Southern Health
NHS Foundation Trust

QUALITY REPORT & QUALITY ACCOUNT 2017/18

Draft V16 Quality Report 17 & 18 - 13apr18 Ready for **Health Overview and Scrutiny Committee**

Table of Contents

Part 1: Statement on quality from Dr Nick Broughton, Chief Executive Officer of Southern Health NHS Foundation Trust

Improving the quality and safety of our services is undoubtedly the highest priority for me and the Southern Health Board. I believe that 2017/18 saw the Foundation Trust continue to make good progress in this regard. Since I joined Southern Health in November 2017 I have met hundreds of staff and visited many of our services across Hampshire. I have been impressed by the energy, commitment and dedication of our workforce and have no doubt that the Trust has the potential to be an outstanding organisation in the future.

Whilst clear progress has been made and I have confidence in the approach we are now taking, I am also acutely mindful of past failings and recognise the ongoing need for improvement at Southern Health.

As in 2016/17 much of our work this year has focused on meeting the recommendations from the Mazars report published in December 2015, and the Care Quality Commission (CQC) warning notice (following a focused inspection in January 2016). We have continued to work closely with NHS Improvement, NHS England and our Clinical Commissioning Group (CCG) on the quality undertakings applied in early 2016.

The Serious Incident and Mortality improvements put in place to meet the recommendations of the Mazars report have been reviewed by external consultants Niche and Grant Thornton who found that we had made significant improvements in the areas of;

- Identification, reporting and monitoring of patient deaths
- The quality, completeness and timeliness of the investigation process
- The process in relation to thematic review and the impact that each one has
- The culture in relation to transparency and learning lessons from deaths
- The practice of the Trust in relation to promoting physical health
- The practice of the Trust in relation to family involvement.

Our Family Liaison Officer, who joined us in late 2016 as part of our improvement plan, has made a real difference and has been well received by families and their loved ones as a dedicated support through the incident investigation process which can be a harrowing and distressing experience. Feedback has been overwhelmingly positive and her caring and compassionate approach has ensured that the voices of families are heard during the investigation phase and that we make improvements as a result of their experiences.

Providing clinical services of the highest quality is only possible if you have an excellent, engaged workforce. Our staff are our greatest asset and one which we must value accordingly. In keeping with this in December 2017 we celebrated our

annual Star Awards. The Star Awards are all about rewarding and recognising colleagues for the hard work and commitment they provide every day to the people we support. Awards have been designed to recognise teams and individuals, both clinical and non-clinical, who truly go above and beyond their call of duty and are passionate about finding new ways of working, and providing the best possible service to people we care for, the local population and their colleagues. In early 2018 we expanded our reward and recognition programme and now also celebrate employees and teams of the month as well as long service. Staff recruitment, retention and engagement is a key quality priority for the coming year as is supporting and developing our workforce at a time when this is a challenge to all healthcare providers.

I am clear that further transformation is required for Southern Health to become an outstanding organisation, and that we must learn from other parts of the NHS which are already delivering the highest standards of quality. In 2017/18 I launched the Transformation Programme which will oversee major change across all the Trust enabled in part by our newly established Quality Improvement approach. This has been developed in partnership with colleagues from Northumberland, Tyne and Wear NHS Foundation Trust (NTW). This organisation is rated as outstanding by the CQC, and have themselves overcome quality challenges not dissimilar to ours. I am grateful to our experts by experience, the carers, families and other external stakeholders who are working alongside us in the development and delivery of this exciting programme.

We must not forget that there are examples of outstanding practice already across Southern Health.

Within our Community Services we are proud of our staff delivering the Health and Wellbeing project, which supports frail patients returning home from hospital, that were finalists at the 2017 Health Service Journal (HSJ) Awards. The project, which is a partnership with Age Concern Hampshire, hosts daily activities in our Petersfield and Gosport War Memorial Hospital rehabilitation wards to speed up patients' recovery and reduce the likelihood of readmission to hospital. Colleagues in our mental health services have launched the innovative Crisis Lounge, based at Antelope House, Southampton, which offers a safe haven to people at times of urgent need. This enables them to avoid having to call an emergency GP or visit a busy A&E department. It is a quiet, safe environment with staff who are experienced in caring for people with mental health conditions. I was also delighted to hear recently that our diabetes service have been shortlisted for the 2018 HSJ Awards for the work they are doing to support service users with mental health problems or learning disabilities – a fantastic example of how being a combined mental and physical health Trust can bring real benefits to the people in our care.

Whilst significant improvements are being made, the impact of past failings continue to be felt and serve as stark reminders of where we have come from and why we must continuously strive to improve.

In September 2017 the Trust was fined £125,000 by the Care Quality Commission in relation to failures to ensure a safe environment at one of our hospitals which led to the injury of a patient. In March 2018 the Trust was fined £2m in relation to the deaths of two patients, Teresa Colvin in 2012 and Connor Sparrowhawk in 2013, following a prosecution by the Health and Safety Executive.

We fully accept that we failed to provide safe care and I apologise unreservedly both personally and on behalf of the Trust for this. Over the past two years our Health and Safety expertise and capacity has been strengthened significantly and this has happened alongside a coordinated, comprehensive program of environmental risk assessments. We are working diligently to make sure that Health and Safety rightfully becomes everyone's responsibility, and that the environments we work in are as safe as possible, both for our patients and our colleagues.

There is huge potential in the year ahead to significantly build on the progress of the last 12 months, and this is something myself and the Board are very excited about. We are looking forward to a comprehensive inspection by the Care Quality Commission in the coming weeks, and are confident that the quality improvements we have made will be recognised, alongside our efforts to better involve service users, carers, families and staff as we continue in our journey of improvement.

The content of this report has been reviewed by the Board of Southern Health NHS Foundation Trust. On behalf of the Board and to the best of my knowledge, I confirm that the information contained in it is accurate.

Date:

Signature:

Dr Nick Broughton

Chief Executive Officer

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

Section 2a. What is a Quality Report?

All NHS Foundation Trust healthcare providers are required to produce an annual Quality Report, to provide information on the quality of services they deliver. We have taken this opportunity to outline how well we have performed over the course of 2017/18, taking into account the views of service users, carers, staff and the public, and comparing ourselves with other Mental Health, Learning Disability and Community physical health Trusts. This Quality Report outlines the good work that has been undertaken; the progress made in improving the quality of our services and identifies areas for improvement.
Every Quality Report must contain priorities for improvement, to be achieved in the following year; we have used 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.

Section 2b. Priorities for improvement in 2018 and 2019

How we decided our quality priorities for the next 12 months

In determining the areas the Trust should focus on for our quality priorities in 2018/19, we sought the views of our patients, carers, staff, governors and stakeholders in a number of ways over a five month consultation period.
Suggested quality priorities were put forward based upon our progress against the 2017/18 quality priorities, our knowledge of incident reporting and complaints, national and local initiatives, and feedback from staff and patients.
Our consultation included a presentation about Quality Improvement and Quality Priorities. Postcards asking for suggestions for inclusion were circulated at numerous events including;

- Annual Quality Conference attended by staff, stakeholders and patient representatives
- Annual Nursing Conferences
- Quality and Safety Meeting through all the Trust's Divisions
- Council of Governance meetings
- The 'Families First' Group
- Through our Head of Patient and Public Engagement at all the meetings they attended
- Via our Weekly Bulletin sent electronically to all of our staff and members

- Through a poster presentation and suggestion box in the Cedar Café at the Trust's Head Office

After careful consideration of the main themes emerging from this feedback, our Governors, the Quality and Safety Committee, the Executive Team and Trust Board reviewed the suggestions and agreed the priorities for 2018/19.

We decided to continue the practice of linking our quality priorities to the three recognised domains of;

- Improving patient safety
- Improving patient experience
- Improving patient outcome.

Priority 1: Domain Improving Patient Safety
Priority 1.1 Risk Assessment and Crisis Contingency Planning
We have rolled this priority forwards from 2017/18 as we want to continue to monitor our improvement work in this area. It is extremely important that our patients feel safe, are involved in their risk assessments and the development of their safety (Crisis and Safety) plans.

In 2017/18 we measured whether all patients in our Adult Mental Health, Learning Disabilities and Older Person's Mental Health services had a risk assessment and crisis plan. In 2018/19 we wish to extend this good work and review the quality of these plans through an audit process undertaken by the senior nursing team. By March 2019 it is expected that a minimum 95% of plans audited will demonstrate excellent quality and the offer of involvement of the patient and their loved ones.

Priority 1.2 Reducing Restrictive Practice
Following recent Care Quality Commission inspections and the proactive work of our internal SAFER forum, reducing restrictive practice remains a key priority for the Trust. A new training programme has been developed and will be implemented during the year.

This year focus we will concentrate on three areas for improvement;

1. Staff training – roll out of Supporting Safer Services "sSs".
2. Accurate reporting
3. Care planning for prone restraint to eliminate this as a regular practice.

The SAFER forum will measure performance against these areas and it is anticipated by March 2019 that 80% of the relevant Safe groups will have received the new training.

Priority 1.3 Collaborating with local communities to reduce suicide

The Five Year Forward View for Mental Health called for the Department of Health, Public Health England and NHS England to support all local areas to have multi-agency suicide prevention plans in place as part of major drive to reduce suicides in England. Following on from the work at Mersey Care we agree with their principle that suicide should not be viewed as "inevitable or unavoidable for anyone within our care". We aim to improve by learning from each tragic death in a multi-service manner.

In order to meet the requirement of the Five Year Forward View we aim to reduce the rate of suicide of our service users by 10% by 2021. On this basis we will be looking to achieve a reduction of 4% based on the April 2015 to March 2016 data in 2018/19.

Priority 2: Domain Improving Patient Experience

Priority 2.1 Consistent Staffing

Building relationships between staff, patients and service users is a key factor in promoting wellness. Establishing trust and understanding of long term patient and service user need is essential to a good therapeutic experience.

Research has shown that without exception patients' experiences are influenced by how care is delivered and their relationship with the key people who deliver it. Experience is adversely affected by constant changes within teams which can lead to the patient or service user distrusting the clinical information and disengaging from the treatment recommended.

Safe staffing is a priority for every NHS Trust and the recruitment and retention of quality staff is a key factor. The national picture for the recruitment of doctors and nurses is challenging. Over the past couple of years it has been recognised that the Trust could improve its efforts to retain its staff, some of whom are choosing to leave within their first 12 months of employment.

The outcomes from all the projects associated with this work stream are planned to reduce vacancy levels from 9% to 7% by March 2019.

Priority 2.2 Triangle of Care

The Trust wishes to revisit and further develop the work achieved in the roll out of the Triangle of Care in the Mental Health Division. This will build on principles for involving families in the care of the patient, and work on information sharing with common sense confidentiality'.

The Triangle of Care emphasises the need for better local strategic involvement of carers and families in the care planning and treatment of people with mental illness. It promotes a therapeutic alliance between service user, carer and clinicians to ensure that a positive, honest and open relationship is created from the first point of contact.

The six key standards state that:

1) Carers and the essential role they play are identified at first contact or as soon as possible thereafter.
2) Staff are 'carer aware' and trained in carer engagement strategies.
3) Policy and practice protocols re: confidentiality and sharing information are in place.
4) Defined posts responsible for carers are in place.
5) A carer introduction to the service and staff is available, with a relevant range of information across the care pathway.
6) A range of carer support services is available.

By March 2019 it is expected that all carers of Mental Health service users will have access to carers' support and carers groups.

Priority 2.3 Reducing Incidents of Violence and Aggression

The Trust aims to reduce two aspects of violence and aggression in the coming year.

1. Incidents of violence and aggression from patients to patients.
2. Incidents of violence and aggression towards staff by patients.

Any incident of violence and aggression is extremely damaging and distressing to all individuals involved, both the perpetrator and the injured. It demonstrates a breakdown in relationships where frustrations have escalated to the point where there is loss of control.

For a service user the experience can result in a strong negative impact on the overall experience of care. For staff the experience can result in a belief that they are not protected in their working environment.

The Trust has liaised with other trusts who have successfully implemented violence reduction initiatives and found that setting targets for reduction does not work and promotes under reporting of incidents. These initiatives, if not supported by a quality improvement methodology, will not be sustained in the long term as they do not embed and support cultural change. Taking this into consideration, the measure is

going be based on the implementation of the SafeCare model across our wider Mental Health Division.

Priority 3: Domain Improving Patient Outcomes

Priority 3.1 Improving the Recognition of Sepsis in the Community (education of patients and their families)

Sepsis is a common and potentially life-threatening condition triggered by an infection. It can arise as a consequence of a variety of infections, though the most common sources are infections of the lung, the urinary tract and the abdominal organs. Though it can affect people of any age, it is most common in the elderly and the very young.

When people suffer from sepsis, the body's immune system goes into overdrive, setting off a series of reactions including widespread inflammation, swelling and blood clotting. This can lead to a significant decrease in blood pressure, which can reduce the blood supply to vital organs, starving them of oxygen. If not treated quickly, sepsis can lead to multiple organ failure and death. But in many cases, sepsis is avoidable, and it is treatable. Source: NHS England 2015

This is a priority for our physical health community teams who recognise that patients, their families and carers require guidance and education about what sepsis is and how to seek urgent advice. By March 2019 it is anticipated that 90% of relevant community staff will have received training to ensure that they are competent in delivering the key messages about sepsis as part of their clinical assessment.

Priority 3.2 Improving the Management of Deep Tissue Injuries, Pressure Ulcers and Wound Care

The cost to the NHS of caring for patients with a chronic wound is conservatively estimated at £2.3bn–3.1bn per year (at 2005–2006 costs); around 3% of the total estimated out-turn expenditure on health (£89.4bn) for the same period (Posnett and Franks, 2007). With proper diagnosis and treatment, much of this burden should be avoidable.

The impact on a patient of having a wound which requires regular dressing changes is dramatic and impacts on general living for both them and their families. It is important that they are partners in the treatment plan and in the prevention of further wounds developing from pressure injuries.

The activities within this Quality Account priority will feature as part of the three year Tissue Viability and Wound Care Strategy. This is once again a priority for the community physical health teams and the key year one activities will focus on training. By March 2019, 350 registered staff will have attended the Wound Care course taught by the Tissue Viability Nurses and all clinical staff will have completed the Pressure Ulcer E-learning training.

Priority 3.3 Improving Access to Psychological Therapies
Psychological therapies are an important part of the treatment pathway for some patients.

It has been recognised within the Mental Health and Older Person's Mental Health services that there is a disparity in the access to psychological therapies which has been associated with long waiting times in some services. During the year we will be agreeing the model for psychological therapies across Mental Health and Older Person's Mental Health that provides the best patient outcome / recovery.

Waiting times are to be improved by 25% over the coming year in those services where the waiting time exceeds the national standard.

All of these priorities will be included in our Trust Quality Strategy document alongside our contractual quality requirements and the national CQUIN programme. Progress will be monitored quarterly by our Quality Governance Business Partners and reported through the Quality Improvement Programme Delivery Group which meets every week.

Section 2c. Progress made in meeting our priorities for improvement in 2017/18
Details of the progress made to meet our priorities for improvement in 2017/18 are given below.

Priority 1: Improving Patient Safety

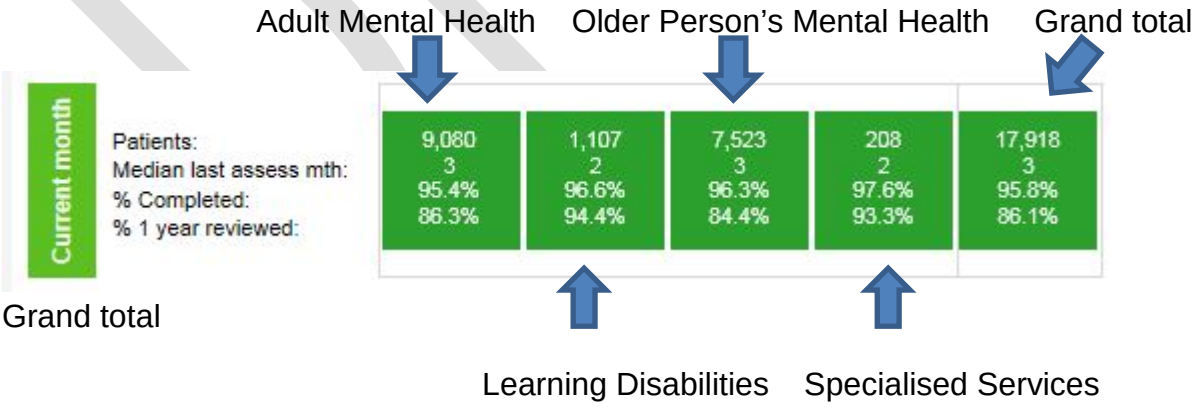
Indicator 1.1
95% of patients should have a risk assessment

Achieved	Partially Achieved	Not Achieved
✓		

Aim: A risk assessment is an assessment of someone's risk, to themselves and others. It is a document that should be written collaboratively with a service user and their family or carer. A risk factor is a personal characteristic or circumstance that is linked to a negative event and that either causes or facilitates the event to occur. A good therapeutic relationship must include both sympathetic support and objective assessment of risk. Risk Assessments are a core component in planning care within Mental Health, and Learning Disabilities. We believe that a Risk Assessment should be focussed on positive risk taking, be structured and evidence based. All of our patients should have a Risk Assessment and these important documents should be completed collaboratively with the patient. A patient should have their individual level of risk assessed at each stage of their journey, or if their clinical condition changes.

Achievements: This indicator applies to services within the Mental Health and Learning Disabilities Divisions. An improving trajectory has been seen, with the divisions meeting this indicator during 2017-2018. Below shows a chart of patients who have had a Risk Assessment completed and the percentage that have been reviewed within the year, the target required is 95%, the graph below shows an improving trajectory, with the divisions meeting this indicator during 2017-2018.

Division's final % in relation to those patients with a Risk Assessment



Data as of 2 April 2018

Future plans: We have seen improvement throughout the year and believe that this is such as important priority that we need to continue our focus on this. We will be continuing to monitor this priority in the coming year, 2018/19, but will be also reflecting the quality of our Risk Assessment not just whether there is one in place.

Indicator 1.2

Risk Assessments should be created using a holistic approach with input from all clinical specialities and input from the patient/carers with a copy sent to the GP. The Risk Assessments of those most unwell patients should be discussed at multidisciplinary meetings.

Achieved	Partially Achieved	Not Achieved
	✓	

Aim: The aim of risk management is to assess likelihood of risk events; this should be completed in conjunction with the patient, carer and family members. The assessment should be an activity of 'no decision in isolation', and as such should be formulated from a multi-disciplinary approach, ensuring that all factors are considered, whether this be social, physical or personal risks. Within Mental Health division a Crisis Plan is a document written collaboratively with the patient to identify signs of crisis and how they would like to be supported during that time. For our Integrated Service Division (ISD) looking at the physical health of patients specific Risk Assessments, such as falls, skin integrity and malnutrition screening tool (MUST) are completed if indicated on the initial patient screening.

Achievements: We completed an audit to measure the collaborative element of the formulation of the Risk Assessment and the quality of that Risk Assessment and Crisis Contingency plans. In the Mental Health division a small improvement has been seen in this year, with the involvement of patients, carers and family. Although an improvement has been seen, it has established that this is an area that needs further work. Risk Assessments were reviewed as part of the weekly Multi-

disciplinary Meetings (MDT) held within Mental Health services, to ensure it is a dynamic assessment with input from all specialities involved in the patients care.

Prior to August of 2017/2018 a Crisis Contingency Plan was in place for patients, to create a plan of what they require as support when in crisis and their behaviours when in crisis; there were also separate plans in place for safety and how they would like to keep themselves safe. This was changed to a combined “My safety/My crisis” plan so that the patient had one single plan that they could work with clinicians to create in order to support them through times of crisis. The quality of the “My crisis/My safety” plan is subjective as it is a document that is owned by the patient. However, as a Trust we measured the quality of both the Risk Assessment and the “My crisis/My safety” plan, by a selection of them being reviewed by the team leaders or managers of wards, to ensure that the information contained within them was of the expected quality in their professional position as a clinician.

Quarter	**Patients with a risk assessment that is holistic and of high quality**	**Patients with a "My crisis/My safety" plan that was of high quality***
Q2	95%	80%
Q3	96%	60%
*Q4***	*98%*	*70%*
* Patients requiring a "my crisis/my safety" plan is only for those who are identified of medium risk and above.		
*** Q4 is not confirmed yet, the number in those columns relate to interim figures.*		

Our Integrated Service Division (ISD) performs an initial holistic assessment of each patient on admission and if indicated a specific Risk Assessment. From these assessments, a Care Plan is developed collaboratively with the patient and/or family/carer. The Quality Assessment Tool (QAT) is a monthly assessment tool that includes a review of patient care plans. Each team is targeted to review three patients a month under the tool, with 491 completed in 2017/18. The results show over 98% of patients felt involved in their Care Plan and that staff were responsive to their needs.

Future Plans: Although an encouraging picture has been seen. The Divisions have created an action plan to address the shortcomings identified; therefore this will continue to be an indicator in 2018/19.

Indicator 1.3
There is a reduction in Risk Assessments and Crisis Plans being a contributory factor in serious incident investigation reports

Achieved	Partially Achieved	Not Achieved
✓		

Aim: An 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 was carried out by Mazars (Mazars, 2015) and published in December 2015.Subsequent CQC inspections identified that "the Foundation Trust did not have robust governance arrangements to investigate incidents, and therefore had missed opportunities to learn from these incidents and to take action to reduce the likelihood of similar events happening in the future". On the basis of this a thematic review was completed in order to review all serious incidents reported to identify if Risk Assessments or Crisis Contingency Plans were a contributory factor in serious incident investigation reports.

Achievements: The thematic review identified that there was a reduction in Crisis Contingency Plans and Risk Assessments being a contributory factor, with the breakdown below.

Quarter and Year	Total number of Serious Incidents*	%
Q4 16/17	16	50%
Q1 17/18	20	40%
Q2 17/18	18	22%
Q3 17/18	15	20%

During this year a launch of the combined 'My Safety/My Crisis Plan' has been completed, this combined plan is proving to be a more satisfactory way to record the patients' wishes in one plan, thus it becomes a less onerous task for both patient and clinician to complete collaboratively.

An external audit was completed by Niche Consulting and the auditors Grant Thornton to establish whether the Trust had implemented the recommendations made within the Mazars report. They confirmed that the Trust had made significant improvements in relation to the themes they had audited.

Themes were:

- Identification, reporting and monitoring of patient deaths
- The quality, completeness and timeliness of the investigation process
- The process in relation to thematic review and the impact that each one has
- The culture in relation to transparency and learning lessons from deaths
- The practice of the Trust in relation to promoting physical health
- The practice of the Trust in relation to family involvement

The grading's of assurance applied by Niche Grant Thornton were:

- A Evidence of completeness and embeddedness and impact
- B Evidence of completeness and embeddedness

- C Evidence of completeness
- D Partially complete
- E Not enough evidence to say complete
- U Yet

The audit indicated the following:

Identification, reporting and monitoring of patient deaths	A
The quality, completeness and timeliness of the investigation process	B
The process in relation to thematic review and the impact that each one has	B
The culture in relation to transparency and learning lessons from deaths	A
The practice of the Trust in relation to promoting physical health	B
The practice of the Trust in relation to family involvement	A

Future Plans

The audit gave the Trust assurance that the learning had been implemented, the grading of B indicates that the auditors found evidence that these actions had been implemented, however it was too soon to evidence that this has been embedded in usual practice, therefore this will be re-audited in quarters two and three of 2018.

The thematic review highlighted that there has been a change in Risk Assessments and Crisis Plans being a contributory factor in serious incidents, however, we will continue to monitor this in the Adult Mental Health quarterly Mortality and Serious Incident meetings.

Priority 2: Improving Patient Experience

Indicator 2.1
There is evidence of patient/ service user family/carer involvement with risk assessments and crisis contingency plans

Achieved	Partially Achieved	Not Achieved
	✓	

Aim: It is part of a holistic risk assessment that it is created collaboratively with patients, carers and family members. NICE guidance CG136 - service user experience in adult mental health: Improving the experience of care for people using adult NHS mental health services (NICE, 2011) identifies that a conversation should occur with the patient to identify how they would like their family/carers to be involved in their care; this should be at different points within their patient journey. Consent should be given by the patient in order to include the family. However, if consent is

denied, it does not mean that family members and carers cannot be involved, it merely means that consideration should be given in relation to the information shared and that the patients request for confidentiality is not breached.

Achievements: An audit was completed during the reporting period to ascertain the involvement of patients, family and carers in relation to Risk Assessments and crisis Contingency Plans. Initial outcomes were disappointing; however, an improving trajectory was seen in quarter three and quarter four,

RESULTS to be inserted. This will be available mid April, once the audit has been completed for Q4

Future Plans: Although an encouraging picture has been seen. The Divisions have created an action plan to address the shortcomings identified; therefore this will continue to be an indicator in 2018/19.

Indicator 2.2
There is evidence of the involvement of patients in Divisional patient participation meetings

Achieved	Partially Achieved	Not Achieved
✓		

Aim: We believe that patients attending Divisional meetings is important and that patient representation will provide opportunity for challenge in relation to our business processes.

Achievements: A Strategy for Experience, Involvement and Partnership has been developed and formally published in June 2017. This strategy sets out a commitment to working in partnership with patients, service users, families, carers, the public and its representatives to ensure that services are delivered in a comfortable, caring, compassionate and safe environment. The strategy will do this by setting minimum standards for involving people in decisions about their care and treatment, and ensuring people who use services are given opportunities to participate meaningfully in the design, development and delivery of services

The Trust's Divisional and Business Unit structures for involving patients/ service users have developed during the year, and vary to reflect the diversity of services. Involvement mechanisms include patient/service user forums, focus groups, task and finish groups including experts by experience and opportunistic discussions. Patient participation at Divisional meetings has been challenging to achieve; this is due to factors in relation to the recruitment of patient representatives and difficulties in generating enough applications in relation to this role.

The Learning Disabilities Division, have a network of locally based participation groups who are involved in many aspects of service development. This is also true of

the Specialised Services Division, who currently has a service user involved in improvement work to review restraint practice within the service.

The Families First Group was put in place in January 2017 and has a significant role in the Trust. One of the group's duties is to review the Trust's policies and procedures to ensure they are fit for purpose, and provide an expert by experience view point for inclusion, into these documents.

In the Health Visiting service they have reviewed the first contact with patients in relation to the musculoskeletal services. Patients were involved in the rewriting of the first appointment letter; a Complaints working group including experts by experience redesigning information on how to make a complaint; and a client with additional communication needs designed an information board about the Health Visiting service.

Future plans: Work continues in all areas of the Trust to ensure that patients, carers and families are consulted on our work and documentation. Carers groups are in place in Learning Disabilities and in the North and West Areas for Adult Mental Health, further groups for Southampton and the East Area of Hampshire are ongoing. These groups are consulted in relation to any proposed changes to the service, and on documentation that will be used. The Older Person's Mental Health Division are currently in the process of developing a support group for patients six weeks post discharge, it is envisaged that this will act as peer support and will be designed to help people stay well.

Indicator 2.3
All new Trust literature will be have undergone coproduction and have been reviewed by patients, they will also be version controlled.

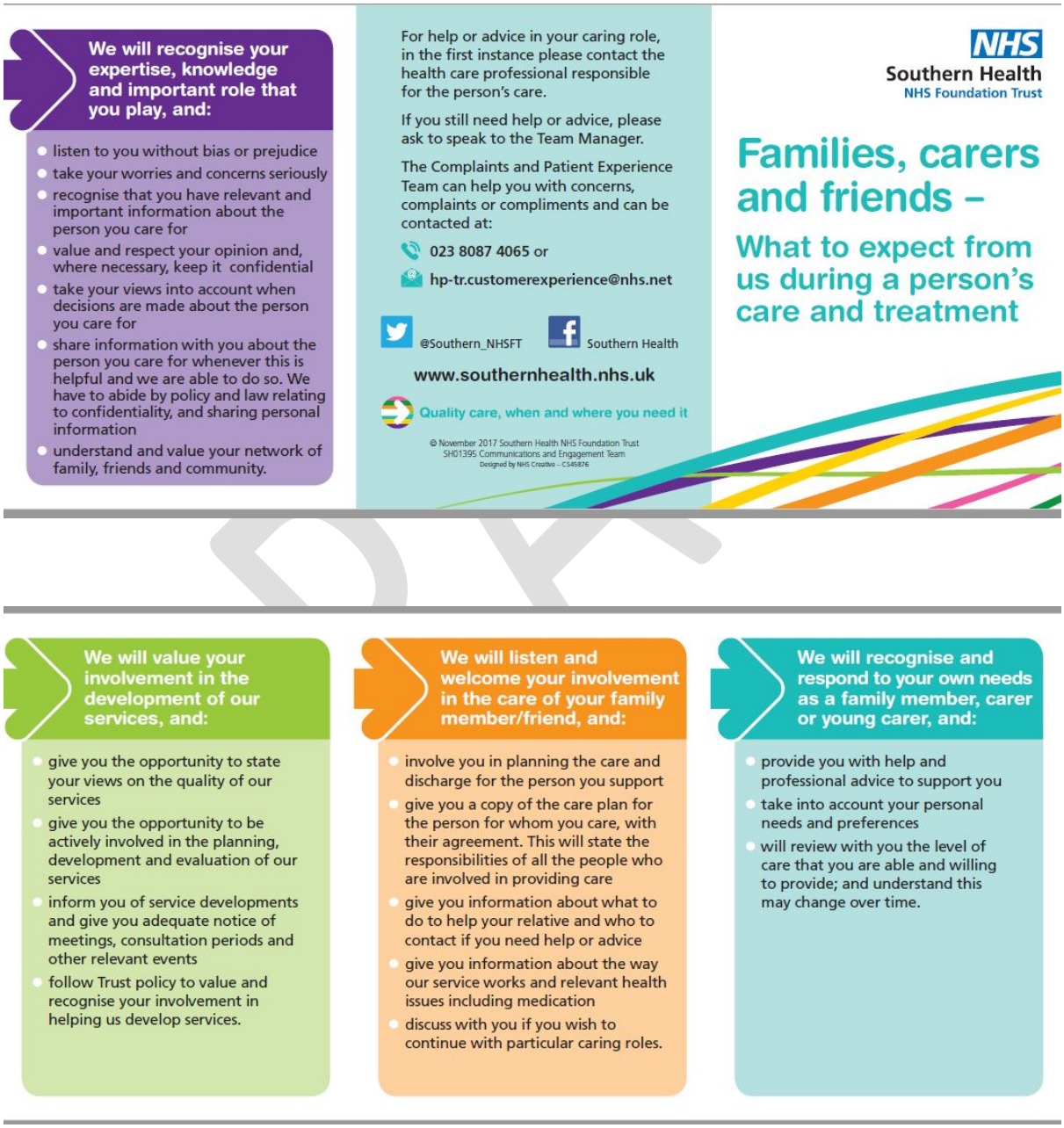
Achieved	Partially Achieved	Not Achieved
✓		

Aim: That patients and users of our literature should have input into the creation of our literature and that it should be in a format that can be easily understood.

Achievements: A standard operating procedure has been created alongside a revised policy for Production of Patient Information, this is to ensure that all patient information requests have a design brief, and can evidence consultation with/ involvement of patients in the development of the information. The process includes a log of all requests, and the completion of each stage. The policy includes a minimum requirement to consult with the target audience on the content and presentation of the information. The group have had involvement in the following information:

A leaflet for the Forensic Community Learning Disability Team, an Emotional Wellbeing leaflet and poster, First Time Parent Group poster and leaflet.

In addition, several publications were completed: A Common Sense Guide to Confidentiality (Adult Mental Health), Trust wide Information sharing leaflet was produced, based on discussion with families and service users at a workshop, and subsequent involvement of the Families First Involvement Group, and consulting with a wider group of families. Two posters were also co-produced with families and service users – '' what to expect from us during a person's care and treatment" – one for families carer and friends and one for patients/service users. Examples of these can be seen below:



We will recognise your expertise, knowledge and important role that you play, and:

- listen to you without bias or prejudice
- take your worries and concerns seriously
- recognise that you have relevant and important information about the person you care for
- value and respect your opinion and, where necessary, keep it confidential
- take your views into account when decisions are made about the person you care for
- share information with you about the person you care for whenever this is helpful and we are able to do so. We have to abide by policy and law relating to confidentiality, and sharing personal information
- understand and value your network of family, friends and community.

For help or advice in your caring role, in the first instance please contact the health care professional responsible for the person's care.

If you still need help or advice, please ask to speak to the Team Manager.

The Complaints and Patient Experience Team can help you with concerns, complaints or compliments and can be contacted at:

023 8087 4065 or

hp-tr.customerexperience@nhs.net

@Southern_NHSFT Southern Health

www.southernhealth.nhs.uk

Quality care, when and where you need it

NHS
Southern Health
NHS Foundation Trust

Families, carers and friends –

What to expect from us during a person's care and treatment

We will value your involvement in the development of our services, and:

- give you the opportunity to state your views on the quality of our services
- give you the opportunity to be actively involved in the planning, development and evaluation of our services
- inform you of service developments and give you adequate notice of meetings, consultation periods and other relevant events
- follow Trust policy to value and recognise your involvement in helping us develop services.

We will listen and welcome your involvement in the care of your family member/friend, and:

- involve you in planning the care and discharge for the person you support
- give you a copy of the care plan for the person for whom you care, with their agreement. This will state the responsibilities of all the people who are involved in providing care
- give you information about what to do to help your relative and who to contact if you need help or advice
- give you information about the way our service works and relevant health issues including medication
- discuss with you if you wish to continue with particular caring roles.

We will recognise and respond to your own needs as a family member, carer or young carer, and:

- provide you with help and professional advice to support you
- take into account your personal needs and preferences
- will review with you the level of care that you are able and willing to provide; and understand this may change over time.

If you have any concerns, or require further information, please speak to your healthcare professional in the first instance.

Alternatively, please contact:

Complaints and Patient Experience Team

023 8087 4065 or

hp-tr.customerexperience@nhs.net

This information is available in other formats and languages including large print, braille and audio.

Please contact:
Communications and Engagement Team
023 8087 4666

@Southern_NHSFT Southern Health

Become a member of our Trust.
Email: membership@southernhealth.nhs.uk
or call 023 8087 4253

www.southernhealth.nhs.uk

Quality care, when and where you need it

NHS
Southern Health
NHS Foundation Trust

Confidentiality and information sharing

Information for patients

The Trust takes confidentiality and privacy very seriously. We need to ask you for personal information that is relevant to your care that will allow us to carry out your treatment effectively and efficiently. This information is kept securely on your clinical record.

Everyone working in the Trust, and within our partner agencies, e.g. GPs and Social Care, has a legal duty to keep information about you confidential. You can be assured that only relevant staff have access to information that is necessary for them to carry out their duties.

In order for us to work together with other health and social care professionals, there are times when we need to share this information. This may be for instance, when your healthcare professional needs to discuss your case in order to plan your care. We do this in order to provide the most appropriate treatment and support for you and your carers, or when the welfare of other people is involved. We will only share information in this way if we have your permission and it is considered necessary.

Overriding Circumstances

However, there may be other circumstances when we must share information with other agencies. In these rare circumstances we are not required to seek your consent. Examples of this are:

- If there is a concern that you are putting yourself at risk of serious harm
- If there is concern that you are putting another person at risk of serious harm
- If there is concern that you are putting a child at risk of harm
- If we have been instructed to do so by a Court
- If the information is essential for the investigation of a serious crime
- If you are subject to the Mental Health Act (1983), there are circumstances in which your 'nearest relative' must receive information even if you object
- If your information falls within a category that needs to be notified for public health or other legal reasons, e.g. certain infectious diseases.

Sharing information with Family, Friends and Carers

We also need to be able to work with the most relevant people in your life, and to do this, may need to share information about you. We would do this with your agreement, and this may include general information about your diagnosis, and medication, i.e. benefits and possible side effects.

This is in order that your carers are helped to understand:

- Your present situation
- Your treatment plan and its aims
- Any written Care Plan, Crisis Plan or Recovery Programme
- The role of each professional involved in your care
- That denied requests for information will be explained to the carer.

You also need to be aware that carers may give information to staff. This is also confidential, and can only be shared with you if the carer agrees.

Future Plans: The Triangle of Care (Carers Trust, 2013) was published to set out best practice to include and recognise carers as partners in care. We remain committed to continuing to implement The Triangle of Care, as it offers key standards and resources to support services to support mental health service providers to ensure carers are fully included and supported with the person they care for in the centre. This will be a focus for our quality priorities in 2018/9.

Priority 3: Improving Patient Safety, Improving Patient Experience

Indicator 3.1
Family Liaison Officer - monitor patient/carer/family involvement, through production of quarterly report

Achieved	Partially Achieved	Not Achieved
✓		

Aim: The involvement of families and carers in the investigation of Serious Incidents is essential to the Trust. The Family Liaison Officer (FLO) is available to provide support to families and carers through this process. The FLO completes a report to identify the involvement they have had with families and this is presented to the Patient Experience, Engagement and Caring Group for the Trust, where it is discussed in detail.

Achievements: The FLO has provided support to 91 families this year; this has involved contact with different family members. Support can be varied, and can include the facilitation of meetings between both internal and external teams and families, supporting families through the Serious Incident investigation and providing information in relation to other organisations, such as the Red Lipstick Foundation or Simon Says, who offer more specialist bereavement services.

The Patient Experience and Caring Group reviews what support the FLO offers and how families have felt about this. Two family members who have had support from the FLO made videos regarding their experiences which were shown at the Trust's Annual Quality Conference in October 2017. This provided invaluable insight into their own experience of the Trust and identified to Trust staff, commissioners, governors and members of the Families Involvement Group how important it is for family members to be engaged in the care provided. The FLO took the opportunity to reiterate that the majority of families/carers want to be involved, whether in the care provided to their relative or in analysing care and that working together can only have benefit for all involved.

The FLO has also been involved in providing support to families who have attended Coroners inquests. This support includes talking them through the process of what an inquest entails, how the inquest is conducted and what they may expect to hear. This enables them to be prepared for what often can be a distressing occasion.

Sharing messages and findings of investigations with families is difficult and the FLO has provided specialist training. The 'Sharing Reports' training was developed with this in mind and has been presented in conjunction with Canon Nick Fennemore, to Investigation officers and senior staff involved in difficult conversations.

The FLO is an active member of the Hampshire Suicide Prevention Forum and the Southampton Citywide Suicide Prevention Strategic Group. A short presentation was made at the World Suicide Prevention Day Event at the Mayor's Parlour in Southampton in September; the focus of the event was 'Take a Minute, Save a Life'. The presentation focused on providing and accessing support for families and partnership working to improve and develop the support that is currently available across Hampshire.

Future Plans: The FLO is working with a number of local support agencies and the Trust Chaplain to try to bring more support into various locations across Hampshire, to support the bereaved, carers and service users.

The FLO is also focused on the development of Carer's Packs, predominantly within the Mental Health units within the Trust, but with consideration to all areas. This area of work has previously been raised through the Families First Group and more recently through the Caring Group. Work is ongoing with the Trust Learning Disabilities unit to develop information to assist those with a learning disability, and their carers, in understanding and coping with a death.

Indicator 3.2
Monitoring and escalation of Duty of Candour compliance

Achieved	Partially Achieved	Not Achieved
✓		

Aim: The Trust believe that promoting a culture of openness is a prerequisite to improving patient / service user safety and as such it ensures communication is open, honest and occurs as soon as possible following an incident between healthcare organisations, healthcare teams and patients/service users and/or their carers. Duty of Candour was introduced for NHS bodies in England (Trusts, Foundation Trusts and special Health Authorities) from November 2014. It applies to incidents that are graded as moderate or above in harm, and is always applied when a patient death occurs be that either expected or unexpected. It consists of three processes:

1a That the patient and/or family should be contacted by the care giver as soon as possible to notify them that a safety incident has occurred and the care giver should, provide an account of all the facts known at the time and provide an apology to the service user.

1b That the care giver should follow up on 1a with written notification which will include an apology for the incident occurring and inform of any investigation that may occur.

2 The completion of any investigation to share the findings with the patient and/or family or carers to apologise for any omission in care and provide opportunity for discussion.

At any stage the patient/family/carer can refuse to be part of this process, however we have a legal duty to record their refusal.

Achievements: The Duty of Candour process has been reviewed by the Caring group on a quarterly basis. Work continues in relation to compliance with this requirement, with daily enquiry in relation to steps taken to meet Duty of Candour. As part of this the Trust implemented a daily panel to review all incidents of moderate grading or above, during the panel, Duty of Candour is discussed and a lead identified to ensure that the patient/family or carer is involved.

To provide assurance that the Duty of Candour process is being followed, an internal audit was conducted by RSM Tenon – Risk Assurance Limited.

Future Plans: Duty of Candour is now embedded within our Divisions and continues to be reviewed on a daily basis.

Priority 4: Improving Clinical Outcomes

Indicator 4.1
Locality team development programme to establish a clear purpose for cross-organisation and multi-disciplinary teams.

Achieved	Partially Achieved	Not Achieved
✓		

Aim: To develop a framework for the delivery local care to ensure resources are targeted to patients who have the highest needs. This includes services such as Extended Primary Care Team (EPCT), Same Day Access Service (SDAS) and Acute Visiting Services (AVS)

Achievements: The local acute hospital in the region of the trial has seen reduction in non-elective and care home admissions. This can be related back to the work of the Extended Primary Care Team.

The Vanguard pilots have drawn to a close; this has provided a good grounding to develop the EPCT model further; including the development of neighbourhood teams for the Trust. CCGs are commissioning an Acute Visiting Service across Hampshire - which is a testament to the success of the model.

There is an Acute Visits Team, a Care Homes Team and a Same Day Access Service (SDAS) operational in Gosport. For Fareham, the Care Homes activity has been extended to two care homes. The Willow Group have implemented an initial

phase of Long Term Conditions (LTC) hubs for respiratory and diabetes which involve primary and community nurses working together.

Future Plans: The Better Local Care project teams have identified the next high impact areas to be addressed to improve patient care; Delayed Transfer of Care (DTOC) and Falls related admissions.

The plan is to establish the blue print for the Neighbourhood Team development (as part of EPCT) and to implement that plan in the Willow Group. CCGs are facilitating the development of a system wide governance structure which will reduce silo based working and support system wide decisions making rather than as separate organisations. The Trust is represented on this board.

Indicator 4.2
The experience of patients will be ascertained in relation to the delivery of their care

Achieved	Partially Achieved	Not Achieved
✓		

Aim: As part of the Hampshire Vanguard project (Better Local Care initiative) the Trust has collaborated in a range of projects. An example is a project in Fareham and Gosport to deliver an extended primary care, breaking down the traditional boundaries between primary and secondary care. The patient feedback on these projects is collated in a number of reports from external companies.

Achievements: Better Local Care Hampshire "Multi - Community Partnership Vanguard" report highlights:

- E-Consult Patient Data – Over 80% of patients were satisfied with the service and would recommend it to others. This is now part of STP Digital Programme.
- Same Day Access Service (SDAS) - High level of patient satisfaction with mode of contacting healthcare services.
- Paramedic Home Visiting Service – Over 85% of patient were satisfied with the service and would recommend it to others.

RSM-PACEC "The power of being understood" report is based on a monthly patient telephone survey. (RSM Tenon is an external audit firm, (Risk Assurance Limited, Public and Corporate Economic Consultants))

- 85% claimed that considerable effort was made to listen to the things that matter most to them about their health issues.
- However, only one in four people cited that family and friends were involved as much as they wanted them to be in decisions about their care.
- Common theme for improvement was having access to one GP that knew the patient's history.

Future Plans: External suppliers will continue to conduct patient interviews and provide evaluation of results on new trialled services.

Indicator 4.3
To ensure shared care records and team working across organisations are in place

Achieved	Partially Achieved	Not Achieved
✓		

Aim: Hampshire Vanguard project (Better Local Care initiative) has looked at how healthcare organisation can have shared views on patient records to improve the efficiency of care delivery.

Achievements: Medical Interoperability Gateway (MIG) projects facilitate the sharing of data between different systems and software providers. Phase one allows Trust Community staff to have access to GP patient records held on EMIS and TPP SystmOne systems.

- Trust staff have one-click access to GP Primary Care records (electronic patient records systems). Approximately 1,000 views each week.
- Records are shared in real time.
- RSM-PACEC Deep Dive Evaluation Report for Phase 1 estimates significant staff time savings where GP records were viewed for new referrals.

Pilots created in Petersfield using EMIS and New Milton using TPP SytmOne.

- Adult Nursing and Therapies team have moved to using EMIS and TPP SystmOne (electronic patient record system).
- Full record sharing and electronic referrals enabled.

Future Plans: MiG Implementation:

- Phase 2- Adult Community, Mental Health and Children's records from RiO, down to progress note level, will be available to GP practices
    - One-click access from EMIS to RiO records – Q1 18/19
    - One-click access from TPP to RiO records to be developed – Q1 18/19.
- 2018/19 funding has been secured to October 2018. (STP Digital work stream and New Care Models work stream.)
- Work has started to transition the functionality to CHIE (Care and Health Information Exchange computer system used in primary care)

EMIS Petersfield and TPP SystmOne New Milton Pilots - Exploring funding options, including the costs of exiting pilots if interest is insufficient.

Section 2d. 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.

1.Review of services

During 2017/18 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 them on the quality of care in 49 of these relevant health services.

The income generated by the relevant health services reviewed in 2017/18 represents 90% of the total income generated from the provision of relevant health services by the Southern Health NHS Foundation Trust for 2017/18.

2.Clinical audits and national confidential enquiries

During 2017/18 ten national clinical audits and one national confidential enquiry covered relevant health services that Southern Health NHS Foundation Trust provide.

During that period Southern Health NHS Foundation Trust participated in 100% of the national clinical audits and 100% national confidential enquires of the national clinical audits and national confidential enquires for which it was eligible.

The national clinical audits and national confidential enquires that Southern Health NHS Foundation Trust was eligible to participate in during 2017/18 are as follows:

National Clinical Audit	Eligible	Participated in
POMH-UK Use of depot/LA antipsychotic injections for relapse prevention (POMH – Prescribing Observatory for Mental Health)	✓	✓
POMH-UK Prescribing valproate for bipolar disorder	✓	✓
POMH-UK rapid tranquilisation	✓	✓
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	✓	✓

Sentinel Stroke National Audit programme (SSNAP)	✓	✓
Society for Acute Medicine's Benchmarking Audit (SAMBA)	✓	✓
UK Parkinson's Audit: (incorporating Occupational Therapy Speech and Language Therapy, Physiotherapy Elderly care Intermediate care	✓	✓
National Clinical audit of Psychosis(NCAP)	✓	✓
National Falls Audit 2017	✓	✓
National Confidential Inquiry into Suicide and Homicide by people with mental illness.	✓	✓

The national clinical audits and national confidential enquiries that Southern Health NHS Foundation Trust participated in, and for which data collection was completed during 2017/18, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

The participation level was reduced in two of the audits. This is thought to be related to the patient population and those who do not receive either Depot/LAI antipsychotic or Valproate treatments. In year 2018/19 the reasons for non-participation will be more clearly recorded.

National Clinical audit	% of required cases submitted
POMH-UK Use of depot/LA antipsychotic injections for relapse prevention	83 cases submitted 32% of sites
POMH-UK Prescribing valproate for bipolar disorder	139 cases submitted 38% of sites
POMH-UK rapid tranquilisation	Data currently being submitted
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	100%
Sentinel Stroke National Audit programme (SSNAP)	100%
Society for Acute Medicine's Benchmarking Audit (SAMBA) - annual since 2012	100%
UK Parkinson's Audit: (incorporating Occupational Therapy Speech and Language Therapy, Physiotherapy Elderly care and neurology)	100%

Intermediate care	100%
National Clinical audit of Psychosis(NCAP)	100%
National Falls Audit 2017	100%

The report of five national clinical audits were reviewed by the provider in 2017/18 and Southern Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

POMH UK The use of depot (long-acting injectable (LAI)) medication for relapse prevention.

- Good compliance with the standards. Future work will focus on moving towards consistency across the Trust and targeting 100% compliance.
- Care Plan standards is an area that was considered generally poor and needs further attention.
- Inpatient and Community teams are formulating local action plans to reflect the key areas for improvement.
- Senior level support is required to prioritise the POMH audits and ensure all clinical teams participate.
- The next audit is expected in October 2019 (provisional date) and will require all relevant clinical teams to participate.

POMH-UK rapid tranquilisation

- Ward staff are encouraged to document the debrief from an episode of rapid tranquilisation within 72 hours as per the NICE guideline.
- Similarly the audit highlighted that Trust and NICE guidelines call for patient physical health monitoring following episodes of rapid tranquilisation.
- Progress monitored with a repeat audit for all areas of the mental health division in early 2018.

Society for Acute Medicine's Benchmarking Audit (SAMBA)

- The Trust mainly run Community Hospitals, providing limited acute services that fall under the SAMBA remit. Hence we have relatively small patient numbers in the audit. Our patient acuity is higher than average, a reflection of age, comorbidities and frailty scores for our region. The data submitted demonstrates the Trust is engaged with Quality Improvement in relation to urgent or emergency care.

National audit of intermediate care

- This was a benchmarking audit for the Integrated Service Division.

Falls audit

- The Royal College of Physicians' Blood Pressure tool for patients in lying and standing positions has been shared across Trust. Practical drop-in sessions have been held to support staff understanding and use of the tool.
- Similarly the Royal College of Physicians' Vision tool has been introduced to Community Hospitals via our Falls Champions, to quickly assess a patient's eyesight in order to prevent them falling or tripping while in hospital.

The reports of 45 local clinical audits were reviewed by the provider in 2017/18 and Southern Health NHS Foundation Trust intends to take actions following these to improve the quality of healthcare provided.

Audit title	Actions
Minor Injuries Unit (MIU) Records	• Update to documentation for patients under 18 to make checks clearer.
Meticillin-resistant Staphylococcus aureus (MRSA)	• Where service users are not MRSA screened on admission, the reason is recorded on their clinical record. • Details of the service user areas MRSA screened are recorded on their clinical record.
GP Communication	• Improve information on the services that Health Visitors, School Nurses and Children in Care specialist nurses offer : o Create "You said we did " letter for GP's following the audit. o Relaunch Health Visiting and School Nursing request for support forms o Redistribute Healthy Child Programme 0-5 and 5-19 leaflets and share with GPs at GP liaison o Promote Health Visitor advice line o Promote "ChatHealth" and resend promotional material
Physical health assessment OPMH	• Updated policy. Ensure induction Nursing staff review individual patient assessments and all patients have physical health care plans to meet their needs. (OPMH medical staff) • Introduce 'new' OPMH Matrons Quality Assessment tool to ensure thorough completion of patient records (Modern matrons and Ward managers)

Audit title	Actions
Wound Audit	• Further education on treatment and prevent of wound infections. 354 wounds showed signs of infection. • Training to report all pressure ulcers and deep tissue injuries and understand the “levels of harm”. • Also training on recognising a deteriorating wound, how to treat and when to refer to a specialist. • 2 day leg ulcer training and follow up to achieve competency within staff. • 2 link nurses within ISD teams available to staff
Physical health assessment – community Learning Disability	• Blood pressure monitoring will be recommended as appropriate and communicated back to the GP/ Primary Care within responses to GP/ Primary care. • Learning Disability Psychiatrists to check the results of investigations to ensure that they have been undertaken and any abnormalities followed up appropriately. • A task and finish group will be coordinated by the Associate Director of Nursing, AHP & Quality (Learning Disabilities) to plan how the Learning Disability Division will manage physical health monitoring.

3.Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by Southern Health NHS Foundation Trust in 2017/18 and staff that were recruited during that period to participate in research approved by a research ethics committee was 1,600.

4.Commissioning for Quality and Innovation Framework (CQUIN)

A proportion of Southern Health NHS Foundation Trust income in 2017/18 was conditional upon 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 2017/18 and for the following 12-month period are available electronically at https://www.england.nhs.uk/nhs-standardcontract/cquin/cquin.

In 2017/18 income totalling £ 5,713,616 was conditional upon Southern Health NHS Foundation Trust achieving quality improvement and innovation goals. In 2016/17

income totalling £5,774,814 was conditional upon Southern Health NHS Foundation Trust achieving quality improvement and innovation goals, of which payment of £5,112,445 was received.

Our CQUIN schemes for 2017-2019 follow the national guidance also available at the link on previous page.

Within Mental Health Service contracts there is a single local scheme in the Hampshire wide Mental Health Service contract and in the Southampton City 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 scheme for the Child Health Information Services (CHIS) and Immunisations team for increasing the participation and reducing inequalities in Immunisation uptake (HPV, Td/IPV and MenACWY) for Children aged between 12 years and 15 years.

5.Care Quality Commission Registration and Actions

Southern Health NHS Foundation Trust is required to register with the Care Quality Commission (CQC) its current registration status is 22 locations registered with CQC under the Health and Social Care Act (2008). Southern Health NHS Foundation Trust has the following conditions on registration: no conditions.

The Care Quality Commission has not taken enforcement action against Southern Health NHS Foundation Trust during 2017/18.

Southern Health NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

On June 2017 the Trust pleaded guilty to charges brought by the Care Quality Commission relating to a health and safety incident which took place in December 2015 at Melbury Lodge in Winchester. The Trust was sentenced in October 2017 and was fined £125,000 for “failing to provide safe care and treatment and putting people at risk of avoidable harm”.

In March 2018 the Trust was fined £2m in relation to the deaths of two patients following a prosecution by the Health and Safety Executive.

6.The Care Quality Commission Inspections

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 2017/18. Each of these was a follow-up inspection to review progress against the actions from the 2015/16 – 2016/17 inspections. One inspection was within the Trust's social care services and this service received an individual rating of 'Good'. Another was within the Foundation Trust's primary care service, The Willow Group. This service received an individual rating of 'Good'.

A further Care Quality Commission inspection at the Trust took place in March 2017 and was reported in July 2017. The inspection was carried out to follow up on areas that CQC had previously identified as requiring improvement or, particularly in mental health, where they had questions and concerns that they had identified from their ongoing monitoring of the Trust. The Care Quality Commission concluded that the Trust had turned a corner. The interim chair and chief executive had a clear vision and understanding of what was required to bring about improvements and were committed to ensuring that improvement was made in a timely manner. They also reported that there had been a notable improvement in the timeliness and quality of investigation reports following serious incidents, including deaths. The Care Quality Commission did not re-rate the Trust following this inspection.

A further focused Care Quality Commission inspection took place between April and June 2017 in two of the Trust's acute mental health units. CQC had received concerns about low staffing levels, high use of bank and agency staff, not enough suitably trained staff on the psychiatric intensive care unit (PICU) and use of seclusion. CQC reported that the Trust had taken significant steps to address the serious concerns raised at the last inspection to address the issues within the seclusion room. They also reported that the senior management team had committed resources to analysing the issues of concern on the ward and there was clear planning with regard to driving improvements across the hospital, this included increasing the numbers of restraint trained staff on the wards, increasing staffing levels and skill mix across the wards too. Because this was a focused inspection CQC did not re-rate the service.

The Trust has been informed by the Care Quality Commission that they plan to carry out a full comprehensive inspection in 2018. The Trust received the request to complete the CQC's Provider Information Request (PIR) on 6 March 2018 and this was submitted on 27 March 2018. Although still to be confirmed by the Care Quality Commission, the Trust is expecting all core services to be inspected during May/June 2018 and for there to be a Well-led review in July/August 2018, after which the Trust will be re-rated.

7.Quality of Data

Southern Health NHS Foundation Trust submitted records during 2017/18 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:
  98.6% for admitted patient care
  100% for outpatient care and
  97.2% for accident and emergency care.
- which included the patient's valid General Medical Practice Code was:
  99.3% for admitted patient care;
  99.9% for outpatient care; and
  98.4% for accident and emergency care.

Southern Health NHS Foundation Trust Information Governance Assessment Report overall score for 2017/18 was 90% and was graded green 'satisfactory'.

Southern Health NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2017/18 by NHS Improvement.

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

- Investing significant resource in supporting improvements in corporate and clinical data quality, including:
  - Patient level validation lists, available daily, for extended clinical measures such as risk assessments, outcome measures and clinical assessment forms
  - Daily availability of governance related data quality validation lists, including mortality reviews, Duty of Candour and action plans resulting from incidents
  - The availability of staff level workforce and financial validation to ensure an employee's Electronic Staff Record accurately reflects the allocation within the Trust's financial ledger
- The above functionality is being extensively used by clinicians and has resulted in sustained improvements to data quality across a range of Trust performance measures.
- During 2018/19 the Trust will be committing to further improvements in data quality through the following initiatives:
  - Clinical validation of one Board level clinical Key Performance Indicator per month to ensure reported performance is supported by robust and reliable clinical documentation
  - Data Quality kite-marks to be incorporated into the Trust Integrated Performance Report on a monthly basis to assess levels of data quality for each Board Key Performance Indicator
  - The development of personalised, employee level performance dashboards within Tableau (The Trust's Business Intelligence Tool)

that will be shared directly with each staff member once a month and which will form part of an employee's formal supervision

8. Learning from Deaths

As a Trust, we must ensure that we regularly review our processes so as to learn when things don't go well and apply that learning to improve the services we provide to the people we serve, their families and carers.

While many deaths do not require detailed investigation, we have a duty to our patients and their families to make sure that any decision not to investigate a death is properly considered and recorded.

It is vitally important that we record deaths accurately and maintain good records.

This approach also means:

- Relevant deaths are recorded using a simple electronic form on our incident recording system; making the process of reporting and investigating deaths more streamlined
- Every case is initially reviewed within 48 hours so we can ensure that the case either proceeds to full investigation or with deaths that do not require an investigation, we will be able to demonstrate to the family why that decision was made.
- It makes it easier for staff to pick up on themes and trends that might otherwise go unnoticed.
- The information that we hold about our patients and the circumstances of their death can help inform regional and national initiatives such as Suicide Prevention Strategies.

The processes for reporting and investigating deaths enable us to ensure we take every opportunity to learn from patient deaths. This learning is shared across the Trust through learning events and publications such as 'Hotspots' and 'Learning Matters'.

Our Criteria for the Reporting of Deaths

Due to the variation of services which the Trust provides, criteria has been written to support which deaths are reported onto the Ulysses Risk management System. These are;

For All Services

- All deaths of patients where any concern is raised about the care provided by the Trust to staff prior to a patient's death, by family or others. This must always be reported regardless of how long the patient may have been discharged.

- Patients / service users who die detained under a Section of the Mental Health Act.

Adult Mental Health & Specialised Services

- All deaths of patients with an open/active referral including palliative care patients
- All suicides or suspected suicides that occur within 12 months of last contact (regardless of whether on open referral or discharged) Patients who die following transfer to an acute/general hospital from a Trust inpatient unit (including those who are under a Section of the Mental Health Act)
- Patients who die following transfer to an acute/general hospital from a Trust inpatient unit (including those who are under a Section of the Mental Health Act.)

Learning Disabilities

- All deaths of patients within 12 months of last contact (regardless of whether an open referral or discharged) and including palliative care patients

Older Person's Mental Health, Physical Health, and Children's (Inpatient)

- All deaths of in-patients, including;
- Palliative care patients
- Patients who die following transfer to an acute/general hospital from a Trust inpatient unit (including those who are under a Section of the Mental Health Act)
- Child deaths may also be subject to a Rapid Response Process through Safeguarding.

Older Person's Mental Health, Physical Health, and Children's (Community)

- The patient had been discharged home from a Southern Health inpatient unit in the preceding 30 days
- The patient was known to have an open referral to adult or children's safeguarding
- Where the death has been reported to the Coroner, or concerns have been raised by any individual or organisation as to the circumstances surrounding the death
- If any acts, omissions or concerns in care provided by Southern Health services have been identified
- All suicides or suspected suicides that occur within 12 months of last contact (regardless of whether on open referral or discharged)

Older Person's Mental Health Liaison Service Services

- OPMH – All deaths by suicide/related to self-harm should be reported.
- Patients who die following transfer to an acute/general hospital from the Trust service under an active Mental Health Act Section.

Psychological Medicine – Liaison Services

- The patient was known to have an open referral to adult or children's safeguarding
- Where the death has been reported to the Coroner, or concerns have been raised by any individual or organisation as to the circumstances surrounding the death
- If any acts, omissions or concerns in care provided by Trust services have been identified
- All suicides or suspected suicides that occur within 12 months of last contact (regardless of whether on open referral or discharged)

Hampshire and Isle of Wight Multi-Agency Pathways (MAPS) - Pathway and Pathfinder Pathway

- The service users within this service are managed by the National Probation Service, some of whom may be registered with a General Practitioner. The primary focus of this service is to support the professional (Offender Manager's) in working with the service user group (personality disordered offenders posing a high risk of harm to others and a high risk of reoffending) and therefore Southern Health care is only time limited joint work sessions with the Offender Manager and service user. All outcomes are reported on the National Probation Service electronic recording system 'Delius'.
- **Pathfinder** – As above although RiO records are kept and a caseload exists the care coordination (for health referrals) or risk management (for criminal justice referrals) remains the responsibility of another party.
  Only report if:
  - If any acts, omissions or concerns in care provided by Trust services have been identified.
  - Concerns have been raised by any family member
  - The service user was under Trust care coordination / mental health services within the previous 12 months.
  - The service will be involved in any investigation undertaken by the National Probation Service, the general practitioner or mental health service provider (Solent or IOW) as requested.

General Practice (operated by the Trust)

Established processes for reporting and reviewing deaths to NHS England and commissioners are in place. This process includes establishing whether there are any concerns that may need further investigation, where this is the case, this procedure would be instigated.

In addition Trust procedure will be instigated where;

- Any death requiring reporting to the Coroner (includes suicides, industrial deaths, Road Traffic Accidents and other unexplained deaths).
- Any complaints or concerns raised to the GP in relation to a death.

For 'The Practice' based at Lymington New Forest Hospital:

- The death of any patients seen by The Practice at Lymington New Forest Hospital within the previous 30 days.

Investigators

We have a team of investigating officers trained in Root Cause Analysis methodology who investigate our most significant incidents and those deaths reported as serious incidents. Their role is to conduct a quality investigation to enable the Trust to learn and improve. Families and loved ones are encouraged to participate in the investigation process, assisting in defining the Terms of Reference for the investigation and individualised support is offered by our Family Liaison Officer.

How do we share our findings?

The process is documented in our Policy and Procedure for Reporting and Investigating Deaths which is publically available on our website. Our Learning from Deaths report which includes our data is produced for the Trust Board on a quarterly basis and is also publically available on our website.

Information collection

Following the publication of the Mazars report in December 2015 and as part of the improvement action plan we have invested in the development of our Safeguard Ulysses Risk Management System to become our operational database for mortality reviews and incident investigations. Prior to this date files were kept electronically, however, not within an operational database which made reviewing data and themes and trends for learning challenging.

During 2017/18 742 of Southern Health NHS Foundation Trust patients died and were reported using the criteria within the policy. This comprised the following number of deaths which occurred in each quarter of that reporting period:

Quarter	Number of Deaths	Number of Case reviews or Investigations
Before 2017/18 (reporting started Dec 2015)	1057*	1057 initial Case Reviews which resulted in; • 107 'Red Rated' or Serious Incident Investigations**
Total 2016/17	730	730 initial Case Reviews which resulted in; • 44 'Red Rated' Internal Investigations • 72 Serious Incident Investigations
Q1 2017/18	165	165 initial Case Reviews which resulted in; • 7 'Red Rated' Internal Investigations

		• 14 Serious Incident Investigations
Q2 2017/18	146	146 initial Case Reviews which resulted in; • 9 'Red Rated' Internal Investigations • 16 Serious Incident Investigations
Q3 2017/18	219	219 initial Case Reviews which resulted in; • 6 'Red Rated' Internal Investigations • 13 Serious Incident Investigations
Q4 2017/18	212	203 initial Case Reviews which resulted in; • 4 'Red Rated' Internal Investigations • 11 Serious Incident Investigations • 9 reviews outstanding as of 31.03.18
Total 2017/18	742	733 initial Case Reviews which resulted in; • 26 'Red Rated' Internal Investigations • 52 Serious Incident Investigations • 9 reviews outstanding as of 31.03.18

*Electronically recorded on the Safeguard Ulysses Risk Management System database since December 2015

**Electronically recorded on the Safeguard Ulysses Risk Management System database since January 2016

Definitions - Red Incidents are those which require a full root cause analysis investigation as per a Serious Incident although do not meet the criteria for external reporting to CCG Commissioners as a Serious Incident under the NHS England 2015: Serious Incident Framework.

By 31st March 2018, 733 case record reviews and 78 investigations have been carried out in relation to 742 of the deaths included above

In 78 cases a death was reviewed by a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

Quarter	Number of Case Reviews Completed	Number of Investigations Commissioned
Q1 2017/18	165	21
Q2 2017/18	146	25
Q3 2017/18	219	19
Q4 2017/18	212	15 with 9 case reviews outstanding

Fifteen, representing 2% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient, as shown in the findings of the investigation.

In relation to each quarter, this consisted of:

Quarter	Deaths related to problems in care provided	Percentage of Deaths in the quarter
Before 2017/18	36*	3.4%**
2016/17	20	2.7%
Q1 2017/18	2	1.2%
Q2 2017/18	5	3.0%
Q3 2017/18	7	3.1%
Q4 2017/18	1***	0.47%
Total 2017/18	15***	2.0%

*Electronically recorded on the Safeguard Ulysses Risk Management System database since December 2015

**Electronically recorded on the Safeguard Ulysses Risk Management System database since January 2016

***Ten investigations remain in progress therefore final impact grading not yet applied

These numbers have been estimated using the Structured Judgement Tool or Initial Management Assessment followed by a comprehensive Root Cause Analysis investigation and application of the Actual Impact Grading tool. For the case review of deaths of those service users with a known Learning Disability the LeDeR methodology has been used as part of the Hampshire project.

For the purpose of this report, deaths attributed to problems in the care provided are those with a final impact grading as Catastrophic Harm.

Actual Impact Grading	
Actual Impact	**Definition**
No Harm	▪ No care or service delivery problems identified. Trust could not have prevented the death. ▪ No root cause (material factors) or contributory factors relating to SHFT care were established.
Low Harm	▪ Some care or service delivery problems identified, but only impact on quality of service, not on patient outcome. Trust could not have prevented the death. ▪ No root cause (material factors), some minor contributory factors relating to SHFT care were established.
Moderate Harm	▪ Contributory factors identified may have had a minor impact on the actual outcome for the person. Trust could not have prevented the death. ▪ No root cause relating to SHFT care was established.
Major Harm	▪ Contributory factors identified that may have an impact on the outcome for the patient. Not clear, although possible we could have prevented the death. ▪ Potential for a contributory factor to be possible root cause relating to SHFT care provided.
Catastrophic Harm	▪ Material care or service delivery gaps established. ▪ Preventable death. ▪ Root cause directly linked to SHFT care provided.

Learning from the case record reviews has highlighted several areas for improvement;

- Communication between providers incorporating collaborative working to ensure patient safety need to be improved. This work must include the sharing of known risk information in the absence of a shared electronic patient system.
- Documentation of the assessment of risk with an emphasis on timely updates being made when the level of risk changes.
- Adherence to policy and the documentation of decision making by the multi-disciplinary team when a policy is not followed. This is apparent in respect of dual diagnosis services users and although improvements have been made, for example, joint clinics held between Trust and Inclusion substance misuse services, more improvement work is required to support this group of service users who may have chaotic lifestyles.
- Involvement of carers and families in the creation of care and 'My safety' plans and ensuring that their views and concerns are heard.

Although not directly related to the deaths the Trust may have prevented, there is a theme for learning emerging from the Q3 and Q4 reports which is a system-wide issue related to the uncontrolled online purchase of medications including strong pain killers which is occurring in the community. The Trust continues to work with Hampshire Constabulary in order to put steps in place to reduce the likelihood of these occurrences. A Learning Network is due to commence in May 2018 which will

involve rich discussion with the police and other interested parties in order to address the issue of online purchases of medication.

Further work with the Police is also in place. The Trust has a singular contact within Hampshire Constabulary in order to work collaboratively in aiming to keep people who are at risk of completing suicide safe. This work, is ongoing.

The improvement work being undertaken into all of these areas continues with;

- The launch of the redesign of the risk assessment module in the patient electronic record to make the creation and updating of assessment easier for staff.
- Business intelligence monitoring through the Tableau informatics system of compliance to updating risk assessments.
- Establishment of quality review audits of randomly selected completed risk assessments to provide assurance that they meet service users' needs.
- Ongoing work with drug and alcohol service to improve communication and create working together approach. A thematic review of these issues has been commissioned by the Serious Incident and Mortality Forum.
- Improvement in communication, for patient safety, with other providers especially those providing out of area beds.

Relaunch of the Triangle of Care as a Quality Priority for 2018/19 to improve the involvement of carers and families in the safety plan of their loved ones to ensure that their views and feelings are heard.

An assessment of the impact of the actions described in above, which were taken by the Provider during the reporting period is standardly reported to the Serious Incident and Mortality Forum. The assessment of impact is made by monitoring the contributory factors and care and service delivery problems which are highlighted in the investigations. As the improvement work begins to have impact the amount of times these factors reoccur is reduced.

Seven case record reviews and 15 investigations completed after 2016/17 which related to deaths which took place before the start of the reporting period.

Twenty, representing 2.7% of the deaths which were investigated in 2016/17, before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the impact grade of catastrophic applied to the investigation at the panel held at the conclusion of the investigation.

Fifteen, representing 2.0% of the deaths during 2017/18 are judged to be more likely than not to have been due to problems in the care provided to the patient. This

number has been estimated using the impact grade of catastrophic applied to the investigation at the panel held at the conclusion of the investigation.

Section 2e. 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 Foundation Trust by NHS Digital.

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

PricewaterhouseCooper (PwC) have considered two mandated indicators Ⓐ against NHS Improvement's requirement. Their opinion is detailed in Annex 3 and complete definitions of these indicators are included within Annex 4.

- Early Intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral. Ⓐ
- Inappropriate out-of-area placements for Adult Mental Health services Ⓐ

2.1 Early Invention in Psychosis (EIP) Ⓐ

People experiencing a suspected first episode of psychosis treated with a NICE approved care package within two weeks of referral

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 reported indicator for people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral is calculated on all patients who are referred as per the guidance given by NHS Improvement and accepted onto the caseload. The indicator looks at patients accessing or waiting for treatment at the two weeks from referral point. The completeness of the data is reliant on the responsible team entering the data, which is then routinely checked and audited by the performance information managers within the Trust. Therefore to the best of our knowledge the data is complete.

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 (internally and externally with Commissioners)

Indicator	Early Intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral. Ⓐ				
	Apr 2016 - Mar 17	Q1 2017-18	Q2 2017-18	Q3 2017 - 18	Apr 2017 - Mar 18
Southern Health	85.4%	85.3%	92.7%	86.0%	To be updated
Average Scoring Trust	74.5%	76.2%	75.6%	74.3%	not available
Highest Scoring Trust	not available	100.0%	100.0%	100.0%	not available
Lowest Scoring Trust	not available	28.6%	0.0%	0.0%	not available

2.2 Inappropriate out-of-area placements for adult mental health services Ⓐ

Inappropriate out-of-area placements for adult mental health services is a new indicator for 2017/18.

The Southern Health NHS Foundation Trust considers that this data is as described for the following reasons; this is taken from Trust records with verification by our external auditors.

The reported indicator for inappropriate out-of-area placements for Adult Mental Health services is calculated as per the NHS England definition of out of area. All out of area admissions are considered to be inappropriate - if the Trust had capacity to admit to a bed within its footprint it would have done so. Any specialist needs that are not provided by the Trust are managed through a separate process and are not counted in this figure (and would in the main be considered an appropriate placement). Occasionally, when there has been a ward closure for planned refurbishment work or for safety concerns, the out of area placements will be considered as appropriate (as are direct re-provision for commissioned capacity) and will be excluded from this total. The Trust currently carries all the financial risk associated with out of area placements and is working with commissioners to review this.

The completeness of the data is excellent as there is a dedicated acute care support team who are responsible for bed finding as well as ensuring payments for the placements are accurate. The data is monitored daily.

The Southern Health NHS Foundation Trust has taken the following actions to reduce the number of patients placed out of area by:

- Daily review of the “Out of area MH acute bed” flash report
- Daily patient flow meetings in all inpatient units

- Escalation process to ensure discharge goals are built into care planning, and capacity is maximised

Indicator	Inappropriate out-of-area placements for adult mental health services Ⓐ				
	Q1 2017-18	Q2 2017-18	Q3 2017-18	Q4 2017-18	Apr 2017 - Mar 18
Monthly occupied bed days out of area	802 / 932 / 722	620/ 493 / 671	662 / 693 / 1010	994 / 669 / 893	-
Quarterly (Average number per month)	819	595	788	852	763

2.3 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 reported indicator for Care Programme Approach 7 day follow up is calculated on all patients who are discharged from an inpatient unit as per the guidance given by NHS Improvement. There are three potential outcomes (exempt, compliant or breach) which are calculated automatically based on the data entry processes being followed. The Trust records patients discharged to non-NHS PICU settings as exemptions. The data is entered by the respective inpatient unit (for those external to the Trust this would be by the respective Community Mental Health Team). This data is then routinely checked and audited by the performance information managers within the Trust. Therefore to the best of our knowledge the data is complete.

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’. Supporting Clinicians to navigate the correct Standard Operating Procedures to ensure the recording is done accurately.
- Monitoring the target at monthly performance meetings, both internally and externally with Commissioners and Regulators

- The Trust exceeds the 95% target for this metric and is in-line with other Trusts.

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.				
	Apr 2016 - Mar 17	Q1 2017-18	Q2 2017-18	Q3 2017-18	Apr 2017 - Mar 18
Southern Health	97.3%	97.5%	96.0%	96.7%	97.2%
Average Scoring Trust	96.6%	97.2%	96.7%	96.7%	not available
Highest Scoring Trust	99.4%	100%	100%	100%	not available
Lowest Scoring Trust	59.5%	92%	91.6%	73.3%	not available

2.4 Crisis resolution teams acting as gatekeeper to admission

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 reported indicator for Gatekeeping is calculated looking at all patients who are admitted into an inpatient unit as per the guidance given by NHS Improvement. There are three potential outcomes (exempt, compliant or breach) which are calculated automatically based on the data entry processes being followed. The completeness of the data is reliant on the responsible team entering the data, which is then routinely checked and audited by the performance information managers within the Trust. Therefore to the best of our knowledge the data is complete.

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’. Supporting clinicians to navigate the correct Standard Operating Procedures to ensure the recording is done accurately.

- Monitoring the target at monthly performance meetings, both internally and externally with commissioners and regulators
- The Trust exceeds the 95% target for this metric and is in-line with other Trusts.

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				
	Apr 2016 - Mar 17	Q1 2017-18	Q2 2017-18	Q3 2017-18	Apr 2017 - Mar 18
Southern Health	99.7%	99.6%	99.2%	99.1%	99.5%
Average Scoring Trust	98.5%	99.6%	99.2%	99.3%	not available
Highest Scoring Trust	100.0%	100%	100%	100%	not available
Lowest Scoring Trust	64.7%	88.9%	94.0%	89.8%	not available

2.5 Admissions to adult facilities of patients under 16 years old

This is a new indicator for 2017/18. The Southern Health NHS Foundation Trust considers that this data is as described for the following reasons;

- All potential admission of patients less than 16 years old are escalated to the Duty Manager. This is supported by a formal reporting process.
- Those detained under the Mental Health Act section 136 are not in scope of the indicator as they are in a place of safety and not detained on an inpatient ward.

The completeness of the data is reliant on the responsible team entering the data, which is then routinely checked and audited by the performance information managers within the Trust. Therefore to the best of our knowledge the data is complete.

The Trust has an escalation process to Duty Managers and Commissioners within 24 hours should a young person be admitted to an Adult Mental Health facility. There have been no occurrences in the last year

Indicator	Admissions to adult facilities of patients under 16 years old. No benchmarking data available				
	Apr 2016 - Mar 17	Q1 2017-18	Q2 2017-18	Q3 2017-18	Apr 2017 - Mar 18
Southern Health	0%	0%	0%	0%	0%

2.6 Our readmission rate for children and adults

This indicator looks at the percentage of patients aged –

(i) 0 to 15; and

(ii) 16 or over

Re-admitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.

The Southern Health NHS Foundation Trust considers that this data is as described for the following reasons; this is taken from internal datasets within the Trust.

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 Trust Board.
- Review of learning at monthly management meeting on medically failed discharges (ISD)
- Involvement of Community teams to support the service users pre and post discharge, enabling a successful transition into the community for Adult Forensic patients.

Indicator	The percentage of patients aged 0 -15 years readmitted to a hospital which forms part of the Foundation Trust with 28 days of being discharged from a hospital which forms part of the Foundation Trust during the reporting period. No benchmarking data is available.		
	Apr 2015 - Mar 2016	Apr 2016 - Mar 2017	Apr 2017 - Mar 2018
Southern Health*	0%	1.9%	0%

Indicator	The percentage of patients aged 16 or over readmitted to a hospital which forms part of the Foundation Trust with 28 days of being discharged from a hospital which forms part of the Foundation Trust during the reporting period. No benchmarking data is available.		
	Apr 2015 - Mar 2016	Apr 2016 - Mar 2017	Apr 2017 - Mar 2018
Southern Health*	12%	17.5%	9.6%

* Annual comparison not applicable due to change in Services in 2017/18. Lymington New Forest Hospital elective surgery data is now reported via University Hospital Southampton (UHS).

2.7 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 Foundation 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 percentage, and so the quality of its services, by:

- Develop a single My Crisis & Safety Plan, and clear guidance to staff on its use, involving service users and families in it
- Involving service users and families, from individual care to service design
- Redesign crisis care in partnership with service users and families
- Medication information forms given to patients when a new medicine is prescribed (Older Person's Mental Health services)

Indicator	Patient experience of contact with a health or social worker*			
	2014 - 2015	2015 - 2016	2016 - 2017	2017 - 2018
Southern Health	6.8	6.7	7.1	7.2
Average Trust score	Not available			
Highest Scoring Trust	7.5	7.4	7.5	7.5
Lowest Scoring Trust	6.5	6.2	6.1	5.9

*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'

2.8 Our rate of patient safety incident reporting

This reporting requirement is the number and, where available, rate of patient safety incidents reported within the Foundation Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

Indicator	Number of patient safety incidents reported to the National Reporting and Learning Service (NRLS)*			
	16/17 Total – 11850*		17/18 total – 8665*	
	Apr 16 – Sept 16	Oct 16 – Mar 17	Apr 17 – Sept 17	Oct 17 – Mar 18
Southern Health*	5901	5949	5283	3382
Average Trust Score**	2963	2910	3160	Not available
Highest Scoring Trust**	6349	6447	7384	Not available
Lowest Scoring Trust**	40	68	12	Not available

*results from internal incident reporting system
**results taken from NRLS

Indicator	i) Number and ii) percentage of such patient safety incidents that resulted in severe harm or death			
	16/17 Total – 140 (1.1%)		17/18 Total – 81 (0.9%)	
	Apr 2016 – Sept 2016	Oct 2016 – Mar 2017	Apr 2017 – Sept 2017	Oct 2017 – Mar 2018
Southern Health*	i) 39 ii) 0.7%	i) 42 ii) 0.7%	i) 34 ii) 0.6%	i) 47 ii) 1.4%
Average Trust Score**	33 / 1.5%	33 / 1.3%	33 / 1.2%	N/A
Highest Scoring Trust**	101 / 3.2%	107 / 2.2%	172 / 3.1%	N/A
Lowest Scoring Trust**	10/1.4$	2 / 0.1%	1 / 0.0%	N/A

*results from internal incident reporting system
**results taken from NRLS

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 and our internal incident reporting system.

The 2017/18 totals are also based on data extracted from the Trust's incident reporting system; Ulysses. These include all Patient Safety Incidents of severe harm or death submitted to NRLS (now NHS Improvement) during the specified time periods.

The numbers of patient safety incidents has shown a downward trend across the year, with the occasional spike in part due to individual patient acuity. Within Adult Mental Health Services the reduction in self-harm and injurious behaviour incidents is seen as improved patient-staff relationships with a positive change in their wellbeing. Within the Community teams there has been a reduction in treatment of care related issues in Petersfield Minor Injuries Unit. While Older Person's Mental Health has seen a reduction in the number of slips, trips, falls and accidents category.

This reduction of incident reporting in the latter half of 2017/18 and increased number of incidents that resulted in severe harm or death has resulted in the percentage for serious harm to increase to the average Trust level in 2016/17 of 1.4%. This is monitored by the Serous Incident and Mortality Forum on a monthly basis.

The Southern Health NHS Foundation Trust is continuing to take the following actions to ensure accuracy of this indicator, and so the quality of its services, by:

- Quality monitoring of the incident reports submitted by the central incident management team
- Increasing incident reporting education through the Quality Governance Business Partners.
- Increasing the ease of use of the Ulysses Incident system through continued development with liaison and feedback of users throughout the Trust. This encourages the timely and accurate reporting of incidents.

2.9 The percentage of staff who would recommend the Foundation 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 Foundation Trust during the reporting period who would recommend the Foundation Trust as a provider of care to their family of friends		
	April 2015 - March 2016	April 2016 - March 2017	April 2017 - March 2018
Southern Health	66%	67%	67%(Q1-4)
Average Trust Score	78%	79%	71%(Q1-3)
Highest Scoring Trust	100%	98%	100%(Q1-3)
Lowest Scoring Trust	45%	44%	49% (Q1-2)

The Southern Health NHS Foundation Trust considers that this data is as described for the following reasons; this is taken from the NHS staff survey.

The Southern Health NHS Foundation Trust is continuing to take the following actions to improve this indicator, and so the quality of it's services, by:

- Making staff aware of the survey to increase the return rate
- Developing a culture of "collective responsibility" to ensure services achieve great outcomes for patients
- Trust staff will support the integration of services within the wider health and social care economy in order to improve the quality, efficiency and effectiveness of our services, therefore resulting in better outcomes for our patients.
- Improving the quality, efficiency and effectiveness of our services through Quality Improvement methodologies.
- Utilising the opportunities afforded through digital technologies.

2.10 The percentage of patients who would recommend the Foundation 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 Foundation Trust as a provider of care to their family of friends		
	April 2015 - March 2016	April 2016 - March 2017	April 2017 - March 2018
Southern Health	94.3%	93.9%	97.2%
Average Trust Score	94.5%	93.3%	93.1% (Q1-Q3)
Highest Scoring Trust	98.8%	98.3%	97.8% (Q1-Q3)
Lowest Scoring Trust	86.6%	67.5%	73.4% (Q1-Q3)

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

The Southern Health NHS Foundation Trust considers that this data is as described for the following reasons: this is taken published data on the NHS England website.

The Southern Health NHS Foundation Trust is continuing to take the following actions to ensure accuracy of this indicator, and so the quality of its services, by

- Reviewed the wording of non-mandated questions to ensure survey appropriate to the service, and offering the survey to all patients and services users.
- Establishing a Patient Experience, Engagement and Caring Group to review all aspects of patient experience and engagement, and provide assurance to the Trust Board
- Increasing the ways in which patients/ service users and families have a voice in service delivery and improvement
- New Head of Patient and Public Engagement appointed in March 2018.

2.11 Cardio-metabolic assessment and treatment for people with psychosis

This is a new indicator for 2017/18 and linked to the CQUIN on assessment and recording of service user Cardio-metabolic parameters. The indicator on Cardio-metabolic assessment and treatment for people with psychosis is broken down into three sections:

a) Inpatient wards
b) Early intervention in psychosis services (EIP)
c) Community mental health services (people on care programme approach)

The Southern Health NHS Foundation Trust considers that this data is as described for the following reasons; this is taken from our external and internal audits completed as part of the CQUIN programme in 2017/18. The cardio-metabolic parameters based on the Lester Tool are: smoking status, lifestyle, body mass index, blood pressure, glucose regulation and blood lipids. Intervention is required if service users fall in the red zone of the Lester Tool. Part b) the EIP audit is based on initial results from the Royal College of Psychiatrists (RCP) and this requires confirmation of the final results.

The completeness of the data is reliant on the responsible team entering the data into the correct forms on RiO (electronic patient record system). Local areas use the newly built Tableau report to monitor their performance, which are reviewed within the AMH performance meetings. Therefore to the best of our knowledge the data is complete.

The Southern Health NHS Foundation Trust is continuing to take the following actions to ensure accuracy of this indicator, and so the improve 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
- Review of all physical health forms on RiO to streamline patient record keeping.

This will facilitate continued developments in physical health monitoring and interventions for the holistic well-being of service users with psychosis.

Indicator	Cardio-metabolic assessment and treatment for people with psychosis - a) Inpatient wards
	Q3 2017/18 audit
Southern Health	94%

Indicator	Cardio-metabolic assessment and treatment for people with psychosis - b) Early intervention in psychosis services
	Q3 2017/18 audit
Southern Health	78%*

*Initial results – waiting confirmation from RCP.

Indicator	Cardio-metabolic assessment and treatment for people with psychosis - c) Community mental health services (people on care programme approach)
	Q3 2017/18 audit
Southern Health	92%

2.12 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.

Indicator	Proportion of people completing treatment who move to recovery (from IAPT dataset)				
	Apr 16 - Mar17	Q1 17-18	Q2 17-18	Q3 17-18	Apr 17 - Mar 18
Southern Health	51.5%	51.0%	51.8%	53.9%	52.4%
Average Scoring Trust	49.9%	51.4%	51.2%	50.8%	not available
Highest Scoring Trust	86.0%	89.0%	100.0%	100.0%	not available
Lowest Scoring Trust	15.0%	23.0%	24.0%	7.0%	not available

The Southern Health NHS Foundation Trust is continuing to take the following actions to ensure accuracy of this indicator, 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				
	Apr 16 - Mar17	Q1 17-18	Q2 17-18	Q3 17-18	Apr 17 - Mar 18
Southern Health	87.2%	88.9%	92.1%	92.8%	91.9%
Average Scoring Trust	86.3%	88.2%	87.9%	87.7%	not available
Highest Scoring Trust	100.0%	100.0%	100.0%	100.0%	not available
Lowest Scoring Trust	15.0%	19.0%	19.0%	4.0%	not available

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				
	Apr 16 - Mar17	Q1 17-18	Q2 17-18	Q3 17-18	Apr 17 - Mar 18
Southern Health	99.9%	99.9%	99.9%	99.6%	99.8%
Average Scoring Trust	97.9%	98.8%	98.2%	98.2%	not available
Highest Scoring Trust	100.0%	100.0%	100.0%	100.0%	not available
Lowest Scoring Trust	33.0%	55.0%	41.0%	23.0%	not available

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 Foundation Trust.

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 service 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.

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. Underpinning this Committee are three clinically led groups covering three of CQC's key lines of enquiry – Patient Safety Group (SAFE), Clinical Effectiveness Group (EFFECTIVE), Patient Experience, Engagement and Caring Group (CARING).

To help keep us on track and to drive quality improvements on the front line we have begun to appoint Quality Ambassadors in every team. These are 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.

The Trust is committed to further developing QI methodology across the organisation and has been working with partners from Northumberland, Tyne and Wear NHS Foundation Trust to establish this programme of work. The Trust will therefore be refreshing the Quality Improvement Strategy for 2018/19 to reflect this.

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, the Trust 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 has been a key focus for the Trust over the last year and the Patient Engagement, Involvement and Partnership Strategy has been 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.

In October 2017 the Trust successfully held its annual Quality Conference. The aim of the conference was to raise the profile of patient safety by sharing experiences and learning. The day focussed on three themes: Patient Safety Culture & Learning, Being Open (with patients and families), and Safety in the System.

A number of external organisations took part and gave interesting presentations on subjects as diverse as; Implementing a Safety Culture, What makes an 'Outstanding' service, Human Factors in investigations, Involving families and carers in investigations and Multi-agency investigations. They included National Air Traffic Services, the CQC, Healthcare Safety Investigation Branch, NHS England and Niche Health and Social Care Consulting. Delegates were also shown poignant videos made by two family members of service users, of their experiences with the Trust.

The conference also included a number of breakout sessions with internal speakers which delegates could choose from, to make learning specific to their experience. The subjects presented included Early Intervention in Psychosis, Sepsis care, Improving the service user Journey, Risk Management in Mental Health, Safety in Forensic Services, Psychiatric Liaison into Acute Trusts, Improvements in Epilepsy Care, Learning from a Serious Case Review and Older People with Frailty.

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. The Trust has been informed by the Care Quality Commission that they plan to carry out a full comprehensive inspection in 2018. The Trust received the request to complete the CQC's Provider Information Request (PIR) on 6 March 2018 and this was submitted on 27 March 2018. Although still to be confirmed by the Care Quality Commission, the Trust is expecting all core services to be inspected during May/June 2018 and for there to be a Well-led review in July/August 2018, after which the Trust will be re-rated.

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.

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;
- 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 3 times throughout 2017-18 and trained a further 71 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 role of the Family Liaison Officer is now established within the Trust and therefore a recent review has taken place to assess the impact of the role and the development opportunities for the future.

From commencement of the post on 5 December 2016 to 31 March 2018 there have been 152 referrals and of these:

- 52 families benefitted from additional support which has now ended (though families may choose to make contact in the future if they want assistance to access support from other agencies).
- 20 families are currently receiving support on a regular basis
- 19 families were contacted by the FLO to provide information, options for external support and contact details on a one-off basis
- 10 referrals are currently under review pending contact from family
- 51 families have not requested FLO support.

The FLO co-presents the 'Sharing Information' training and presents the 'Duty of Candour' training as part of the Investigating Officers training schedule. She is also

a member of the Trust's 'Patient Experience, Engagement and Caring Group', the 'Family Experience and Engagement Group', and the 'Families First Group'.

In supporting families through a Serious Incident Investigation or Complaint process, the FLO has been able to encourage a number of family members to provide their input and insight into various aspects of the Trust improvement work. This work has included: reviewing and commenting on 'Sharing information' literature; participating in videos to provide the family perspective for clinicians; reviewing 'Carer's Information' and attendance at meetings to focus on specific clinical issues affecting service users.

The FLO endeavours to raise any additional issues which families may mention during conversations, such as; the lack of signage at Royal Hampshire County Hospital for Melbury Lodge for people using public transport (which has subsequently been addressed); access to information leaflets in reception areas for families and feedback on what would be helpful (this is being taken forward through the Families First Group in considering Carer's Pack information).

She also continues to be an active member of the Hampshire Suicide Prevention Group and the Southampton Suicide Prevention Group and is utilising this network to encourage voluntary support agencies to work together to address the need for more access to support in various parts of Hampshire.

Sign up to Safety Campaign

Southern Health continues to participate in the national Sign up to Safety campaign, which is drawing to the end the initial 3 year phase. We are pleased to report the successful end to this year of the programme. The philosophy of the campaign is **locally led, self-directed safety improvement.** Whilst at present we await a final steer from the National Campaign as to their proposals for continuation of this programme, the intention will be to develop new priorities moving forward.

We have achieved:

- Duty of Candour e-learning training has been developed and rolled out across the Trust.
- All patients and families are now offered the opportunity to participate in developing terms of reference for Serious Incidents.
- External audit of the Serious Incident and Mortality action plan found improvements completed and embedded with the impact being seen within the Trust in relation to processes to identify, investigate and learn from Serious Incidents.
- 'You said, we did' posters are now displayed in inpatient sites and on our website, and also feature within the Annual Complaints report.

- Information on all risks/Serious Incidents and complaints are now showing on Tableau (business reporting system) so that staff can drill down information to team level, and interrogate the data as required.

Staff Survey

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

The most recent indicators for KF26 and KF21 are:

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%↔

These results remain broadly the same as in 2016/17. To address the issues raised by staff, we have:

- Organised a Health and Well-being event entitled “Tackling bullying and harassment from any source”.
- Developed a network Health and Well-being champions.
- Promoted the role of the Freedom to Speak Up Guardian and the Speak Up Service.

Based on the most recent results, we will be developing local action plans where there are issues of particular concern, for example, where people report they are subject to bullying and harassment as a result of their ethnicity or gender.

Freedom to Speak Up

A dedicated Freedom to Speak Up Guardian was appointed in 2016/17 following the recommendation of Sir Robert Francis, following his review and subsequent report into the failings in Mid-Staffordshire NHS Foundation Trust.

The Guardian has been in post over a year, during this time she has had 74 contacts from every directorate and all staff groups covering a vast array of subjects throughout the year. She continues to travel about the Trust speaking with staff and teams to provide independent and confidential support to staff who want to raise concerns. As a result of concerns raised this year there have been:

- Changes made to policies,
- Workshops conducted on Speaking Up, Bullying and Harassment programs
- Input provided into the newly designed Managers’ Induction programme.

Freedom to Speak Up Champions have been recruited from a diversity of staff and directorates to assist in spreading confidence to raise concerns. The Guardian remains the primary contact to collate and respond on concerns raised.

Annex 1: Statements from commissioners, local Healthwatch organisations and Oversight 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
- Clinical Commissioning Group - Fareham & Gosport
- Clinical Commissioning Group - Southampton City
- Healthwatch organisations – Hampshire, Southampton, Portsmouth.
- Governors
- Overview and Scrutiny Committees – Hampshire, Southampton, Portsmouth,

Feedback that has been received is included in this annex.

The feedback from all stakeholders has been taken into consideration and changes have been made from the earlier version of this document which was supplied for review. We now hope that the reader will be able to clearly understand which of the priorities for 2017/18 have been achieved and the level of that achievement.

West Hampshire Clinical Commissioning Group statement

Representing West Hampshire, South Eastern Hampshire, North Hampshire, Fareham and Gosport Clinical Commissioning Groups

LETTER TO ADD (Previously dated 19 May17 – Heather Hauschild)

Southampton City Clinical Commissioning Group

LETTER TO ADD – previously dated 2nd May from John Richards

Southern Health NHS Foundation Trust – Governors

Letter from Council of Governors,→ the Patient Experience & Engagement Group (PEEG) considered the draft Quality Report and Account 17/18.

Healthwatch

LETTER TO ADD

Health Overview and Scrutiny Committee

LETTER TO ADD

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 2017/18 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 2017 to March 2018

  Papers relating to Quality reported to the Board over the period April 2017 to March 2018

  feedback from commissioners dated 2 May 2017 (Southampton City) and 19 May 2017 (**West Hampshire Clinical Commissioning Group** Representing West Hampshire, South Eastern Hampshire, North Hampshire, Fareham and Gosport Clinical Commissioning Groups)

  feedback from the governors dated 16 May 2017

  feedback from local Healthwatch organisations dated 15 May 2017

  feedback from Overview and Scrutiny Committee dated 19 May 2017

  the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2017

  The latest national patient survey 2017

  The latest national staff survey 2017 – NHS England Friends and Families Test

  The Head of Internal Audit's Annual Opinion over the Trust's control environment dated May 2017. Lorna Raynes in RSM Tenon –

assurance on the wider internal audit program
lorna.raynes@rsmuk.com

CQC inspection reports received between April 2017 and March 2018

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

Independent Auditors' Limited Assurance Report to the Council of Governors of Southern Health NHS Foundation Trust on the Annual Quality Report

Annex 4: Data definitions

PwC tested the following indicators

Early Intervention in Psychosis (EIP)
People experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral

Detailed descriptor:

The reported indicator for People experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral is calculated on all patients who are referred as per the guidance given by NHS Improvement and accepted onto the caseload.

Data definition

Numerator

xx.

Denominator

xx.

Details of the indicator

xx

Exemptions x

Accountability

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.

Inappropriate out-of-area placements for Adult Mental Health services
Detailed descriptor

xx.

Data definition

Numerator

xx.

Denominator

xx.

Details of the indicator

xx

Exemptions x

Accountability

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.