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Welcome to the Quality Report for the year 2018/19. In this document we will start with an introduction to Southern Health; an overview of who we are and what we do, our vision and values, and our priorities for the year ahead.

In part one you will read a statement from our Chief Executive Dr Nick Broughton, in which he discusses our achievements and challenges from the past twelve months, and how we are developing to ensure we can continue to improve quality of care and positive outcomes for our patients. We will also show you our plans for the coming year, discuss how we define and measure quality, and how the quality priorities talked about in this report fit alongside our other areas of work.

In part two we will set out our quality priorities for the year 2019/20 and tell you how we plan to meet these. We will then review the past year; by reporting on a number of our key indicators and our previous quality priorities, in part 3, detailing the work we have done to achieve these in the last year.

Our aim is that this report provides an open account of how we work to provide quality care for our patients, their families and carers. We are going through a period of substantial change; as a Trust, within our local health system and as a part of the NHS as a whole, and we are very clear that our central focus is and must always be our patients, and how we work with them to achieve the best possible outcomes for their health and wellbeing. We know we don’t always get it right, and we are still working to become the outstanding organisation we want to be. The only way we can do that is with the support of staff, patients, service users and families so if you have any questions or feedback about what you read here or if you think we could be doing things differently, we want to hear it. You can contact us using any of the methods listed in the back of this report.

Who we are
Southern Health NHS Foundation Trust is one of the largest providers of mental health, specialist mental health, community physical health and learning disability services in the country with an annual income in excess of £315 million. We provide these services across Hampshire to a population of 1.5 million people, as well as highly specialised services supporting the regional and national population, and we do this with a skilled workforce of around 6,000 people.

The way the NHS is funded is a complex system, and the money we receive each year comes from many different sources, including NHS England, local commissioners and local authorities. We work very closely with all these organisations to ensure we use the funding effectively and that we deliver the care that is best for our local communities.
We operate from around 300 sites including community hospitals, health centres, inpatient units and community based services.

Our services cover:

- treatment and support to adults and older people experiencing mental illness in the community and through our inpatient services
- mental health treatment for adults and young people in secure and specialised settings.
- IAPT (Improving Access to Psychological Therapies) service
- healthcare and support for adults with learning disabilities, delivered by community teams working in partnership with local councils
- specialist learning disability inpatient services
- a diverse range of community health services, including community nurses, end of life care, diabetes services, speech and language therapy, stroke services, X-ray, pain management, orthopaedic choice, physiotherapy and podiatry
- health visiting and school nursing teams working to deliver the Healthy Child Programme across Hampshire.

During 2018/19 we have been working closely with partner organisations in Hampshire and the Isle of Wight to look at how health and social care services can be better aligned to provide person centered care. As result we have developed a new structure to services called: New Models of Care. This is in line with the national NHS agenda described in the Long Term Plan and the Five Year Forward View, both of which highlight the need for care to be delivered closer to home, within a natural community that focuses on a person’s physical and mental health needs. The aim of the new structure is to make us a better organisation to work for, with stronger leadership, clearer direction and improved morale.

As a key provider of community physical and mental health services it is essential that we are a leading partner in these changes and make sure we align our services to this new structure across Hampshire to better meet people’s needs. In January 2019 we launched a change programme that introduced five new directorates which will align our services and help us focus on delivering holistic, joined-up care to our local populations.

Our Board is made up of Executive Directors and Non-Executive Directors. They are responsible for our overall performance and our plans for the future. We also have a Council of Governors who are the ‘voice’ of local people, representing people in their constituency areas, helping us make key decisions and holding the Trust to account. As a Foundation Trust, we also have over 8,000 members drawn from local communities who elect our Council of Governors and are invited to take part in events and influence Trust developments.

**Our vision and values**

In order to become the outstanding health care provider our patients deserve, we must have a clear aim of what we aspire to, values that underpin everything we do and clear strategic objectives that set out how we will achieve our goals.
In 2017 we worked closely with our staff and partners to develop a refreshed set of values. These remain the core principles that underpin everything we do, from ward to the Board. Our values are:

**Patients and People First** - providing compassionate, safe care, listening to each other, doing the right thing, appreciating each other, delivering quality

**Partnership** - communicating clearly, supporting each other, working as a team, building relationships, making things happen

**Respect** - acting with honesty and integrity, respecting each other, taking responsibility, getting the best from our resources, doing what we say we will do

This year we have been working with our staff, service users, patients, families, carers and partners to develop a new vision and purpose for the organisation. These describe our aspirations as a Trust. They complement the values as a common thread that unite people, articulating why we do what we do, what we are working to achieve, and what people can expect from us at every level of the organisation.

**Our vision – World class treatment and care together**

**Our purpose – Holistic care in partnership that improves lives**

To achieve our purpose and ensure our service delivery supports the New Models of Care structure in Hampshire, we need our services to transform the way we provide healthcare for the better. In order to achieve this, we have launched a quality improvement programme and have finalised our organisational strategy for the next five years. This shows how we are going to bring about change and should be published in summer 2019.

Our organisational strategy is led by a set of four strategic priorities that support the delivery of our purpose and define how we achieve our goals. For each of these we have articulated what success looks like, and how we will make this happen with tangible actions. The quality priorities that are detailed in this Quality Report all fit within these four areas and can clearly be linked our direction for the organisation.

Our four strategic priorities for this year are:

**Quality** – deliver high quality, safe services that inspire the confidence of people who use or rely on them, supported by a Trust-wide transformation programme.

**People** – attract and retain people to pursue a relentless focus on improving and providing quality services to enable people to reach their full potential.

**Transformation** – transform our care models in mental health, secure services and community services to deliver great outcome for the people we care for.

**Money** – focus on eliminating waste, and increasing productivity and effectiveness, to create the financial flexibility and resilience needed to invest in the future of our services.
Dr Nick Broughton, Chief Executive of Southern Health NHS Foundation Trust

This year has been one of tremendous progress, learning and reflection, and one in which quality has been a focus at every level of the organisation. We started the year by completing our Trust Board with the addition of a new Medical Director, Chief Operating Officer and Director of Nursing, and we also welcomed three new Non-Executive Directors: Robert Goldsmith who joined in October 2018, and Michael Bernard and Kate FitzGerald who joined in May 2019.

As part of our coming together as a Board we had to be honest about the scale and breadth of change required in the organisation over the coming years. We spent time reflecting on a number of issues we face as a Trust, considering the scale of the financial challenge for us and the whole of the NHS, and recognising our considerable strengths and achievements.

In the past year we have been extremely proud to see developments in services that have made a tangible difference to our patients and service users and we would like to take this opportunity to thank our staff for their achievements and commitment this year. Some of our highlights include:

- In June we announced that the Crisis Lounge in Southampton had extended its opening hours to be available 24 hours a day, seven days a week for people experiencing mental health crisis in the city.
- In August we sponsored and marched in the Southampton Pride event to demonstrate our organisation’s commitment to equality and diversity.
- In September we held our most popular Annual Members’ Meeting to date, and proudly featured a collection of talks, performances and displays from staff, service users and carers.
- In October we were able to start treating older people in the New Forest in their homes thanks to the launch of partnership project Frailty Cars, and we also launched Chat Health, a text message support service for parents and carers of children under five.
- In December we celebrated some truly wonderful staff through our annual Star Awards ceremony.
- In January Bluebird House was selected for a £45,000 grant to transform its clinical environment with extraordinary artworks by world-class artists, in collaboration with the unit’s staff and young patients.
- In March we worked with partners to launch a team working in the 111 call centre to provide 24 hour mental health support for callers in Hampshire and the Isle of Wight.
- Throughout the year we have helped grow the number of GP surgeries across Hampshire achieving Learning Disability Friendly status with training and advice.
- We have seen many teams win national awards, including the tissue viability team, research and development team and the falls team.

It has not all been celebration however. Some of the challenges of the past year have included our response to past failings or serious incidents. This includes prosecution by the Health and Safety Executive in March 2018, the findings of our staff survey, feedback from our patients, carers and families, findings from inspection reports and national reports, and how we compared to some of the
best NHS Trust’s in the country.

These have highlighted that we still have significant improvements to make in a number of key areas, such as improving quality, safety and consistency of care, how we involve people in their care, joining up care across our own or partnering services, supporting our workforce better, and transforming care pathways to better fit patient’s needs.

These are the areas that we have been working on over the last 12 months with our 6,000 staff. We often spend time with our staff and we know they are compassionate, skilled and dedicated people who have chosen to work in the NHS because they want to make a difference. They give us a strong foundation to build upon.

It's also important to note the many areas in which we have already seen our services begin to develop.

This work has been recognised through a number of key milestones this year:

• In June 2018 NHS Improvement lifted some of the regulatory undertakings placed on Southern Health following the Mazars report published in 2015. Independent scrutiny found significant improvements in the way the Trust now investigates and reports patient deaths and involves family members in this process as well a culture of increased openness and transparency.

• Our re-inspection by the Care Quality Commission in the Summer showed evidence of widespread improvements across the organisation. Whilst the Trust’s rating remained as ‘requires improvement’, over 76% of service areas are now rated as good or outstanding.

• In the Autumn, we received the results of a national survey which annually benchmarks the experiences of people using community mental health services. Overall our patients’ experience rating was 73%, 5% higher than the national average, of those surveyed, 88% considered Southern Health (compared to the national average of 83%) treated them with dignity and respect.

• In November our regulator, NHS Improvement confirmed that Southern Health had been removed from the category of NHS Trusts requiring specific additional oversight, after being encouraged by the results of our CQC inspection.

• In March 2019, the results of our national staff survey showed significant improvement in a number of areas. More staff completed the survey than ever before, and our staff told us they now feel more engaged, with our score now in the top third of NHS Trusts.

We know we still have more to do and there will be further challenges ahead, but we firmly believe we are well on the way to creating a culture and organisation that our patients and their families deserve.

Creating the right culture requires strong, stable and effective leadership and earlier this year we started the process of restructuring the organisation. This moves from our current divisional structure to one made up of a number of locality and speciality specific directorates. Each of these are led by a Clinical Director who continues to work in their own clinical speciality. As we write this report we are putting in place the management teams to support each directorate and hope to have these in place later on in the spring.

One of the most exciting things to see this year was the progress we have made in relation to quality improvement. We are implementing a systematic approach to transforming our services, and to date we have a small group of specialist coaches leading the work and supporting their colleagues to
learn and run projects all over the Trust. Over 60 members of staff have undergone intensive quality improvement training and are now implementing over 20 projects intended to redesign how we work and improve how we deliver services.

A key part of transforming our services is to better involve our patients and carers. We made a key appointment with our first Head of Patient and Public Involvement in the summer, and this has helped us drive through a number of improvements such as the establishment of our Working in Partnership committee, which helps us gather feedback from patients, service users, carers, voluntary sector and community groups.

We have also been pleased to welcome three experts by experience; people who have used, and indeed are using services and can use their insights to bring a new perspective. They are developing how we involve patients, carers, families and staff in Trust projects, and all three have made great strides in ensuring patient voices are heard in a meaningful way.

The next 12 months are certain to be busy, and I’ve no doubt that alongside our continued progress there will be new challenges for us to face. But I am clear however, that Southern Health has what it takes and is heading in the right direction to become an organisation that consistently delivers truly outstanding care to our patients and service users.

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.

Signature:

Dr Nick Broughton
Chief Executive
23 May 2019
Our five-year strategy

**Vision**

Our ambition

**Purpose**

Why we exist

**Strategic priorities**

What we will do to deliver our vision

**What will success look like?**

By 2024 we will have achieved:

* An outstanding CQC rating that creates confidence in our services
* A culture of continuous quality improvement
* Top 10% rating nationally for patient safety, experience and outcomes
* Measurable reduction in suicide of people who rely on our services

Key actions we will take in 19/20

In year one we will have delivered:

* Our CQC, regulatory requirements and quality priorities
* A zero suicide approach and full implementation of the Triangle of Care
* Elimination of mixed sex accommodation
* Six quality improvement (QI) coaches, 60 trained facilitators, 600 staff actively involved, 6000 staff engaged, 12 QI projects delivered
* Greater positive participation of people in their care

**World class treatment and care, together**

Holistic care in partnership that improves lives

**Improve value**

* No patients receiving care out of area
* Efficient and effective use of resources and improved outcomes as a result
* Reduced variation in practice and waste

**Improve health and wellbeing through outstanding services**

* A vacancy rate of 5%
* Reduced violence and harm towards staff by 50%
* A workforce that is representative of our local community at all levels
* Top scores in the NHS staff survey
* Leadership for mental health across the Hampshire and Isle of Wight system
* Capacity and capability to deliver priorities

**Become the best employer**

* Innovative care for children and young people
* Whole person, evidence-based care for the populations we serve
* Improved access for people in crisis

**Transform services through integration and sustainable partnerships**

* Redesign of secure and children's services
* Improved crisis care, single point of access and national standards in mental health care
* Improved community services across Hampshire
* A plan for needs-led, integrated physical and mental health services
* A plan for services based around primary care
* Integrated intermediate care for frailty and long term conditions

**Our values**

* Patients & people first
* Partnership
* Respect

* New pathways for dementia, psychosis and perinatal services
* Our financial targets including cost improvements
* Effective use of our estate and digital solutions
Part 2: Priorities for improvement and statements of assurance from the Board

For 2018/19, NHS Improvement specified that foundation trusts must have at least three indicators, which we refer to as quality priorities, in the following categories:

- improving patient safety
- improving clinical effectiveness
- improving patient experience.

These quality priorities have been selected on the basis of feedback from our patients, stakeholders and staff and are approved by the Trust Board. They have been selected as part of the wider development of the Quality Improvement Strategy and will help enable us to deliver the Trust strategy as well as meeting the requirements of the NHS Long Term Plan.

The delivery of these priorities is monitored by the Board through the Quality and Safety Committee. This is underpinned by our working groups for Patient Engagement, Caring, Clinical Effectiveness and Patient Safety, which all have clinical representation.

We have also been working on a new five year Quality Improvement strategy. For the first time, the new strategy brings together the areas of:

- quality improvement methodology
- quality planning
- quality control
- quality assurance.

All of this work contributes to how we will continue to improve and develop our services to achieve our long term goals. In order to see what these goals are, and how we will use the next 12 months to progress towards them, the following image sets out our objectives. These are combined from the quality priorities detailed in this report, actions raised as part of our CQC inspection, our Trust strategic priorities and those identified as part of local and national schemes and external reviews.
- Trust priorities
- Quality Account priorities
- Commissioning contracts
- Service specifications
- KPIs

- Quality dashboard
- Quality metrics
- Patient experience feedback
- Outcome measures
- Quality assessment tool

- QI tools
- Training, coaching
- Transformation programmes
- Small change projects
- Conferences
- Learning & sharing events

- Clinical audit
- Peer review
- NICE guidance
- Accreditation process
- External reviews
Section 2a. What is a Quality Report?

Quality is at the heart of everything we do at Southern Health and this is reflected in our Trust values, our plan and supporting strategies. For us quality is evident in knowing we have delivered the best care at the right time and in the right way for each person, treating them as individuals, resulting in the positive outcomes for our patients.

We want to be able to reduce unnecessary processes, reduce waiting times, improve people’s experiences of the Trust, and empower people to make improvements where they work or receive care. All of these things are indicators of quality for us, and alongside data collection and measuring outcomes we can see if we are achieving our objectives and giving people the best possible service as a healthcare provider and as an employer.

In order to improve how we deliver services and fit in with the wider system changes around the New Models of Care, we have had to begin a large scale transformation of how we work as an organisation. Fundamental to this has been the engagement of service users, carers, families and staff; as active participants in the design, delivery and monitoring of our services and this is reflected in our quality improvement programme.

Beginning this work has meant a shift in culture, in giving our employees the autonomy and confidence to make changes where they know that outcomes for patients can be improved, and involving our patients in developing these changes. Our staff, patients, service users, their carers and families are the experts in what makes a good healthcare experience, and therefore best placed to come up with the ideas and plans for making the right changes within our legal framework.

A main focus for the Trust this year has been in better engaging our service users, patients and carers. We are committed to working together in partnership with people to ensure the services we provide are of high quality and are delivered in a comfortable, caring, compassionate and safe environment.

It is vital we use the insight gained from our local communities in a robust and meaningful way. There are already many examples of great practice in this area however it is not something that is consistent across all our areas, and we are improving this through establishing our first Head of Patient and Public Engagement role in 2018, providing a renewed focus on how we work and engage with patients, carers and families.

In July 2018 we held a stakeholder workshop to reflect and revisit on our current strategy. This has allowed us to update our plans for the year ahead, which has included:

- re-establishing the Families First group
- establishing a Trust-wide Working in Partnership Committee
- co-producing an organisation plan for carers and their families
- producing materials for carers and staff
- establishing a patient and public involvement leads internal network
- working with external partners to agree plans and opportunities for joint working, e.g. Healthwatch, Hampshire County Council, CCGs
- developing a peer support framework
- agreeing a plan of engagement work with a young people’s social enterprise looking at experiences of mental health.

We are also really proud to have begun a new approach to working more closely with our service users, and this year we have made three new appointments. The first joined the Trust as an Expert
by Experience in August 2018, working with the Transformation Team. Having undergone training to be a Quality Improvement Facilitator, he is leading projects that are changing how we deliver services across the Trust, and supporting others as they learn and develop too. He has also experienced many different services as a patient, including some of Southern Health’s, and has worked as a Peer Support Worker. He supports the involvement of service users, patients and their carers in a variety of projects and working groups across the organisation, using his insight to bring a new perspective and ensuring patient voices are heard in a meaningful way.

In January 2019 we were joined by two user involvement facilitators. One is working with our Mental Health and Learning Disability services and the second is working with the Integrated Service Division. Both are collecting ‘real time’ feedback from our service users and using this to drive changes. They have also been instrumental in working with us in developing the Smoking Cessation Policy and solutions to a number of other issues for our service users, including the development of a more robust Peer Support network.

**How do we measure quality?**

Our strategic priorities are translated into key objectives and measures. These are given clearly defined metrics, thresholds and ratings for each business unit, team and individual. There is regular oversight through reports and performance meetings at each level (individual, team, business unit and Trust-wide) with a clear approach for escalation.

This year we have also commenced implementation of a revised Performance Management and Accountability Framework. This focuses on using information and analysis to identify risks and trends by using performance management dashboards to bring together quality and safety, finance, performance, and workforce indicators. This will provide triangulated information and analysis for our business units, divisions and Board to scrutinise. Measurement is not just about performance metrics, it is also about learning. We use a wide variety of information from different sources, both quantitative and qualitative, to gain a better understanding of the care we deliver and to share improvements and challenges across the organisation.

Listening to feedback from our staff, patients, service users, their carers and families, Governors and members allows us to look at the effectiveness and quality of our services. We use the Friends and Family Test, the Staff Survey, any compliments, concerns or complaints received as well as discussions from our patient experience working groups and events, site visits, and Patient Led Assessments of the Care Environment (PLACE) inspections. All of this is used to help measure the quality of care we deliver and shape services.

**Improvements in data quality**

During 2018/19 we committed to make further improvements in data quality through the following initiatives:

- Clinical validation of one Board-level clinical Key Performance Indicator (KPI) per month to ensure reported performance is supported by robust and reliable clinical documentation.
- Data quality kite-marks have been incorporated into our Integrated Performance Report and audited on a monthly basis. This allows us to assess levels of data quality for each Board KPI.
- We have the additional monitoring of patient-level validation lists which are now available daily. These extend to clinical measures such as risk assessments, outcome measures and clinical assessment forms.

This has also led to the content and presentation of Board performance reports to be improved. There is now more robust assessment and assurance including detailed reviews of areas of concern, improvement trajectories and benchmarking against other relevant Foundation Trusts.
Evidence of our progress so far
So far we have discussed developments in how we plan and measure improvements in service delivery and quality, and a change in our approach to how we meet patient needs and involve them in their own care planning for better outcomes. It is also important for us to acknowledge our history as an NHS Trust, and progress in some specific areas. As we begun this financial year we had recently been prosecuted by the Health and Safety Executive for failings relating to the deaths of two patients in 2012 and 2013. We pleaded guilty to the charges and fully accepted the findings.

These patient deaths and the subsequent investigations and findings have been catalysts for huge change across all of our services. However, the job of improving safety and quality is never complete and it remains our highest priority.

An external audit in 2018 assessed our progress against the recommendations made in the 2016 Mazars report. This resulted in our regulator, NHS Improvement, lifting some of the regulatory undertakings against the Trust. The audit found significant improvements in the way we investigate and report patient deaths and involve family members in this process, as well as in creating a culture of increased openness and transparency.

Throughout June and July 2018 we underwent a full comprehensive inspection by the Care Quality Commission. This was the first comprehensive report into the Trust since 2014. Whilst our rating remained as ‘requires improvement’, overall the CQC found many signs of progress across the organisation with over 76% of service areas now rated as good or outstanding.

All of our community services are now rated good. In addition, three of our services now have outstanding ratings; Perinatal Mental Health Services, Long Stay Mental Health Rehabilitation Wards for Working Age Adults (Hollybank and Forest Lodge), and Wards for People with Learning Disabilities (Willow Assessment and Treatment Unit and Ashford Ward). The report also reflected the significant strides we have made to improve how we engage with families and carers and that staff feel more valued and supported.

There were also areas where we have more work to do. The services which remain as requiring improvement are typically those where we have some of our greatest staffing challenges. This is especially the case in our Older Peoples Mental Health wards and we took the difficult decision to temporarily close Beaulieu Ward at the Western Community Hospital in November 2018 for a period of six months.

As part of the inspection we were served with a warning notice under Section 29A of the Health and Social Care Act 2008. The notice was in relation to two locations; Bluebird House and Leigh House. At the time of the inspection the CQC felt that we did not have sufficient staff to ensure the safe care and treatment of the young people at these locations. On an unannounced inspection a few weeks later the CQC found that significant improvements had been made and as such, they lifted the warning notice.

The CQC also identified several other areas for improvement and issued us with seven Requirement Notices. A quality improvement plan was developed to address these areas. The plan focuses on themes with a work stream approach to understand and address root causes with quality improvement methodology being used to support the improvements. Improvement actions are monitored through the weekly Quality Improvement Plan Delivery 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.
Some of the improvements already put in place include:

- greater involvement of patients and families in investigations
- how we use patients’ and families’ views about their experience to improve care and services
- increased use of Store & Forward (using and gathering patient information offline to overcome any connectivity problems) within community teams
- improved recruitment and retention processes
- extensive programme of estate improvements and ligature reduction works
- roll out of Supporting Safer Services (sSs) training
- new My Crisis and Safety Plans developed with user and carer involvement
- increased use of Store & Forward (using and gathering patient information offline to overcome any connectivity problems) within community teams
- risk assessment training e-learning package launched
- improved working with local GPs to improve learning disability patients access to regular health checks
- improved end of life training and competencies
- opening of the Crisis Lounge at Antelope House to provide a 24/7 service.

What is a Quality Report?
The quality of services is measured by looking at patient safety, the effectiveness of treatments that patients receive, the outcomes achieved as a result of treatment and patient feedback about the care provided. Patients want to know they are receiving the very best quality of care, and producing a Quality Report helps us to improve public accountability in the care we provide.

NHS healthcare providers are required to publish a quality account each year by the Health Act 2009, and in the terms set out in the National Health Service (Quality Accounts) Regulations 2010. NHS Improvement also requires all NHS foundation trusts to produce Quality Reports as part of their annual reports. The Quality Report incorporates all the requirements of the quality accounts regulations as well as additional reporting requirements.

The Quality Report is also an opportunity for us to honestly address the current state of our services; to show where we are making improvements, and in other areas where there is still more work for us to do. The collection of data, reflection on the past year and planning for the year ahead allows us to take stock of what we have achieved, the changes we have successfully embedded, and where further improvements might be needed. It provides assurance for us, our patients and service users, their carers and families, and for our stakeholders.
By 2024 we will have achieved:

- An outstanding CQC rating
- A culture of continuous quality improvement
- Top decile rating nationally for patient safety, experience and outcomes
- Measurable reduction in suicide of people who rely on our services

During 2019/20 we will deliver

**Safe**
- Trust wide
  - Compliance with safer staffing requirements (CQC)
  - Improved trust wide learning events (QA, CQC)
  - Improved provision of equipment for community users (CQC)
  - Full implementation of the Triangle of Care (SP)
- MH/LD/OPMH services
  - Implement NEWS2 & PEWS2 for improved recognition and management of the deteriorating patient to MH/LD/OPMH (QA, EXT)
  - A zero tolerance approach to suicide (SP)

**Effective**
- Trust wide
  - Catheter care – prevention of urethral erosion (QA)
  - Improved staff supervision processes (CQC)
  - The new operational organisational structure (SP)
- MH/LD/OPMH services
  - Care pathways which are evidence based 
  - Follow NICE guidance (SP, QA)
  - New pathways for dementia, psychosis 
  - Perinatal services (SP)
- LD services
  - Implementation of the communication standards toolkit (QA)
- ISDs
  - Implementation of Making Every Contact Count (MECC) (QA)

**Person Centred**
- Trust wide
  - Complaints process improvement plan (CQC)
  - Improved recording of DNACPR decisions (CQC)
- MH/LD/OPMH services
  - Improved quality of risk assessment, care plans and crisis plans ensuring they are personalised (QA, CQC)
- The new operational organisational structure (SP)
- Elimination of mixed sex accommodation (SP)
- ISDs
  - Intermediate care pathways for frailty and long term conditions (SP)

**Timely**
- Trust wide
  - New leadership development, revised workforce planning, improved recruitment & retention processes (SP, QA, CQC)
- The QI Strategy (EXT, CQC, SP)
- 6 QI coaches trained and leading the QI programme (SP)
- 60 trained QI facilitators (SP)
- Completed 12 transformation projects & 28 small scale projects (SP)
- At least 600 practitioners (SP)
- 6000 staff engaged in QI
- MH/LD/OPMH services
  - Increased access to psychological therapies (QA, CQC)

**Efficient**
- Trust wide
  - Collaborate with local communities to reduce suicide (QA)
  - Plan for care models based around primary care (SP)
  - Plan for an ageless, integrated physical & mental health (SP)
- The QI Strategy (EXT, CQC, SP)
  - 6 QI coaches trained and leading the QI programme (SP)
  - 60 trained QI facilitators (SP)
- Completed 12 transformation projects & 28 small scale projects (SP)
- At least 600 practitioners (SP)
- 6000 staff engaged in QI

MH/LD/OPMH services
- Increased access to psychological therapies (QA, CQC)

**Equitable**
- Trust wide
  - Collaborate with local communities to reduce suicide (QA)
  - Plan for care models based around primary care (SP)
  - Plan for an ageless, integrated physical & mental health (SP)
- The QI Strategy (EXT, CQC, SP)
  - 6 QI coaches trained and leading the QI programme (SP)
  - 60 trained QI facilitators (SP)
- Completed 12 transformation projects & 28 small scale projects (SP)
- At least 600 practitioners (SP)
- 6000 staff engaged in QI

MH/LD/OPMH services
- Increased access to psychological therapies (QA, CQC)

Legend
QA – Quality Account priority
CQC – priority resulting from CareQC inspection
SP – Trust Strategic priority
EXT – external reviews / national initiative
Section 2b. Priorities for improvement in 2019 and 2020

How we decided our quality priorities for the next 12 months
In order to agree the areas to focus on for our quality priorities in 2019/20, we sought the views of our patients, carers, staff, governors and stakeholders in a number of ways over a four month consultation period.

Suggested quality priorities were put forward based upon our progress against the 2018/19 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. This was also communicated to our staff via our electronic Weekly Bulletin. Postcards asking for suggestions for inclusion were circulated at numerous events including:

- quality and safety meetings through all divisions
- Council of Governors meetings
- the ‘Families First’ group
- through poster presentation and suggestion boxes in 20 of the reception areas of Trust buildings across Hampshire.

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 2019/20.

We will be following the guidance from NHS Improvement given last year and setting three quality priorities, with sub priorities in each of these areas, as set out below:

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

- improving patient safety
- improving clinical effectiveness
- improving patient experience.

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<tr>
<th>Improving patient safety</th>
<th>Staffing</th>
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<td></td>
<td>NEWS2 and PEWS in mental health inpatient services</td>
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<td>Learning events</td>
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<td>Improving Access to Psychological Therapies (IAPT) rollover</td>
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<th>Improving clinical effectiveness</th>
<th>Catheter care for physical health patients</th>
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<td>Care pathways in adult mental health services</td>
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<td>Wound management in physical health services</td>
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<td>Working with local communities to reduce suicide</td>
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<tr>
<th>Improving patient experience</th>
<th>Personalised care planning in mental health services</th>
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<td></td>
<td>Making Every Contact Count within physical health services</td>
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<tr>
<td></td>
<td>Communications standards within Learning Disabilities services</td>
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</table>

Progress in our quality priority work will be reported quarterly to the Quality and Safety Committee that reports to the Trust Board.
Priority 1: Improving patient safety

Priority 1.1 Staffing, Trust-wide
There is now considerable evidence from both the NHS and further afield that creating a culture (the way we think, behave and act) where people feel supported and enabled to thrive is the most effective way to achieve the best outcomes for the people using our services.

Safe staffing is a priority for every NHS Trust, with the recruitment and retention of quality staff a key factor. We recognise that the recruitment of doctors and nurses is challenging across the whole of the NHS, and we feel these same pressures. We have developed a five year people and organisational development strategy to address these challenges. This includes supporting current staff to develop, providing defined career pathways, succession planning and the Board’s commitment to our people in making our organisation a great place to work.

Aim
Attract and retain people to pursue a relentless focus on improving and providing quality services to enable people to reach their full potential (patients and staff).

How will we do this:
Effective leaders who can adapt to deal positively with different situations in order to motivate and energise their teams, are fundamental to instilling an organisational culture where staff are engaged to deliver services of the highest possible standards. We will set up a collaborative leadership programme to ensure our staff work in an environment where they can develop and fulfil their aspirations and develop a culture of compassionate leadership. The programme will be rolled out across the Trust and be accessible to all staff regardless of role or banding. We will review and evaluate our education/learning impact across the Trust and look to extend partnerships in order to increase opportunities for training.

Through our ongoing quality improvement project we will continue to work on achieving a sustained reduction in the lead time for recruitment to reduce delays felt by recruiting staff and potential candidates, to improve the experiences of all parties.

How will we measure this:
We will review the staffing levels through the Retention and Recruitment group. They will be looking at trends and themes of why people may be leaving the Trust, information obtained from exit interviews and feedback from managers. The “acuity and dependency” tool will continue to be used to ascertain required staffing levels; this will remain a collaborative process in order to ensure that we have sufficient staff to provide safe and therapeutic care to our patients.

We will also monitor the numbers of staff taking part in the collaborative leadership programme and review their feedback to measure its effectiveness.

The annual NHS staff survey for the Trust has been amended for the coming year with two additional questions which will allow for a staff culture measurement. This will be monitored for the impact of future staff health and wellbeing activities.
Priority 1.2 NEWS2 and PEWS for mental health division

NEWS2 and PEWS (National Early Warning Score and Paediatric Early Warning Score) are tools developed by the Royal College of Physicians. They involve monitoring a range of physical measures such as blood pressure or temperature to identify when a patient’s condition is deteriorating.

The NEWS2 tool has been used in our physical health services for the last year, however it is not currently used in mental health or learning disability services. We know that people with a mental illness or learning disability may suffer from more physical health problems, resulting in more illness and mortality than the general population. As such, monitoring physical health is essential in order to address any signs of deterioration early and offer appropriate interventions. The existing widely used tool is called ‘Track and Trigger’.

Aim:
To create consistency and better communications across all divisions, the mental health and learning disability divisions will begin use of the nationally recommended NEWS2 and PEWS model.

In situations where a patient requires transfer to an acute service these tools will be more familiar and help for quick treatment and support to be put in place. It also benefits the Trust by having a set of consistent tools and enables easier movement of staff between wards and services. The initial focus for this year is on the roll out of the tools to inpatient units, with community services to follow in 2020.

How will we do this:
We will carry out a phased roll out of training across Mental Health and Learning Disabilities teams. Trained NEWS2 and PEWS champions will be identified in each inpatient unit to assist their colleagues with specialist knowledge in how to complete the forms and the impact of the tool.

We recognise that sometimes it is not appropriate to complete tactile observations on some of our patient groups, such as those who are acutely unwell or who find physical contact distressing; therefore we are also launching a non-contact observations framework that will allow staff to identify when deterioration may be occurring from a series of visual prompts.

How will we measure this:
Staff training on the tool will be monitored, and we expect to see active use in the latter half of 2019 on inpatient wards. Following the roll out we will also audit the tool to establish if any amendments or further support is required for use within the mental health or learning disability divisions, and this will include embedding lessons learnt between wards. Feedback from the champions on each ward will also help establish if staff are confident in using the tool and where best practice or areas for development can be shared with others. If gaps are identified then assistance will be given by the champions with support from the Trust Resuscitation team.
Priority 1.3 Trust wide learning events

We want to be a world class health organisation, and ensure the outcomes we help to deliver for our patients are always of the highest standard. In order to do this we need to achieve continual improvement in patient safety and experience, using feedback from our staff, patients, their carers and families.

Aim:
Wherever there is an opportunity to learn from incidents, new practices, or changes in process, we will ensure these updates are shared across the Trust in a variety of ways. Learning events are an effective way to share information, and we will hold 12 of these throughout the year in different forms. These events will provide the space to openly discuss different issues, explore new ways of working and hear from colleagues, patients or their carers to provide new perspectives and create an open dialogue around how we learn and make improvements in our services. It is important to note that our learning events will be open to all stakeholders, including staff, patient representatives, external services and the third sector where applicable. Events will also cover the wide geographical area of the Trust to provide access for people wherever they live or work.

How will we do this:
Events will happen throughout the year, and will either be held as regular learning events within divisions, or to highlight specific areas of work. The regular events will have themes based on incidents that might have happened, feedback or complaints from patients or carers, or trends in data. Some of the more focused events will cover suicide awareness and prevention, projects taking place within the Transformation programme, and Patient Experience. Teams can also suggest topics, and generate discussions with colleagues that ask ‘could it happen here?’

The events will be publicised in a variety of ways, including on the staff intranet, the Trust website, corporate social media channels and also highlighted in the weekly bulletin, with some of the events targeted at speciality services. This will not exclude those who want to learn more about the service and apply knowledge in other areas.

Due to the geographical area that the Trust provides services to, and the busy nature of many of our teams and units, we understand that it may be difficult for staff to make the events that are relevant or of interest to them, so we will also use webinars and videos in order to ensure the learning information is accessible after the event.

How will we measure this:
The number of learning events will be monitored, as well as the number of attendees, how many people engage with videos or webinars, and the feedback received afterwards. With the expansion of these learning events we are optimistic this will improve the culture of the organisation and provide more opportunities for people to learn and develop. We do not expect that the events will result in the reduction of patient safety incident reporting, and may even create an increase because we foster a positive culture in relation to reporting incidents. We expect to improve patient safety by this programme of looking at potential gaps in our care and how we share learning with all our colleagues and stakeholders.
**Priority 1.4 Improving Access to Psychological Therapies (IAPT)**

This priority is being carried over from the previous year’s quality priorities and relates to improving access to psychological therapies for patients in adult mental health wards. Although we have made some progress in the last year, we have not achieved all the areas we identified, and we feel it’s important to continue making all the improvements we set out in 2018.

This priority will have some cross over with the staffing priority (quality priority 1.1 on page 137) because it requires the recruitment of more psychologists to deliver therapeutic interventions to our patients. It is identified the use of psychological therapies can have a significant effect on the management of anxiety and depressive disorders. This is supported by the Five Year Forward View, which includes the need for timely access to psychological therapies within mental health services.

**Aim**

Improve timely and consistent access to psychological therapies for our adult and older persons mental health service users.

**How will we do this:**

We will have a two pronged approach to this quality priority. First to improve the retention and recruitment of psychologists, and second to conduct a review of existing waiting times to identify improvements across the Trust.

Recruitment to psychology posts is challenging due to the current employment market. We will review the current career pathway for psychologists to ensure we nurture and retain talented staff.

We have reviewed the current process for the recording of waiting times, and there are different processes used across our mental health services. We will carry out further investigation to identify the reasons for this and what changes are needed to create consistency and parity across the services, to ensure that no patients wait longer than they need to.

**How will we measure this:**

We will review and monitor feedback from psychologists and the numbers of people joining or leaving these posts in order to measure an improvement in the availability of specialist support for patients.

The waiting times to receive psychological therapies will be monitored to ensure equity across services and so that we can see where improvements are being made, or where some teams may need more attention. This will help in achieving the same experience for all patients who need support from this service.

We have also identified that sometimes having to wait to receive psychological therapy is a factor in relation to serious incidents, therefore we will be monitoring these incidents where they do occur in order to reduce or eradicate the waiting time as a factor, unless the wait is clinically appropriate.

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**Priority 2: Improving clinical effectiveness**

**Priority 2.1 Catheter care for physical health patients**

Patients in hospitals or at home may require the use of a catheter to support them with a range of health conditions. During 2018/19 we identified an increase in reported incidents of urethral erosion due to the use of a catheter as a medical device; however analysis of these incidents has shown no
themes or common factors. There is also no national guidance or research into this issue, and yet we know it is the cause of considerable pain for patients, often with lasting physical and psychological effects.

Without early identification and treatment, in the worst cases it can require reconstructive surgery or urinary diversion. We are clear that incidents of urethral erosion due to the use of a catheter are entirely preventable, and we will focus on reducing these incidents across the Trust.

**Aim:**
Our aim is to increase awareness and understanding of urethral erosion issues, to share this knowledge and develop preventative measures.

**How will we do this:**
Working with the University of Southampton Health Sciences department to develop a collaborative research project in order to further our knowledge and understanding of urethral erosion, how we can prevent incidents and better identify risks and early warning signs. Recruitment of a PhD student is expected over the summer months ready to begin in the new academic year.

This project will give us a detailed analysis of incidents. The outcomes will be shared with staff across the Trust, and used to develop clearer education materials and care advice for staff, patients and carers. The evidence from this project will also be used to develop an accurate grading of harm.

Due to the lack of existing research, we believe this project will be pioneering in the NHS, and will be shared to support colleagues working at various levels of the health and social care system. The outcomes will be used to develop clearer education materials and care advice for staff, patients and carers.

All occurrences of urethral erosion are reported as incidents on Ulysses to allow for accurate monitoring, continued analysis, and identification of best practise and to further support development of a grading scheme.

In addition, we have begun work to update catheter guidelines for staff use, and to update the formulary used to advise on the best products for quality. We will also work with some of our stakeholders to produce education materials and a training package to ensure staff, patients, families and carers can access information that will give them the knowledge to prevent or ensure early detection of urethral erosion and reduce possible patient harm.

**How will we measure this:**
A patient / carer questionnaire will be developed to assess the knowledge and confidence of patients and carers in their ability to identify and prevent catheter harm for patients with long term catheter use.

It is expected that alongside more education and understanding of the symptoms and issues, the number of patient safety incidents reported as a result of catheter use will increase in 2019/20, and the level of harm reported will decrease.

The level of awareness amongst staff will be measured through numbers of staff who attend or watch training sessions, and the number of people who visit specific web pages on catheter care.
Priority 2.2 Care Pathways in adult mental health division

As a Trust we are moving how we manage and treat the health problems people experience from traditional patient ‘clusters’ (where people with similar symptoms or experiences are given similar treatment) to clinical care pathways, that will provide individualised patient care and improve outcomes. A care pathway provides a ‘map’ of the care a person will receive, and each one is unique to the individual, and importantly can be used by any professional, reducing the need for repeated assessments or appointments across different services. We recognise that a patient’s physical symptoms or social situation can have an effect on their mental health, and as such the care given should be holistic and recovery focused.

Aim

We will build on existing care pathways to ensure they are used consistently, are effective and measurable. This priority has been identified by mental health services as requiring significant work, which has also been supported by our local commissioning colleagues.

How will we do this:

The pathways we are using within mental health services are evidence based and NICE approved. Currently the pathways are in place but have not been evaluated to identify the impact on patient outcomes in a measurable way, so carrying out these evaluations will be a key factor of our analysis over the next year. This work will be overseen by the Care Pathways Group.

Ensuring the care pathways are effective will require good relationships with colleagues across the Trust and partners in other agencies. Many people who seek support from our mental health services suffer due to issues such as housing, relationships, finances or poor nutrition. It is our responsibility to consider every aspect of a person’s life, recognise where they may need extra help or support and know where they can get that from.

In order to monitor the impact of the care pathways on patients we will record a baseline measurement of both DIALOG \(^1\) and HoNOS \(^2\) and then compare these with the same measurements taken in relation to every episode of care, to see if the person is experiencing a positive or negative outcome, and why this is. We will also publish our pathways so that staff, patients, carers and family members are aware of what the pathways are, and can familiarise themselves to understand what comes next in a person’s treatment, or ask questions of clinicians and support workers if they need to.

How will we measure this:

We will compare the data for episodes of care from the beginning to the end outcome. We will also work collaboratively with our commissioning group colleagues, who will be carrying out quality visits to hear about people’s experiences and feedback on the impact of the care pathway.

\(^1\) A patient reported outcome, conducted by a questionnaire with the patient
\(^2\) Health of the National Outcomes Scales
**Priority 2.3 Wound management within the Integrated Services Division**

This priority will build on the wound management work from 2018/19 to reduce patient discomfort from chronic wounds. Wound care is the third largest cost to the NHS after diabetes and cancer care, and was valued at £5.3 billion in 2016. We know that living with a chronic wound has a serious impact on patients’ quality of life, including physical and psychological stresses, and limitations to their lifestyle.

**Aim**

To support staff to complete appropriate patient risk assessments and care plans in order to improve early recognition of the risk of pressure ulcers and wounds to improve clinical outcomes for patients.

**How will we do this:**

The highest number of incidents reported in our physical health services in 2018/19 was related to pressure ulcers. This year we carried out a quality improvement project with the aim of reducing both the number of pressure ulcers developing under our care and the levels of harm. The outcomes of this project will continue to be implemented, including the roll out of improved mandatory training and guidance for all relevant staff. In order to provide effective wound care we will support teams to complete patient records at the point of care, carry out timely risk assessments and care plans in partnership with the patient and we will use clinical supervision to identify and embed learning.

The completion of a full wound assessment at the earliest opportunity facilitates timely healing and minimises patient discomfort. By ensuring our teams are better equipped and supported, through training and updated guidance materials to use while working on a ward or in the community, we expect for less incidents and patient harm to be reported.

**How will we measure this:**

The number of staff who attend training and receive the guidance materials will be monitored. We will review incidents of pressure ulcers and chronic wounds to assess if there is a reduction in the level of harm. We will monitor full wound assessments to ensure that the assessments are holistic in nature and collaborative, with input from the patient, carers and family members (if the patient wishes them to be involved).

**Priority 2.4 Collaborating with local communities to reduce suicide**

When a person takes their own life it is a tragic event that can have a dramatic impact on all of those involved; family, friends, colleagues and any healthcare professionals involved in their care. In recent years Mersey Care NHS Foundation Trust have led the way in aspiring to eliminate suicide, and we agree with their principle that suicide should not be viewed as "inevitable or unavoidable for anyone within our care".

The Five Year Forward View for Mental Health, published in 2014, 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.

**Aim**

As a Trust we are signed up to the Zero Suicide Alliance, with an aim to reach a point where no one in our services takes their own life. In order to begin meeting this target we aim to reduce the rate of suicide of our service users by 4% in this financial year based on April 2016-March 2017 data. We will then reduce the rate by a total of 10% by 2021.
How will we do this:
We will be creating a small working group in order create a Zero Suicide Strategy, to explain the steps we will take to achieve our aim. We will improve by learning from each tragic death in a multi-service manner, which means we will share the outcomes of investigations with staff across the organisation to help build awareness, understanding, and embed a culture that will support our aim of recording zero suicides. A vital part of this work will to be through our Family Liaison Officer, to continue using views of families and friends as part of how we learn from incidents and improve our services.

How will we measure this:
We will continue to ensure all suicides or suspected suicides are reviewed. In order for suicides to be prevented we understand that it is essential to have robust and available crisis provision to support patients and as such we will be reviewing our current models in order to provide an optimum crisis service. Further detail can be found on page 185.
## Priority 3: Improving patient experience

### Priority 3.1 Personalised care planning within mental health division
We recognise that truly personalised care planning, which is written collaboratively with a patient (and carers where appropriate) and explores their hopes, goals and wishes, is an essential tool, balancing a person’s medical needs with their recovery goals.

**Aim**
We have made improvements to care plans with some personalised elements, but this piece of work aims to make greater strides towards truly personalised, co-produced plans across all four of our Adult Mental Health inpatient units. Once achieved, the personalised care plans will be rolled out to other mental health teams.

**How will we do this:**
Patients and clinical staff will spend therapeutic time completing their care plans together. This allows for focus on recovery objectives and on the aspirations of the patient and their family/friends/carers, taking a more holistic approach to the patient’s care.

Improvements are required to provide assurance that every patient has had their individual level of risk assessed at every stage of their journey and/or on changes to their clinical condition. A dedicated project lead will manage the process to ensure a level of momentum is maintained and that there is some accountability, and will support staff within our inpatient units to build upon skills they have already developed through peer to peer working. The lead will also oversee working groups established in each unit to ensure the new process is working well.

**How will we measure this:**
The project lead and working groups will review care plans to monitor their quality and effectiveness and identify areas for focus or support. Through feedback and patient data we can track the outcomes for patients, and how the care planning process has affected their experiences.

### Priority 3.2 Making every contact count (MECC) within the Integrated Services Division
Making Every Contact Count (MECC) is a national approach to behaviour change, and for Southern Health it’s about enabling our staff to recognise the opportunity they have through their day to day interactions with people to improve awareness of their own health and wellbeing and support prevention of ill health within our communities.

**Aim**
Embedding the MECC approach within our services has been identified by the physical health division and local commissioners as a key area of focus in the coming year. This approach empowers patients to best manage their long term health condition(s) and personal wellbeing by adopting healthier lifestyle choices and recognising treatment options available.

**How will we do this:**
We will use a train-the-trainer approach to roll out information to all staff. Hence we will start with training a mix of ward and community based staff to provide brief interventions to raise awareness, motivate and to signpost people (if appropriate) to other services. This will then be cascaded through local staff meetings and one on one support sessions. It is expected that this quality priority benefit will be seen over a two year period as staff complete training, provide guidance and for patients to follow intervention advice.
How will we measure this:
We will report on the number of staff that have received training and measure through a trajectory set out over the year. A baseline will be established regarding the number and type of visits to patients and will expect to see a reduction in patient visits in the second year of the programme. We will also review qualitative evidence through in depth case studies of both staff and patient experiences.

Priority 3.3 Communication standards - learning disabilities
People with learning disabilities may have communication difficulties, being unable to express themselves fully or understand what others are trying to say. As communication difficulties increase, behaviours that are considered challenging typically increase in frequency, intensity or duration, and this can be very distressing for both the individuals themselves and their carers or family and friends. The majority of our patients with a learning disability live in local authority care or private provider housing. The support staff who work in these units have expressed concerns in relation to how they communicate with the residents, and the need for greater support. Our Learning Disabilities teams have identified that we need to work with our non-NHS colleagues to ensure they have sufficient communication skills, so they can better support the people they work with.

A set of five good communications standards has been developed by the Royal College of Speech and Language Therapists, which are ‘reasonable adjustments to communication that individuals with learning disability and/or autism should expect in specialist hospital and residential settings’. These are listed below:

**Standard 1:** There is a detailed description of how best to communicate with individuals.

**Standard 2:** Services demonstrate how they support individuals with communication needs to be involved with decisions about their care and their services.

**Standard 3:** Staff value and use competently the best approaches to communication with each individual they support.

**Standard 4:** Services create opportunities, relationships and environments that make individuals want to communicate.

**Standard 5:** Individuals are supported to understand and express their needs in relation to their health and wellbeing.

**Aim**
To improve the communication support for non-NHS staff working with people living with a learning disability. During discussions with colleagues and commissioners it was agreed that standards one and three would be the priority for 2019/20 because they are more focused on supporting the care providers to communicate effectively.

**How will we do this:**
We will provide training to our colleagues in how to adopt the communication standards. We will supplement this by identifying communications champions in each service to support the teams. We will also identify patients who require additional communications support through communication assessment and treatment evaluations, to ensure non-NHS colleagues are able to monitor their relationships and interactions to avoid any communications challenges and increase support where necessary.

**How will we measure this:**
We will monitor the numbers of staff who take part in the training offered, and we will evaluate the training sessions to assess the feedback. The communication champions working in non-NHS services will receive additional training too. We will measure the impact to patient’s outcomes through the use of the goals based outcomes (GBO) measure which is a qualitative tool. This looks at the quality of life, reduction in challenging behaviour and health outcomes. We will also use therapy outcome measures (TOMS), which are a statistical measure.
Section 2c. Statements of assurance from the Board

The quality account regulations\(^3\) set 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 2018/19 the Southern Health NHS Foundation Trust provided and/or subcontracted 84 relevant health services.

The Southern Health NHS Foundation Trust has reviewed all the data available to them on the quality of care in 84 of these relevant health services.

The income generated by the relevant health services reviewed in 2018/19 represents 90% of the total income generated from the provision of relevant health services by the Southern Health NHS Foundation Trust for 2018/19.

2 Clinical audits and national confidential enquiries

During 2018/19 14 national clinical audits and one national confidential enquiries covered relevant health services that Southern Health NHS Foundation Trust provides.

During that period Southern Health NHS Foundation Trust participated in 86% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Southern Health NHS Foundation Trust participated in, and for which data collection was completed during 2018/19, 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.

\(^3\)SI 2010/279; as amended by the NHS (Quality Accounts) Amendment Regulations 2011 (SI 2011/269, the NHS (Quality Accounts) Amendment Regulations 2012 (SI 2012/3081) and the NHS (Quality Accounts) Amendment Regulations 2017 (SI 2017/744).
<table>
<thead>
<tr>
<th>National Clinical Audit</th>
<th>Eligible</th>
<th>Participate</th>
<th>% of required cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribing Observatory for Mental Health (POMH-UK) Rapid tranquillisation</td>
<td>Y</td>
<td>Y</td>
<td>28 cases</td>
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<tr>
<td>Prescribing Observatory for Mental Health (POMH-UK) Prescribing clozapine</td>
<td>Y</td>
<td>Y</td>
<td>172 cases</td>
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<td>Prescribing Observatory for Mental Health (POMH-UK) Assessment of the side effects of depot antipsychotics</td>
<td>Y</td>
<td>Y</td>
<td>Report due April 2019</td>
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<tr>
<td>Prescribing Observatory for Mental Health (POMH-UK) lithium</td>
<td>Y</td>
<td>Y</td>
<td>Report due July 2019</td>
</tr>
<tr>
<td>National Audit of Anxiety and Depression</td>
<td>Y</td>
<td>Y</td>
<td>100%</td>
</tr>
<tr>
<td>National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Chronic Obstructive Pulmonary Disease Secondary Care</td>
<td>Y</td>
<td>Y</td>
<td>Report due July 2019</td>
</tr>
<tr>
<td>National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Pulmonary rehabilitation</td>
<td>Y</td>
<td>Y</td>
<td>Due to submit in October 2019</td>
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<tr>
<td>National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Adult Asthma Secondary Care, Organisation audit</td>
<td>Y</td>
<td>Y</td>
<td>100%</td>
</tr>
<tr>
<td>National Clinical Audit of Psychosis</td>
<td>Y</td>
<td>Y</td>
<td>100%</td>
</tr>
<tr>
<td>Sentinel Stroke National Audit programme (SSNAP)</td>
<td>Y</td>
<td>Y</td>
<td>100%</td>
</tr>
<tr>
<td>Society for Acute Medicine’s Benchmarking Audit (SAMBA)</td>
<td>Y</td>
<td>N</td>
<td>(Insufficient cases)</td>
</tr>
<tr>
<td>National Audit of Care at the End of Life (NACEL)</td>
<td>Y</td>
<td>Y</td>
<td>100%</td>
</tr>
<tr>
<td>National Audit of inpatient falls</td>
<td>Y</td>
<td>Y</td>
<td>100%</td>
</tr>
<tr>
<td>National Audit of Intermediate care</td>
<td>Y</td>
<td>N (declined)</td>
<td></td>
</tr>
<tr>
<td>National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)</td>
<td>Y</td>
<td>Y</td>
<td>95%</td>
</tr>
</tbody>
</table>
The reports of 10 national clinical audits were reviewed by the provider in 2018/19 and Southern Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Examples of recent audits:

- POMH audit on prescribing for bipolar disorder (use of sodium valproate):
  - ensure all women aged 50 or under who are prescribed sodium valproate have a discussion documented in their clinical notes regarding the need for them to use adequate contraception, due to the risks sodium valproate would pose to an unborn child
  - teams will ensure that baseline weight or body mass index (BMI), liver function test (LFT) and full blood counts (FBC) are documented prior to initiation of sodium valproate. On-going monitoring of weight or BMI, plasma glucose and plasma lipids will also be documented
  - teams will ensure that patients prescribed sodium valproate receive written information about its use specifically for treating bipolar disorder
  - teams will ensure documented reviews of patients’ tolerability of sodium valproate (side effect monitoring).

Older Persons Mental Health (OPMH) Rapid tranquilisation:

- Teams to follow the Trust’s rapid tranquilisation guideline and associated rapid tranquilisation monitoring checklist.

National audit of care at the end of life:

- committee is developing a feedback form to capture information from those who have been bereaved on their experience
- communication training will be introduced to staff delivering end of life care
- the Trust end of life strategy is being refreshed
- bereavement literature across the Trust is being reviewed.

The reports of 73 local clinical audits were reviewed by the provider in 2018/19 and Southern Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

<table>
<thead>
<tr>
<th>Audit title</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s records</td>
<td>- Targeted support to individual practitioners where record keeping concerns have been identified</td>
</tr>
<tr>
<td></td>
<td>- Changes in Family and Child Assessment Form to rename text boxes to make analysis and voice of the child clearer for practitioners to complete.</td>
</tr>
<tr>
<td></td>
<td>- Communication and updates cascaded to teams.</td>
</tr>
<tr>
<td></td>
<td>- Cascade list of approved abbreviations through clinical team leads and practice teachers</td>
</tr>
<tr>
<td></td>
<td>- Record keeping aide memoire “Record keeping top tips” distributed to be shared amongst all practitioners to support the training</td>
</tr>
<tr>
<td>Covert medication</td>
<td>- Teams need to ensure there is a clear rationale for the use of covert medication on the forms as well as in the notes.</td>
</tr>
</tbody>
</table>
| Community mental health teams (CMHT) referrals | CMHT will confirm distribution of information cards with referral criteria and actively engage with primary care when the opportunities arise to further enhance referral detail.
Follow up audit showed improved GP referral information received. Referrals contained details of previous treatment and duration, up from 65% to 79% |
| Unified Do Not Attempt Cardio Pulmonary Resuscitation Policy (uDNACPR) | Clearly date, time and sign the patient's notes
Document evidence of a discussion in the patient notes
Document in the patient notes a reason why an uDNACPR discussion was not held with the patient or family. |
| Methicillin-resistant Staphylococcus aureus (MRSA) Trust wide | Ensure staff have pathology system access codes and are familiar with local system of checking, actioning and documenting MRSA screen results within 72 hours |
| Disengagement children and families | Practitioners to use the family and child assessment form with the information they have received and any significant history to demonstrate analysis to inform their plan
Consider if disengagement for the antenatal contact should be addressed separately within the Child and Family Was Not Brought and Disengagement Guideline
All staff in school nurse teams to be reminded to follow the processes in the policy, should a parent/carer not return the school entry health review questionnaire
There is no current agreed process to write to parents and to inform the GP if the parent declines the school entry health review. This needs to be reviewed by the service to see if this is a process that should be followed in future
Follow up processes to be strengthened around children/young people where there are known vulnerabilities |
| Identification and management of mental health problems for learning disabilities service users | 33% of patients did not have their annual health check status recorded. These are potentially missed opportunities for health promotion.
Consultant psychiatrists have been reminded to record the annual health check status of patients they review.
Communication screens should be completed for all patients and are currently completed at first assessment. |
Clinical research

There are a number of benefits of clinical research, and each of these aligns to the Trust values:

• Reduced mortality: we are able to support the Trust in putting patients and people at the heart of everything we do. Clinical research enables staff to deliver safe services, provide compassionate safe care, listen to each other, to do the right thing, appreciate each other and deliver quality.

• Improved outcomes and experience: working in partnership with our colleagues, communicating clearly, supporting each other, working as a team, building relationships and making things happen.

• Cost effectiveness of treatments: we can ensure we are getting the best value for money through testing treatments, and acting with respect for each other and our patients, acting with honesty and integrity, taking responsibility, getting the best with our resources, and doing what we say we will do.

• Staff engagement: research enhances staff skills set and the Trust’s reputation.

The number of patients receiving relevant health services provided or sub-contracted by Southern Health NHS Foundation Trust in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee - 602.

Overall we have recruited a total of 1527 (patients and staff participants) into our National Institute for Health Research (NIHR) Portfolio studies in the 2018/19 financial year.

Examples of some of the studies we have initiated in 2018/19 include:

<table>
<thead>
<tr>
<th>Study Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Digital medicine study</td>
<td>A multicentre, 8-week, single-arm, open-label, pragmatic trial to explore acceptance and performance of using a digital medicine system with healthcare professionals and adult subjects with schizophrenia, schizoaffective disorder, or first episode psychosis on an oral atypical antipsychotic.</td>
</tr>
<tr>
<td>Lose weight (Saxenda trial)</td>
<td>Liraglutide and the management of obesity and overweight people with schizophrenia: a pilot study.</td>
</tr>
</tbody>
</table>
| EMHeP (Efficiency, cost and quality of mental health provision) | A questionnaire study looking at how patients and mental health service professionals value service quality and outcomes of mental healthcare.  
|                                                | Link to questionnaire: [www.sheffield.ac.uk/scharr/sections/heds/mvh/emhepsus](http://www.sheffield.ac.uk/scharr/sections/heds/mvh/emhepsus)                                                                 |
| DFEND                                          | A randomised, double-blind, placebo-controlled, parallel-group trial of Vitamin D in people presenting with their first episode of psychosis neuroprotection design.                                                |
| COPe-support                                   | E-support for families and friends of individuals affected by psychosis (EFFIP) project developed an online resource, called COPe-support (Carers or People with Psychosis e-support resource).  
|                                                | Online COPe-support provides peer support, information on psychosis and ways for carers to look after themselves.                                                                                         |
Commissioning for Quality and Innovation Framework (CQUIN)

The Commissioning for Quality and Innovation (CQUIN) framework supports improvements in the quality of services and the creation of new, improved patterns of care across the NHS. A proportion of Southern Health NHS Foundation Trust income in 2018/19 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 2018/19 and the following 12 months are available electronically at www.england.nhs.uk/nhs-standardcontract/cquin/cquin.

In 2018/19 income totalling £5,783,000 was made conditional upon the Trust achieving quality improvement and innovation goals. In the previous year (2017/18) income of £5,714,000 was possible, upon the condition that we achieved quality improvement and innovation goals, of which a payment of £5,579,000 was received.


In addition to the CCG national CQUINs, local CCGs and NHS England CQUINs schemes are also available to the Trust. The local CQUIN was for our mental health division to offer service users a ‘personalised care and support planning’ review. This could then be used by individuals for a Personal Healthcare Budget (PHB). Note the latter part of this process is managed outside of the Trust and is still being developed.

NHS England offers a Specialised Services CQUIN for reducing the length of stay in specialised mental health services (medium and low secure units) and a scheme to increase immunisation of children aged 12-15 in diverse groups, such as children receiving education at home.

Care Quality Commission Registration and Actions

Southern Health NHS Foundation Trust is required to register with the Care Quality Commission and 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 taken enforcement action against Southern Health NHS Foundation Trust during 2018/19.

On 29 June 2018 the Care Quality Commission served us with a warning notice under Section 29A of the Health and Social Care Act 2008. The notice was in relation to two registered locations, Bluebird House and Leigh House. The reasons for the Commission’s view were that at the time of the inspection (19 to 21 June 2018) we did not have sufficient staff to ensure the safe care and treatment of the young people at these locations. The Commission undertook an unannounced inspection on 18 July 2018 to check whether we had taken the necessary actions. The Commission found that significant improvements had been made and as such, they lifted the warning notice.

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

Southern Health NHS Foundation Trust submitted records during 2018/19 (Q1 and Q3) 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:
  99.9% for admitted patient care
  100% for outpatient care
  97.8% for accident and emergency care.
- which included the patient’s valid General Medical Practice Code was:
  100% for admitted patient care
  99.9% for outpatient care
  96.0% for accident and emergency care.

Southern Health NHS Foundation Trust Information Governance Assessment Report overall score for 2018/19 was 100% and was graded green “satisfactory”. This is based on the completion of the NHS Digital Data Security and Protection Toolkit (DSPT) self-assessment tool where all mandatory assertions were confirmed.

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

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 our financial ledger.
- The above functionality is being extensively used by clinicians and has resulted in sustained improvements to data quality across a range of our performance measures.
- During 2019/20 we will be committing to further improvements in data quality through the following initiatives:
  - Continued clinical validation of one Board level clinical Key Performance Indicator (KPI) per month to ensure reported performance is supported by robust and reliable clinical documentation.
  - Data quality kite-marks to be included in our Integrated Performance Report on a monthly basis to assess levels of data quality for each Board KPI.
  - Further development of personalised, employee level performance dashboards within Tableau (our business intelligence tool) that will be shared directly with each staff member once a month and will form part of an employee’s formal supervision.
  - Reviewing and refining reports to ensure colleagues can focus on the measures that are most pertinent.
Learning from deaths

Southern Health provides both physical and mental health services. The majority of deaths which occur in our physical health inpatient and community services are naturally occurring deaths at the end of life. There is the opportunity for patient and family involvement in planning care and how this is delivered when a person has entered their end of life phase, making their passing as comfortable as possible. We have an End of Life Committee which reviews the care that is provided and provides assurance to the Quality and Safety Committee that best practice guidance is followed.

The process of reviewing deaths is to ensure we continuously learn and improve, both from when things go wrong or when they go well. While many deaths do not require detailed investigation, we have a duty to our patients and their carers and families to make sure any decision not to investigate a death is properly considered and recorded. The Trust follows the National Guidance of the National Quality Board; on Learning from Deaths (March 2017).


and Engaging with Bereaved Families and Carers:


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’, ‘Learning Matters’ and thematic reviews.

Our criteria for the reporting of deaths

Due to the variation of services which we provides, criteria has been written to support staff in deciding which deaths are reported onto the risk management system, which is called Ulysses. These are listed below.

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 whilst detained under a Section of the Mental Health Act.

Adult mental health and 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).

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. LEDER

Older person’s mental health, physical health, and children’s (inpatient)

- All deaths of in-patients.
- 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 services

- All deaths by suicide or related to self-harm should be reported.
- Patients who die following transfer to an acute/general hospital from the Trust service whilst 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 GP. 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 to 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:
  - 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 GP or mental health service provider (Solent NHS Trust and Isle of Wight NHS Trust) 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.

Our process for reviewing deaths

Relevant deaths are recorded using a simple electronic form on our incident recording system; making the process of reporting and investigating deaths more streamlined. This process is overseen by the Serious Incident and Mortality Forum.

Every case is initially reviewed within 48 hours through a panel approach with a membership of senior clinicians. This panel is responsible for making the decision whether a case either proceeds to full investigation or with deaths that do not require an investigation, records the information to demonstrate to the family why that decision was made. This process 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. Once a decision to investigate has been made this is coordinated by the investigation team.

Investigating Team

We have a team of investigating officers trained in Root Cause Analysis (RCA) methodology who investigate our most significant incidents and those deaths reported as serious incidents. Their role is to conduct a quality investigation to enable us 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 commenting of draft findings. Support to families and carers is offered by our Family Liaison Officer who is completely independent of the investigation process.

How do we share our findings?

The process is documented in our policy and procedure for Reporting and Investigating Deaths which is publicly 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 publicly available on our website.

It is important that staff at all levels of the organisation learn from the investigations and we use a variety of different methods for this which includes:

- patient stories at Quality and Safety meetings
- patient stories at Mortality meetings
- incident review at team meetings
- hotspots and Learning Counts publications
- ‘Could it happen here?’ presentations
- Learning Network meetings in each of the four adult mental health localities
- immediate learning alerts are automatically issued through an electronic system
- Learning from Incidents meetings
- individual clinical supervision
- reflections within the multi-disciplinary team conversations
- clinical training.

For the cases where the investigation has found there were serious failings within the care we delivered the improvement action plan is presented to an Evidence of Improvement Panels. This is chaired by a member of the executive team and attended by other stakeholders such as commissioners. The duty of the panel is to review the change and improvement evidence provided by the operational team as a method which prevents reoccurrence.
**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.

During 2018/19 678 of Southern Health NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Number of deaths</th>
<th>Number of case reviews or investigations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before 2016/17</td>
<td>1057*</td>
<td>1057 initial case reviews which resulted in;</td>
</tr>
<tr>
<td>(reporting started Dec 2015)</td>
<td></td>
<td>- 107 ‘Red Rated’ or Serious Incident Investigations**</td>
</tr>
<tr>
<td>Total 2016/17</td>
<td>730</td>
<td>730 initial case reviews which resulted in;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- 44 ‘Red Rated’ internal investigations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- 72 Serious Incident Investigations</td>
</tr>
<tr>
<td>Total 2017/18</td>
<td>742</td>
<td>742 initial case reviews which resulted in;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- 28 ‘Red Rated’ internal investigations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- 54 Serious Incident Investigations</td>
</tr>
<tr>
<td>Q1 2018/19</td>
<td>181</td>
<td>181 initial case reviews which resulted in;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- 7 ‘Red Rated’ internal investigations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- 17 Serious Incident Investigations</td>
</tr>
<tr>
<td>Q2 2018/19</td>
<td>165***</td>
<td>165 initial case reviews which resulted in;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- 3 ‘Red Rated’ internal investigations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- 14 Serious Incident Investigations</td>
</tr>
<tr>
<td>Q3 2018/19</td>
<td>168</td>
<td>168 initial case reviews which resulted in;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- 9 ‘Red Rated’ internal investigations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- 12 Serious Incident Investigations</td>
</tr>
<tr>
<td>Q4 2018/19</td>
<td>164</td>
<td>164 initial case reviews which resulted in;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- 6 ‘Red Rated’ internal investigations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- 9 Serious Incident Investigations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- 0 reviews outstanding as of 31.03.19</td>
</tr>
<tr>
<td>Total 2018/19</td>
<td>678</td>
<td>678 initial case reviews which resulted in;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- 25 ‘Red Rated’ internal investigations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- 52 Serious Incident Investigations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- 0 reviews outstanding as of 31.03.19</td>
</tr>
</tbody>
</table>

*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

***Figure adjusted from quarterly Board report – death reported late

**Definitions** - Red Rated 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 the CCG as a Serious Incident under the NHS England 2015: Serious Incident Framework.
By 31 March 2019, 678 case record reviews and 77 investigations have been carried out in relation to 678 of the deaths included above.

In 77 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Number of case reviews completed</th>
<th>Number of investigations commissioned</th>
</tr>
</thead>
</table>
| Q1 2018/19 | 181                              | 17 Serious Incident Investigations  
|          |                                   | 7 ‘Red Rated’ internal investigations  
|          |                                   | Total 24                             |
| Q2 2018/19 | 164                              | 14 Serious Incident Investigations*  
|          |                                   | 3 ‘Red Rated’ internal investigations  
|          |                                   | Total 17                             |
| Q3 2018/19 | 168                              | 12 Serious Incident Investigations*  
|          |                                   | 9 ‘Red Rated’ internal investigations  
|          |                                   | Total 21                             |
| Q4 2018/19 | 164                              | 9 Serious Incident Investigations*    
|          |                                   | 6 ‘Red Rated’ internal investigations  
|          |                                   | Total 15                             |

*Q2 – Two serious incidents downgraded following investigation by the CCG.
Three, representing 1.9%, 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.

In relation to each quarter, this consisted of:
- nil for the first quarter
- two representing 1.2% for the second quarter
- one representing 0.59% for the third quarter
- nil for the fourth quarter. (Note for fourth quarter, eight investigations remain in progress therefore final impact grading not yet applied).

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Deaths related to problems in care provided</th>
<th>Percentage of deaths related to problems in care provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before 2016/17</td>
<td>36</td>
<td>3.4%</td>
</tr>
<tr>
<td>2016/17</td>
<td>20</td>
<td>2.7%</td>
</tr>
<tr>
<td>2017/18</td>
<td>11</td>
<td>1.4%</td>
</tr>
<tr>
<td>Q1 2018/19</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Q2 2018/19</td>
<td>2</td>
<td>1.2%</td>
</tr>
<tr>
<td>Q3 2018/19</td>
<td>1</td>
<td>0.59%</td>
</tr>
<tr>
<td>Q4 2018/19</td>
<td>0**</td>
<td>0%**</td>
</tr>
<tr>
<td>Total 2018/19</td>
<td>3**</td>
<td>0.44%**</td>
</tr>
</tbody>
</table>

*Electronically recorded on the Safeguard Ulysses Risk Management System database and adjusted year end position after all investigation were closed in Q2 2018/19.

**Eight investigations remain in progress therefore final impact grading not yet applied, number will be adjusted in Q2 2019/20.

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 Learning Disabilities Mortality Review (LeDeR) Programme, methodology has been used as part of the Hampshire-wide 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'.
Learning from the case record reviews has highlighted several areas for improvement:

- communication between different healthcare providers who do not share electronic records
- transfer of care between different teams within Southern Health focusing on timely communication to ensure patients are not ‘lost’ or ‘delayed’ in the referral processes at a potentially vulnerable time
- documentation of the assessment of risk and creation of a ‘my safety, my crisis’ plan with the patient, families and carers for those assessed as medium risk and above
- communication and involvement of care of families and carers especially in circumstances where a patient has not given consent to share information.

Patients who have a severe mental illness are at risk of having an alcohol or drug / substance dependency also, this is referred to as dual diagnosis. Although patients cannot be forced into dealing with their dependency issues, mental health services have a responsibility to encourage and help with access to these services. These services are very often provided by a different Trust or Healthcare Company than mental health services and communication has been recognised as an issue within investigation findings. All four mental health localities now have operational forums in place with the providers of the drug and alcohol services to discuss patients and the provide assurance that referral processes between the service are as robust as they can be. In some areas this involves alcohol and substance misuse workers attending our mental health hospitals to see patients, and community mental health nurse running mental health clinics in the alcohol and substance misuse services.
During the past year, the training on risk assessment for staff has been relaunched as a mandatory requirement for all qualified staff groups to undertake. The electronic patient record which captures the risk assessment detail has been redeveloped, but a further piece of work to reduce the sheer quantity of documents that our staff need to complete when a patient is admitted to services is underway by the Record Keeping Group. This should streamline processes and release time spent on paperwork back to clinical care.

Following the relaunch of the Triangle of Care as a Quality Priority for 2018/19 to improve the involvement of carers and families, a new communication plan has been created as part of the electronic patient record for staff to complete with relatives or carers. This is extremely important as our improvement work to date has told us that the engagement of families and carers is of prime importance at the earliest opportunity. Families and carers can be a vital part of a person’s recovery; they may notify services if they feel that their loved one has a worsening condition, assist in keeping the person safe, and should be partners in care. The impact of this will be monitored throughout 2019/20.

Nine case record reviews and 12 investigations completed after 31 March 2018 which related to deaths which took place before the start of the reporting period. One, representing 0.59%, of the patient deaths, before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. 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. Three, representing 0.48%, of the patient 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.

Section 2d. 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 them by NHS Digital. (Where the tables overleaf show the Trust comparison information for 2018/19 as "not available" as the data is expected to be released in May 2019, this is too late for inclusion in this report).

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

PricewaterhouseCoopers (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)

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

The reported indicator for people experiencing a first episode of psychosis and treated with a NICE approved care package within two weeks of referral is calculated on all patients who are referred and accepted onto the caseload, as per the guidance given by NHS Improvement. 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 NHS England NICE standard is set at 53%.

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

- validating data with teams prior to national data submission to ensure all diary entries and records are accurate
- taking part in annual audits such as the CCQI audit self-assessment tool (the Early Intervention in Psychosis Network), which benchmarks against other Trusts the developmental process against NICE concordant measures

The above actions ensure a robust performance management framework for the service with a consistent compliance rate over the required 53% and often report over 85% compliance.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Early Intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southern Health</td>
<td>85.4%</td>
</tr>
<tr>
<td>Average scoring Trust</td>
<td>74.5%</td>
</tr>
<tr>
<td>Highest scoring Trust</td>
<td>changed criteria*</td>
</tr>
<tr>
<td>Lowest scoring Trust</td>
<td>changed criteria*</td>
</tr>
</tbody>
</table>

*Data collection started October 2016, criteria was changed hence no benchmark available.
An enquiry in 2018/19 through the Health Service Journal asked about the funding levels and spends within our services, the following response was shared:

“Southern Health NHS Foundation Trust does supply data to Time4recovery. When submitting data for costings, providers are not asked to provide full costs of the service (reference costs) only the net staffing costs. As current data around spend and investment does not take into account all service costs, such as estates and wider trust costs, this can present a deficit. This is why spend per patient appears to be lower than the national recommendation, when in reality it is not.

Whilst spend per patient would appear to be lower than the national recommendation, at a gross level the Trust invests somewhere in the region of £8,400 per patient, per year. It is difficult to give an exact number without reviewing the caseloads in greater detail. This is due to the complexity of the patients who access EIP teams and reflected in the average three year clinical pathway.

We are working with commissioners on further investment into the services during 2019/20 to expand into older age groups and are looking forward to further discussions on this shortly.”

2.2 Service users placed out of area overnight for adult mental health services (inappropriate out of area placements) A

The Southern Health NHS Foundation Trust considers that this data is as described for the following reason: 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. 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 numbers of out of area placements has increased significantly in 2018/19 with demand demonstrated by higher referral rates and Mental Health Act detentions.

The Trust is bench marked in the lower quartile nationally at 14 mental health acute inpatient beds per 100,000 weighted population. The average would be 25% higher at 19 beds/100,000 population and 50 rehabilitation beds, compared to the Trust’s 33 rehabilitation beds.

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

• amended the weekly Executive Flash Report and Performance Dashboard to highlight progress and identify issues at a glance
• implemented a revised process to sign off Delayed Transfers of Care with Hampshire County Council (the responsible organisation)
• completed an internal audit on the processes for out of area beds
• reviewed the balance of community and inpatient resources to improve the patient pathway
• implemented a Right Care, Right Place fortnightly meeting to provide a forum to prioritise and discuss bed flow.

The Executive Team approved seven key areas to support patients and reduce the demand for out of area placements. These actions will continue into 2019/20:

◊ embedding flow principles and supporting processes
◊ tackling cultural issues within the workforce
◊ developing and embedding the Emotionally Unstable Personality Disorder (EUPD) pathway
◊ increasing the visibility of operational pressures to the whole system
◊ accommodation review to provide real alternatives to hospitalisation
◊ ease of access to longer term placements
◊ system-wide review of capacity and demand.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Inappropriate out of area placements for adult mental health services (A)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust monthly occupied bed days out of area</td>
<td>1573/1281/1406</td>
</tr>
<tr>
<td>Trust quarterly (Average number per month)</td>
<td>763</td>
</tr>
</tbody>
</table>
2.3 Our patients on a Care Programme Approach who were followed up within seven days of discharge from psychiatric inpatient care

Evidence suggests that people with mental health problems, especially those with severe and enduring mental illness, are at risk of suicide and that people are particularly vulnerable in the period immediately after they have been discharged from a mental health inpatient ward. The national measure is to follow up 95% of patients within seven days of discharge.

To meet the national criteria the contact has to be between the day after discharge and within the next seven days. Visiting on the day of discharge would be identified as good practice and good care planning, however, this does not meet the national guidance.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>The percentage of patients on Care Programme Approach who were followed up within seven days after discharge from psychiatric inpatient care during the reporting period.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southern Health</td>
<td>97.3%</td>
</tr>
<tr>
<td>Average scoring Trust</td>
<td>96.6%</td>
</tr>
<tr>
<td>Highest scoring Trust</td>
<td>99.4%</td>
</tr>
<tr>
<td>Lowest scoring Trust</td>
<td>59.5%</td>
</tr>
</tbody>
</table>

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

The reported indicator for Care Programme Approach seven day follow up is calculated on all patients who were 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 Psychiatric Intensive Care Unit (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 indicator, and so the quality of its services, by:
- updated policy for patients that are high risk of self-harm to be followed up within 48 hours of discharge from an inpatient setting
• daily checks by the performance team, in addition to local business support managers, checking daily with teams to ensure appointments have been booked and outcomed correctly.

In quarter two there was a dip in performance. Since October 2018 changes implemented have resulted in 95% compliance or above to meet the NHS Improvement target, ensuring discharged inpatients are seen within the seven days. The process amendments were to ensure highest risk patients are prioritised and seen within 48 hours.

The updated Trust policy on admission, transfer and discharge now states “All patients will have appropriate arrangements for follow up after discharge. This may be for them to arrange to see their own GP, attend a clinic or in the case of patients discharged from mental health and learning disability care settings, an appointment will be made to be seen within a maximum of seven days following discharge and within 48 hours if the patient presented as a risk of self-harm during admission.”

The policy requires:
• patients requiring 48 hour follow-up should be identified early in the admission period
• follow up to be by a named person, identified and recorded before discharge. This can be by telephone call or face-to-face
• the person making the contact could be member of the ward, acute or community mental health teams
• patient records contain details on all staff involved in the care of the patient
• the discharging ward/unit ensures the patient contact details (including next of kin) and the follow up is booked before the patient leaves the ward/unit.
2.4 Crisis resolution teams acting as gatekeeper to admission

The data made available to the Trust 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 reason: this is taken from the national dataset using the data provided.

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

- updated the gatekeeping form on RiO to record the rationale as to why a service user judged not suitable for home treatment and to capture the admission objectives if admission required
- aligned gate keeping processes and recording on RiO
- the Trust exceeds the 95% target, running at over 99% for the last three years.

The updated process initially met some teething issues as the order in which administrative tasks were completed affected compliance; these were resolved and teams are now aware of the sensitivities.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>The percentage of admissions to acute wards for which the crisis resolution home treatment team acted as a gatekeeper during the period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southern Health</td>
<td>99.7%</td>
</tr>
<tr>
<td>Average Scoring</td>
<td>98.5%</td>
</tr>
<tr>
<td>Trust</td>
<td></td>
</tr>
<tr>
<td>Highest Scoring</td>
<td>100.0%</td>
</tr>
<tr>
<td>Trust</td>
<td></td>
</tr>
<tr>
<td>Lowest Scoring</td>
<td>89.8%</td>
</tr>
<tr>
<td>Trust</td>
<td></td>
</tr>
</tbody>
</table>
2.5 Admissions to adult facilities of patients under 16 years old

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

- continue to monitor and signpost under 16s to appropriate services.

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.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Admissions to adult facilities of patients under 16 years old.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No benchmarking data available</td>
</tr>
<tr>
<td></td>
<td><strong>Apr 2016 – Mar 17</strong>  <strong>Apr 2017 – Mar 18</strong>  <strong>Q1 2018–19</strong>  <strong>Q2 2018–19</strong>  <strong>Q3 2018–19</strong>  <strong>Apr 2018 – Mar 19</strong></td>
</tr>
<tr>
<td>Southern Health</td>
<td>0%  0%  0%  0%  0%  0%</td>
</tr>
</tbody>
</table>

2.6 Our readmission rate for children and adults

The data made available to the Trust by NHS Digital with regard to the percentage of patients aged:

(i) 0 to 15 years or
(ii) 16 years or over,

who were 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 reason: this is taken from internal datasets within the Trust which are uploaded onto NHS digital.

Overall for 2018/19 the Trust is at 7% re-admission rate reflecting the cohort of patients, services commissioned and local supporting networks. The Trust balances the risk of early release resulting in re-admission against the benefits of continuing recovery at home. The metrics are monitored monthly via local and divisional performance meetings.

The Trust supports a small number of under 16s in our children and adolescent mental health services hospitals. One service user was re-admitted in 2018/19, this corresponds to a 4% re-admission rate.
Within adult mental health services a threshold level of 12% is set. Above this level commissioners were informed on a case by case basis as part of the monthly contract review meeting.

Our community hospitals run both medical assessment units (MAU) and rehabilitation wards. The hospitals treat a limited range of acute conditions, such as sepsis and mild cardiac illness, as well as patients with chronic conditions. These patients are more likely to be readmitted at some point in the future and the threshold is set at 10%. Rehabilitation wards are typically at the 2% re-admission level.

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

- continuing to monitor at team level for any reoccurring themes and escalate as appropriate
- involving carers and families in discharge planning processes to ensure improved home support
- review of any learning points at the monthly management meeting on medically failed discharges (Integrated Services Division)
- 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 within 28 days of being discharged from a hospital which forms part of the Foundation Trust during the reporting period.**

No benchmarking data is available.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Southern Health</td>
<td>0%</td>
<td>1.9%</td>
<td>0%</td>
<td>3.6%</td>
</tr>
</tbody>
</table>

### Indicator

**The percentage of patients aged 16 or over readmitted to a hospital which forms part of the Foundation Trust within 28 days of being discharged from a hospital which forms part of the Foundation Trust during the reporting period.**

No benchmarking data is available.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Southern Health*</td>
<td>12%</td>
<td>17.5%</td>
<td>9.6%</td>
<td>6.9%**</td>
</tr>
</tbody>
</table>

* 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) NHS Foundation Trust.

** Mental health metrics, all admissions (including out of area placements), with exceptions for 135/136 suites and the Ministry of Defence ward admissions.
2.7 Patient experience of community mental health services
The Trust contracted with ‘Quality Health’ to undertake the national community mental health survey in 2018. This included an indicator of 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 reason: this is taken from the national dataset using the data provided.

Patient experience

Mental health service user: "After a period on acute psychiatric wards, I was moved to Hollybank. My mental health further improved during my time on Hollybank with the support of very caring and dedicated staff. The biggest problem I have had to face was housing. I was not eligible for supported or social housing or housing benefits and so had to find somewhere to rent privately. This proved very difficult as landlords and managing agents required working people. With ongoing support from the team my persistence paid off, I am now living in a shared house with reasonable rent. So my moto is never give up trying and a very big thank you to all on Hollybank who helped me so much in my journey."

Physical health patient: A patient with complex needs was considered a high risk discharge. The treating team discussed with local commissioning group how best to meet the patient’s wish to return home rather than look at alternative options. His family were organising renovations at his house including woodworm treatment, replacing floorboards and carpeting. The occupational therapist reviewed the equipment the patient would need at home and the delivery timeline. The patient was transferred home with a package of care, his ward bed was held for 48 hours to ensure he was stable in his new environment.
The Southern Health NHS Foundation Trust has taken the following actions to improve the indicator, and so the quality of its services, by:

- new methodologies used to record patient experience and shared with staff as a learning tool. Patient experience recorded in written, digital and filmed formats
- worked with service users and carers to co-produce action plans from surveys and monitor progress against the plans via the Working in Partnership committee
- co-producing Trust ‘in house’ surveys ensuring questions are chosen by service users and carers, so that we are collecting data on what matters to them
- working with Experts by Experience and User Involvement Facilitators so that we improve and design services having taken their views and feedback into account
- training for team leaders/managers covers best practice in relation to patient experience and involvement in care pathway. This is used with staff as part of clinical supervision and appraisal discussions.

The objective is to increase the numbers of service users who report they were given enough time to discuss their needs and treatment, supported by improved staff understanding of how clinical interactions may feel from a service user perspective.

The table below evidences how Southern Health NHS Foundation Trust compares to other Trusts that provide community mental health services.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Patient experience of contact with a health or social worker*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southern Health</td>
<td>6.8</td>
</tr>
<tr>
<td>Average scoring Trust</td>
<td>Not available**</td>
</tr>
<tr>
<td>Highest scoring Trust</td>
<td>7.5</td>
</tr>
<tr>
<td>Lowest Scoring Trust</td>
<td>6.5</td>
</tr>
</tbody>
</table>

*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’.
** The CQC annual survey does not report average trust scores.
*** 2017/18 survey results corrected from the 2017/18 report to provide the section 1 health and social care worker experience rather than the overall experience (Section 10).
2.8 Our rate of patient safety incident reporting

The data made available to the Trust by NHS Improvement with regard to the number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

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 2018/19 totals are 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 the National Reporting and Learning System (part of NHS Improvement) during the specified time periods.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Number of patient safety incidents reported to the National Reporting and Learning System (NRLS)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>16/17 Total – 12,460</td>
<td>17/18 Total – 8665*</td>
</tr>
<tr>
<td>Southern Health*</td>
<td>6072</td>
</tr>
<tr>
<td>Average scoring Trust**</td>
<td>2963</td>
</tr>
<tr>
<td>Highest scoring Trust**</td>
<td>6349</td>
</tr>
<tr>
<td>Lowest scoring Trust**</td>
<td>40</td>
</tr>
</tbody>
</table>

* results from internal incident reporting system
** results taken from NRLS
<table>
<thead>
<tr>
<th>Indicator</th>
<th>i) Number and ii) percentage of such patient safety incidents that resulted in severe harm or death</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>16/17 Total – 140 (1.1%)</td>
</tr>
<tr>
<td>Apr 16 – Sept 16</td>
<td>Oct 16 – Mar 17</td>
</tr>
<tr>
<td>Southern Health*</td>
<td>i) 64 i) 1.1%</td>
</tr>
<tr>
<td>Average scoring Trust**</td>
<td>i) 33 i) 1.5%</td>
</tr>
<tr>
<td>Highest scoring Trust**</td>
<td>i) 101 i) 3.2%</td>
</tr>
<tr>
<td>Lowest scoring Trust**</td>
<td>i) 10 i) 1.4%</td>
</tr>
<tr>
<td></td>
<td>17/18 Total – 81 (0.9%)</td>
</tr>
<tr>
<td>Apr 17 – Sept 17</td>
<td>Oct 17 – Mar 18</td>
</tr>
<tr>
<td></td>
<td>i) 76 i) 1.2%</td>
</tr>
<tr>
<td></td>
<td>i) 34 i) 0.6%</td>
</tr>
<tr>
<td></td>
<td>i) 33 i) 1.2%</td>
</tr>
<tr>
<td></td>
<td>i) 21 i) 0.7%</td>
</tr>
<tr>
<td></td>
<td>i) 17 i) 0.3%</td>
</tr>
<tr>
<td></td>
<td>18/19 total – 38 (0.4%)</td>
</tr>
<tr>
<td>Apr 18 – Sept 18</td>
<td>Oct 18 – Mar 19</td>
</tr>
<tr>
<td></td>
<td>i) 47 i) 1.4%</td>
</tr>
<tr>
<td></td>
<td>i) 36 i) 1.1%</td>
</tr>
<tr>
<td></td>
<td>i) 37 i) 1.3%</td>
</tr>
<tr>
<td></td>
<td>Not available</td>
</tr>
<tr>
<td>Southern Health*</td>
<td>i) 10 i) 1.4%</td>
</tr>
<tr>
<td>Average scoring Trust**</td>
<td>i) 2 i) 0.1%</td>
</tr>
<tr>
<td>Highest scoring Trust**</td>
<td>i) 1 i) 0.0%</td>
</tr>
<tr>
<td>Lowest scoring Trust**</td>
<td>i) 0 i) 0.0%</td>
</tr>
<tr>
<td></td>
<td>Not available</td>
</tr>
</tbody>
</table>

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

The Trust Ulysses system is used to report all incidents including those related to staff health and safety, and other events in addition to the patient safety events. The Trust continues to promote a culture of open and honest incident reporting and the total number of incidents reported has shown an upward trend across the year.

The following trends are noted within the divisions: A downward trend in learning disabilities services in regards to assaults to staff. The decrease in assaults was due a number of successful therapeutic interventions to modify patients challenging behaviours, on the wards. Adult Mental Health services show a decrease in assaults but an increase in self harm or self-injurious behaviours and/or incidents. These have occurred mainly in our specialised services wards where two patients have required nasogastric feeding. A number of new restraint techniques have been used to reduce the assaults to staff. The physical health services have seen an increase in reporting of pressure ulcers, this is due to national changes in reporting categories.

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

- sustained improvement in managers receiving and reviewing incident forms from teams within 10 working days. This allows for timely learning and sharing information from an incident
- Sustained improvement of family engagement in serious incident investigations.
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 (FFT), although it did not make this a mandatory requirement for community Trusts.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>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</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southern Health*</td>
<td>66%</td>
</tr>
<tr>
<td>Average scoring Trust</td>
<td>78%</td>
</tr>
<tr>
<td>Highest scoring Trust</td>
<td>100%</td>
</tr>
<tr>
<td>Lowest scoring Trust</td>
<td>45%</td>
</tr>
</tbody>
</table>

* 2017/18 Southern Health number has been corrected from 69% to 63% as shown in question 21d of the 2018 Staff survey.

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

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

- achieved a Trust record response rate for the 2018 NHS Staff Survey of 44%. A staff survey action plan has been created and key leads across the Trust will be engaged to identify delivery actions to ensure a strong programme of ‘you said we did’ communications and staff engagement going forward
- launched the Board led Staff Engagement and Inclusion Forum in January 2019
- 10 additional cultural questions were added to the 2018 NHS Staff Survey and the full data set will be used to launch a Cultural Dashboard giving team level data to promote cultural awareness and diversity in recruitment.
2.10 The percentage of patients who would recommend the Foundation Trust as a provider of care to their family and friends

Southern Health NHS Foundation Trust routinely seeks feedback from patients in relation to how likely they are to recommend the Trust as a provider of care. The table below gives the percentage of patients who reported that they would recommend the Trust to family and friends and offers comparative data from other similar Trusts with both community and mental health services.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>The percentage of patients during the reporting period who would recommend the Foundation Trust as a provider of care to their family of friends</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southern Health</td>
<td>94.3%</td>
</tr>
<tr>
<td>Average scoring Trust</td>
<td>94.5%</td>
</tr>
<tr>
<td>Highest scoring Trust</td>
<td>98.8%</td>
</tr>
<tr>
<td>Lowest scoring Trust</td>
<td>86.6%</td>
</tr>
</tbody>
</table>

*updated result taken from NHS England published data (was reported as 97.2% in 2017/18 report).

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

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

- appointed an experienced Head of Patient Experience and Patient and Public Involvement lead who is taking forward the revised strategy
- established a ‘Working in Partnership’ Committee whose membership includes service users, carers, voluntary and third sector representatives and staff. The committee reports to the Caring and Patient Experience Group and has direct access to the Board
- appointed Experts by Experience as integral to the quality improvement agenda
- appointed Experts by Experience and User Involvement Facilitators to progress and support the ways in which the patient’s voice is incorporated into service delivery and improvement
- researched the potential to outsource the collection of the Family and Friends test data using different collection methodologies. For example, texting, to facilitate ease of service user reporting and offer assurance of improved impartial data collection to the Trust Board and public.
2.11 Cardio-metabolic assessment and treatment for people with psychosis

This indicator on physical health monitoring for the holistic well-being of service users 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 a care programme approach).

The Southern Health NHS Foundation Trust considers that this data is as described for the following reasons; this is taken from the data collected for an external audit run by the Royal College of Psychiatrists (RCP). 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. The results from the RCP audits are expected after the deadline for this report; hence the results shown are based on internal analysis. The method used to calculate results has changed in 2018/19; only service users with a full suite of cardio-metabolic assessments and appropriate interventions are counted as complete. This accounts for the decline in the percentages for two of the audit this year.

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 a Tableau report to monitor their performance, which are reviewed within the Adult Mental Health division performance meetings. Therefore to the best of our knowledge the data is complete.

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

- continuing to monitor the target at monthly performance meetings
- completed review of all physical health forms on RiO to streamline patient record keeping.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Cardio-metabolic assessment and treatment for people with psychosis - a) inpatient wards</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2017/18</td>
</tr>
<tr>
<td>Southern Health</td>
<td>94%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Cardio-metabolic assessment and treatment for people with psychosis - b) Early intervention in Psychosis services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2017/18</td>
</tr>
<tr>
<td>Southern Health</td>
<td>78%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Cardio-metabolic assessment and treatment for people with psychosis - c) community mental health services (people on care programme approach)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2017/18</td>
</tr>
<tr>
<td>Southern Health</td>
<td>92%*</td>
</tr>
</tbody>
</table>

* Initial results – waiting confirmation from RCP.
2.12 Improving Access to Psychological Therapies (IAPT)
The Improving Access to Psychological Therapies (IAPT) programme treats adults with anxiety disorders and depression. The therapy or treatment is delivered by fully trained and accredited practitioners, matched to the mental health problem and its intensity and duration designed to optimise outcomes. A stepped care model is used depending on the level of intervention required.

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

The Trust is performing in line with the average trust results for the proportion of people that complete treatment and move to recovery.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Proportion of people completing treatment who move to recovery (from IAPT dataset)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>51.5%</td>
</tr>
<tr>
<td>Average scoring Trust</td>
<td>49.9%</td>
</tr>
<tr>
<td>Highest scoring Trust</td>
<td>86.0%</td>
</tr>
<tr>
<td>Lowest scoring Trust</td>
<td>15.0%</td>
</tr>
</tbody>
</table>

* internally reported data ( NHS digital data is not available within this report deadline)

National benchmarking networks show the Trust has performed above both Wessex and national levels for patients entering treatment waiting times at six and 18 weeks, with targets at 75% and 95% respectively. For the patients that fall out of this metric, analysis showed there were long waits for step three interventions, this was due to staff losses in year and the increase in more complex presentations.
The Southern Health NHS Foundation Trust has taken the following actions to improve the indicator, and so the quality of its services, by:

- continuing to monitor performance of both six and 18 weeks referrals at monthly meetings
- in the latter part of 2018 implemented efficiencies in telephone and referrals centre productivity and treatment for patients at Step 2
- contract reviewed with commissioners and third parties to address potential conflicts of interest.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Improving access to psychological therapies: people with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southern Health</td>
<td>87.2%</td>
</tr>
<tr>
<td>Average scoring Trust</td>
<td>86.3%</td>
</tr>
<tr>
<td>Highest scoring Trust</td>
<td>100.0%</td>
</tr>
<tr>
<td>Lowest scoring Trust</td>
<td>15.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Improving access to psychological therapies: people with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southern Health</td>
<td>99.9%</td>
</tr>
<tr>
<td>Average scoring Trust</td>
<td>97.9%</td>
</tr>
<tr>
<td>Highest scoring Trust</td>
<td>100.0%</td>
</tr>
<tr>
<td>Lowest scoring Trust</td>
<td>33.0%</td>
</tr>
</tbody>
</table>
Progress made in meeting our priorities for improvement in 2018/19
Details of the progress made to meet our priorities for improvement in 2018/19 are given below.

■ Priority 1: Improving patient safety

Indicator 1.1 Risk assessment and crisis planning within the mental health division

Aim:
A risk assessment looks at 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 our mental health and learning disabilities divisions. We believe that a risk assessment should be focused on positive risk taking, should 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. We aimed that each patient should have an up to date risk assessment that has been reviewed in a timely manner, with involvement from the patient, family, loved ones and carers.

Achievements:

<table>
<thead>
<tr>
<th></th>
<th>Adult mental health</th>
<th>Learning disabilities</th>
<th>Older person mental health</th>
<th>Specialised services</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>% completed*</td>
<td>96%</td>
<td>97%</td>
<td>95%</td>
<td>96%</td>
<td>98%</td>
</tr>
<tr>
<td>% 1 year review</td>
<td>84%</td>
<td>94%</td>
<td>86%</td>
<td>91%</td>
<td>85%</td>
</tr>
</tbody>
</table>

*95% target

Data from Tableau as of 11 April 2019. Adult mental health percentages with risk assessment, and risk assessment and review.
During this year the Assessment and Management of Clinical Risk policy has been reviewed, this was in relation to learning that had been identified following a serious incident. The changes within the policy allow for clarity when collaborative risk assessments are being conducted and ensuring the dovetailing with other policies so that a suite of policies are available.

A consultation with staff was conducted to identify gaps in the risk assessment electronic form on RiO (electronic patient record) and adjustments were made based on the responses received.

Training in relation to assessment and positive risk taking has also been refreshed in order to align with the updated policies, RiO risk page and risk reflective practice sessions.

During this year we have been auditing the quality of both the risk assessment and crisis plans, ensuring they are holistic and have the involvement of family and carers where relevant.

<table>
<thead>
<tr>
<th></th>
<th>Patients with a risk assessment that was holistic and of high quality</th>
<th>Patients with a &quot;My crisis/My safety&quot; plan that was of high quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>88%</td>
<td>85%</td>
</tr>
<tr>
<td>Q2</td>
<td>93%</td>
<td>62%</td>
</tr>
<tr>
<td>Q3</td>
<td>93%</td>
<td>74%</td>
</tr>
<tr>
<td>Q4</td>
<td>92%</td>
<td>94%</td>
</tr>
</tbody>
</table>

There has been a small increase in the quality of risk assessments, however the quality of the patient’s ‘My Crisis/My Safety plan’ has been variable. The latter is wholly owned by the patient and offers guidance to clinicians in order to support in a crisis. Its completion depends on whether the patient is well enough to complete the plan and as such some of these will be a work in progress. The quality of risk assessments will remain a focus for the services, and discussions continue with patients and staff on improving the quality of assessments.

The involvement of carers and family in risk assessments and crisis planning has shown an improvement from the previous year. However we know that there is further work to be done in involving families. This will be part of the Triangle of Care quality indicator identified in the 2019/20 quality contract.

<table>
<thead>
<tr>
<th>Family/carer involvement in</th>
<th>2017/18</th>
<th>2018/19 Q2</th>
<th>2018/19 Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family/carer involvement in risk assessment</td>
<td>59%</td>
<td>43%</td>
<td>49%</td>
</tr>
<tr>
<td>Family/carer involvement in my crisis/my safety plan</td>
<td>38%</td>
<td>54%</td>
<td>50%</td>
</tr>
</tbody>
</table>
Our older person's mental health services measure the quality of risk assessments through a tool called the Quality Assessment Tool. This is used on a monthly basis and it is when a senior clinician reviews medical records to identify any gaps or good practice in record keeping, talks to patients and carers to ascertain their views on the care and treatment given, and also speaks to staff in order to get a full complement of quality information with which to complete the assessment.

Quality assessment tool for older persons mental health inpatient services from Tableau April 2019

Quality assessment tool for Older Persons Mental Health Community services from Tableau April 2019
The infographics on the previous page show us that the overall quality score has varied during the year for inpatient services with a dip in October to 82%, and average score of 86.8%. Community services scores dipped in March and July with an average score of 88.4%. The dips correspond to changes in the organisation leadership and staff vacancies.

The question that relates to the inpatient risk assessment states: “Risk assessments and management plans are reviewed and updated at admission, discharge, a minimum of every week or according to clinical need.” The overall score for older person’s mental health inpatients was at 96%.

The question that relates to risk assessments in the community services states: “An appropriate risk assessment has been completed and kept up-to-date in RiO”. The overall score for community services is recorded as 90%. Although this may seem low it very much depends how often the patient is seen by services, as some may have frequent contact and others an annual review. Therefore there may be some risk assessments that have not been updated as frequently.

**Future plans:**
Risk assessments remain a focus for the Trust. Although not identified as a quality priority for the forthcoming year, work will continue to refine the risk assessment to ensure ease of use for patients and clinicians.

**Indicator 1.2 Reducing restrictive practice in the mental health division**

**Aim:**
We are committed to reducing the need for restrictive interventions because they detract from the therapeutic environment on the ward. We recognise that occasionally some service users may behave in an aggressive or violent manner and that where all else fails, may necessitate the use of restrictive interventions. We also recognise the rights of staff to use such force as is reasonable, in order to protect themselves from an attack, or to prevent an unlawful attack on others.

Part of this indicator was in relation to ensuring that if a patient required restraint, it was a planned intervention and as such staff were trained adequately in the least restrictive methods, and patients were aware of what would happen.
**Achievements:**

Care plans within specialised services do include the views of patients, the care plan is written collaboratively with the young person. This is particularly pertinent to our young patients who may require restraint in order to have naso-gastric feeding.

For our adult mental health and older persons mental health colleagues restraint for the administration of medication is not routinely recorded in care plans, due to the often urgent requirement for this medication to be administered to patients who are acutely unwell. The decision to complete this intervention is done so with multi-disciplinary discussion. A debrief is completed with the patient when they are physically and mentally able to do so, this is usually with a psychological input, and the discussion relates not to why the restraint occurred, but how the patient feels about it, and the impact of the restraint. The incident is only discussed with families and carers if requested by the service user.

Physical health monitoring including comparison with physical health indicators is completed upon admission and after a course of medication, such as rapid tranquilisation, is completed. Each of the prone restraints are discussed in order to review the care both prior, during and after the event, debrief with the patient and any lessons learned. This is shared between all areas in order that learning can be disseminated.

The Safe Wards initiative has been implemented in the majority of our inpatient units, and has supported safer staffing requirements to match the acuity on the wards at that time.

The training of staff to ensure restraints are completed safely is called Supporting Safer Services. We are compliant with over 95% staff trained (the green line on the chart shows the percentage compliance, while the purple bars on the graph show the number of staff completing training each month)
Future plans:
We will be reviewing our restrictive practices to ensure they are evidence based, and promote a safe environment for patients and staff. This includes a working group of stakeholders reviewing our current Supporting Safer Services training to ensure it is robust and appropriate for our patient groups which can vary over time. This is especially true of our young person’s services.

Indicator 1.3 Collaborating with local communities to reduce suicide

Aim:
To reduce deaths of our patients through suicide. To include lessons from serious incidents in relation to those who have attempted or taken their own life. We also want to ensure that there is sufficient crisis provision to support patients in a crisis situation.

Achievements:
- We held a joint suicide conference which was attended by clinicians.
- Our keynote speaker at the event was Thomas Joiner, who created the Joiner model (the interpersonal theory of suicide that attempts to explain why individuals engage in suicidal behaviour and to identify individuals who are risk) which was explored during the conference. Clinicians reported that the topics covered afforded them time for rich discussion and reflection
- We are committed to continue our work with the Zero Suicide Alliance
It has been noted there was an increase in suicides in the period 2016/17, this is due to the addition of inquests where the coroner records a narrative verdict. These were not included in previous years’ data, so will show an increase. Due to this we will be carrying this indicator over to the next year. The chart above shows data for 2016/17 with the narrative verdicts identified.

Our Family Liaison Officer (FLO) has attended both the Southampton and the Hampshire Suicide Prevention Groups. She gave a presentation to the Hampshire group to highlight the need for additional support, both for bereavement and for families and carers of those at risk of suicide, and to suggest options for that support. The Hampshire group have asked the FLO to be part of a sub-group to explore and propose options for additional support in the wider community. It was also suggested that the three Hampshire prevention groups should work collectively to explore the options for joined up support across the county.

The FLO has also been invited to attend the Portsmouth Suicide Prevention Group to participate in a Task and Finish Group considering bereavement support and protocol development.

During this year the Communications Team assisted with the production of a video involving a family member and an investigating officer to show how the family liaison role has supported them. This video will be included in several conferences and meetings including the ‘Investigations and learning from deaths in NHS Trusts’ event in London, the Mental Health Joint Commissioners Quality Meeting, and our local senior leadership meeting.

The provision of crisis management has been challenging due to the geographical area that we cover. Therefore a large scale quality improvement project group was created; this involved other Trusts (including Solent NHS Trust) and local authorities.

Last year we launched a major programme of work supported by Northumberland, Tyne and Wear NHS Foundation Trust and collaborating with Solent NHS Trust. During 2018 we undertook months of careful observations of how teams are currently working, examination of processes and records, and over 150 hours of workshops and consultation involving hundreds of patients/service users, carers and staff discussing how services should look in the future and particularly how people would like to access community mental health services.

“It's not about IF these changes will happen, because I believe they will, but it’s WHEN. Not everything can happen quickly but we need to be kept informed of progress at every step.”
This is a large scale programme of changes and improvements. The group are working to ensure that good governance and robust project management is in place so that our progress will be tracked and measured. It is planned that the combined crisis service will be launched by summer 2019. The project group are committed to the principle of coproduction and we will build on the inclusive approach to service change that we have already started.

**Future plans:**
We will be creating a Trust suicide prevention group in order to review best practice, share and discuss lessons learned and understand how we can better support our patients to reduce the risk of suicide. As part of this group we will also plan for a second suicide prevention conference.

In order to have more timely information on deaths by suicide we will be publishing an annual suicide report, which will enable us to implement changes to practice and improve prevention more swiftly. We currently produce a benchmarking report to compare against the National Confidential Inquiry into Suicide and Safety in Mental Health (NCI). However the data within the NCI report is usually two years behind current data. We will continue to do the benchmarking report, but feel the annual report will allow for quicker implementation of change.

### Priority 2: Improving clinical effectiveness

**Indicator 2.1 Improving the recognition of sepsis in the community (Trust-wide)**

**Aim:**
Prevention and early recognition of sepsis in community patients is a priority for the Trust. Sepsis is a common and potentially life-threatening condition which in many cases, if detected at an early stage, is treatable and long term harm avoided. We aim to provide guidance and education to all community patients, their families and carers.

**Achievements:**
The mental health and integrated services divisions have introduced the UK Sepsis Trust advice leaflet. This is discussed with and given to all patients, families or carers in order to educate people about the early signs and recognition of sepsis and where to access medical assistance if needed.

Our Families First stakeholder group agreed the previous leaflet was helpful, however it also agreed that further divisional modifications would be beneficial. Our learning disabilities services designed an
easy read version of the leaflet to share with service users, their families and carers. They also have a learning network which includes quizzes and workshops in order to support staff with early recognition of sepsis.

Staff resuscitation training covers the basic elements of sepsis awareness. The training highlights the importance of early recognition of sepsis and appropriate escalation for treatment, during Intermediate Life Support (ILS) training a practical sepsis scenario is completed. The current compliance rate for life support training across clinical staff is 90.4%. This is lower than our 95% target due to high staff vacancy rates limiting timely refresher training completion over the winter. February and March training rates exceed the 95% target.

The Integrated Services Division has delivered sepsis training to all community teams in the format of a presentation which was delivered at team meetings. The target of 90% has not been documented by Q4 in part due to systems recording problems and staff turnover.

**Future plans:**
We have rolled out National Early Warning Score (NEWS2) across all physical health inpatient services. This is a system used to identify and respond to patients at risk of deteriorating. This will be expanded to roll out NEWS2 and the paediatric version (PEWS) Trust-wide. To facilitate this staff will be trained in sepsis recognition and how to use an appropriate and effective tool to inform clinical practice.
Aim:
Prevention and early recognition of wounds is a priority for the Trust. Patients with chronic non-healing wounds have a significant reduction in the quality of their life and such wounds are substantial economic burden to NHS (recent estimates put wound care at 6% of the NHS budget.)

Our Trust aims are to improve the clinical outcomes for patients across the Integrated Services Division (ISD) through education and learning from incidents to improve practice.

Achievements:
The ISD has introduced standardised terms of reference for all wound and pressure ulcer incident investigations. Human factors (organisational, environmental and social circumstances) are included as elements of the investigation. All teams undertake clinical supervision for each pressure ulcer incidents that enables staff to extract and embed learning, supporting immediate improvements in patient care.

A quality improvement (QI) project was completed as part of the transformation programme ongoing within the Trust. Five elements for improvement were identified; equipment, panels, triage, documentation and training. Pathways, standard operating procedures and a robust action plan were written up during the initial workshop, and the changes and updates were communicated via a
roadshow visiting all ISD community teams across the Trust for maximum exposure. Staff gave positive feedback throughout; however, there was also a fair amount of anxiety with the level of changes involved. Staff will be supported by the Practise Development leads to manage these changes.

Delays in equipment provision for patients with chronic wounds was identified as an issue. The list of reported incidents were presented at the clinical quality review meeting for Hampshire commissioning groups to review with Hampshire County Council (HCC). The issues will continue to be addressed in 2019/20.

The pressure ulcer panel review process has been streamlined. A redesigned single questionnaire is now used as part of clinical supervision. The new process has freed up clinicians from sitting on panels for up to 12 hours a week, allowing more time to discuss patient care, identify learning and make positive changes to local practice.

In 2018/19 there was an improvement in the percentage of staff undertaking e-learning in relation to pressure ulcers over 2017/18. Changes in the NHS pressure ulcer grading system and actions identified as part of the QI programme meant the e-learning course was revised and supplemented with a face-to-face training option for 2019/20. Staff will now be able to choose their preferred method of training.

**Future plans:**
Work on this quality priority will continue into 2019/20; the ISD Practice Development Leads will continue to support teams to implement the QI action plan, including a plan to buddy up teams for support. The expectation will be to reduce the number of moderate pressure ulcer graded as moderate or above by 40% and increase the number of full wound assessments and holistic assessments by 50%.
Indicator 2.3 Improving access to psychological therapies. Adult mental health (AMH) and older person mental health divisions (OPMH).

Aim:
Psychological therapies are an important part of the treatment pathway for some patients. Within mental health and older persons mental health services there is a disparity in the access to psychological therapies which has been associated with long waiting times. Our aim was to understand and reduce inequalities and to address areas where psychological therapies are not frequently available.

Achievements:
It became apparent when we were reviewing the waiting list data that there was an inconsistency of approach when recording waiting times, not only for psychology intervention, but also for carers groups, making it difficult to have an accurate baseline on which to show any progress. This also identified a disparity between areas on the length of time people spent waiting.

A quality improvement project was carried out to examine the availability of psychological therapies on Berrywood Ward, part of the Older People’s Mental Health service at the Western Community Hospital in Southampton. The project included a workshop week that took place in September 2018 and identified a number of improvement areas.

During the weekly planning meeting it became apparent that the therapeutic time spent with patients and patient’s social interaction was limited, this was due to many factors but the environmental impact meant that it was not conducive to psychological therapies being completed. The initial ‘quick wins’ included reorganising the patient lounge areas see if there was impact on time spent on therapeutic activities, it was found that the environment was a key factor and the simple change of layout had a positive effect on patient interactions. The layout was changed from:

Before

After
The introduction of a psychologist was a key action and has already been implemented. The group recognised that one psychologist would not have the capacity to provide all of the interventions required; therefore they will also be providing training to staff in order to deliver psychological formulations.

**Future plans:**
Further embedding of the psychological work within Older Persons Mental Health services. This priority will also be carried over to next year’s priorities as we have not fully achieved this within the year, we are aware the Trust is going through a process of restructure and as such we will need to review the priority to ensure it meets the needs of patients once the restructure has concluded.

■ **Priority 3: Improving patient experience**

**Indicator 3.1 Consistent staffing**

- **Aim:** To ensure we have a stable workforce to provide high quality care to our patients. Interview staff to understand why high numbers are leaving within 12 months and implement a workforce strategy to address the issues that are highlighted. We have achieved this indicator, however, the retention of quality staff is challenging across the NHS, therefore it will also be one of our priorities for the coming year.

- **Achievements:** During this year we have implemented a workforce strategy. We wanted to understand why some staff leave within 12 months of employment. Through exit interviews it was found that the reasons for leaving are varied, with many related to lack of career progression, lack of flexible working and high pressure of work. The main group leaving within this time period are nursing staff.

  We are progressing this work with the retention hotline number being staffed by HR professionals, and exit questionnaires automatically sent to all leavers. We are aware of the need locally and across the system to develop more flexible working patterns and roles to both attract and retain staff and there are specific actions detailed within the workforce strategy work plans to address this and improve the health and wellbeing of our staff.
The numbers of staff leaving within 12 months of employment has fluctuated during the year:

It has been identified that our slow recruitment process was resulting in potential new employees taking up alternative employment. In order to redesign the process a quality improvement project was undertaken, with a workshop in September 2018.
The team were able to implement some immediate changes. A plan to reduce the recruitment process by 34 days included changes to forms and templates and keeping the candidate better informed. The internal recruitment process was amended and implemented straight away, and this was well received by managers who were in the process of recruiting candidates from within the Trust.

The updated recruitment approval process has saved time by avoiding the need for all nursing and clinical posts to be checked by the executive team.

Further improvements have included:
- changes to essential forms
- use of alternative application forms for specific roles
- communication plan for applications
- revision of some areas of NHS jobs.

“It has been tiring but invigorating to be involved in the week long workshop, we have done so much in a short space of time. The impact of this change will not only improve the process for new candidates (as this will be their first touch with Southern Health) but also the job satisfaction for the recruitment team, and reduce the frustration of recruiting managers.”

Shelly Mason – Matron for Older Persons Mental Health
We know that we need to support our staff in order to retain them and we recognise that we need a co-ordinated approach to do so. Our People Development team have developed an infographic to identify the different areas applicable to retaining staff. This team also offers a range of support for groups across the Trust to improve team building, culture and personal development which have retention benefits in helping make the Trust a more desirable place to work, where the focus is on having a career pathway, not just a job.
A learning festival commenced during this year, where groups of staff attended to learn from leaders within Southern Health NHS Foundation Trust, other NHS Trusts and External leaders. Over 240 staff members attended the eight sessions.

To better support our clinical staff and ensure they do not come to harm at work we have been working in partnership with Hampshire Constabulary to launch Operation Cavell. This is an initiative at improving how we support and protect our colleagues working on inpatient wards, and focuses on how reports of assaults, threatening or challenging behaviour against staff are handled. This procedure is aimed at those whose behaviour is not caused by an illness or condition, and where, despite being advised not to, they continue to abuse or assault staff, or cause damage.

Operation Cavell was started as a pilot in two inpatient units and three community teams within adult mental health and specialised services, and will be rolled out across the Trust over the coming year.
**Future plans:**
We recognise that developing leadership skills should be accessible for staff across all professions both clinical and non-clinical, and at all pay levels. As such we have completed focus groups as part of a fact finding mission in relation to leadership training, the outcomes of these focus groups have fed into the workforce strategy and a leadership training programme has been developed. This programme is due to go live in 2019/20 and will operate in a tiered approach so it can be available to all groups of staff.
Indicator 3.2 Triangle of care

Aim:
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 ill-health. 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 aim was to ensure that we included our carers in all aspects of their loved ones care. We worked with staff, carers and interested groups, such as the Families First group, so that staff are trained in being "carer aware". We have achieved this, however appreciate that there is additional work by the project leader in 2019/20. This will not be reported as a quality priority going forward.

Achievements:
The Triangle of Care exists of six principle:
- carers, and the essential role they play, are identified at first contact or soon after
- staff are ‘carer aware’
- confidentiality protocols are in place
- carers Leads are in place
- carer introduction is in place with relevant information across the acute care pathway available
- carer support/information is in place.

Collaborative work has taken place with the Families First group and other stakeholders in order to produce leaflets and carers packs for inpatient units, this is now being expanded with input from one of the Trust’s user involvement facilitators.

During this year we have created a carers communication plan, this has been written with input from stakeholders at every stage, and identified what was important to carers such as:
- recording details about the carer; their contact details and how they are involved with the patient or service user
- recording significant information/triggers
- identifying support and information for carers.

Embedding this fully is a key aim for the year ahead.
This has now been implemented on RiO and a draft Tableau report is being created so we can review how many communication plans we have in place and monitor numbers. Below is a draft version of the Tableau report.

We have also created a package of training for staff to make them more aware of the importance of carers in some people’s lives and the value of appropriately involving them in planning and delivering patient care. The training covers:

- identifying ‘who is a carer?’
- the importance of sharing information with carers
- issues/barriers to sharing information
- our four key principles of engagement with families, carers and friends.
- a dedicated booklet to aide carer awareness for staff members.

This training is enhanced to support carer’s leads in each of the mental health inpatient units. The majority of the lead roles have been assigned to individual staff members with a particular interest in supporting carers. At the end of Q4 2018/19 65% (25 of 39) of carers leads had been trained, with future dates in place to complete the remainder. Several of the trained carers leads are already carrying out training with their teams in relation to carer awareness.

Carers groups are established at all adult mental health inpatient units and the groups are undertaking reviews to assess the quality of the inpatient carers packs.

**Future plans:**
We recognise that the work completed within the adult mental health division relates to a small part of our Trust, and we are pleased to have support of the Trust Board to develop this further.
Indicator 3.3 Reducing Incidents of Violence and Aggression

Aim:
Any incidence of violence and aggression is extremely damaging and distressing to all individuals involved. 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.

Achievements:
A quality improvement initiative was implemented on Kingsley Ward at Melbury Lodge, in order to improve the overall safety of the environment. During the initiative a group of staff, patients, carers and other stakeholders met to review the data and experiences of people who work or are admitted on to the ward.

During a week-long workshop the group generated over 100 ideas for improvement.
It became evident that the amount of therapeutic time spent with patients was not balanced with the amount of time taken to do administration tasks. Areas for attention were as follows:

- increase the staff feeling of ‘time for patients’
- improve ward round process
- enhance the feeling of safety
- culture change.

Historically one member of staff per shift was allocated to undertake 30 minute observations of each patient. The QI project members trialled stopping this as felt it added no value to patient interactions. This simple change had a huge impact, with staff and patients quickly reporting they had more time for therapeutic contact and felt happier. Other simple but effective changes included providing better storage for patient property, improving the seating in reception area, and releasing two staff members per shift to join patients for meals, which has increased positive interactions and relationship building. Importantly, the numbers of safety incidents that are being reported by the team have reduced dramatically, to the point where the security team asked what had changed because the difference was so noticeable.

“From Wednesday we started to split into groups, each group looking at the key themes identified and starting to unpick them. The issues felt most important to address, by the whole group, were patient observations, ward rounds and the management of leave. At the same time, we identified ‘quick wins’ which were issues that could be addressed quite easily and quickly (the clue is in the title!) for the benefit of patients. For example, clock radios for patient rooms and the revision of the patient Welcome Pack.”

Sarah Curtis – patient representative on Kingsley quality improvement project.

Some of the larger issues relate to the environment of Kingsley Ward and involve undertaking building works; these are currently being explored with the Trust Estates team.

Staff from other units have made contact with the Kingsley Ward Manager, to learn what changes they have made how the process could be applied to their own units and teams.

**Future plans:**

Inpatient units will consult Kingsley Ward staff to review what practices they could implement from the quality improvement work Kingsley ward have completed.
Section 3b. Further information

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

1 Our quality improvement programme 2018–19

Our key priority is to deliver 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 and transforming the services we provide.

We have embarked on a period of substantial transformation, beginning with a focus on our approach to quality improvement (QI). We have learnt from best practice seen in other NHS Trusts and have implemented some of these successes locally, as well as building on the excellent work already taking place within our own organisation. We have given our employees the autonomy, and confidence, to make changes where they know that outcomes for patients can be improved. Initially we have done this by working in close partnership with colleagues from Northumberland Tyne and Wear NHS Foundation Trust, to learn from their experience in this process of transformation and improvement.

Our QI programme has seen approximately 60 staff take part in intensive QI training this year, learning practical tools and methodologies that can be applied in all our services. These staff go on to lead individual projects, providing support and training to others to deliver real change. Six of these staff are working within the team which manages the programme and are seen as QI coaches, providing a central pool of expertise and experience and managing delivery of training and project support. Not all members of staff (including some Board members) that took part in the intensive training course were able to devote sufficient time to support projects, so additional training is planned for quarters one and two in 2019/20 to maintain a pool of 60 active QI facilitators across the Trust. In addition, newly qualified health care professionals will have a session on QI tools in their preceptor training.

The Trust Board is clear that in order to make the right changes in the right places, a collection of staff, service users, patients and their carers and families must be involved at every stage. Those who deliver and receive our services are the experts in helping to make them more effective. This work is also being delivered in line with the Trust’s new vision and strategy and together will help shape our path for the future.

A QI Programme Board has been set up to oversee and drive forward our plans to improve our services. The board is chaired by our Medical Director, and has a broad membership including staff, carers and service users, reflecting our commitment to genuine co-production.

In the past year around 20 quality improvement projects have been initiated as part of this programme. These include:

- a review of community learning disability health services
- improving the environment, activities and engagement with patients at Bluebird House
- improving access to community mental health services in Portsmouth and South East Hampshire
- reducing incidents and improving safety on Kingsley Ward
- improving how we prevent, identify and manage pressure ulcers
- improving and streamlining the recruitment process
- improving access to psychological therapies for older people on Berrywood Ward.
• improving the Electro Convulsive Therapy pathway for patients and staff
• reducing patient waiting times and improving the flow at Lymington Minor Injuries Unit
• meetings and papers review - improving corporate processes.

2 Our organisational learning 2018–19

We want Southern Health to be an organisation 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.

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 listening to a person’s voice has been a key focus for us over the last year.

Learning is shared at different levels within the Trust depending on its nature. This includes an internal alerting system to share immediate learning from serious incidents, as well as service level hotspots, learning matters and divisional learning posters. Learning is also shared via learning networks and quality, safety and professional conferences.

During 2018-2019, the team leading the quality improvement programme have delivered our first ever QI Conference, sharing the learning from the training and various projects taking place. 140 members of staff, service users, carers, family members and commissioners attended the event, with very positive feedback received from participants. One result has been past patients now volunteering at the Trust. After the success of this first event a larger conference is set to take place in June 2019.

A modular training program has been launched which includes modules on observational skills, quick wins and PDSA (plan, do, study, act). It is expected that over 600 training slots will be available in 2019/20.
The Care Quality Commission (CQC) undertook a comprehensive inspection of our mental health, learning disability and community health services between 21 May 2018 and 5 July 2018. We were rated as Requires Improvement.

Although the overall rating remained the same as in 2014 when we were last rated, the CQC reported many examples of good practice and improvements throughout their inspection report. Six of the our 15 core services inspected improved their overall rating, eight remained the same and only one went down. Our perinatal and eating disorder services were not inspected in 2018 so their ratings remained the same as in 2014. In total three of our total 17 core services were rated Outstanding and ten were rated Good with only four rated Requires Improvement.
### Ratings for mental health services

<table>
<thead>
<tr>
<th>Safety</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="#">Forensic inpatient or secure wards</a></td>
<td><a href="#">Good Sept 2018</a></td>
<td><a href="#">Good Sept 2018</a></td>
<td><a href="#">Good Sept 2018</a></td>
<td><a href="#">Requires improvement Sept 2018</a></td>
<td><a href="#">Requires improvement Sept 2018</a></td>
</tr>
<tr>
<td><a href="#">Wards for people with a learning disability or autism</a></td>
<td><a href="#">Good Sept 2018</a></td>
<td><a href="#">Requirements improvement Sept 2018</a></td>
<td><a href="#">Good Sept 2018</a></td>
<td><a href="#">Requires improvement Sept 2018</a></td>
<td><a href="#">Requires improvement Sept 2018</a></td>
</tr>
<tr>
<td><a href="#">Eating disorder services (not inspected during this inspection or included in ratings aggregation)</a></td>
<td><a href="#">Good Sept 2018</a></td>
<td><a href="#">Requirements improvement Sept 2018</a></td>
<td><a href="#">Good Sept 2018</a></td>
<td><a href="#">Good Sept 2018</a></td>
<td><a href="#">Good Sept 2018</a></td>
</tr>
</tbody>
</table>

**Overall**
On 29 June 2018 the CQC served us with a warning notice under Section 29A of the Health and Social Care Act 2008. The notice was in relation to two registered locations, Bluebird House and Leigh House. The reasons for the Commission’s view were that at the time of the inspection (19 to 21 June 2018) we did not have sufficient staff to ensure the safe care and treatment of the young people at these locations. The CQC undertook an unannounced inspection on 18 July 2018 to check whether we had taken the necessary actions, and found that significant improvements had been made and as such, they lifted the warning notice.

The CQC identified several other areas for improvement within their inspection report and issued us with seven Requirement Notices. A quality improvement plan was developed to address these areas, and the plan focused on themes with a work stream approach to understand and address root causes with quality improvement methodology being used to support the improvements.

Using a programme management approach all CQC related improvement actions are monitored through the weekly Quality Improvement Plan Delivery 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.

4 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.

We have continued to support this by:

- reviewing our Duty of Candour policy and procedure to provide greater clarity to staff on their responsibilities
- developed a series of tools to support staff in properly and consistently demonstrating the behaviours and practices that are required, including:
  - an e-learning training package for staff on the requirements of Being Open and Duty of Candour
  - reviewed our Ulysses Safeguard Risk Management system, where Duty of Candour compliance is recorded, routinely carrying out a review of any moderate and above incidents where staff have indicated that Duty of Candour could not be undertaken to ensure that there is a valid reason for this (for example where the patient/family has explicitly asked for no contact)
  - undertaken audits to confirm compliance with each step of the Duty of Candour requirements, 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
  - 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 4 times throughout 2018-19 and trained a further 77 Investigating Officers
  - completed refresher training for our first cohort of investigators who were trained in 2015.
Duty of Candour continues to be 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.

5 Role of the Family Liaison Officer (FLO)

We have had an established Family Liaison Officer role since December 2016.

During 2018/19 there were 92 referrals for FLO support. Overall there was a reduction in the number of referrals from staff; however, an increased number of families received support. The reduction of referrals from staff is due to improved awareness and understanding of the role, leading to more appropriate referrals.

Each individual referral received may result in support being extended to multiple members of family or carers but usually will only be counted as one case.

The breakdown of referrals is as follows:

- 53 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)
- 26 families are currently receiving support on a regular basis
- 10 families were contacted by the FLO to provide information, options for external support and contact details on a one-off basis
- 12 referrals are currently under review pending contact from family
- 41 families have not required direct FLO support.

This year more enquiries were received from staff to discuss options for better communication with families in complex situations. These discussions did not result in a formal referral unless there was a place for direct FLO input, but is a very positive step in improving how we support families and carers across the organisation and a generally unseen aspect of the role.

The FLO co-presented the ‘Sharing Information’ exercise as part of the Investigating Officers training schedule. She is a member of the Trust’s Patient Experience, Engagement and Caring Group and the Families First Group. A key part of the role is sharing best practice across the NHS and linked organisations. Over 10 formal presentations and training sessions were given at external conferences and events.

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 our improvement work and ensures the families receive updates on this continuing work.

In the past year the FLO has focused on the following issues:

- ensuring that families and service users received appropriate support
- reinforcing the need for staff to communicate with service users, carers and families from day one through training, internal and external presentations and general conversation
- staff training
- working with external agencies to resource further support for bereaved families in the community
- updating Carer’s Packs and information
- providing support information on death and dying for people with learning disabilities and those
who support them
• supporting the ‘Triangle of Care’ work in mental health services.

The FLO continues to be an active member of the Hampshire and Southampton Suicide Prevention Groups and has utilised these networks to work with voluntary support agencies to improve provision in various parts of Hampshire. She has also participated in the Task and Finish Group set up by the Portsmouth Suicide Prevention Group to review and develop bereavement support in the area.

6 Staff survey

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

The most recent results for indicators KF21 (now called 14) and KF26 (now called 13c) are:

<table>
<thead>
<tr>
<th>Reference</th>
<th>Details of indicator</th>
<th>2017 Survey</th>
<th>2018 Survey</th>
<th>2018 Average survey result</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF 21</td>
<td>Percentage believing that the Trust provides equal opportunities for career progression or promotion</td>
<td>88%</td>
<td>90%</td>
<td>87%</td>
</tr>
<tr>
<td>KF 26</td>
<td>Percentage of staff experience harassment, bullying or abuse from staff in the last 12 months</td>
<td>20%</td>
<td>17%</td>
<td>15%</td>
</tr>
</tbody>
</table>

In the last year we have taken a number of actions to improve equal opportunities for career progression. These include completing and publishing a Workforce Diversity Scorecard to scrutinise the involvement of protected groups in recruitment, selection, employee relations, training and development. We have also delivered the Workforce Race Equality (WRE) Action Plan, achieving positive outcomes across the WRE standards metrics. We have hosted three diversity and inclusion engagement events in 2018/19, in order to scrutinise staff experience data for protected groups, identify current methods of engagement, and co-design staff engagement and inclusion activities for 2019/20. In August 2018 we were a proud official partner of the Southampton PRIDE event, and in October celebrated Black History Month.

The People Development team undertook ‘An ethnographic review into black and minority ethnic (BME) disciplinaries at Southern Health to review people’s experiences at every point of the employee journey for BME staff, including recruitment, selection, employee relations and exit interviews. The review will be completed and presented in quarter one of 2019/20. The team has also delivered development programmes that include an ‘Introduction to Line Management’ module, which highlights the importance of wellbeing, diversity and inclusion.

In the last year we have also taken a number of actions to reduce staff experience of harassment, bullying or abuse from colleagues. A new working group met in January 2019 to design a delivery programme for tackling bullying, harassment, violence and aggression from any source, and we launched Operation Cavell, a partnership project with Hampshire Constabulary to improve how we manage incidents of violence and aggression that has been implemented in some mental health teams.
We have completed a baseline assessment of how we provide support to staff following a critical incident, and where required delivered staff and team support via Human Resources; Critical Incident Stress Management (CISM) and the Health and Safety Team. We have continued to implement the ‘Time to Change – Employer Pledge’ action plan on changing the way we think and act about mental health at every level of the organisation, and completed a baseline mapping exercise with regards to NICE Standards on Health and Wellbeing Management. Through the staff engagement events we’ve gathered feedback that has been used to design the Health and Wellbeing (HWB) Champions toolkit. The toolkit embraces the principles of Positive Psychology and offers staff the opportunity to identify ‘what we are doing well’ and ‘what needs to improve’.

7 Freedom to Speak Up

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

In October 2018 the post became substantive with full time hours. Over the last year, the contacts from staff have risen to over 200, an increase of approximately 200%. A broad range of subjects have been raised, with the highest number of contact themes being patient safety, bullying and harassment and organisational risk. This reflects the challenges of recruitment and retention in our workforce.

The guardian has been supported by the Executive Director for Workforce, Organisational Development and Communications, and a Non-Executive Director with a special interest in this subject area. The Guardian meets monthly with the Chief Executive, each of the directors and Trust chair, to discuss themes and areas of concern.

She has worked closely with different groups and teams in the Trust, including Staff Engagement and People Development, and central to her role is speaking with staff and teams across all service areas to provide independent and confidential support to those who want to raise concerns.

HR data and staff reflections show the formal HR processes are not always helpful, can take time, be disruptive and have a hidden cost of loss of engagement or job focus, with potential impacts on quality of care, absence and other staff. Therefore reducing the number of cases where staff are subject to formal processes is key.

Changes as a result of concerns raised this year:
- the whistle blowing policy has been updated, making it clearer and less intimidating
- we have Defined the ‘Human Resources (HR) offer’ – for dealing with key cases such as Bullying & Harassment, Grievance, Disciplinararies, Whistleblowing. This will involve a review under each of:
  1) what we do
  2) how we support staff/teams through it
  3) potential options to avoid unnecessary formal processes (where appropriate).
Information on the Speak up program where staff can raise concerns over quality of care, patient safety or bullying and harassment was provided to staff by:

- staff intranet link to the Trust Freedom to Speak Up Guardian and how she can be contacted by mobile phone or dedicated email
- staff notice boards across the Trust provide information on Freedom to Speak Up Guardian and her contact details
- the guardian role is promoted at staff induction, staff wellbeing events, Conflict Resolution and Management Induction training
- recruited “Freedom to Speak Up Champions” from a diversity of directorates to assist in spreading confidence amongst staff to raise concerns.

The guardian worked directly with staff that raised concerns and kept them informed of progress as the matter was escalated (if required). Feedback was given via face to face or telephone meetings and followed up with a letter.

We ensure staff who speak up do not suffer detriment by handing concerns raised confidentially directly to the guardian. Where required, the senior management team would aid resolution and ensure the staff member was supported to continue working in their role and location.

The Freedom to Speak Up Guardian links into the National Guardian network and attended national and regional meetings and conferences during the year.
NHS Doctors in training

This is a new indicator in the 2018/19 Quality Report that gives assurance that the doctors in training are safely rostered and their working hours are complaint with the terms and conditions of service junior doctors’ 2016 contract. Our Guardian of Safe Working’s (GOSW) annual report on rota gaps and plans for improvement to reduce these gaps is summarised below.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Doctor in training - Trainee numbers, rota gaps and outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1 2018–19</td>
</tr>
<tr>
<td>Total trainees</td>
<td>92</td>
</tr>
<tr>
<td>Non training programme doctors</td>
<td>1</td>
</tr>
<tr>
<td>Vacant training posts</td>
<td>15</td>
</tr>
<tr>
<td>On call rota gaps</td>
<td>15</td>
</tr>
<tr>
<td>Total exception</td>
<td>17</td>
</tr>
<tr>
<td>Outcome – No further action</td>
<td>4</td>
</tr>
<tr>
<td>Outcome – TOIL/payment</td>
<td>13</td>
</tr>
<tr>
<td>Outcome – Level 1 review</td>
<td>0</td>
</tr>
<tr>
<td>Outcome – Level 2 review</td>
<td>0</td>
</tr>
</tbody>
</table>
Doctors in training numbers and assignments are coordinated nationally by Health Education England (HEE), and we are supporting the HEE school boards regionally. We operate six non-residential rotas and two full shift residential rotas covering all five areas across Hampshire.

The table above reflects all trainee doctors including foundation years (FY) one and two, widening access to specialty training (WAST), General Practitioner specialist trainees (GP ST), core and specialty trainees. The quarterly trainee numbers may fluctuate due to the number of doctors working less than full time in a rota.

All the activity on rotas is monitored by the rota coordinator in the medical human resources department (HR). The GOSW works closely with Medical HR and junior doctors to monitor and improve the service for all stakeholders.

We have taken the following actions to reduce rota gaps:

- Established the Junior Doctor Forum (JDF) with junior doctors, medical HR, local negotiating committees (LNC), management and executive team members. This provides an opportunity to discuss concerns and agree improvement plans.
- Reorganisation in the Trust with clinical tutors and a chief registrar appointed.
- We have appointed three Training Programme Directors (TDP); a foundation year TDP, a Mental Health Higher TPD and a Forensic TPD. The latter two have been involved in working on regional HEE strategies to fill training gaps. This is particularly important in that any single Trust does not have control over training doctor appointments which are managed nationally.
- The Regional GMC (General Medical Council) conducted a Trust Education Quality Review and Inspection in 2018 and reported positively on trainee induction, supervision, targeted training with senior members of the organisation being visible, identifiable and approachable.
- The GMC recommendations for improvements have been addressed, with continuing actions on use of differing information systems and supporting diversity matters for groups such as ‘less than full time training’, and international medical graduates.

9 Nurses and Allied Health Professional training and development

The Trust works with local universities to offer student nurses and Allied Health Professionals (AHP) a wide variety of placements within the Trust, across the duration of their training programme.

Students completing the Registered Nurse Degree Apprenticeship programme (RNDA) are Southern Health employees who are supported to complete their RNDA on a part time basis with the Open University.

We offer a wide variety of additional training and support for nurses and AHPs. For example the Trust induction includes information on how to raise concerns, the Freedom to Speak Up Guardian role and information governance amongst other elements. The trainees are supported according to the Nursing Midwifery Council (NMC) and the HCPC (AHP governing body) regulation, with a practice based mentor, access to student forums to augment their theoretical learning and consider how to apply theory to practice. We have practice educators based within the Learning Education and Development team who support students and newly qualified staff.
Student nurses and AHP staff are not rostered on shifts as per the doctors in training and do not count in the safer staffing team numbers.

<table>
<thead>
<tr>
<th>Nurses and AHP in training</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student nurses</td>
<td>1205</td>
</tr>
<tr>
<td>Student AHP</td>
<td>133</td>
</tr>
<tr>
<td>Nurse apprenticeship</td>
<td>23</td>
</tr>
<tr>
<td>Nursing associates</td>
<td>10</td>
</tr>
<tr>
<td>Assistant practitioners</td>
<td>10</td>
</tr>
<tr>
<td>Preceptorship</td>
<td>132</td>
</tr>
<tr>
<td>Return to practice (Nursing and AHP)</td>
<td>8</td>
</tr>
</tbody>
</table>

Once qualified, there are many exciting opportunities for trainees to gain employment in the Trust, and they are offered a seven month preceptorship programme that includes seven training days, placed into action learning sets and supported in practice by practice educators. They complete the programme by undertaking a quality improvement project or clinical audit which they present to senior staff from across the Trust.

We also offer a ‘return to practice’ entrance route for qualified staff not currently working in the NHS. A full mentoring programme is also offered.

Each placement is evaluated by the students through their university. Average scores are extremely positive at 94% good or very good and feedback included comments such as;

- "I enjoyed my time with staff at the community care team greatly. I always felt well supported and was given many opportunities to learn and develop new skills. My mentor was an excellent example of the kind of nurse I would like to aspire to be, and by the end of my placement I really felt like a part of the team. I would highly recommend this placement to other student nurses."

- "This placement was a great insight into the community. My mentor was great to work with as she was really thorough with her work and explained it really well to me. She gave me the opportunity to take on tasks such as holistic assessment on my own which improved my communication skills and confidence. This is great placement to learn about wound care and dressings. I gained a lot of experience in understanding the aim of enhanced recovery is to promote, educate and encourage independence for the patients by giving them the skills and building their confidence to continue with their activities of daily living after discharge from hospital."

In 2018/19 there was a focus on general recruitment of nurses and AHPs. Previously existing staff have cited a lack of career progression opportunities as a reason for leaving, so teams have looked at rotations and secondments in order to better recruit and retain staff. In 2019/20 there will be work to look at career structures and more opportunities for nursing and AHP staff including Advanced Practice pathways and Non-Medical Consultant roles. Wider rotation opportunities are also being explored across physical, mental health and learning disability services, as well as via the local sustainability and transformation partnership (STP). There is also a need to explore opportunities provided for AHPs by the new advanced clinical practitioner (ACP) and pre-registration apprenticeships roles.
Learning disability improvement standards

This is a new section in our Quality Report for 2018/19. We completed a benchmarking exercise for the Learning Disability Improvement Standards in November 2018. This will become an annual activity for all Trusts with data collated by NHS Improvement.

The standards reflect the strategic objectives and priorities described in national policies and programmes, in particular those arising from Transforming care for people with learning disabilities – next steps and the Learning Disabilities Mortality Review (LeDeR) programme.

We plan to take the following actions to improve our performance against these standards by:
- developing a learning disability flag on patient records to enable staff to make reasonable adjustments in service provision and allow future tracking of NHS services
- our estates service will consider amendments to new building designs to accommodate people with disabilities. Examples of such facilities include quiet / low stimulation waiting areas and changing rooms for people using incontinence products
- working collaboratively with other established projects such as Quality Improvement, Greenlight tool kit and CQUIN 3b to ensure that the Learning Disability Standards are considered in ongoing work but that endeavours are not duplicated
- learning Disability Health Facilitators provided awareness training across all trust divisions. The uptake, feedback and decisions on resources will be reviewed in 2019/20.

The benchmarking exercise involved 87 questions which were RAG (red, amber, green) rated. Over 50% of the red and amber questions could be address or partly addressed though flagging people with a learning disability on RiO. Where there were variations across the divisions we answered for the majority of services provided.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2018 baseline audit on the Learning Disability Improvement Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southern Health</td>
<td>20%                    15%                        65%</td>
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Annex 1: Statements from external organisations

The opportunity to provide feedback on the Quality Report was offered to the following bodies:

- Clinical Commissioning Groups - West Hampshire, South Eastern Hampshire, North Hampshire, Fareham & Gosport.
- Clinical Commissioning Group - Southampton City.
- Council of Governors.
- Healthwatch organisations – Southampton, Hampshire.
- Overview and Scrutiny Committees – Southampton and Portsmouth declined to comment.

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 2018/19 have been achieved and the level of that achievement.
WEST HAMPSTEAD CLINICAL COMMISSIONING GROUP
Representing West Hampshire, South Eastern Hampshire, North Hampshire, Fareham and Gosport Clinical Commissioning Groups.

9 May 2019

Dr Nick Broughton
Chief Executive Officer
Southern Health NHS Foundation Trust
Sterne 7
Tatchbury Mount
Calmore
Southampton
Hants SO40 2RZ

Email: Nick.Broughton@southernhealth.nhs.uk

Dear Nick,

Southern Health Quality Account 2018/19

West Hampshire Clinical Commissioning Group (CCG), North Hampshire CCG, Fareham and Gosport CCG and South Eastern Hampshire CCG are pleased to comment on Southern Health NHS Foundation Trust’s Quality Account for 2018/19 for the services that the Hampshire CCGs commission. All of these CCGs have worked with the Trust over the past year in monitoring the quality of care provided to their local population and identifying areas for improvement.

Following the previous, very challenging years, there has been some real progress seen during 2018/19, some of which are summarised in your quality statement. In addition it is pleasing to see that all nine of your quality priorities were achieved or partially achieved. The report following the inspection by the Care Quality Commission during 2018, whilst not changing the overall rating, showed individual service improvement. The aspiration of the Trust to achieve an ‘Outstanding’ rating, at the next review in four years’ time, is admirable and it is hoped that quality oversight during the transition to the revised organisational structure does not adversely affect the consistency in meeting the quality standards.

The nine quality priorities identified for 2019/20 are supported by the Commissioners and many are included within the quality elements of the contract for 2019/20. Commissioners wish to contribute positively to the quality and safeguarding agendas and would welcome the continuation of participation at the Trust’s internal meetings, particularly the Mortality Forum and Quality & Safety Committee. Commissioners are encouraged to see the emphasis on care pathways and personalised care planning in the mental health services as these are areas where we have some concerns and we hope that this will also encompass an improved focus on ‘My Safety’ / Crisis plans where appropriate. Commissioners would also have liked to see a continued focus on the quality of risk assessments as this also remains
an area of concern. We are also pleased to see the Trust will continue the focus on wound management including pressure ulcers and chronic wounds. It is positive to note that the trust has signed up to the Zero Suicide Alliance and the accompanying challenging targets and it is hoped that the Trust will continue to work with Commissioners and local Authorities to facilitate this. Commissioners will monitor progress against many of these quality priorities through contract reviews.

It is good to hear that the Trust is taking actions to reduce the numbers of service users placed out of area, however there is no mention of whether the trust has carried out a quality impact assessment of those placements deemed inappropriate and commissioners would like to be assured that the Trust is cognisant of these placements before placing service users in them.

Another area of concern for commissioners is that of the care of patients with co-occurring conditions (referred to as dual diagnosis in your report). Whilst we acknowledge the development of the operational forums in the mental health localities, commissioners remain concerned that progress still needs to be made to ensure these service users receive the appropriate care. The Trust and Commissioners are members of the Hampshire Co-occurring Conditions Steering Group run by Public Health and we would hope that the outputs from this will be seen and interpreted at local level. Commissioners will continue to monitor progress over the next twelve months.

Commissioners concur with your statement in relation to the progress the Trust has made in the development of the Quality Improvement process and have been pleased to have been invited to participate in a number of the rapid process improvement workshops and would like to continue this during 2019/20. We look forward to seeing the consolidation of the actions from these workshops and the positive impact on patient care in the coming months. The impact of the actions from the Quality Improvement initiative on Kingsley Ward, to reduce incidents of violence and aggression, is already seeing benefits to service users and staff and we will be interested to see how this is rolled out across the other mental health wards.

The Clinical Commissioning Groups acknowledge the collaborative work with service users and carers in peer reviews and commend the three new appointments to support the trust working more closely with service users; will this be repeated in other areas? Commissioners have seen at first hand the benefit of having service users involved in the peer reviews and we hope to continue to be involved in these as a critical friend.

The Freedom to Speak up section is an additional requirement in this year’s Quality Account and the improved process the Trust now has in place to provide independent and confidential support to people who want to raise concerns, is more robust and it is particularly encouraging to see the Chief Executive taking a specific interest in this.

The Trust Evidence in Improvement panels which monitor how the learning and actions identified from Serious Incidents have been implemented, have gone from strength to strength and most of them have CCG representation. These are all chaired at Executive level and apply appropriate scrutiny and challenge. The presentations given by teams have improved although there is still room for improvement in some areas. It is good to see that another priority for 2019/20 is continuing the theme of learning with the development of the learning events and will include patients and carers as well as staff. Commissioners would also be interested in attending a selection of these events.

CCGs are disappointed to note that the Trust is still not meeting the agreed timescales for responses to complaints, which has not improved over the last two years, however, we acknowledge that this has been the subject of a recent rapid process improvement
workshop, to which commissioners attended, and we look forward to seeing the impact of the identified actions on the response times.

One of the continuing concerns for both the Trust and Commissioners remains the vacancy and turnover rates for all grades of staff and the high percentages of staff leaving within twelve months of starting. However commissioners have stepped down the bimonthly workforce meetings with the Trust as we felt assured that the Trust is taking positive action to address the difficulties. In addition to the sustained activities the Trust has in place for recruitment, the Trust has continued to recognise the importance of looking after the current staff and, as well as delivering health and wellbeing programmes for staff you are now also working on developing a culture of compassionate leadership; this, together with the quality improvement work on staff induction may well have a positive impact on staff retention and we look forward to seeing how this develops over the coming months.

The Trust has made significant effort over the winter months to encourage staff uptake of the flu vaccinations and this has resulted in an increase, however, there is still a way to go to improve staff uptake with this important safety precaution and we would like to see a continued improvement next year.

This Quality Account complies with national guidance and demonstrates areas of achievement as well as areas where improvement is required. The Clinical Commissioning Groups are satisfied that the overall content of the Quality Account meets the required mandated elements.

The Clinical Commissioning Groups are engaged with the Trust on several levels and have developed strong relationships with the Trust’s local management teams through open communication and robust, but fair, challenge and we acknowledge the level of openness and transparency the Trust has afforded us over the past year. We look forward to continuing the close working relationship with the Trust over the coming year to deliver continued quality improvement to the mental health, learning disability and integrated community service users.

Overall West Hampshire CCG, North Hampshire CCG, Fareham and Gosport CCG and South Eastern Hampshire CCG are satisfied with the Quality Accounts for 2018/19 in that they provide a clear and accurate statement.

Yours sincerely

Heather Hauschild (Mrs)
Chief Officer
West Hampshire CCG

cc
Julia Barton - Executive Director of Quality and Nursing, Hampshire and Isle of Wight Partnership of Clinical Commissioning Groups
Emma Holdin - Executive Director of Quality and Nursing, Hampshire and Isle of Wight Partnership of Clinical Commissioning Groups
09 May 2019

Dr Nick Broughton
Chief Executive
Southern Health NHS Foundation Trust
Sterne 7; Tatchbury Mount
Calmore
Southampton
Hants
SO40 2RZ

Dear Nick

Southern Health NHS Foundation Trust (SHFT) Quality Report 2018/19

Southampton Clinical Commissioning Group (CCG) is pleased to comment on Southern Health NHS Foundation Trust’s Quality Report for 2018/19: for the services that it commissions. We have continued to work with the Trust over the past year in monitoring the quality of care provided to the local population of Southampton and in identifying areas for improvement.

It is evident from the report that progress has been made against the 2018/19 priorities, with all nine being clearly described as either achieved or partially achieved.

Although not carried forward to next year’s priorities, the CCG would welcome a continued focus on Risk Assessments, as there are further improvements to be made. This particularly relates to the quality of assessments and the involvement of patients and family. The CCG would also like to see further improvements in performance in relation to meeting agreed timescales for responses to complaints and it is hoped the impact from the recent rapid process improvement workshop, which included CCG attendance, will support the required improvements. We are pleased to see the continuation of work around Personalised Care Planning and will be working with the Trust to support the delivery of agreed relevant quality indicators.

A key concern over the last twelve months, particularly within Southampton, has been the high caseloads in Community Mental Health Teams and staffing issues on the inpatient wards. Although the Quality Report reflects that SHFT achieved their 2018/19 priority relating to staffing; this has not been as evident in Southampton. Staffing issues have been linked with inpatient beds being closed to admission and the temporary closure of wards. The CCG will be closely monitoring the new 2019/20 priority relating to safe staffing to see how this can deliver effective recruitment and retention strategies and create a culture where staff feel supported and enabled to thrive.

The Trust has made further improvements this year with an increase in the staff uptake of flu vaccinations; we would like to see this continue next year.

In relation to next year’s priorities, the CCG is pleased to see the inclusion of a focus on care pathways within the adult mental health services. It is really important that these pathways are effective, used consistently across the organisation and that the Trust is able to evidence the impact on patient outcomes. We also welcome the priority relating to communication standards in learning disabilities, where priorities were agreed in discussion with commissioners.

The Quality Report provides detail on how the Trust will measure each of the priorities for 2019/20; this would have been strengthened by the inclusion of specific measurable key performance indicators to support delivery and monitoring of progress.
There have been a high number of senior leadership changes across the organisation over the past year and the Trust are currently going through another period of re-organisation. The CCG would now welcome a period of consistency, so that these changes can be fully embedded and support the Trust with its aim of increasing staff morale and formulating robust governance processes.

It is evident that the Trust has continued to proactively involve carers across the organisation and the Quality Report contains many excellent examples of where this is happening, including within the Quality Improvements Programme, Peer Reviews and in the development of the priorities for the next twelve months. Further information is provided in the report relating to the role of the Family Liaison Officer and the CCG has seen, throughout the year, how this role continues to benefit both service users and their families.

The CCG supported the opening of the Crisis Lounge at Antelope House to provide a 24/7 service; but is disappointed that there have been numerous closures of the lounge during the year, which has meant this has not been fully achieved.

The Trust has continued on its improvement journey over the last twelve months, having another challenging year. It is encouraging to see that the prosecution by the Health and Safety Executive is being described by the Trust as a catalyst for huge change and that they are already making progress to deliver and embed related improvements. The most recent Care Quality Commission (CQC) Inspection noted significant improvements had been made in some areas and rated 84% of services as good or outstanding. This is a reflection of the efforts made by the Trust over the past year. The CCG has also seen continued improvement in the reporting and learning from deaths and continues to receive regular updates from the Trust. However, the CCG notes the areas identified for improvement, specifically those linked to the Requirement Notices issued to the Trust at the time of the inspection and those outlined in the Trust's wider Quality Improvement Plan. The CCG will continue to monitor progress over the next twelve months.

There have been many positive developments during the past year, including the launch of a new Quality Improvement Programme to support transformation of services. The CCG has been invited to participate in some of these work streams; which has provided an excellent opportunity for us to work closely with the Trust on quality improvement initiatives. This transparency is welcomed and we look forward to continuing this over the coming year.

Organisations are required to report performance against a specific set of core indicators within their Quality Report; these are included, although some of the performance data is not yet available in the draft report, so we are unable to comment further on this. An additional consideration for inclusion in 2018/19 is for organisations to provide details of ways in which staff can speak up. It is good to see there is Executive support for this and the permanent appointment of the Freedom to Speak up Guardian in October 2018.

Overall the Quality Account reflects both the challenges experienced by SHFT and many positive service developments over the last twelve months. The CCG agrees that there are still significant improvements to be made in a number of key areas, but acknowledges the many areas of quality improvement as outlined in the report.

The Quality Account meets the minimum national requirements, but as suggested in previous years, the CCG would really like to see the inclusion of patient stories. These provide a different perspective and an opportunity to understand personal experiences in order to inform improvements.

Overall Southampton CCG, are satisfied with the Quality Report for 2018/19 and supports the new and continued quality priorities relevant to Southampton. We look forward to working closely with Southern Health NHS Foundation Trust over the coming year to further improve the quality of local Mental Health and Learning Disability services.
Overall Southampton CCG, are satisfied with the Quality Report for 2018/19 and supports the new and continued quality priorities relevant to Southampton. We look forward to working closely with Southern Health NHS Foundation Trust over the coming year to further improve the quality of local Mental Health and Learning Disability services.

Yours sincerely

[Signature]

John Richards  
Chief Officer  
Southampton CCG
OVER THE LAST 12 MONTHS WE HAVE SEEN SOME PROGRESS TOWARDS IMPROVING THE QUALITY OF CARE AND THE CULTURE AT SOUTHERN HEALTH, ALTHOUGH WE REMAIN CONCERNED THAT TRUST FINANCES ARE CHALLENGING. THE QUALITY REPORT IS A REFLECTION OF THIS PROGRESS AND CAPTURES THE KEY AREAS THE TRUST MUST PRIORITISE IN THE YEAR AHEAD.

IT IS CLEAR TO US THAT THE TRUST BOARD CONTINUES TO FOCUS ON QUALITY, WORKING TO ENSURE THAT THE CARE PROVIDED TODAY IS SAFE AND EFFECTIVE. IT IS ALSO CLEAR TO US THAT THE TRUST BOARD HAS CLEAR PLANS TO TRANSFORM SERVICES FOR THE FUTURE. THIS APPROACH IS ENSHRIINED IN THE ORGANISATIONAL VISION, VALUES AND STRATEGY, AND DEMONSTRATED IN THE ONGOING INVESTMENT THE TRUST HAS MADE TOWARDS QUALITY IMPROVEMENT WHERE EARLY PROJECTS HAVE SHOWN ENCOURAGING OUTCOMES.

WE HAVE SEEN EXAMPLES OF THE TRUST MAKING GOOD ITS COMMITMENT TO GREATER INVOLVEMENT OF PATIENTS AND FAMILIES. FOR INSTANCE, GOVERNORS ATTEND THE WORKING IN PARTNERSHIP COMMITTEE WHICH IS CHAIRED BY A CARER AND REPRESENTS THE VIEWS OF PATIENT AND CARER GROUPS ACROSS HAMPSHIRE. WE ALSO NOTE THE APPOINTMENTS MADE DURING THE YEAR OF A HEAD OF PATIENT ENGAGEMENT AND USER INVOLVEMENT FACILITATORS, AND THE GROWING BODY OF EXPERTS BY EXPERIENCE WHO ARE ACTIVELY INVOLVED IN THE WORK OF THE TRUST.

THERE IS INCREASING EVIDENCE THAT THE TRUST’S APPROACH IS DELIVERING RESULTS. THE CARE QUALITY COMMISSION COMPREHENSIVE INSPECTION, WHICH REPORTED IN OCTOBER 2018, REVEALED SIGNIFICANT IMPROVEMENTS ACROSS A RANGE OF SERVICES, ALTHOUGH MAINTAINING AN OVERALL REQUIRES IMPROVEMENT RATING. WE WERE ALSO ENCOURAGED BY THE RESULTS OF THE NHS STAFF SURVEY, WHICH SHOWED AN INCREASE IN STAFF ENGAGEMENT.

WHilst we are confident that the Trust is moving in the right direction, we are also clear that there remain challenges to overcome. The recruitment and retention of staff continues to pose a risk to the Trust and indeed the wider NHS. Continuing financial pressures may affect the pace at which change and improvement can be made. We are also disappointed and frustrated that the Trust has not been able to significantly and sustainably reduce the number of local patients receiving mental health inpatient care beyond the borders of Hampshire. It is important that the Trust remains committed to mitigating these risks and challenges for the benefit of patients, and Governors will continue to proactively support and encourage work to overcome these challenges, at pace.

WE HAVE A PARTICULAR ONGOING CONCERN REGARDING OUR MENTAL HEALTH SERVICES IN THE CITY OF SOUTHAMPTON. FURTHER ISSUES RELATING TO PATIENT SAFETY, STAFFING LEVELS AND CRISIS CARE HAVE BEEN IDENTIFIED IN THE YEAR, AND BROUGHT TO WIDER ATTENTION WITH RECENT INQUEST VERDICTS. WE ARE FOCUSING ON THE RECENTLY ANNOUNCED ORGANISATIONAL CHANGES, PARTICULARLY THOSE IN SOUTHAMPTON, AND HAVE BEEN PLEASED TO SEE GREATER INVESTMENT FROM THE CITY CCG IN AREAS WE BELIEVE WILL IMPROVE PATIENT SAFETY AND PATIENT OUTCOMES.

In the year ahead, it is vital that the Trust maintains and builds upon the momentum for change which it has developed thus far, and that staff, patients and families are at the heart of everything we do. We very much look forward to providing further support and constructive challenge towards achieving this in 2019/20.

The Governors of Southern Heath NHS Foundation Trust
May 2019
Feedback from Healthwatch Southampton on the Quality Account 2018/19 for Southern Health

Healthwatch Southampton is pleased to have the opportunity to comment on the quality account 2018-19.

We note the comment made by Healthwatch Hampshire last year. We have much sympathy with their comment about the format of the report and their view that it is largely inaccessible to the public. Nevertheless, we will attempt to make some comment from the perspective of patients and the public in Southampton.

Overall, we find the report somewhat confusing and not an easy read. We might have expected the ‘statement on quality’ by the Chief executive to open the report. We are presented with a Five-year strategy with 4 listed strategic priorities, what will success look like and Key actions together with a list of what is to be achieved in year one. Then on another page we have a list of aspirations for achievement by 2024 and six headings listing what is to be delivered during 2019/20 and finally in section 2b we have a list of ‘Priorities for improvement in 2019 and 2020’. Although there is some commonality this is confusing. The explanation ‘What is a Quality Report?’ is left until the end of section 2a.

The draft last year was submitted with the previous year’s achievements listed close to the priorities for the coming year but the final report had relegated these to part 3 of the report. Regrettably, this year the results of last year’s priorities are once again separated from the priorities for the coming year making it very difficult to follow progress. We understand that the ‘Detailed requirements for quality reports’ allows for the priorities to be put into the context of previous years achievements and not simply relegated to part 3. Indeed, other trusts in the region have all listed the achievements of previous years in Part 2.

However, there are some very positive aspects written into the report. Southern Health FT provides adult mental health services to the City with Antelope House as its prime In-patient centre in Southampton City and we concentrate our comments on those aspects of the report that apply to Southampton. Opening the Crisis Lounge at Antelope house 24/7 is welcomed as a positive step. The statement on quality from the Chief Executive officer is again welcomed and we are pleased to read the honest appraisal of the Trust’s position. The restructuring of the organisation to locality and specialised directorates should be a positive move and for Southampton, we hope it will result in tighter control and more rapid access over the services provided to City residents.

We welcome the move to better involve patients and carers and the appointment of a Head of Patient and Public Involvement is very positive. The establishment of a ‘Working in Partnership’ committee, is supported and we are pleased to have a member sitting on that committee.
Healthwatch Southampton once again took part in the PLACE inspection at Antelope House and the other facilities provide by the Trust for the City. We were pleased with the result of these inspections which showed a good standard of facility for patients. The standard of facilities at Forest Lodge and Willow Ward, Moorgreen Hospital, were especially pleasing.

We were informed of the Trusts intention to temporarily close Beaulieu Ward at the Western Hospital and although this was disappointing, we acknowledge that the Trust had little choice given the staffing position.

Improving patient safety, is of course essential and staffing is an essential first step. The move to locality directorates should assist and we support the establishment of a collaborative leadership programme to achieve compassionate leadership. The introduction of NEWS2 has been shown to be effective and we are pleased that it will now be expanded to mental health patients. Learning from events is clearly sensible and we hope the Trust will involve the ‘Working in Partnership’ committee. Improving Access to Psychological Therapies is being carried forward as a priority but it is clear that its achievement will depend on the recruitment and retention of good psychologists.

The two priorities for mental health in Priority 2, Improving clinical effectiveness, are both welcomed. The principle of individual care pathways for mental health patients and the evaluation of its effects should be a step forward and we note that it will require significant work. The aim to reduce the number of suicides of patients in the care of the trust is very important and we sincerely hope the trust achieves its targets.

Personalised care planning within the mental health division is part of Priority 3, Improving patient experience. We are pleased to see that co-produced plans are a key element in this priority. The aim to improve the communication support for non-NHS staff working with people living with a learning disability is welcomed.

For the current year, we are pleased that the trust achieved, either wholly or in part, its objectives.

As previously stated, the overall plan for the organisation is ambitious but we agree that the Trust management should aspire to achieve this, and we wish the Trust well in its efforts. Healthwatch Southampton has offered to assist and will work with the to ensure that the Trust hears the patient and relatives voice.

H F Dymond MBE
Chair, Healthwatch Southampton
Rehab Assistant Claire Shipp
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 2018/19 and supporting guidance; Detailed requirements for quality reports 2018/19
- 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 2018 to March 2019.
  - Papers relating to Quality reported to the Board over the period April 2018 to March 2019.
  - Feedback from the commissioners dated 9 May 2019 (Southampton City) and 9 May 2019 (West Hampshire Clinical Commissioning Group Representing West Hampshire, South Eastern Hampshire, North Hampshire, Fareham and Gosport Clinical Commissioning Groups).
  - Feedback from local Healthwatch organisations dated 8 May 2019.
  - Feedback from Overview and Scrutiny Committees
  - Southampton and Portsmouth - declined to comment
  - Hampshire Health and Adult Social Care Select Committee - feedback not received in time for inclusion in report
  - The Trust’s complaints report published under regulation 18 of the Local Authority Social services and NHS Complaints Regulations 2009, dated 5 June 2018
  - The latest national patient survey 2018
  - The latest national staff survey released 26 February 2019
  - The Head of Internal Audit’s draft annual opinion over the Trust’s control environment dated April 2019.

- 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 23 May 2019

Lynne Hunt
Chair

Date 23 May 2019

Dr Nick Broughton
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

We have been engaged by the Council of Governors of Southern Health NHS Foundation Trust to perform an independent assurance engagement in respect of Southern Health NHS Foundation Trust’s Quality Report for the year ended 31 March 2019 (the ‘Quality Report’) and specified performance indicators contained therein.

Scope and subject matter
The indicators for the year ended 31 March 2019 subject to limited assurance (the “specified indicators”) marked with the symbol ☀ in the Quality Report, consist of the following national priority indicators as mandated by Monitor (operating as NHS Improvement) (“NHSI”):

<table>
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<tr>
<th>Specified Indicators</th>
<th>Specified indicators criteria (exact page number where criteria can be found)</th>
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<tr>
<td>Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral</td>
<td>Page 235</td>
</tr>
<tr>
<td>Inappropriate out-of-area placements for adult mental health services</td>
<td>Page 236</td>
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Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the NHS Foundation Trust Annual Reporting Manual (“FT ARM”) and the ‘Detailed requirements for quality reports 2018/19’ issued by NHSI. The Directors are also responsible for the conformity of the specified indicators criteria with the assessment criteria set out in the FT ARM and the ‘Detailed requirements for external assurance for quality reports 2018/19’ issued by NHSI and for reporting the specified indicators in accordance with those criteria, as referred to on the pages of the Quality Report listed above.

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

- The Quality Report does not incorporate the matters required to be reported on as specified in the FT ARM and the ‘Detailed requirements for quality reports 2018/19’;
- The Quality Report is not consistent in all material respects with the sources specified below; and
- The specified indicators have not been prepared in all material respects in accordance with the criteria set out in the FT ARM and the ‘Detailed requirements for external assurance for quality reports 2018/19’.
We read the Quality Report and consider whether it addresses the content requirements of the FT ARM and the ‘Detailed requirements for quality reports 2018/19’; and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially consistent with the following documents:

- Board minutes and papers for the period April 2018 to March 2019.
- Papers relating to quality reported to the Board over the period April 2018 to March 2019.
- Feedback from Healthwatch Southampton dated 8 May 2019.
- The latest national staff survey released 26 February 2019.
- The Head of Internal Audit’s annual opinion over the Trust’s control environment dated April 2019.

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

**Our Independence and Quality Control**
We complied with the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics, which includes independence and other requirements founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour. We apply International Standard on Quality Control (UK) 1 and accordingly maintain a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

**Use and distribution of the report**
This report, including the conclusion, has been prepared solely for the Council of Governors of Southern Health NHS Foundation Trust as a body, to assist the Council of Governors in reporting Southern Health NHS Foundation Trust’s quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Southern Health NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.
Assurance work performed
We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) ‘Assurance Engagements other than Audits or Reviews of Historical Financial Information’ issued by the International Auditing and Assurance Standards Board (‘ISAE 3000 (Revised)’). Our limited assurance procedures included:

- reviewing the content of the Quality Report against the requirements of the FT ARM and the ‘Detailed requirements for quality reports 2018/19’;
- reviewing the Quality Report for consistency against the documents specified above;
- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
- making enquiries of relevant management, personnel and, where relevant, third parties;
- considering significant judgements made by the NHS Foundation Trust in preparation of the specified indicators;
- performing limited testing, on a selective basis, of evidence supporting the reported performance indicators, and assessing the related disclosures; and
- reading the documents.

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

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

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable, measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the FT ARM and ‘Detailed requirements for quality reports 2018/19’.

The nature, form and content required of Quality Reports are determined by NHSI. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts/organisations/entities.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Report, which have been determined locally by Southern Health NHS Foundation Trust.
Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that for the year ended 31 March 2019:

- The Quality Report does not incorporate the matters required to be reported on as specified in the FT ARM and the ‘Detailed requirements for quality reports 2018/19’;
- The Quality Report is not consistent in all material respects with the documents specified above; and
- The specified indicators have not been prepared in all material respects in accordance with the criteria set out in the FT ARM and the ‘Detailed requirements for external assurance for quality reports 2018/19’.

PricewaterhouseCoopers LLP
Southampton
29 May 2019

The maintenance and integrity of the Southern Health NHS Foundation Trust’s website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.
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: The number of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral.
Denominator: The number of people experiencing a first episode of psychosis who are referred as per the guidance given by NHS Improvement and accepted onto the caseload.

**Details of the indicator**
This indicator applies to anyone with a suspected first episode of psychosis who is aged 14 to 65. Southern Health Foundation Trust is only commissioned to provide a NICE approved package of care within two weeks of referral to people with a first episode of psychosis that are aged 35 and under. This is the data reported in Section 2. Exemptions include referrals of people who are experiencing psychotic symptoms with a confirmed organic cause, for example brain diseases such as Huntington’s and Parkinson’s disease, HIV or syphilis, dementia, or brain tumours or cysts.

**Accountability**
Achieve more than 53% of people with first episode of psychosis (FEP) are treated with a NICE-approved package of care within two weeks of referral.

**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. Documents titled: Guidance and FQAs for reporting against access and waiting time standards: Children and young people with an eating disorder and Early Intervention in Psychosis. This is available at: https://www.england.nhs.uk/mental-health/resources/access-waiting-time/
**Inappropriate out-of-area placements for Adult Mental Health services**

**Detailed descriptor**
An inappropriate ‘out of area placement’ for acute mental health in-patient care happens when: A person with assessed acute mental health needs who requires adult mental health acute inpatient care, is admitted to a unit that does not form part of the usual local network of services. This maybe an inpatient unit that does not usually admit people living in the catchment of the person’s local community mental health service and where the person cannot be visited regularly by their care coordinator to ensure continuity of care and effective discharge planning.

Examples where an out of area placement maybe appropriate include – safeguarding issues, employment reasons, or an individual’s choice.

**Data definition**
Total number of bed days patients have spent out of area in the last month deemed inappropriate. Exemptions include where an out of area placement is appropriate as given in the guidance.

**Accountability**
Progress in line with agreed trajectory for elimination of inappropriate adult acute out of area placements no later than 2021.

**Detailed Guidance**

Further information on Government website:
## Appendix 5: Glossary

<table>
<thead>
<tr>
<th>Abbreviation/term</th>
<th>Full text</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHP</td>
<td>Allied Health Professional</td>
</tr>
<tr>
<td>BAME</td>
<td>Black, Asian and Minority Ethnic</td>
</tr>
<tr>
<td>BLS</td>
<td>Basic life support training</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Child and Adolescence Mental Health Services</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
</tr>
<tr>
<td>COG</td>
<td>Council of Governors</td>
</tr>
<tr>
<td>Commissioner</td>
<td>Member of Clinical Commissioning Groups (CCGS)</td>
</tr>
<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>CQUIN</td>
<td>Commissioning for Quality and Innovation Framework</td>
</tr>
<tr>
<td>DIALOG</td>
<td>An outcome measure used in mental health services</td>
</tr>
<tr>
<td>DNACPR</td>
<td>Do Not Attempt Cardio Pulmonary Resuscitation</td>
</tr>
<tr>
<td>DSTP</td>
<td>Data Space Transfer Protocol</td>
</tr>
<tr>
<td>EIP</td>
<td>Early Intervention in Psychosis</td>
</tr>
<tr>
<td>FFT</td>
<td>Friends and Family Test</td>
</tr>
<tr>
<td>GBO</td>
<td>Goals based outcomes</td>
</tr>
<tr>
<td>GDPR</td>
<td>General Data Protection Regulation</td>
</tr>
<tr>
<td>HCPC</td>
<td>The Health and Care Professionals Council</td>
</tr>
<tr>
<td>Healthwatch</td>
<td>Healthwatch is an independent organisation which ensures the voice of patients and carers are heard. They raise issues of concern and work with organisations to improve services.</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
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</tr>
<tr>
<td>HoNOS</td>
<td>Health of the National Outcomes Scales</td>
</tr>
<tr>
<td>ILS</td>
<td>Intermediate life support training</td>
</tr>
<tr>
<td>LeDeR</td>
<td>The Learning Disabilities Mortality Review Programme</td>
</tr>
<tr>
<td>LD</td>
<td>Learning disabilities</td>
</tr>
<tr>
<td>LGBTQ+</td>
<td>Lesbian, gay, bisexual, transgender, queer and other</td>
</tr>
<tr>
<td>MDT</td>
<td>Multidisciplinary Team</td>
</tr>
<tr>
<td>MECC</td>
<td>Making every contact count</td>
</tr>
<tr>
<td>MHA</td>
<td>Mental Health Act</td>
</tr>
<tr>
<td>MIU</td>
<td>Minor Injuries Unit</td>
</tr>
<tr>
<td>MSK</td>
<td>Musculoskeletal services – any injury, disease or problems with your muscles, bones or joints</td>
</tr>
<tr>
<td>NEWS2</td>
<td>National Early Warning Score - used to identify and respond to patients at risk of deteriorating</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute of Health and Care Excellence</td>
</tr>
<tr>
<td>NIHR</td>
<td>National Institute for Health Research</td>
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<tr>
<td>NHS</td>
<td>National Health Service</td>
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<tr>
<td>NHSE</td>
<td>NHS England</td>
</tr>
<tr>
<td>NSHI</td>
<td>NHS Improvement</td>
</tr>
<tr>
<td>PEWS</td>
<td>Paediatric Early Warning score - used to identify and respond to paediatric patients at risk of deteriorating</td>
</tr>
<tr>
<td>PICU</td>
<td>Psychiatric Intensive Care Unit</td>
</tr>
<tr>
<td>POMH</td>
<td>Prescribing Observatory for Mental Health</td>
</tr>
<tr>
<td>Q1, Q2, Q3, Q4</td>
<td>Quarter 1 (April to June), Quarter 2 (July to September), Quarter 3 (October to December), Quarter 4 (January to March)</td>
</tr>
<tr>
<td>RCA</td>
<td>Root Cause Analysis</td>
</tr>
<tr>
<td><strong>Recovery College</strong></td>
<td>An educational approach to provide a safe space for people to connect, gain knowledge and develop skills</td>
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<tr>
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<tr>
<td><strong>RiO</strong></td>
<td>Our electronic patient record</td>
</tr>
<tr>
<td><strong>RTT</strong></td>
<td>Referral to Treatment</td>
</tr>
<tr>
<td><strong>SHFT</strong></td>
<td>Southern Health NHS Foundation Trust</td>
</tr>
<tr>
<td><strong>The Trust</strong></td>
<td>Southern Health NHS Foundation Trust</td>
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<tr>
<td><strong>TOMS</strong></td>
<td>Therapy Outcome Measures</td>
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<tr>
<td><strong>Triangle of Care</strong></td>
<td>A programme launched in July 2010 between the Carers Trust and the National Mental Health Development Unit, emphasising the need for better local strategic involvement of carers and families in the care planning and treatment of people with mental ill-health.</td>
</tr>
<tr>
<td><strong>WRES</strong></td>
<td>Workforce Race Equality Standard</td>
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