound assessment in adult services (re-audit).

158 patients with wound care plans were audited of which 137 (87%) had a TIMES wound assessment which exceeded requirements and showed an improvement

from 80% in the last audit and 65% in the previous year's audit.
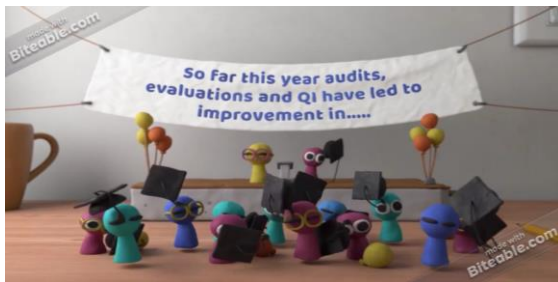
Complication rates of vasectomies in Sexual Health (re-evaluation).

This evaluation showed that the occurrence of complications had been overestimated. Re-coding using clear definitions gave an overall complication rate for Solent vasectomy department of 0.79% (12/1525 operations) which is within the limits quoted in the evidence and an improvement on the previous rate of 5.8%.

Radiological investigation in non-accidental injury of children (re-audit).

The audit looked at 79 patients under 2-years old with suspected physical abuse following community paediatric examination, from 2013-18.

84% of under two year-olds had a skeletal survey when physical abuse was suspected (increased to 100% in 2018). Children under 1 year were significantly more likely to get a skeletal survey (94%).

89% of follow-up skeletal surveys were carried out (100% in the last 4 years) which is

impressive as much of the published literature reports high attrition rates.

Planning for transition of young persons to adults (re-audit).

There was an improvement from 42% in 2014 to 62% for a plan of transition starting at the appropriate age. Information in the health care plan had also significantly improved with, for example, including young person' views increasing from 47% to 55% and inclusion of a list of professionals increasing from 33% to 100%.

Post-op complications following Podiatry nail surgery (re-evaluation).

The number of patients lost to follow up before wound healing improved by 3.7% to 13.3%. Post-operative infection rates improved by 19% to 13.3% whilst delayed wound healing improved by 6% to 33% patients.

Nutritional screening in adult services (re-audit).

100% (37) of patients were screened for malnutrition status within 24 hours of admission - this showed an 11% improvement from 2017-18 Qtr. 3 and 7% improvement from 2018-19 Qtr. 1; 92% overall had this repeated weekly.

The inpatient wards have consistently demonstrated the appropriate use of food and fluid charts when the patient's MUST score is medium or above.

End of life medication records in adult services (re-audit).

The audit gives a clear picture of the EOL medication prescribed & administered to patients and shows improvement from previous audits. More records contained information regarding disposal of no longer needed medication, than found in previous audits (91% compared to 56% last year).

Pressure Ulcer Prevention and Management in adult services (re-audit).

Improvements were noted in ulcer categorisation, use of at risk care planning and Waterlow score, advice to patients and carers, equipment provided, MUST use and onward referral with compliance ranging between 93% and 100%. Range of improvement was between 5% and 35%.

Infection prevention and control in specialist dentistry (re-audit).

The lowest level of compliance was 96%. Areas of good practice were: prevention of blood borne virus exposure (18 clinics - 100% compliant); use of personal protective equipment (19 clinics - 100% compliant); management of dental medical devices (18 clinics - 100% compliant).

Adoption medical reports (re-audit).

The overall quality has considerably improved. Of 27 standards, 24 are now 100% compliant. The overall average compliance increased from 87% to 97%. The lowest level of compliance increased from 27% to 60%.

Improvement was specifically seen in: availability of information from Social Care; stating if immunisations are up to date; inclusion of comments on emotional and behavioural issues (from 27 to 90%), vision &

hearing; details of head circumference; information about hereditary and family risks.

Service Evaluations

The examples below illustrate how service evaluations can help us understand how our services work now and how they could work in the future.
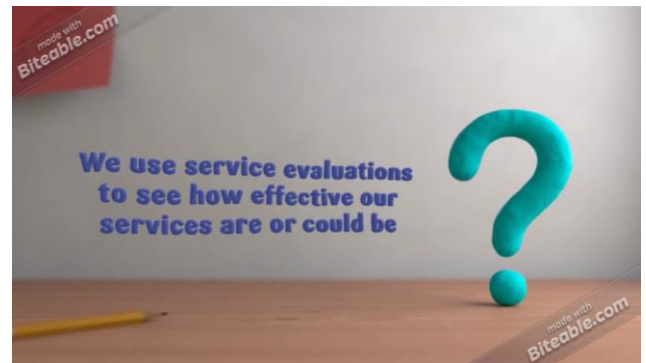
Musculoskeletal (MSK) telephone triage service compared to GP telephone calls (evaluation).

This evaluation compared the effectiveness of a newly established MSK telephone triage service with GP telephone calls. 51% of MSK patients speaking to a GP duty team were given on the day appointments, compared to 9% from the MSK telephone triage. For GP duty team, 33% were given a prescription compared to 9.5% from MSK. Only 9% of patients were given only advice by the Duty Team, compared to 40% within MSK. MSK telephone triage appears to saves time on appointments, prescriptions and provides more advice than the GP duty team. 54% of patients made no further contact with the GP

surgery or MSK Triage service for the same problem within the following 3 months.

Epilepsy passports for children (evaluation).

21 people (including 4 patients and 10 caregivers) responded to a survey. The majority perceived the epilepsy passport to be useful. Caregivers mainly recognised its helpfulness in emergency situations, whereas health care professionals identified its potential for improving communication between teams.

Factors affecting drop out from emotional coping skills and dialectical behaviour therapy in mental health services (evaluation).

No significant differences (e.g. symptom severity, demographics) were found between dropouts and completers of these forms of therapy. Substance-use was not found to be a significant predictor of dropout, contrary to previous research. Interpretation of the results suggested that psychological assessment should address the likely impact of behaviour and mood on patient ability to attend therapy. Assertive engagement may be valuable for people struggling with chaotic behaviour and low mood. Motivational work may also be benefical to try and increase inital engagement with therapy after being placed on a waiting list.

Patients views on the acceptability of e-prescribing in Sexual Health (evaluation).

1281 service users took part in this survey. In general, most participants preferred to either be given the medication by a doctor (20%) or collect it at a pharmacy (34%). However, for chlamydia treatment and contraceptive pills, many (45%) chose 'home delivery' as their preferred method. When asked directly,

around 83% of participants were willing to receive antibiotics and contraceptive pills by post. For medication by post, most (76%) participants were not concerned about the confidentiality, but 44% would be concerned about the medication delivery if they were absent.

Preferences for video consultations in sexual health (evaluation).

246 service users completed a paper based survey. 70% of patients preferred face-to-face consultations at the clinic as the first point of contact; 73% were willing to use live web chat services and 58% video-consultations. Only 40% reported that artificial intelligence chatbots would be acceptable. The findings demonstrate the importance of human interaction in SH services and the potential for inequity of provision if services are too focused on digital provision.

Some audits are used to measure change in our QI programme

Dragon's Den – Innovation

In Solent, staff and patients are able to bid for small scale innovation grants to test new ideas within their services. Bidding is invited

four times a year, and grants are worth up to £10,000. There are currently ten projects underway across the Trust. For example:

Pillowcase to position the arm post stroke (Neuro rehabilitation service, Southampton)

To help patients, carers and staff position an arm correctly post stroke, a physiotherapist has designed a pillowcase that shows where the arm should be placed. The pillow sits under the arm – the innovation fund is supporting the development of a prototype and a range of cases to test.

Pedometers to support increased exercise for those in receiving therapy for mental health illness.

Often, people with mental health illness also have physical health challenges. In one service in Portsmouth, they are trialling pedometers with service users, and supporting within therapy, to try and increase levels of activity.
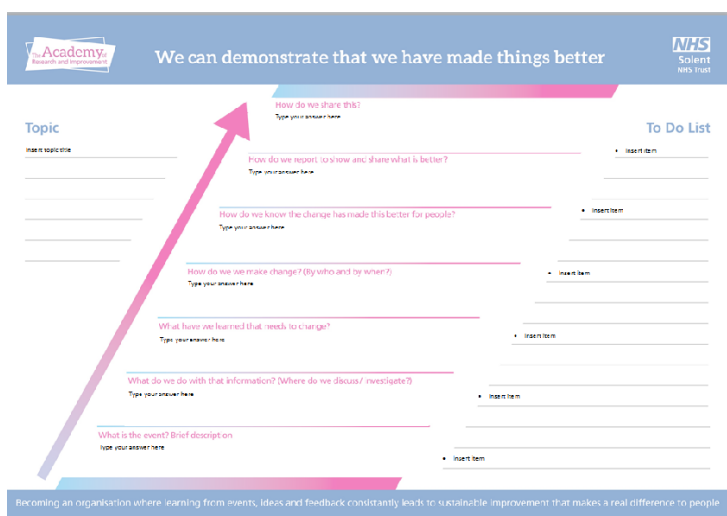
Learning

One of the strategic goals of the Academy, and the Trust, is to share learning and improvement. At the core of this is supporting a model that focuses not on what tasks have been done per se, but on what improvements these have led to, and what has been learned.

To facilitate this, a number of activities have got learning framework has been produced with a range organisation. This aims to help change the focus to learned following events or actions.

underway in 2018/19. A of staff from across the has changed or been

One example where this is now happening effectively is via our reporting on clinical audit and evaluation – this now focuses on changes and improvement between audits rather than on long action plans. All audits and improvement projects now also have one page summaries to help other teams and patients easy read about and learn from them.

A learning zone is being created on the intranet, and a process to support learning from positive events has been piloted and is being implemented across the Trust.

The Academy is now moving into its second year, with a range of projects planned. For on-going updates, please see www.academy.solent.uk or follow us on social media (@solentacademy).