Southern Health NHS
NHS Foundation Trust

QUALITY REPORT & QUALITY ACCOUNT 2016/17 - DRAFT

Contents

Part 1: Statement on quality from Julie Dawes, Interim Chief Executive Officer of Southern Health NHS Foundation Trust

To be included when approved

Part 2: Priorities for improvement and statements of assurance from the Board

Every Quality Report must contain priorities for improvement, to be achieved in the following year, in the three dimensions of quality identified by Lord Darzi:

- Improving patient safety;
- Improving clinical outcomes; and
- Improving patient experience

These priorities are selected on the basis of feedback from our patients, stakeholders and staff, and are approved by the Trust Board.

The 2015/16 Quality Report identified the priorities to be achieved in 2016/17. A summary of the performance against each of these priorities is described below with more detail being provided in Part 3.

Priority 1: Improving Patient Safety

Priority 1.1 To develop a framework to share learning from serious incidents leading to a reduction in recurrent themes

During 2016/17 we have successfully developed and launched our Organisational Learning strategy and learning activities are now integrated in all of the clinical divisions.

Monitoring the success of the learning activities is complex but has been achieved through the bi-annual thematic review of serious incident reports. We have over the year seen a reduction in certain themes although it is felt that only twelve months is not statistically robust and improvements should be judged over a minimum of eighteen months. We believe that the target has been partially met and work will continue into the coming year.

Priority 1.2 Inpatients in community hospitals will have a venous thromboembolism (VTE) assessment on admission

We are pleased that a repeat clinical audit in November 2016 which measured current practice against the standards in NICE clinical guidance 92 ‘Venous thromboembolism: Reducing the risk’ showed significant improvement. This audit found 92% of patients audited had a VTE risk assessment form completed on admission and 8% had the form completed at a later date. This met our target of 90% of patients having the assessment on admission and compares favourably to the previous audit results.

Priority 1.3 To reduce the number of pressure ulcers

This year there were 87 grade 3 and 4 pressure ulcers reported onto StEIS, the national reporting system for serious incidents. This did not show a reduction compared to previous years however this is not directly comparable, due to changes in the definition but we are able to evidence robust monitoring, investigating and learning processes.

Priority 1.4 Implement robust governance processes to effectively identify, manage and reduce ligature risks in all out impatient units

All inpatient sites were assessed for ligature risks between April – October 2016 with community sites assessed by February 2017. Action plans and programmes of building work were developed where necessary. All of these were closely monitored by the Ligature Management Group. The project manager supported the clinical areas to develop mitigation plans for those risks that remained.

Priority 2: Improving Clinical Outcomes

Priority 2.1 To embed care planning frameworks in our clinical services

Clinical audit results demonstrate that whilst there has been an overall increase in the numbers of patients with care plans in place, the number of patients involved in designing these has fallen in some areas. We are making good progress towards meeting this target in many areas but inconsistencies across the Trust require that we continue this improvement work into the coming year.

Priority 2.2 The physical health needs of inpatients in Learning Disability and Mental Health services are appropriately assessed, monitored and treated with action taken if there is any deterioration in physical health

This is a priority which was extremely important to the Trust and involved retraining and assessing the competency of every clinical staff member. We are very pleased to say that in January 2017, 87% of staff in adult mental health and older peoples mental health had been assessed and verified as competent to assess physical health of patients. Adult Mental Health and Specialised Services audit demonstrated that 94% of patients had a full physical health review within 7 days of admission or a reason recorded why it was not appropriate. Learning Disability services demonstrated that 72% of patients had a full physical health assessment carried out on admission. In the five cases where this was not completed but two of those cases (40%) recorded why this was not possible and the plan in place to monitor physical health.

Priority 2.3 Risk assessments and appropriate risk management plans are in place for all community and inpatients Mental Health, Specialised, Older Person's Mental Health and Learning Disability services

We are making good progress towards meeting this target in many areas but recognise this is not consistent across the Trust and that there is more still to do.

Risk assessments completed in RiO are reported via Tableau and the chart below demonstrates that levels of compliance with risk assessment completion are over 95% in all divisions, except for Adult Mental Health services. This is an improving picture from the baseline audit conducted in June 2016 when the majority of teams had compliance figures of less than 90%.

Priority 3: Improving Patient Experience

Priority 3.1 Our complaints process provides satisfaction to the complainant

We have partially achieved this indicator, meeting the target of having 90% of the standards in the 'Assurance of Good Complaints Handling' in place, but did not meet the 90% final response target.

As part of the process when someone makes a complaint, the customer experience advisor discusses with the complainant a timeframe for the complaint to be investigated and a response letter to be sent. We are disappointed that improvements made in 2015/16 were not sustained with overall 79% sent within agreed timeframes.

Priority 3.2 To involve patient and carers in the development of services

In May/June 2016 70 clinical teams completed self-assessments which mapped how they were involving patients, carers and families in services being provided. The self-assessments identified both elements of good practice and areas where increased engagement was required.

'A best practice guide to working with the people who use our services' was developed following the above self-assessment. The guide showcased examples of best practice within the Trust which staff could use as a resource to develop further the way they work with patients. It also described the different levels of engaging and involving others with a description of what 'good looked like'.

Priority 3.3 To have a strategy to reduce restrictive practice in adult mental health services

Our aim was to develop and implement a reducing restrictive practice strategy in our Adult Mental Health Services. This has been completed in part with the Safer Forum focusing on three main areas of work;

- development of a comprehensive suite of policies and documents for the wider mental health division incorporating adult mental health, specialised services and learning disabilities
- review of restraint training provided by the Trust
- liaison / relationship with the police.

There is ongoing work to implement the strategy aligned with learning from other organisations.

Priorities for improvement in 2017/18

In November 2016 a working group of Clinical Directors and Associate Directors of Nursing from all Divisions met to generate the quality account priorities for the year 2017/18. Representatives at the meeting also included information which they had gained from stakeholders, staff and patients to feed into the conversations. Also taken into consideration were the views and findings reported to us by the Care Quality Commission and Healthwatch.

It was important to the group that the priorities represented the following:

- Quality improvement work already in progress through within the Trust the Serious Incident and Mortality, Care Quality Commission and the Family Involvement action plans.
- The engagement of patient and service users in their own health management.
- The new models of care being developed through the multispecialty community provider (MCP) models.
- Reflected the views of our commissioners and linked with the annual quality contracts.

The specific detail of each priority was ascertained using a GAP analysis technique.

Priority 1: Domain - Improving Patient Safety

Improving Risk Assessments and Crisis Planning

Priority 1.1
Improvements are required to provide assurance that every patient has had their individual level of risk assessed at every stage of their journey and / or on changes to their clinical condition.

Priority 1.2
The improvement activity of 'no decision in isolation' must become a key safety feature of every multi-disciplinary meeting for the most unwell people such as inpatients, those open to Adult Mental Health teams or on shared care.

Priority 1.3

Improvements are required to ensure that patients are discharged from services with a crisis contingency plan which is individualised to their needs and shared, where applicable, with their carer or family member, general practitioner (GP) or other relevant health or social care organisations.

Why have we chosen these priorities?

Using a GAP analysis methodology these priorities have been chosen for the following reasons:

- Quality risk assessments and crisis contingency planning are a preventative safety feature of the care delivered to any patient; patients and their families must feel involved in care, and creating risk and treatment plans through joint working (co-production) is of paramount importance for true engagement and partnership working. Our engagement activities tell us that this has not always been the case and patients and their families have not always felt involved.
- A review undertaken into the factors that contributed to serious incidents highlighted poor risk assessments and crisis planning. This featured in 75% of the investigation reports. Assessing and planning care and treatment directly with patients should reduce related patient safety incidents.
- The Mazars report, *Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015*, published in December 2015 recommended a principle of learning and improving from our reviews of multiple rather than isolated incidents through thematic reviews. Risk assessments and care planning have been identified as a theme in incidents therefore it is important to be recognised as a specific Trust-wide priority for improvement.
- Our commissioners are aware of some instances of poor risk assessment and crisis planning which has become apparent from their observation of our serious incidents and complaints; we have been tasked to improve in this area as a quality contract requirement.

Ambition

Every patient must have an updated and individualised risk assessment which is clearly accessible within the clinical records.

Risk assessment must be created using a holistic approach, including both physical and mental health needs and accompanied by specific care plans.

Risk assessment must evidence input from all clinical specialities involved in the individuals' care.

Risk assessments must be discussed and approved at multi-disciplinary meetings to ensure 'no decision in isolation'. The purpose of this review is to ensure that there is an activite management plan in place for each individual.

The discharge risk assessment and crisis contingency plan must be created involving the patient and carers, and a copy shared with the GP.

How we will measure and monitor progress

Progress will be measured on a monthly basis against agreed performance targets. These will include the percentage of staff being trained in how to complete a risk

assessment and crisis contingency plan. Results will be discussed at the Quality Improvement Delivery Meeting on a monthly basis and be formally monitored on a quarterly basis internally through the Quality and Safety Committee and externally at the Clinical Quality Review Meeting chaired by our Commissioners.

Priority 2: Domain - Improving Patient Experience

Self-Management Agenda

All patients and service users are actively encouraged to participate in their own care playing an active part in creating and agreeing the contents of their management plans for both mental and physical health needs.

The associated priorities are:

Priority 2.1
Every patient and service user, and their families and carers (when appropriate) must be offered the opportunity to be involved in the creation of their risk assessment, care plans and crisis contingency plans in a format that they understand.

Priority 2.2
All patients and service users are actively encouraged to manage their own health needs and are supported to do so. Where appropriate, families are involved in information gathering about patients and service users, helping to inform assessment and development of care plans and support ongoing care.

Priority 2.3
All patients and service users should play an active part in creating and approving all patient literature that is in a format that they understand.

Why have we chosen these priorities?

This priority links directly to the work supported by NHS England who state:

"People have a key role in protecting their own health, choosing appropriate treatments and managing long-term conditions. Self-management is a term used to include all the actions taken by people to recognise, treat and manage their own health. They may do this independently or in partnership with the healthcare system.

We need to fully understand how self-management can improve people's health and what support people need for good self-care. NHS England has a number of projects underway to look at the best ways of approaching self-management in the NHS."

Learning Disabilities division will be taking a lead in this priority as self-management features as an aspect of importance to all of their service users.

Ambitions

There will be a framework and guidance tool to support clinicians developing crisis contingency plans with patient and carer / family input and supported by training.

All Divisions will create patient participation / involvement forums to provide assurance that patients and service users and their families are consulted on the design of plans and how they are completed to ensure there is true understanding and partnership working.

How we will measure and monitor progress

Progress will be measured on a monthly basis against agreed performance targets. Results will be discussed at the Quality Improvement Delivery Meeting on a monthly basis and be formally monitored on a quarterly basis internally through the Quality and Safety Committee and externally at the Clinical Quality Review Meeting chaired by our Commissioners. Patient and family participation forums will be supported by the Head of Patient Experience and Engagement and their activities will be reported to the Caring Group which reports to the Quality and Safety Committee.

Priority 3: Domain - Improving Patient Safety, Improving Patient Experience

Outcomes related to the Serious Incident and Mortality Improvement Action Plan

A substantial amount of work has been prioritised in 2016/17 in creating and embedding processes to meet the recommendations of the Mazars report thus improving the way we manage investigations into serious incidents and deaths. In 2017/18 it is important to be reassured that the outcome of our activities provides positive outcomes both internally and externally to stakeholders such as families and commissioners. The associated priorities are:

Priority 3.1
Families and / or patients / service users are actively encouraged, where appropriate, to participate in serious incident investigations and are supported to do so by the investigating officers and the family liaison officer.

Priority 3.2
Families and / or patients / service users receive a copy of the investigation report in all cases where it is appropriate to do so.

Priority 3.3
The views and opinions of families / or patients / service users will be gathered after the investigation has occurred to ascertain ‘just how it felt?’ as key evidence to assist improvement for future investigations.

Priority 3.4
Evidence of improvement in key areas highlighted by the serious incident investigation process will be reported quarterly to the Board through a ‘what have we done to improve’ section.

Why have we chosen these priorities?

Whilst a substantial amount of improvements in our reporting and investigation processes have been undertaken during 2016 / 2017 there is a need to ensure that improvements are not only maintained but also continue to advance. Key stakeholders wish to be assured throughout 2017 / 2018 of the continued success of the improvements. Key stakeholders requesting this priority are:

- The 'Family First' group
- Mortality Forum
- The Commissioners of our services (CCG's)
- NHS Improvement
- Care Quality Commission

Ambitions

Our ambition is that families are involved in the serious incident investigation process and feel supported and informed during the process by staff who have received bespoke training from the Family Liaison Officer as part of the investigating officers course.

How we will measure and monitor progress

Progress will be measured on a monthly basis against agreed performance targets. Results will be discussed at the Quality Improvement Delivery Meeting on a monthly basis and be formally monitored on a quarterly basis internally through the Quality and Safety Committee and externally at the Clinical Quality Review Meeting chaired by our Commissioners.

Priority 4: Domain – Improving Clinical Outcomes.

The role of the community team working in partnership with General Practitioners

Within the development of the new models of care to provide 'better local care' there is a requirement that all clinical staff regardless of their employer work together to form cohesive locality driven teams to provide a quality service to all patients and service users.

Priority 4.1 Clinical and care outcomes will be improved for people with complex health and care needs, through extended multi-practitioner care teams providing integrated care locally.

Priority 4.2 Patients' experience will be improved by a team-based approach to the delivery of their care, and holistic assessment and joint care planning to achieve their own health and care goals, and to stay independent for longer.

Priority 4.3 Safety, quality and systems will be safeguarded as shared care records and team working across organisations provides high quality evidence based care to people with complex health and care needs.

Why have we chosen these priorities?

The priority has been chosen in communication with the Chief Quality Officer from the South East and North Hampshire Clinical Commissioning Groups as an assurance to underpin the new models of care which are in development across Hampshire. Gaining assurance that all health care professionals are committed to working together in their locations will improve service access and cross professional communication. This will benefit patients ensuring that there is access to the appropriate professional, in the appropriate location, local to the patient.

Ambitions

To gain assurance that all health care professionals are committed to working together in their locations will improve service access and cross professional communication. This will benefit patients ensuring that there is access to the most appropriate professional, in the most appropriate location, local to the patient.

How we will measure and monitor progress

Progress will be measured on a monthly basis against agreed performance targets. Results will be reported directly to the Southern Health Integrated Service Division business unit meetings and shared with the Clinical Commissioning Groups.

2.2 Statements of assurance from the Board

These are nationally mandated statements which provide information to the public which is common across all quality reports. They help demonstrate that we are actively measuring and monitoring the quality and performance of our services, are involved in national initiatives aimed at improving quality, and are performing to quality standards.

Review of services

During 2016/17 the Southern Health NHS Foundation Trust provided and/or subcontracted 49 relevant health services.

The Southern Health NHS Foundation Trust has reviewed all the data available to it on the quality of care in 49 of these relevant health services.

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

Clinical audits and national confidential enquiries

During 2016/17 nine national clinical audits and no national confidential enquiries covered relevant health services that Southern Health NHS Foundation Trust provides.

During that period Southern Health NHS Foundation Trust participated in 89% of the national clinical audits which it was eligible to participate in.

The national clinical audits that Southern Health NHS Foundation Trust were eligible to participate in during 2016/17 are as follows:

National Clinical Audit	Eligible
Learning Disability Mortality Review Programme (LeDeR)	Y
Sentinel Stroke National Audit Programme	Y
Society for Acute Medicine Benchmarking Audit (SAMBA)	Y
Prescribing Observatory for Mental Health (POMH) – Rapid Tranquillisation.	Y
Prescribing Observatory for Mental Health (POMH) – Monitoring of Patients Prescribed Lithium	Y
Prescribing Observatory for Mental Health (POMH) – Prescribing high dose and combined antipsychotics	Y
Prescribing Observatory for Mental Health (POMH) – Prescribing for substance misuse: alcohol detoxification	Y
Prescribing Observatory for Mental Health (POMH) – Prescribing antipsychotic medication for people with dementia	Y
National Audit of Intermediate Care	Y

The national clinical audits that Southern Health NHS Foundation Trust participated in during 2016/17 are as follows:

National Clinical Audit	Participated in
Learning Disability Mortality Review Programme (LeDeR)	Y
Sentinel Stroke National Audit Programme	Y
Society for Acute Medicine Benchmarking Audit (SAMBA)	Y
Prescribing Observatory for Mental Health (POMH) – Rapid Tranquillisation.	Y
Prescribing Observatory for Mental Health (POMH) – Monitoring of Patients Prescribed Lithium	Y
Prescribing Observatory for Mental Health (POMH) – Prescribing high dose and combined antipsychotics	Y
Prescribing Observatory for Mental Health (POMH) – Prescribing for substance misuse: alcohol detoxification	Y
Prescribing Observatory for Mental Health (POMH) – Prescribing antipsychotic medication for people with dementia	Y
National Audit of Intermediate Care	N

The national clinical audits that Southern Health NHS Foundation Trust participated in, and for which data collection was completed during 2016/17, are listed below alongside the number of cases submitted to each audit as a percentage of the number of registered cases required by the terms of that audit.

National Clinical Audit	% of required cases submitted
Learning Disability Mortality Review Programme (LeDeR)	100%
Sentinel Stroke National Audit Programme	100%
Society for Acute Medicine Benchmarking Audit (SAMBA)	100%
Prescribing Observatory for Mental Health (POMH) – Rapid Tranquillisation.	In Progress
Prescribing Observatory for Mental Health (POMH) – Monitoring of Patients Prescribed Lithium	100%
Prescribing Observatory for Mental Health (POMH) – Prescribing high dose and combined antipsychotics	In Progress
Prescribing Observatory for Mental Health (POMH) – Prescribing for substance misuse: alcohol detoxification	100%
Prescribing Observatory for Mental Health (POMH) – Prescribing antipsychotic medication for people with dementia	100%

The reports of three national clinical audits and one confidential inquiry were reviewed by the provider in 2016/17 and Southern Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- Clinical teams should use local networks and the new Early Intervention in Psychosis Network to share good practice and implement changes needed to increase the proportion of people who are engaged with services within a two week period.
- Electronic Doctors' worklist will be employed to enable us to identify and record the times of consultant review and clerking times to aid data collection.
- Falls and fractures have a major impact on people with Parkinson's and so it is vital that services consider how bone health may be adequately addressed within the clinic setting. The Parkinson's Excellence Network is developing structures to support improved management of bone health in Parkinson's. These improvements will hopefully be reflected in future audits.
- Implementation of the mortality action plan to improve our learning following serious incidents.

The reports of 43 local clinical audits were reviewed by the provider in 2016/17 and Southern Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

Audit title	Actions
Bruising Protocol (Children & Families)	• Training on different types of skin marks and hyperpigmentation • To produce an up to date leaflet which is available to staff

Track and Trigger (Specialised Services)	• Competencies to be revisited in how to accurately record physiological observations onto the Track and Trigger chart. • For all concerns raised / escalated to be clearly documented and for an incident form to be completed. • For internal regular spot checks to be undertaken by the Clinical Ward Manager and Modern Matron.
Dysphagia Referrals (Learning Disabilities)	• Offer opportunities for new adult services colleagues working in Learning Disabilities to shadow/meet with the Speech and Language Therapist (SLT) to increase their awareness of eating and drinking difficulties and when to refer.
Seclusion (Mental Health)	• The Trust, in conjunction with Health Education Wessex, should carry out a review of the adequacy of on-call trainee doctor cover. • It is recommended that the seclusion module on the electronic record is enhanced and used for recording and monitoring of seclusion.
Sepsis (SWISD)	• The handover from General Practitioners and the Ambulance Service should include consideration that the patient could be septic. • On call medical staff should be made aware of an incoming patient with suspected sepsis. • The “Sepsis Clock” should be used as a communication aid.
Discharge Summary MIU Petersfield (SEISD)	• All discharge summaries to be sent electronically. • All discharge summaries to be sent within 24 hours, even if over a weekend or bank holiday.

Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by Southern Health NHS Foundation Trust in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee was 1350. CHECK NUMBER END APRIL

Commissioning for Quality and Innovation Framework (CQUIN)

A proportion of Southern Health NHS Foundation Trust income in 2016/17 was conditional on achieving quality improvement and innovation goals agreed between Southern Health NHS Foundation 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.

Further details of the agreed goals for 2016/17 and for the following 12-month period are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-. In 2016/17 income totalling £ 4,894,312 was conditional upon

Southern Health NHS Foundation Trust achieving quality improvement and innovation goals.

In 2015/16 income totalling £4,546,184 was conditional upon Southern Health NHS Foundation Trust achieving quality improvement and innovation goals, of which payment of £4,355,782 was received.

Our CQUIN schemes for 2017-2019 follow the national guidance also available at the link above. Within mental health service contracts there is scope within the national guidance to agree a single local scheme.

We are therefore currently in the process of agreeing a local scheme in the Hampshire wide mental health service contract for the introduction of Personal Health Budgets.

In addition to this in the NHS England contract there is a single specialised services CQUIN for Reducing the Length of Stay in Specialised Mental Health services (Medium and Low Secure version).

There is also a proposed scheme for the Child Health Information Services (CHIS) and Immunisations element of this contract for increasing participation and reducing inequalities in coverage (School Aged Immunisations). There is no scheme yet agreed for the Oxford City CCG Learning Disabilities contract.

Care Quality Commission Registration and Actions

Southern Health NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is: registered in full with no conditions. Southern Health NHS Foundation Trust has 30 locations registered with CQC under the Health and Social Care Act (2008).

The Care Quality Commission has not taken enforcement action against Southern Health NHS Foundation Trust during 2016/17.

Southern Health NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2016/17: Health and Safety investigation.

Southern Health NHS Foundation Trust has not yet received the final response from this investigation although the Trust has been notified of Care Quality Commission's intention to prosecute.

Southern Health NHS Foundation Trust has not yet received the final response for this investigation and will finalise any action plan to address recommendations once

received. Immediate safety concerns with respect of the estate have however been rectified.

The Care Quality Commission and Warning Notice

The Care Quality Commission undertook a comprehensive inspection of the Mental Health, Learning Disability and Community Health services of the Trust in 2014. The Trust was rated as Requires Improvement.

The Care Quality Commission has carried out four inspections during 2016/17. Each of these was a follow-up inspection to review progress against the actions from the 2014/15 inspections. Three inspections were within the Trust's social care services and these services received individual ratings of 'Good' for two of them and 'Requires Improvement' for the third. Action plans have been developed to address areas for improvement that were identified.

A further Care Quality Commission inspection at the Trust took place in September 2016. The inspection focused on improvements made since their inspection in January 2015 where an enforcement action was issued. The Care Quality Commission found that that the trust had taken sufficient action to meet the requirements set out in the warning notice, however, further improvements were still required. The Care Quality Commission did not re-rate the Trust following this inspection as this can only be done as a result of a full comprehensive inspection.

A further focused Care Quality Commission inspection took place in late March 2017. The inspection this time focused on the completion of all of the action plans created from 2014 onwards, assessment against the well-led key line of enquiry and improvements made in governance processes inclusive of the management of serious incidents and learning lessons from both incidents and complaints. Within this inspection physical health, mental health and older persons mental health in-patient hospitals and community services were visited.

Quality of Data

Southern Health NHS Foundation Trust submitted records during 2016/17 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patient's valid NHS number was:
  #% for admitted patient care
  #% for out patient care and
  #% for accident and emergency care.
- which included the patient's valid General Medical Practice Code was:
  #% for admitted patient care;
  #% for out patient care; and

#% for accident and emergency care. *NB data available 15th May*

Southern Health NHS Foundation Trust Information Governance Assessment Report overall score for 2016/17 was 88% and was graded green 'satisfactory'.

Southern Health NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2016/17 by the Audit Commission.

Southern Health NHS Foundation Trust will be taking the following actions to improve data quality:

- Data quality has continued to have a significant focus over the last 12 months and will continue to be prioritised within the Trust to ensure our reported performance is of a sufficiently high standard;
- Regular data quality updates are given to the Trust Board via the Service Performance and Transformation Committee and members of the Trust Executive Board have been closely involved in ensuring this work programme continues to be delivered;
- The Trust ensures that data collected within the Electronic Patient Record is used to report performance, avoiding the need for manual collection of performance information. Developments within Open RiO have continued to support better recording practices across the Trust;
- The Trust invested in a new business intelligence tool 'Tableau' which has been in place since August 2015. The use of Tableau has made reporting of data quality more accessible and easier to understand for colleagues throughout the Trust. This has led to improvement in the data quality of some key areas and will continue to support the Trust in further improving the level of data quality.

2.3 Reporting against core indicators

Since 2012/13 NHS Foundation Trusts have been required to report performance against a core set of indicators using data made available to the Trust by NHS Digital.

Southern Health NHS Foundation Trust is reported and compared as a Mental Health/Learning Disabilities Trust.

Price Waterhouse Cooper have considered two mandated indicators against NHS Improvement's requirement. Their opinion is detailed in Annex 3 and complete definitions are within Annex 4.

- 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.

- The percentage of admissions to acute wards for which the crisis resolution home treatment team acted as a gatekeeper during the period.

Our patients on a Care Programme Approach who were followed up within 7 days of discharge from psychiatric inpatient care

The data made available to the National Health Service trust or NHS foundation trusts by NHS Digital with regard to the percentages of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period.

The Southern Health NHS Foundation Trust considers that this data is as described for the following reasons; this is taken from the national dataset using the data provided.

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

- Providing performance information that is easily available to clinicians through the business intelligence tool, 'Tableau'.
- Monitoring the target at monthly performance meetings

Indicator	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.				
	Q1 2016-17	Q2 2016-17	Q3 2016 -17	Apr 2015 - Mar 2016	Apr 2016 - Mar 2017
Southern Health	97.1%	98.1%	97.3%	97.0%	97.2%
Average Scoring Trust	96.2%	96.8%	96.7%	97.0%	available after 12.04.16
Highest Scoring Trust	100%	100%	100%	99.8%	
Lowest Scoring Trust	28.6%	76.9%	73.3%	82.8%	

Our crisis resolution teams

The data made available to the National Health Service trust or NHS foundation trusts by NHS Digital with regard to the percentages of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period.

The Southern Health NHS Foundation Trust considers that this data is as described for the following reasons; this is taken from the national dataset using the data provided.

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

- Providing performance information that is easily available to clinicians through the business intelligence tool, 'Tableau'.
- Monitoring the target at monthly performance meetings.

These activities have proven the sustainability of this indicator.

Indicator	The percentage of admissions to acute wards for which the crisis resolution home treatment team acted as a gatekeeper during the period				
	Q1 2016-17	Q2 2016-17	Q3 2016-17	Apr 2015 - Mar 2016	Apr 2016 - Mar 2017
Southern Health	99.7%	99.6%	100.0%	99.0%	99.4%
Average Scoring Trust	98.1%	98.4%	98.7%	97.2%	available after 12.04.16
Highest Scoring Trust	100%	100%	100%	100.0%	
Lowest Scoring Trust	78.9%	76.0%	88.3%	64.7%	

Our readmission rate for children and adults

The data made available to the National Health Service trust or NHS foundation trusts by NHS Digital with regard to the percentage of patients aged –

(i) 0 to 15; and
(ii) 16 or over,

readmitted 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.

The Southern Health NHS Foundation Trust considers that this data is as described for the following reasons; this is taken from the national dataset using the data provided.

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

- Accurate monitoring at division, service and team level showing areas where improvements may be made.
- Discharge planning processes involving carers and families to ensure improved home support.
- Providing performance reports to board.

Indicator	The percentage of patients aged 1-15 years readmitted to a hospital which forms part of the Trust with 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.	
	Apr 2015 - Mar 2016	Apr 2016 - Mar 2017
Southern Health	0%	1.9%

Indicator	The percentage of patients aged 16 or over readmitted to a hospital which forms part of the Trust with 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.	
	Apr 2015 - Mar 2016	Apr 2016 - Mar 2017
Southern Health	12%	17.5%

Patient experience of community mental health services

The data made available to the National Health Service trust and NHS Foundation Trust with regard to the trust's 'Patient experience of community mental health services' indicator score, and with a focus on a patient's experience of contact with a health or social care worker during the reporting period.

The Southern Health NHS Foundation Trust considers that this data is as described for the following reasons: this is taken from the national dataset using the data provided.

The Southern Health NHS Foundation Trust has taken the following actions to improve this indicator, and so the quality of its services, by:

- Improving the collaboration between the service user and practitioner when planning care.
- Ensuring that service users know who to contact in a crisis. Introduction of My Crisis Plan and the new My Safety Plan provide opportunities for service users to describe what they would find helpful in a crisis and can include the contact details for the out of hours service.
- A focus on physical health within Adult Mental Health, to improve the identification and support of a person's physical health needs. This will include the use of a physical health screening tool.
- Development of patient information, as led by patients. This includes information about medicines.

Indicator	Patient experience of contact with a health or social worker*

	2014 - 2015	2015 - 2016	2016 - 2017
Southern Health	6.8	6.7	7.1
Average Trust score	Not available		
Highest Scoring Trust	7.5	7.4	7.5
Lowest Scoring Trust	6.5	6.2	6.1

*Data is based on responses on a 0-10 scale where 0 is 'I had a very poor experience' to 10 'I have a very good experience'

Our rate of patient safety incident reporting

This reporting requirement is 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 harm.

Indicator	Number of patient safety incidents reported to the National Reporting and Learning Service (NRLS)*			
	15/16 Total – 12,295		16/17 Total – 12,460	
	Apr 2015 – Sept 2015	Oct 2015 – Mar 2016	Apr 2016 – Sept 2016	Oct 2016 – Mar 2017
Southern Health	6,723	5,572	6,072	6,388
Average Trust Score	2,587	2,613	N/A	N/A
Highest Scoring Trust	6,723	5,572	N/A	N/A
Lowest Scoring Trust	8	25	N/A	N/A

Indicator	i) Number and ii) percentage of such patient safety incidents that resulted in severe harm or death			
	15/16 Total – 156 (1.3%)		16/17 Total – 140 (1.1%)	
	Apr 2015 – Sept 2015	Oct 2015 – Mar 2016	Apr 2016 – Sept 2016	Oct 2016 – Mar 2017
Southern Health	i) 76 ii) 1.1%	i) 80 ii) 1.4%	i) 64 ii) 1.1%	i) 76 ii) 1.2%

Average Trust Score	i) 27 ii) 1.1%	i) 30 ii) 1.3%	N/A	N/A
Highest Scoring Trust	i) 97 ii) 3.7%	i)119 ii) 6.0%	N/A	N/A
Lowest Scoring Trust	i) 0 ii) 0%	i) 0 ii) 0%	N/A	N/A

The 2016/17 totals are based on data extracted from the Trust's incident reporting system Safeguard Ulysses on Patient Safety Incidents submitted to the NRLS during the time period, whereas the 2015/16 totals are based on recently published NRLS datasets.

The percentage of staff who would recommend the Trust as a provider of care to their family and friends

In 2013/14 NHS England asked NHS providers to consider reporting on the staff element of the Friends and Family Test, although it did not make this a mandatory requirement for community trusts.

Indicator	The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family of friends	
	April 2015 - March 2016	April 2016 - March 2017
Southern Health	66%	62% (Q1 and Q2)
Average Trust Score	78%	74% (Q1 and Q2)
Highest Scoring Trust	100%	100% (Q1 and Q2)
Lowest Scoring Trust	45%	47% (Q1 and Q2)

The percentage of patients who would recommend the Trust as a provider of care to their family and friends

In 2013/14 NHS England asked NHS providers to consider reporting on the patient element of the Friends and Family Test, although it did not make this a mandatory requirement for community trusts.

Indicator	The percentage of patients during the reporting period who would recommend the Trust as a provider of care to their family of friends	
	April 2015 - March 2016	April 2016 - March 2017

Southern Health	94.3%	93.9%
Average Trust Score	94.5%	93.3%
Highest Scoring Trust	98.8%	98.3%
Lowest Scoring Trust	86.6%	67.5%

The figures for the percentage of patients who would recommend the Trust as a provider of care are calculated by combining the published results for the Trust's community and mental health services. Comparison figures include other Trusts where they have both community and mental health services.

Part 3 Other Information

Further Information

Please refer to the Annual Report and the Annual Governance Statement for further details on the quality of services and the quality governance frameworks in place within the Trust.

Progress made in meeting our priorities for improvement in 2016/17

Details of the progress made to meet our priorities for improvement in 2016/17 are given below.

Priority 1: Improving Patient Safety

Priority 1.1 To develop a framework to share learning from serious incidents leading into a reduction in recurrent themes.

Aim

Learning from incidents is extremely important to the Trust. The independent review of deaths of people with a learning disability or mental health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015 conducted by Mazars recommended improvements to the review and investigation of deaths process including an emphasis on learning. These improvements would need to be fully compliant with the NHS England Serious Incident Framework.

Achievements

We developed a framework for learning which is published within our Organisational Learning strategy and includes a variety of different methods which can be used:

- Clinical supervision
- Learning Network meetings / Case Study review
- Hotspot and Learning Matters publications
- Immediate Trust-wide learning alerts

Learning has been an active part of policy review and change within the Trust. Early in the year there was a theme of clinical disengagement being a contributory factor in our serious incident reports and it was apparent that the policy was not providing the guidance which clinicians required. Through a working group approach the policy was rewritten and launched in October. Since this launch and retraining of the staff a reduction in this theme has been seen.

Use of the Trust-wide Track and Trigger tool for recognising a deteriorating patient was highlighted as an emerging theme however further investigation proved that a policy change was not required but retraining and competency assessment of clinical staff which is now underway.

Immediate Trust-wide learning alerts were used to share information that required instant practice changes linked to preventing patient safety incidents. Examples were:

- ensuring that correct sling sizes were selected for patient hoists to prevent falls from equipment
- horizontal laying of home oxygen cylinders to prevent injury from toppling.

Monitoring the success of the learning activities is complex but has been achieved through the bi-annual thematic review of serious incident reports. We have over the year seen a reduction in certain themes although it is felt that only twelve months is not statistically robust and improvements should be judged over a minimum of eighteen months.

There is no national benchmarking or historical data available.

Future plans

Organisational learning will continue to be a priority to the Trust and will be monitored through the next year as part of the new priority Outcomes related to the Serious Incident and Mortality Improvement Action Plan.

Priority 1.2 Inpatients in community hospitals will have a venous thromboembolism (VTE) assessment on admission

Aim

Venous thromboembolism (VTE) is a serious, potentially fatal, medical condition. Patients who are unable to move around very much are more at risk of developing blood clots and so it is important to complete a risk assessment on admission to hospital. Lymington New Forest Hospital submits data to Unify on the percentage of patients who have a VTE risk assessment completed on admission and consistently meets the 95% target set nationally (for acute trusts). However, results from clinical audit in October 2015 showed less consistent results across the Trust with 69% of patients having a VTE risk assessment form completed on admission.

We therefore repeated a similar indicator for 2016/17 which aimed to ensure consistent good practice across the Trust.

National benchmarking data is not available.

Achievements

We are pleased that a repeat clinical audit in November 2016 which measured current practice against the standards in NICE (The National Institute for Health and Care Excellence) clinical guidance 92 'Venous thromboembolism: Reducing the risk' showed significant improvement. This audit found 92% of patients audited had a VTE risk assessment form completed on admission and 8% had the form completed at a later date. This met our target of 90% of patients having the assessment on admission and compares favourably to the previous audit results.

Data collection for a further clinical audit is underway in March 2017. The results will drive further improvement actions as required.

A new process to collect VTE risk assessment and treatment (prescription of medication) information on a daily basis from community hospital wards was introduced in October 2016. This enables a more timely review of data with any ward not meeting standards identified and actions put in place to address.

A mini review of the Trust's VTE policy and procedures has identified some minor changes are required to reflect new organisational structures within the Trust. A full review will be undertaken when the new NICE guidance is circulated.

The training package provided to junior doctors at Lymington New Forest Hospital is being circulated to all doctors across the Trust.

Future Plans

This indicator will not be repeated in 2016/17 as the target has been met. Work will continue, however, with a focus on ensuring our practice meets the new NICE guidance due out in January 2018.

Priority 1.3 To reduce the number of pressure ulcers

Aim

Pressure ulcers can be painful, increase the risk of associated infection and seriously affect the quality of life for a patient.

In 2015/16 focused actions led to a significant reduction of over 35% in the numbers of avoidable grade 3 and 4 pressure ulcers reported as serious incidents with 71 reported in 2015/16 compared to 116 in 2014/15. Although we were pleased with this improvement, we recognised that pressure ulcers continue to be the most commonly reported serious patient safety incident in our community services. We therefore

repeated a similar indicator for 2016/17 with the aim of sharing best practice and learning across the Trust to reduce pressure ulcers following national guidelines.

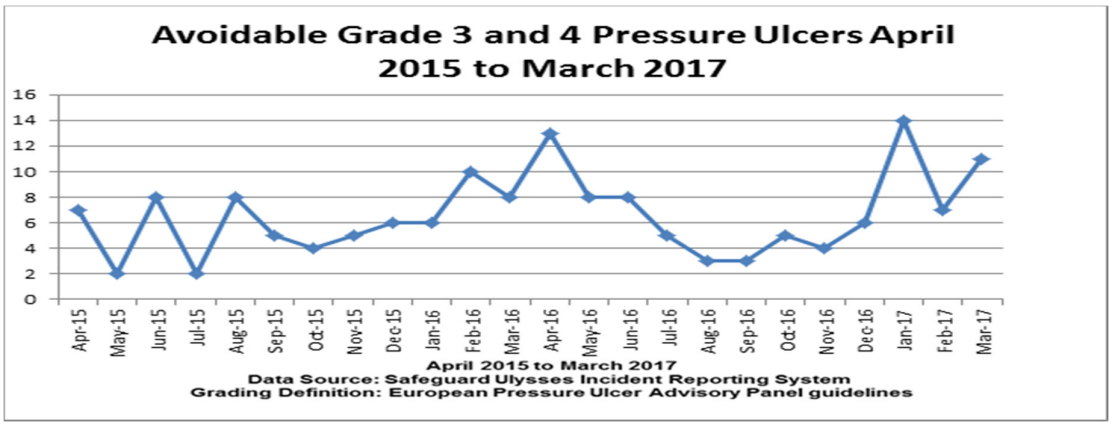
The definition of 'avoidable' pressure ulcer has changed in the National Serious Incident Framework 2016/17 which makes comparison difficult between this year's figures of pressure ulcers and previous year's.

National benchmarking data is not available.

Achievements

This year there were 87 grade 3 and 4 pressure ulcers reported onto StEIS, the national reporting system. This did not show a reduction compared to previous years however this is not directly comparable, due to changes in the definition but we are able to evidence robust monitoring, investigating and learning processes.

Numbers of grade 3 and 4 pressure ulcers reported and confirmed on StEIS April 2016 to March 2017 (StEIS - strategic executive information system)



There are weekly pressure ulcer panels, chaired by a senior clinical lead with a tissue viability nurse attending, which review all pressure ulcers reported by teams and makes a decision as to whether a full serious incident investigation to identify the cause and any contributory factors should be completed. Themes from these panels are collated and fed back to teams on a monthly basis so that actions to address any shortcomings can be implemented.

The tissue viability team also complete 'deep dives' into pressure ulcers every quarter in order to identify themes and learning further. Key issues are circulated to teams via 'Learning Matters' newsletters so that best practice can be shared across the Trust leading to a reduction in pressure ulcers.

A new e-learning training module was launched in November 2016 as part of 'Stop the Pressure week' activities.

A comprehensive audit was completed in partnership with a university which analysed the results. Actions to address these findings were added to individual

teams' quality improvement plans which are monitored monthly by the matrons to ensure progress made.

The tissue viability team are leading a clinical supervision day for team leaders so that they can make best use of the weekly panels and are better able to support their teams to identify and care for pressure ulcers.

Intensive support to clinical teams with the highest number of reported pressure ulcers is in place.

A representative from the tissue viability team continues to attend the NHS England Pressure Ulcer Strategy group which reviews national strategy and best practice, supports collaborative working and gives direction on new initiatives.

Future Plans

We will continue to focus on reducing the numbers of pressure ulcers developed by patients in our care, but will not include this as a specific indicator for 2017/18.

Priority 1.4 Implement robust governance processes to effectively identify, manage and reduce ligature risks in all out impatient units

Aim

Some patients within our services have complex mental health needs and we need to ensure that our care environments are the safest possible for them. We need to provide care in settings where ligature risks are identified and action is taken to mitigate these risks, with appropriate remedial work undertaken within individual services and across the Trust as a whole.

A Care Quality Commission inspection in early 2016 found that improvements could be made to the processes used to identify, manage and reduce ligature risks and therefore this indicator was included in 2016/17.

Historical and national benchmarking data is not available.

Achievements

We have met this aim with an annual ligature risk assessment programme and a building works programme in place for inpatient sites.

The Ligature Management Group (LMG) has led on the development of a ligature assessment programme with a project manager appointed to support the clinical teams, provide a link to the estates services and ensure that all actions are completed.

All inpatient sites were assessed for ligature risks between April – October 2016 and community sites assessed by February 2017. Action plans and programmes of

building work were developed where necessary. The project manager supported the clinical areas to develop mitigation plans for those risks that remained.

The LMG reviews the results of all the ligature assessments and checks that all actions are completed.

All information is saved on a central 'sharepoint' so that it is easy to review information, check progress made on the schedules of work and identify any areas where additional action is required.

The LMG has led on the review and updating of policies and procedures relating to ligature risks.

There is a three year capital investment programme in place which has prioritised the building works to be completed and monitors the schedule of works to ensure they are on track.

Ligature training is mandatory for relevant staff with 98% training compliance in March 2017. There is online information for staff about ligature risk assessment and management with the project manager providing scenario based training to teams if requested.

'Back to the floor 'site visits by senior staff check that ligature assessments have been completed and that staff understand ligature risks and the actions in place to address any issues. Posters display relevant information as reminders to staff.

Next steps

Although this indicator is not included as one of the priority improvements in 2017/18, the ligature assessment programme will continue with inpatient sites revisited throughout 2017 and building works implemented.

Priority 2: Improving Clinical Outcomes

Priority 2.1 To embed care planning frameworks in our clinical services

Aim

We aim to put patients at the heart of everything we do. We want to involve them and their carer's in the plans of care developed to ensure continuity of care, improved clinical outcomes, enhanced patient safety and a positive experience of our services.

This priority builds on the 2016/17 indicator which focused on developing a care planning framework and creating care plans in partnership with patients that best meet their needs and goals. In 2017/18 we want to continue with this work and fully involve patients and carers in their own care and ensure that staff are equipped with the skills they may need to ensure this is available for all.

The data source for this indicator is progress made against divisional work plans which are reported to and monitored by the Record Keeping work stream.

Achievements

We are making good progress towards meeting this target in many areas but there remain some inconsistencies across the Trust.

Clinical audit results demonstrate that whist there has been an overall increase in the numbers of patients with care plans in place, the number of patients involved in designing these has fallen in some areas.

Peer reviews are carried out within all clinical areas of the Trust and during these the clinical records are reviewed and patients are asked about their experiences. From looking at 56 of the reports created following visits that were undertaken during 2016/17 there are still areas where the quality contained within the care plan is inconsistent. There were also times when the patient and/or their carer was not as involved in their care planning as they would have liked to be.

In April 2016 analysis was undertaken to identify gaps in the provision of care planning training and this has led to the development of an education pathway. Further plans are in place for 2017/18 to strengthen the training available, with a suite of best practice guidance and competencies to be launched in April 2017 for all clinical staff. The focus of this training will be on the expected quality that staff must adhere to when completing a clinical record, including care plans. The suite will be supported by an integrated standard operating procedure (SOP) which will provide detailed guidance to staff on all actions to complete.

Care planning forms and templates on RiO were reviewed with requests for change made to RiO Change Board. As a result of this new care planning templates were launched on RiO in January 2017.

A quick reference guide for staff when co-designing care plans has been created with plans for a more detailed pocket guide to cover all areas of clinical record keeping. A video guide is also being produced and this will be accessible via the intranet site.

Future Plans

We will be repeating a similar indicator in 2017/18 with a focus on patients and carers actively encouraged to participate in creating their own care and management plans.

Priority 2.2 The physical health needs of inpatients in Learning Disability and Mental Health services are appropriately assessed, monitored and treated with action taken if there is any deterioration in physical health

Aim

A holistic approach is essential to all aspects of good physical and mental health care and this includes the active identification and management of physical health needs. People with an existing physical and/or mental illness are more prone to physical illness than the general population, may not receive the optimum physical healthcare that they need and have an associated higher morbidity and mortality rate than the general population. Physical illness can have a significant impact on a person's mental health and conversely mental illness can seriously impact on a person's physical health. The Trust aims to ensure that patients and service users are appropriately assessed in relation to their physical health needs.

The data source for this indicator was an audit undertaken in November 2016 in mental health, learning disabilities, specialised services and older peoples mental health services to assess whether the physical health needs of patients are being assessed, monitored and treated appropriately.

In addition to this, physiological track and trigger systems should be used to monitor all adult patients in hospital settings. This was also audited in mental health inpatient settings.

Achievements

Physical health monitoring

In October/ November 2016 in Adult Mental Health and Specialised Services data collection was completed on 173 patients. This demonstrated that 94% of patients had a full physical health review within 7 days of admission or a reason recorded why it was not appropriate.

In Learning Disability services in October/November 2016 data collection was completed on 18 patients. (72%) of patients had a full physical health assessment carried out on admission. In the 5 cases where this was not completed (2/5 40%) recorded why this was not possible and the plan in place to monitor physical health. Care plans were in place for all patients where applicable.

The Trust is continuing to monitor the compliance and improve the physical health assessment of patients and has participated in the Royal College of Psychiatrists physical health assessment tool in February/ March 2017. The results of this are awaited.

Track and Trigger

The aim of this audit was to identify how many of the patients/service users who require care in mental health clinical inpatient settings, were assessed using an early warning score.

The audit demonstrated that 99% of patients were assessed using the Track and Trigger tool. This audit demonstrated however that further training is needed to ensure staff follow the correct process where the patient required further action.

The training package has been reviewed and modified with components mapped to single day training which is easier for clinical staff to attend. Staff competencies have been developed for the various clinical grades of staff. An extensive training programme is now available. In January 2017, 87% of staff in adult mental health and older peoples mental health had been assessed and verified as competent to assess physical health of patients. Further work is being completed on this and a more detailed staff survey is currently underway to establish the competencies in relation to staff grades.

A strategy to meet physical health needs of patients in mental health and learning disability has been developed and is being implemented.

Future plans

The Trust will be re-auditing the assessment of physical health in 2017/18 The Physical Health policy and procedures are currently being reviewed and will include details of improved staff training packages.

Priority 2.3 Risk assessments and appropriate risk management plans are in place for all community and inpatients Mental Health, Specialised, Older Person's Mental Health and Learning Disability services

Aim

The Trust aims to ensure that effective and updated risk assessments and corresponding risk management plans are in place for all patients to safeguard them from harm and allow them to benefit maximally from the support offered by clinical services.

This priority builds on the 2016/17 indicator which focused on reinforcing the importance of up to date and accurate risk assessments.

The data source for this indicator is progress made against divisional work plans which are reported to and monitored by the Record Keeping work stream.

Achievements

We are making good progress towards meeting this target in many areas but recognise this is not consistent across the Trust and that there is more still to do.

Risk assessments completed in RiO are reported via Tableau and the chart below demonstrates that levels of compliance with risk assessment completion are over 95% in all divisions, except for adult mental health. This is an improving picture from

the baseline audit conducted in June 2016 when the majority of teams had compliance figures of less than 90%.

Peer reviews are carried out within all clinical areas of the Trust and during these the completion of risk assessments is reviewed. From looking at 17 of the reports created following visits that were undertaken during 2016/17 it was identified that some patients (12%) did not have sufficient risk assessments or these had not been updated as frequently as they should have been.

A working group called “My Safety Planning” has been established, co-facilitated with representation from acute services, adult mental health and service users. Ongoing work is planned for 2017/18 with the aims to:

- Ensure risk assessments are co-produced and owned by the patient
- Enable honest conversation about risks
- Develop co-created plan which lists how the person and service will improve the safety of the patient

The ‘My Safety Plan’ is a new approach to collaborative management of people’s safety who use our services. We want to work collaboratively with people to identify things in their life which may cause someone to be unsafe, be that due to lifestyle choices, where someone lives, desires to hurt themselves or difficulty walking upstairs and work with them to agree a plan which will help them to stay and remain safe. To support the implementation of this training is currently being developed with lead Psychologists and LEaD training department.

Future Plans

We will be repeating a similar indicator in 2017/18 with a focus on further improving the number of patients with updated risk assessments and corresponding risk management plans.

Priority 3: Improving Patient Experience

Priority 3.1 Our complaints process provides satisfaction to the complainant

Aim

Patient experience is extremely important to the Trust; receiving complaints shows we haven't got something right for the patient or their carers.

We made improvements in meeting the agreed timeframe to send final response letters to complainants with 88% successfully sent overall in 2015/16. However, there was variation across services in their ability to meet the 90% target and therefore the indicator is repeated in 2016/17.

We also aimed to achieve 90% of the standards in the 'Assurance of Good Complaints Handling for Acute and Community Care' published by NHS England in November 2015.

Complaints are recorded as per the Local Authority Social Services and National Health Services Complaints (England) Regulations 2009. National benchmarking data for percentage of final response letters sent within agreed timeframes is not available.

Historical data is shown below.

Table: Percentage of final response complaint letters sent within agreed timeframes. Data source: Safeguard Ulysses Reporting System

2013/14	2014/15	2015/16	2016/17
55%	58%	88%	79%

Achievements

We have partially achieved this indicator, meeting the target of having 90% of the standards in the 'Assurance of Good Complaints Handling' in place, but did not meet the 90% final response target.

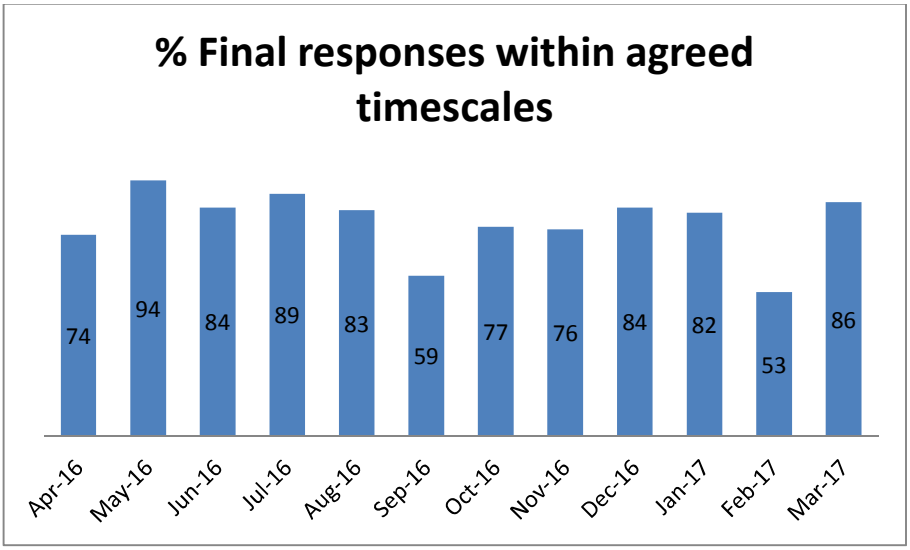
As part of the process when someone makes a complaint, the customer experience advisor discusses with the complainant a timeframe for the complaint to be investigated and a response letter to be sent. We are disappointed that improvements made in 2015/16 were not sustained with overall 79% sent within agreed timeframes.

We have taken several actions to address this decline in performance, introducing a more detailed focus on tracking the progress of all complaints, developing closer links between the customer experience team and clinical services and introducing an escalation process to senior managers if the agreed timeframe is at risk of not being met.

We are also piloting a process whereby complaints will be considered initially at a panel chaired by a clinical lead with clear dates set for the investigation to be

completed and a letter written which will be approved by a divisional panel before sign off by the Chief Executive.

Table: Percentage of final response complaint letters sent within agreed timeframes
Data source: Safeguard Ulysses Reporting System



A review of the complaints pathway within the Trust was completed in June 2016 with good practice identified and recommendations made for improvements. These recommendations were considered by a working group which contained both staff and members of the public. The group reviewed and made comments on the 'have your say' leaflet, information on the website, current policy and proposed what they considered to be the ideal process to deal with complaints. The latter informed the pilot mentioned above.

The customer experience team provide training to investigators within clinical services to develop their skills to investigate and identify reasons underlying the complaint and make recommendations as to actions required to address any shortcomings. Learning from complaints is shared at team meetings with themes identified and shared.

Future Plans

We will continue to focus on improving our timely response to complaints but will not include this as a specific indicator in 2017/18.

Priority 3.2 To involve patient and carers in the development of services

Aim

We aim to put patients at the heart of everything we do. We want to involve them and their carers in the development of services so that we can best meet their needs and provide a positive experience of our services.

This priority builds on the 2015/16 indicator which focused on developing the involvement of patients in the design of specific services identified by the Care Quality Commission in October 2014. In 2016/17 we want to build on this work and involve patients and carers in the development of services across the whole Trust.

The data source for this indicator is progress made against divisional work plans which are reported to and monitored by the Patient Experience and Engagement work stream. There is no historical or national benchmarking data.

Achievements

We are making good progress towards meeting this target in many areas but recognise this is not consistent across the Trust and that there is more still to do.

In May/June 2016 70 clinical teams completed self-assessments which mapped how they were involving patients, carers and families in services being provided. The self-assessments identified both elements of good practice and areas where increased engagement was required.

'A best practice guide to working with the people who use our services' was developed following the above self-assessment. The guide showcased examples of best practice within the Trust which staff could use as a resource to develop further the way they work with patients. It also described the different levels of engaging and involving others with a description of what 'good looked like'.

The Quit 4 Life service has adapted their service following feedback from patients who requested help in cutting down their tobacco use before quitting. This service, in partnership with other local healthcare services, has delivered rapid access and treatment plans for patients suffering with respiratory diseases and has won the 'Leading Service Improvement and Innovation' award at the NHS Thames Valley and Wessex Leadership Academy Recognition Awards 2017.

Service users are involved in peer reviews of our Learning Disabilities services. They provide feedback and suggestions for improvements based on their observations.

Adult mental health services have involved service users and carers in the development of clinical pathways with training and workshops being delivered jointly. The Early Intervention in Psychosis teams have involved carers in the development of carer support packs. A carer is a member of the steering group which is implementing the psychosis pathway to make sure services best meet the service user's needs.

Health visitors, mums with experience of antenatal and/or postnatal mental health problems, and their partners, have worked together to understand what it is like to experience mental health problems and to co-design a support group, 'Knowing me, Knowing you', A short film has been made that is used with both parents and staff to

help explain the illness and the services available. A more acceptable leaflet is being designed to address stigma and to encourage parents to talk about how they are feeling.

Patients, carers and the public have been involved in writing an Experience, Involvement and Partnership strategy which will be launched later in 2017. The strategy sets out the principles and standards for the involvement of patients and carers in the future development of services.

Future Plans

We will be repeating a similar indicator in 2017/18 with a focus on patients and carers actively encouraged to participate in creating their own care and management plans.

Priority 3.3 To have a strategy to reduce restrictive practice in adult mental health services

Aim

Our aim was to develop and implement a reducing restrictive practice strategy in our Adult Mental Health Services.

We want to provide environments for patients and staff where they feel safe and supported and where use of restrictive practices such as restraint are minimised. One of the highest categories in patient safety incident reporting on Ulysses Safeguard, our electronic incident reporting system, is assault, abuse and threat to staff.

We wanted to build on existing actions and continue to work collaboratively with patients to reduce restrictive practices and improve patient experience.

Achievements

Over the year the Safer Forum has focused on three main areas of work;

- development of a comprehensive suite of policies and documents for the wider mental health division incorporating adult mental health, specialised services and learning disabilities
- review of restraint training provided by the Trust
- liaison / relationship with the police.

Although the Trust has had policies on management of violence and aggression, seclusion and rapid tranquillisation, it did not previously have an overarching policy which described its approach towards the use of restrictive practices. Under the guidance of the Deputy Director of Nursing for the Mental Health division an overarching policy was devised. This has been further revised and is intended as a position statement regarding the use of restrictive practices in Southern Health. In

addition, a more detailed policy describing the use of various individual restrictive interventions, including seclusion, restraint and rapid tranquillisation, has also been developed.

A number of clinical services within the trust have raised concerns over the last few years regarding the suitability of the contents of our training known as PRISS. For instance, PRISS, in the form that has been taught so far, does not explicitly make links with moving and handling training, rapid tranquillisation training, or basic life support training; and it is felt that it did not have enough emphasis on de-escalation or trauma-informed care. A formal review of PRISS has been completed, which recommended that any training in manual restraint provided by Southern Health would need to meet some clear specifications. This review also recommended that the Safer Forum should meet with a team from Mersey Care NHS trust, which has implemented a program called "No Force First", which has resulted in a significant decrease in the use of restrictive interventions in that organisation. The team from Mersey Care NHS Trust will visit Southern Health in April, and the learning from the presentation will be incorporated into the formal review of PRISS.

The other important area of focus for the Safer Forum has been liaison with the police. Following case law some years ago, Hampshire Constabulary, in common with other police forces across the country, has stated to mental health providers that its officers are no longer able to routinely attend mental health units in order to provide support when patients present with high risks to other patients and staff. The police have stated that it is the responsibility of mental health providers to make arrangements for managing such high-risk incidents, and that the police will only attend if there is immediate danger to life or limb. This has resulted in a number of incidents in the Trust, particularly in specialised services, where patients have threatened, or actually inflicted harm, on staff with everyday items used as opportunistic weapons, and police have refused to attend, or in some instances, have attended but have refused to be involved. Whilst all of these incidents have been managed by staff teams so far, this presents a real risk to the trust.

Future Plans

We have met the indicator requirement of developing policies to support a reduction in restrictive practice. This has led to highlight further work that needs to be completed in 2017/18. Although not described as a specific indicator for 2017/18 the Safer Forum will be continuing this progressive work to ensure that services are as safe as they can be for both patients and staff.

Single Oversight Framework Indicators

These indicators are taken from the NHS Improvement Single Oversight Framework and were not mandated to be in part 2 of this report.

Meeting commitment to serve new psychosis cases by early intervention teams

This indicator was replaced with the EIP Waiting indicator listed below as of 2016.

Care Programme Approach

The data for the following two was obtained from the nationally published NHS England (NSHE) figures that are based upon trust's Mental Health Service Data Set (MHSDS) submissions. Southern Health is not responsible for the data quality of the data reported from other Trusts but has seen an improvement in performance for both indicators this year.

Indicator	The percentage of patients on care Programme Approach who had a formal review within 12 months.				
	Q1 2016-17	Q2 2016-17	Q3 2016-17	Apr 2015 - Mar 2016	Apr 2016 - Mar 2017
Southern Health	96.8%	97.1%	97.4%	96.4%	96.7%
Average Scoring Trust	73.1%	78.7%	83.7%	64.3%	Not yet available
Highest Scoring Trust	100%	100%	100%	98.9%	Not yet available
Lowest Scoring Trust	4.2%	12.5%	12.7%	3.6%	Not yet available

Figures published by NSH England – Mental Health Service Dataset

Early Invention in Psychosis (EIP)

Indicator	Early Intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE approved care within two weeks of referral.				
	Q1 2016-17	Q2 2016-17	Q3 2016-17	Apr 2015 - Mar 2016	Apr 2016 - Mar 2017
Southern Health	84.7%	88.7%	82.1%	71.1%	Not yet available
Average Scoring Trust	68.7%	76.2%	76.3%	62.9%	Not yet available
Highest Scoring Trust	94.7%	100%	100%	100%	Not yet available

Lowest Scoring Trust	9.1%	0%	33.3%	12.0%	Not yet available

Improving Access to Psychological Therapies (IAPT)

The data made available to the National Health Service trust or NHS foundation trusts by NHS Digital with regard to the percentages of access times to psychological therapies.

The Southern Health NHS Foundation Trust considers that this data is as described for the following reasons; this is taken from the national dataset using the data provided.

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

- Providing performance information that is easily available to clinicians through the business intelligence tool, 'Tableau'.
- Monitoring the target at monthly performance of both 6 and 18 weeks at meetings

Indicator	Improving access to psychological therapies: people with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral				
	Q1 2016-17	Q2 2016-17	Q3 2016-17	Apr 2015 - Mar 2016	Apr 2016 - Mar 2017
Southern Health	87.8%	85.7%	87.0%	86.2%	
Average Scoring Trust	not available	not available	not available		available after 12.04.16
Highest Scoring Trust	not available	not available	not available	100.0%	
Lowest Scoring Trust	not available	not available	not available	15.0%	

Indicator	Improving access to psychological therapies: people with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral				
	Q1 2016-17	Q2 2016-17	Q3 2016-17	Apr 2015 - Mar 2016	Apr 2016 - Mar 2017
Southern Health	100%	99.9%	99.8%	99.9%	

Average Scoring Trust	not available	not available	not available	89.4%	available after 12.04.16
Highest Scoring Trust	not available	not available	not available	100.0%	
Lowest Scoring Trust	not available	not available	not available	33.0%	

Our Quality Improvement Strategy 2016 – 2021

Our key priority is to give patient centred care which is safe, effective and provides a positive patient experience. Achieving this is the responsibility of every single member of staff. Everyone should be focused on our vision and committed to continually improving the services we provide.

The Quality Improvement Strategy was developed to give a clear picture of our aims and ambitions, giving our staff the focus to provide the best possible care and patient experience. We are committed to investing in employing the right staff to deliver the best care. Through our appraisals, training and team business planning activities we will ensure each member of staff knows the role they have to play. We are also developing new ways for staff to truly understand the experiences of people who use our services so this insight is used day by day to further improve our services.

The Quality Improvement Strategy sets out what quality care looks like for our patients and service users and states our commitment to listening to them and their support networks, acting on their feedback to continually improve and share this learning throughout our Trust.

To measure the quality of our services we use the Care Quality Commission (CQC) five key lines of enquiry - Is it safe? Is it effective? Is it responsive? Is it caring? Is it well-led? We have worked to develop a quality scorecard which enables the Board, senior managers and all staff to understand whether the care we are giving to our patients is as good as it can be. We also have a well-established programme of peer reviews which are used to assess services against the CQC's five key lines of enquiry.

Every team has developed a quality improvement plan. These plans describe how they will provide high quality, safe care for their patients and services users looking at improvements and changes that need to take place. Through these plans teams are able to measure their effectiveness and benchmark themselves against others in the Trust, encouraging the sharing of best practice and learning.

From 1 April 2016 we have also been embedding a new Quality Structure within the Trust to provide assurance to our Board on quality issues. The Trust has an established Quality and Safety Committee (QSC) to measure and monitor clinical quality and the health and safety of our patients, service users, visitors and staff. The

committee is chaired by a Non-Executive Director and is responsible for overseeing the development of this Quality Improvement Strategy and ensuring the quality priorities are met.

To help keep us on track and to drive quality improvements on the front line we are looking to appoint Quality Ambassadors in every team during the summer months of 2017/18. These will be staff at support worker level (Health Care Support Worker/Health Care Assistant) who will be responsible for: attending a quarterly development day; developing a team quality noticeboard to display quality improvement initiatives, innovations and best practice; sharing learning with their team; and facilitating team quality improvements utilising the PDSA (Plan, Do, Study, Act) model.

Our Organisational Learning Strategy 2017-2022

To support the implementation of the Trust's Quality Improvement Strategy, the Organisational Learning Strategy builds on improvements and achievements made by our Trust in the safety and quality of care that people who use our services have received over the last few years. It reflects national developments underpinning the importance of organisational learning and the approach to be taken to further support and embed learning within the Trust.

Our Trust Organisational Learning Strategy supports the overall Trust strategic vision and goals. It aims for the organisation to be one in which all staff will understand and embrace their role in learning to deliver and improve quality and safety for our patients, service users and their families as part of their working practice. The strategy defines quality and governance processes to ensure comprehensive and effective systems are in place to learn from our mistakes as well as sharing excellence and innovations to embed a learning culture across the Trust. This will support our services to operate at the high standards that we, our patients, service users, families and stakeholders expect.

It aims to ensure that we are an organisation where people continually expand their capacity to improve, learning from mistakes as well as sharing best practice and knowledge. As a teaching and learning organisation, Southern Health supports medical, nursing and therapy students and trainee doctors as well as delivering continuous professional development opportunities for all staff. Our people development programme empowers staff to achieve their potential and deliver high quality care. Our Team Viral education programme enables teams space to develop, and time to consider how they address the unique challenges they face.

We are passionate about creating an open and listening culture where people who use our services contribute to the running of the organisation. Listening to and engaging patients, service users, children and their families in their care decisions and developing care plans in partnership is the foundation stone for excellent care. Truly hearing the person's voice is a key focus for the Trust over the next year and a

Patient Engagement, Involvement and Partnership Strategy has been developed and will be launched this year.

The Strategy sets out how learning is shared at different levels within the Trust depending on its nature (Team, Area, Divisional or Trust-wide) and describes the tools which are in place to support staff. Our mechanisms for sharing learning for improvement which will be developed as part of this strategy include:

- Quality Ambassadors in every team
- Quality Noticeboards in every team
- Could it Happen Here? presentations
- Central Alert System Internal alerts to share immediate learning from serious incidents
- One to Ones and Clinical Supervision
- Hot spots, Learning Matters Posters and Divisional learning posters displayed across the division and wider
- Learning Networks and Quality, Safety and Professional Conferences; a number of these are already in place across the organisation.

Our Care Quality Commission ratings

Although the Trust has had numerous focused inspections since the 2014 comprehensive inspection, the CQC ratings which were applied in 2014 remains unchanged. It is anticipated that these will be reviewed late 2017/18 through the process of a full comprehensive inspection.

Overall rating for mental health and community health services	Requires Improvement
Are mental health and community health services safe?	Requires Improvement
Are mental health and community health services effective?	Requires Improvement
Are mental health and community health services caring?	Good
Are mental health and community health services responsive?	Good
Are mental health and community health services well-led?	Requires Improvement

Further information regarding these inspections can be found earlier in this report.

Using a programme management approach all CQC related improvement action plans are monitored through the weekly Quality Improvement Development Group and progress is reported to the Quality and Safety Committee and Trust Board on a

monthly basis. Progress is externally shared with the Quality Oversight Committee attended by all commissioners and NHS Improvement.

Reporting and Investigating Deaths

Significant work has continued over the past year to consolidate previous work to improve the quality of investigations and to ensure that relatives/carers are afforded the opportunity to be fully involved in these.

The central lead investigators team continues to provide support to our frontline clinical staff and to lead the improvements. The team comprises four senior specialist nurses who have an interest in, and the skills to support, complex investigations.

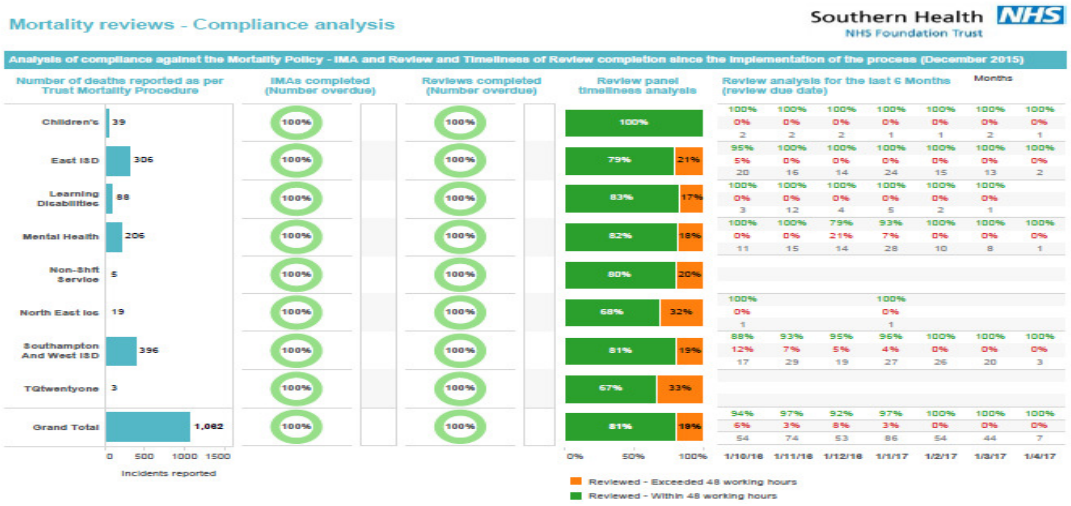
This team work to ensure that investigations are carried out:

- in a timely manner as required by the NHS Serious Incident framework document
- Efficiently, with the involvement of family members and loved ones in an open and transparent manner with a full explanation and apology provided when things have gone wrong; and
- In a way that ascertains root causes and contributory factors to aid the development of effective action plans.

The training of frontline staff via the Investigating Officers (IO) training continues with 151 staff trained in the 2016/17 period. The training the IO's receive is regularly refreshed following feedback and any legislative changes.

Deaths are now consistently reviewed by a panel of staff, chaired by a senior clinician, in order to establish whether the death requires an investigation, and if so, at what level this should be. This process also determines whether a death meets the criteria for external reporting and also whether an internal investigation should be undertaken. The process takes into account how much involvement the Trust, as a community service provider, has had in the care of service users who die in the community and whether a commissioner-led, multi-agency investigation would be more appropriate.

Divisional and Trust-wide mortality reviews continue on a regular basis with a focus on ensuring learning and service improvement takes place. These groups also monitor compliance to process which has improved over the past year and is shown in the Tableau report below.



How we are implementing Duty of Candour

We are continuing to support and encourage our staff to be open and honest with patients and their families when things go wrong. We are committed to the principles outlined in the Duty of Candour regulations and are striving to ensure that we engage with patients and their families in a way that is meaningful to them.

In the past year there have been several developments to support this:

- We have reviewed our Duty of Candour policy and procedure to provide greater clarity to staff on their responsibilities;
- We have developed a series of tools to support staff in properly and consistently demonstrating the behaviours and practices that are required.
    - This includes an e-learning training package for staff on the requirements of Being Open and Duty of Candour – which we are in the process of rolling out;

    - Having reviewed our Ulysses Safeguard Risk Management system, where Duty of Candour compliance is recorded, we routinely carry out a review of any moderate and above incidents where staff have indicated that duty of candour could not be undertaken to ensure that this there is a valid reason for this (for example the patient/family has explicitly asked for no contact);

    - Audits have also been undertaken to confirm compliance with each step of the Duty of Candour requirements. This is aided by our Business Intelligence System, Tableau, which enables all staff to see Duty of Candour compliance data (at team level and above). This gives immediate oversight of compliance to the three stage process, enabling managers to see incidents that need urgent attention to validate whether Duty of

Candour has taken place, or where it hasn't to ensure that this is promptly actioned.

- We have continued to provide 'face-to-face' training within our bespoke investigator's training course which focuses on how to involve service users and families in serious incident investigations – we have run the investigating officers course 6 times throughout 2016-17 and trained 151 investigating officers.

We have included Duty of Candour as a standing item on our executive-led corporate panels which sign-off serious incident investigations. This ensures that it is not only the quality of the investigation which is reviewed but also the requirements of the Duty of Candour policy.

Role of the Family Liaison Officer (FLO)

The Family Liaison Officer was a new post in December 2015. The post holder is a very experienced individual who has worked as a Coroner's Officer and was active within bereavement services. The position was put in place to support families who have suffered bereavement with an emphasis towards providing guidance through the investigation process but remaining independent of the investigation. The role was initially based on similar roles seen within police forces although a family do not need to be part of an investigation process to gain support, just have had a loved one or relative die whilst in the care of the Trust. External to the Trust the Family Liaison Officer is an active member of the Southampton and Hampshire Suicide Prevention Groups.

To date there have been 51 referrals made for those wishing to have support. As of 31st March 2017:

- 15 families are receiving support on a regular basis
- 25 families have received less intensive support
- 11 families have received an initial engagement contact.

As part of family engagement work an initial task was to design and implement a feedback questionnaire to reflect the experience of families in the investigation process. The general consensus from the responding families (one third of those contacted) was that the timing of contact from the Investigating Officer was acceptable and that a clear explanation of what the investigation process involved was given. It was also evident that sharing a draft copy of the report should be considered best practice. Half of the responders felt that the reports were difficult to understand which highlights the need for better communication to families regarding the report structure, content, conclusions and future actions. This will be a focus of the continued improvement work during 2017/18.

There is currently an emphasis on training design and implementation with the focus on improving communication with families. A communication masterclass for clinical staff is being jointly developed by the Trust Chaplain and the Family Liaison Officer and will run in the summer of 2017.

Sign up to Safety Campaign

Southern Health continues to participate in the national Sign up to Safety campaign and we are pleased to report the successful end to year two of the programme. The philosophy of the campaign is locally led, self-directed safety improvement and as we enter year three of the campaign we will be refreshing our improvement ambitions through the Patient Safety group.

One of priorities which we have achieved is the complete redevelopment of our serious incident investigation process. We have achieved:

- rewrite of policies and procedures for incident reporting and being open (Duty of Candour)
- permanent recruitment of dedicated Lead Investigating Officers
- two day training course for investigating officers
- establishment of corporate assurance panel for all serious incident reports with executive level Chair
- involvement of families in the investigation process
- compliance to the NHS England Serious Incident Reporting Framework

Staff Survey

The NHS staff survey is one way that the Trust can hear directly from staff about their experience at work. We activity encourage all staff to participate.

The most recent indicators for KF26 – percentage of staff experience harassment, bullying or abuse from staff in the last 12 months and KF21 percentage believing that the Trust provides equal opportunities for career progression or promotion are shown below:

KF 26	percentage of staff experience harassment, bullying or abuse from staff in the last 12 months	20%↓
KF 21	percentage believing that the Trust provides equal opportunities for career progression or promotion	88%↔

Freedom to Speak Up

A dedicated Freedom to Speak Up Guardian has been appointed during the year following from the recommendation of Sir Robert Francis, following his review and subsequent report into the failings in Mid-Staffordshire.

The guardian, who was recruited from a clinical background has a key role in helping to raise the profile that staff are able to safely raise concerns. She provides confidential advice and support to staff in relation to concerns they have about patient safety, the way they are investigated and responded too. As the role has dedicated time for this responsibility, she is able to offer opportunities through team visits and face-to-face sessions rather than being just contactable by phone which we believe will encourage a better reporting culture.

Annex 1: Statements from commissioners, local Healthwatch organisations and Overview and Scrutiny Committees

The opportunity to provide feedback on the Quality Account was offered to the following bodies:
Clinical Commissioning Groups - West Hampshire, South Eastern Hampshire, North Hampshire, Fareham & Gosport
Healthwatch organisations – Hampshire, Southampton, Portsmouth.
Governors
Overview and Scrutiny Committees – Hampshire, Southampton, Portsmouth,

Feedback that has been received is included in this annex.

Annex 2: Statement of directors' responsibilities for the quality report

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

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

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

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2016/17 and supporting guidance

- the content of the Quality Report is not inconsistent with internal and external sources of information including:

    board minutes and papers for the period April 2016 to the date of signing the limited assurance statement

    papers relating to quality reported to the board over the period April 2016 to the date of signing the limited assurance statement
    feedback from commissioners dated xxxxxxx

    feedback from the governors dated xxxxxxx

    feedback from local Healthwatch organisations xxxxxxx

    feedback from Health Overview and Scrutiny Committee dated xxxxxxxxx

    the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated xxxxxxxx

    the national patient survey 2016

    the national staff survey 2016

    the Head of Internal Audit's annual opinion over the trust's control environment dated May 2017

    CQC inspection report dated xxxxxx

    the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered

the performance information reported in the Quality Report is reliable and accurate

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

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

the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

……Date……..Chairman

……Date……..Chief Executive

Annex 3: External Auditor's Limited Assurance Report

Annex 4: Data definitions

PwC tested the following indicators
100% enhanced Care Programme Approach (CPA) patients receive follow up contact within seven days of discharge from hospital

Detailed descriptor
The percentage of patients on Care Programme Approach (CPA) who were followed up within seven days after discharge from psychiatric inpatient care during the reporting period.

Data definition
Numerator
The number of people under adult mental health illness specialities on CPA who were followed up (either by face to face contact or by phone discussion) within seven days of discharge from psychiatric in-patient care during the reporting period.

Denominator
The total number of people under adult mental illness specialities on CPA who were discharged from psychiatric in-patient care. All patients discharged from psychiatric in-patient wards are regarded as being on CPA during the reporting period.

Details of the indicator
All patients discharged to their usual place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within seven days of discharge. Where a patient has been transferred to prison, contact should be made via the prison in-reach team. The seven-day period should be measured in days not hours and should start on the day after the discharge.

Exemptions include patients who are re-admitted within seven days of discharge; patients who die within seven days of discharge; patients where legal precedence has forced the removal of the patient from the country; and patients transferred to a psychiatric inpatient ward.

All CAMHS (child and adolescent mental health services) patients are also excluded.

Accountability
Achieving at least a 95% rate of patients followed up after discharge each quarter.

Detailed Guidance
More detail about this indicator and the data can be found within the Mental Health Community teams Activity section of the NHS England website.

Admissions to inpatient services had access to crisis resolution home treatment teams

Detailed descriptor
The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team (CRHT) acted as a gatekeeper during the reporting period.

Data definition
In order to prevent hospital admission and give support to informal carers, CRHT are required to gatekeep all admissions to psychiatric inpatient wards and facilitate early discharge of service users.

Numerator
The number of admissions to the trust's acute wards that were gatekept by the CRHT during the reporting period.

Denominator
The total number of admissions to the trust's acute wards.

Details of the indicator
An admission has been gatekept by a crisis resolution team if it has assessed the service user before admission and was involved in the decision-making process which resulted in an admission. An assessment should be recorded if there is direct contact between a member of the CRHT team and the referred patient, irrespective of the setting, and an assessment is made. The assessment may be via a phone conversation or by any face-to-face contact with the patient.

Exemptions include patients recalled on Community Treatment Order; patients transferred from another NHS hospital for psychiatric treatment; internal transfers of service users between wards in the trust for psychiatry treatment; patients on leave under Section 17 of the Mental Health Act; and planned admissions for psychiatric care from specialist units such as eating disorder units.

Partial exemption is available for admissions from out of the trust area where the patient was seen by the local crisis team (out of area) and only admitted to this trust because they had no available beds in the local area. Crisis resolution team should assure themselves that gatekeeping was carried out. This can be recorded as gatekept by crisis resolution teams.

This indicator applies to patients in the age bracket 16-65 years and only applies to CAHMS patients where they have been admitted to an adult ward.

Accountability
Achieving at least 95% of patients in the quarter.

Detailed Guidance
More detail about this indicator and the data can be found within the Mental Health Community teams Activity section of the NHS England website.