Quality Report 2016 - 2017
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On behalf of the Board of Directors of Nottinghamshire Healthcare, I am pleased to be able to present our Quality Report which covers the year April 2016 to March 2017. It focuses on the quality of the services we deliver and is a restatement of our wish to be publically accountable for the quality of the services we deliver.

The Trust is committed to the safety and wellbeing of all its patients, service users, carers, volunteers and staff. The Board of Directors is clear about positioning safety as a key quality priority. In January 2014 Board members made an explicit commitment to the Sign Up to Safety campaign to bring together all of the existing safety work already going on in the Trust. This was intended to ensure robust reporting and support an improved safety culture and work has continued throughout 2016/17, led by the Quality Committee. The Trust already had a good culture of reporting, but there was some variation. This campaign is part of a drive to reduce that variation and systematically improve safety in all services.

Six key priority areas were identified, linked with existing clinical priorities already in place. These priority areas cover every aspect of physical and mental health:

- Prevention of falls
- Medication safety
- Reducing restrictive practice
- Reducing violence and assaults
- Reducing suicide and self-harm
- Reducing pressure ulcers

Freedom to Speak Up continues to be a quality priority to drive openness and transparency as an integral part of the Trust's workplace culture. The Board of Directors recognises that we will not achieve our quality priorities, without the required workforce behaviours. To this end we have engaged clinicians from a wide range of disciplines to agree the key priority areas so they are owned by clinical leaders. It is also recognised that we need to create the right culture for our people to perform at their best; therefore in February 2017 the Board approved our new People and Culture Strategy.

Furthermore, to deliver safe, quality care the Trust has undertaken establishment reviews of all in-patient areas which has resulted in some changes to staffing establishments. It is recognised that this has not been undertaken using a recognised tool to determine staffing levels, as these were previously unavailable for Trust services. However, these are now available for Trust services with the exception of high and medium secure services and therefore required safe staffing levels will be re-evaluated as a priority early in 2017/18.

As a demonstration of our commitment to learn from deaths of patients using our services, this became one of our quality priorities for 2016/17. Throughout the year the Trust has continued to build on previous improvements, including our response to the publication of Mazar's report into the investigation of deaths at Southern Health. The Trust has also considered the Learning, Candour and Accountability report published by the Care Quality Commission (CQC) and the National Quality Board’s Guidance on Learning from Deaths to review practice. A new Serious Incident and Review of Deaths Policy will be published in May 2017. The implementation of this during 2017/18 will be a priority for the Trust, working in collaboration with other Trusts in the midlands to share and implement best practice.

The Trust has continued to replicate the methodology used by Mazar’s on the number of deaths of patients and whether these were investigated and presented the results to the Board of Directors in August 2016 and February 2017. We have continued to work with the
Patient Safety Collaborative during the year on the Academic Health Science Network (AHSN) funded work bringing together clinical staff from East Midlands' trusts with academics to test an innovative way of using human factors principles to analyse serious incidents. This work has enabled us to gain an understanding of some of the underlying causes of incidents which has been fed into the Sign up to Safety work streams and other forums to focus and prioritise resources. This will continue to be a priority for the Trust and a review of how we analyse mortality data and undertake investigations to maximise the potential for learning is underway. This approach is being used to drive and embed an improved culture of safety and unwarranted variation and the work to date continues to be well received and our internal and external feedback indicates that, as part of a system of continuous improvement, we are making inroads.

CQC is the independent regulator of health and adult social care in England which ensures that health and social care services provide people with safe, effective, compassionate, high-quality care. Our last Trust wide inspection by the Chief Inspector of Hospitals from the CQC was in April 2014 and we were delighted to be rated as Good overall, with an outstanding rating for our caring staff. During 2016/17 we have continued to improve the issues raised around safety and compliance with the Mental Health Act and during this time there have been further inspections to some of our services by the CQC. The outcomes of these are reported on in Part 2 of this Quality Report. The most recent inspection was in March 2017 of Rampton Hospital. The Trust has received the draft inspection report which identifies many areas of good practice; however, there are some areas of non-compliance with the fundamental standards. CQC have issued the Trust with a warning notice under Section 29a of the Health and Social Care Act 2008 because low staffing levels meant that safety to both patients and staff was at times compromised. The Trust has developed an improvement plan to ensure compliance with the regulations by 12th June 2017 as required by the warning notice and is also responding to the other requirements set out within the draft report.

We were authorised by Monitor as a Foundation Trust on 1 March 2015. Our standards and governance procedures were robustly examined and were found to be strong enough to allow for authorisation. We have however undertaken a full review of our governance structures during the which has resulted in some changes to the committee structure supporting the Board’s Quality Committee, which are effective from 1st April 2017. This revised structure will be embedded during 2017/18 which will also strengthen our assurance and escalation processes. To support this, a review of the quality and clinical governance resources and skill mix required to deliver the Quality Strategy through the revised committee structure has been undertaken. In addition, the Trust is also planning an independent review of the Well-Led Framework in 2017/18. As our quality governance processes have not been independently reviewed since Monitor’s assessment.

Cost Improvements are important for every NHS organisation, making sure that public money is being invested in cost efficient and quality services. The impact of those improvements on the quality of services we deliver is closely monitored by both our Medical Director and our Director of Nursing. We are determined to ensure financial challenges do not impact on patient safety and this continues to be an area of close scrutiny for our Quality Committee.

To the best of my knowledge the information contained in the Quality Account is accurate.

Ruth Hawkins
Chief Executive

Date: 25th May 2017
PART TWO: Priorities for Improvement and Statements of Assurance from the Board

Performance against Priorities for Quality Improvement 2016/17

This section reviews progress made against the Trust’s 2016/17 quality priorities. These priorities were identified and developed in consultation with commissioners, the Council of Governors, clinical divisions, staff, service users, carers, the Joint Health Scrutiny Committee and HealthWatch, reflecting concerns identified through the national staff survey, and the patient survey (commissioned by the Trust, using the national patient survey questions) and our own service user survey. Page 10 to 20 provides an update of the Trust’s quality priority performance.

Sign up to Safety

Signing up to the campaign in 2015, Nottinghamshire Healthcare NHS Foundation Trust set out a three year Patient Safety Improvement Plan as an extension to its existing quality priorities outlined in the Trust Quality Strategy. The campaign was to help reduce avoidable harm in the NHS over the next 3 years by listening, learning and acting when things go wrong.

The Trust identified six safety priority work streams for the campaign which are also aligned to specific quality priorities. For each of the six work streams there is a group overseeing the implementation of the detailed quality and safety improvement plan. During 2016/17 these were:

1. Medication Errors – Medicines Safety Group
2. Assaults – Violence Reduction Strategy Group
3. Pressure ulcers – Tissue Viability Group
4. Patient Falls – Trust Falls Group
5. Suicide prevention and self-harm – Trust Suicide and Self-harm Oversight Group
6. Restrictive Practice – Restrictive Practice Group

Each work stream monitors progress against their quality and safety improvement plan, and provides a report outlining the key achievements and any issues or significant slippage against their plans bi-monthly. These plans are overseen by the Clinical Incident Review Creating a Learning Environment (CIRCLE) Group and for the ‘assaults’ work stream, the Health, Safety, Security and Emergency Preparedness Sub-Committee. These sub-committees report to the Board’s Quality Committee on any risk and/or assurances.

The key achievements from the Sign Up to Safety campaign include:

Medication Errors –
- The Trust has created a formal link with Central and North West London Foundation Trust, to benchmark medicines safety parameters and share learning and good practice
- A Trust-wide pharmacy and medicines risk register has been developed and is reviewed as a standing agenda item at the Medicines Safety Group
- Safety across the whole patient journey - interim interface group set up to consider issues at discharge from secondary care to primary care, particularly related to difficulties with medicines administration in community and ensuring continuity of care. Trust Medicines Safety Officer working in conjunction with CCG leads and primary care providers to develop audit to be completed in primary care to gather data to inform discussion/identify actions required.
Quality Report 2016/17

Assaults –
- Consensus reached on proposals for structure of new Ulysse (risk management system) categories for reporting assaults.
- A Forensic Services procedure/operational guidelines are currently under development. The procedure outlines 2 levels: Diffusion- a staff cohort has now been trained and a Psychological Debrief- a staff cohort is currently being trained in the forensic division. The threshold for the activation of post incidents reviews is currently been operationalised and will form the basis for future practice.
- Local Partnerships Managing Violence & Aggression (MVA) training department established process for recruiting a Peer Support Worker to role as MVA instructor
- Review of all existing clinical risk assessment protocols across our organisation in terms of their effectiveness, evidence- base and fitness for purpose

Pressure Ulcers –
- Trust participation in cross organisational public awareness campaigns evaluated well from Conference held in November 2015. Quality Improvement Matron participating in regional public awareness campaigns through the East Midlands Academic Health Science Network and new materials being shared across organisations.
- The use data to better inform clinical practice a Human Factors Analysis of acquired avoidable pressure ulcers in Health Partnerships was undertaken with the final report presented at the 23/06/2016 Trust Wide Tissue Viability Steering Group meeting.
- Following agreement with commissioners a trial of the Root Case Analysis (RCA) process via a Reflection Group is currently underway (commenced July 1st 2016).

Patient Falls –
- Ulysses reporting system changes for falls came into effect on 1 April 2016 continues to be under reviewed re any further changes required and baseline data collection for future reporting. Data reports being refined and developed to enable learning to be shared with clinical teams
- Trust Falls Group making learning from incidents and case discussions core focus for 2017
- Post Falls Protocol (in line with NICE QS86) completed and signed off by Patient Safety and Effectiveness Committee July 2016 – adherence across Trust to be audited in 2017
- Local Services Case Notes Audit of falls undertaken by Governance leads in Mental Health Services for Older People (MHSOP), Adult Mental Health (AMH) and Specialist Services Directorate (SSD) in 2016. Falls Audit under development for implementation across all adult services based on MHSOP pilot completed in 2016.

Suicide Prevention and Self-Harm –
- Self-harm audit has been formulated and being used at Rampton. This will then be rolled out Trust wide followed by Depression audit.
- Amended incident categories on the Trust incident management system to enable improved learning.
- Human Factors approach on Root Cause Analysis Investigations Project to improve learning from incidents.

Restrictive Practice –
- Rampton Hospital research project is now collating data regarding patient experience of restrictive practice following interviews.
- MVA Training and Development Strategy has been developed and implemented across Forensic and Local services.
Duty of Candour

All registered staff have a professional duty to be honest and open when things go wrong. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ensures that healthcare providers are open and transparent in relation to care and treatment with people who use their services, setting out specific requirements that providers must follow when things go wrong with care or treatment, including informing people about the incident, providing reasonable support, giving truthful information and apologising when things go wrong.

The Trust’s Duty of Candour policy was reviewed to ensure that the infrastructure is in place to ensure that patients, carers and staff all feel supported when patient safety events occur. The Trust recognises that improvements can be made to evidencing that the Duty of Candour has been applied on all occasions when the threshold for applying this has been met. Following an internal audit which had a limited assurance opinion improvements continue to be made. These include improvements within the Trust’s ‘Ulysses’ incident reporting system ensures that such incidents continue to be recorded and monitored effectively. Each Duty of Candour incident is reviewed and those meeting the specified threshold are overseen by the relevant managers to ensure a meaningful apology is given.

The Trust introduced a Serious Incident Review Group during 2016/17 to review all new serious incidents each week which includes consideration of whether the Duty of Candour applies and ensuring this occurs. In addition, the Trust CIRCLE Group receives regular reports on duty of candour incidents across the Trust on a regular basis and builds on its existing learning to enhance the quality and consistency of how the Trust manages such incidents going forward.

NHS Staff Survey Results

The NHS National Staff Survey collects the experiences and opinions of NHS staff on a range of matters such as job satisfaction, wellbeing and raising concerns. The result enables the Trust to identify areas where things are going well and potential areas for improvement.

During 2016/17 a decision was made in the Trust to survey all staff in the Trust, this meant that instead of a sample of staff being surveyed, all eligible staff (8510) had an opportunity to take part in the survey.

The headline information in relation to the National NHS Staff Survey 2016 is:

- The Trust’s response rate was 48% (4085 staff) - this is higher than the average for Mental Health, Learning Disability & Community Trust’s in England [44%]. This puts the Trust’s response in the ‘better than average’ ranking.

- Staff engagement levels have deteriorated from the previous year, and the Trust score an ‘average’ ranking.

- A high level of the surveyed staff stated that they would recommend the Trust as a place to work or receive treatment. This scores the Trust in the ‘better than average’ ranking.

The following tables provide details of the percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months and the percentage believing that the trust
Quality Report 2016/17

provides equal opportunities for career progression or promotion as requested to be reported on by NHS Improvement.

**KEY FINDING 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months**

<table>
<thead>
<tr>
<th>Percentage score</th>
<th>Trust score 2016</th>
<th>Trust score 2015</th>
<th>National 2016 average for combined MH/LD and community trusts</th>
<th>Best 2016 score for combined MH/LD and community trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>22%</td>
<td>21%</td>
<td>21%</td>
<td>15%</td>
</tr>
</tbody>
</table>

**KEY FINDING 21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion**

<table>
<thead>
<tr>
<th>Percentage score</th>
<th>Trust score 2016</th>
<th>Trust score 2015</th>
<th>National 2016 average for combined MH/LD and community trusts</th>
<th>Best 2016 score for combined MH/LD and community trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>87%</td>
<td>91%</td>
<td>88%</td>
<td>91%</td>
</tr>
</tbody>
</table>

**Responding to Patient Experience**

The Trust is committed to listening and responding to the views of patients, service users and carers as well as ensuring we do this in a publically transparent way. We have a website ‘Your Feedback Matters’ where all the feedback we receive from our Trust Feedback Survey and Patient Opinion is accessible so people can see what is being said about each of our services. We also report the changes made as a result of feedback on this site.

In addition, all of our Directorates and Localities produce a quarterly Involvement and Experience Report that details changes that have been made as a result of feedback. These are reported quarterly to the Divisional Governance Groups. We also produce a monthly Board Patient Voice report that looks at a Directorate/Locality each month in-depth. This highlights the key issues from and what action is planned as well as updating on the Directorate/ Locality that was looked at three months previously. These reports are visible on our feedback website.

Regarding positive and negative comments:

The Patient Advice and Liaison Services (PALS) offers assistance with immediate concerns, as well as advice and information about services. PALS also registers and passes on compliments, comments and suggestions from patients to respective managers for action.

We encourage all our teams to welcome both positive and negative feedback and we receive a wide range of feedback – both positive and negative. Patient Opinion is one source. However, in 2016-17 we received 25,155 responses to our Trust survey. This included over 8,500 comments in answer to the question ‘What could we do better? All of these comments were analysed into themes so services can see what people feel needs to be improved. In addition, we ask each Directorate/Locality to produce a quarterly Experience Action Plan that identifies the key issues from all sources of feedback including surveys,
complaints, Forums etc. Patient experience is covered in more detail in the Trusts Involvement report.

**Trust’s participation in our national quality improvement programmes 2016/17**

The Trust has participated in accreditation schemes, quality networks and Quality Improvement Programme (QIP) topics audited by the Prescribing Observatory for Mental Health (POMH-UK). It is a national requirement for English Trusts to participate in the Mental Health Commissioning for Quality and Innovation (CQUIN). Nottinghamshire Healthcare Foundation Trust has taken part in:

- Psychiatric Liaison Accreditation Network
- Quality Network for Community CAMHS (Child and Adolescent Community Mental Health Services) Eating Disorders
- Electro Convulsive Therapy Accreditation Service
- EIP Self-Assessment
- Perinatal In-Patient & Community settings
- Quality Network for Forensic Mental Health Services
- Quality Network for Inpatient CAMHS (Child and Adolescent Community Mental Health Services)
- Quality Network for Prison Mental Health Services
- AIMS–PICU (Accreditation for Psychiatric Intensive Care Units)
- AIMS – Rehab (Quality Network for Mental Health Rehabilitation Services)
- Prescribing Observatory for Mental Health (POMH)

The CQC recognises the value of participation in accreditation schemes and quality improvement networks. Participation demonstrates that staff members are actively engaged in quality improvement and take pride in the quality of care they deliver.
SAFE

Quality Priority

1. Reduce avoidable harm, with clear focus on (1) Physical assaults, (2) Pressure Ulcers, (3) Medication errors, (4) Patient falls
2. Suicide prevention and reducing self-harm
3. Reduce restrictive practice to ensure the 'least restrictive' principle is applied for all patients

How we will monitor and measure the priority

<table>
<thead>
<tr>
<th>Ambition</th>
<th>Current Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective delivery of Safety Improvement Plans for each work stream should enable the Trust, over time, to achieve our ambition.</td>
<td>Sign Up to Safety Year Two data showed an increase in reporting across all identified topics and reductions in degrees of harm when compared to 2015/16. This continues to be monitored over 2016/17.</td>
</tr>
<tr>
<td>Each work stream will identify one key action from their plan which will achieve the most impact for delivery in 2016/17.</td>
<td>Each action plan work group has identified priority areas for 2016/17</td>
</tr>
<tr>
<td>To assess the impact of implementation of the Safety Improvement Plans some key metrics will be monitored:</td>
<td>Specific data relating to metrics have been developed and added to the quality priority dashboard</td>
</tr>
<tr>
<td>• % incidents causing moderate harm or above (assaults, medication errors, falls, self-harm)</td>
<td></td>
</tr>
<tr>
<td>• % incidents high volume/low number of patients (assaults, falls, self-harm)</td>
<td></td>
</tr>
<tr>
<td>• Number of suicides potentially preventable</td>
<td></td>
</tr>
<tr>
<td>• Restrictive Practice metrics to be confirmed</td>
<td></td>
</tr>
<tr>
<td>• Number of Stages 3 &amp; 4 pressure ulcers</td>
<td></td>
</tr>
<tr>
<td>• Number of repeated issues identified through Root Cause Analysis (RCA) that could have prevented pressure ulcers</td>
<td></td>
</tr>
<tr>
<td>Run charts with key actions mapped and use of Statistical Process Control</td>
<td></td>
</tr>
<tr>
<td>Metric to monitor accuracy of recording degree of harm to be developed</td>
<td></td>
</tr>
<tr>
<td>Board 'Lessons Learned' Report – 6 monthly</td>
<td></td>
</tr>
</tbody>
</table>

**Monitored by: Patient Safety Sub-Committee**

Physical Assaults

The graphs show the number of reported incidents and the level of harm reported for both patients and staff in 2016/17 compared to the previous year. They show that there have been increases, overall in 'no' and 'low' harm reporting during 2016/17 compared to the 2015/16. However, there has been a reduction in the 'moderate' harm incidents in line with the Trust’s ambitions. ‘Near Misses’ reporting has continued to be reported throughout the year for improved learning. The Assaults Quality and Improvement Plan is continually updated and provides assurances to the Health, Safety, Security and Emergency Preparedness Sub Committee. There are 45 improvement actions identified with good progress and most are complete. 6 of the actions with no progress are due for completion in Year 3.
Incident Tracker

Pressure Ulcers

- Target Zero for stages 3 and 4 pressure ulcers, actual reported figures for March 1 x stage 3; no stage 4 ulcers.
- At Year end 2016/17, Local Partnerships: Community are above the agreed end of year trajectory of 14 acquired avoidable pressure ulcers per month, reporting 20 for March 2017. Nonetheless, the Division is able to report that pressure ulcer prevalence has reduced over 2016/17 when compared to 2015/16, with an average of 20 pressure ulcers per month for the second half of 2016/17 versus an average of 26 pressure ulcers per month for the first half of 2016/17.
- Stage 3 acquired avoidable pressure ulcers have reduced month on month since December 2016 by 88% (from 9 down to 1 in March 2017). Taking into consideration the winter pressures during this quarter, this is a significant achievement. There has been one instance of a stage 4 acquired avoidable pressure ulcer reported in Local Partnerships: Community throughout 2016/17 (September 2016).

Medication Errors

- Medication error reporting continues to show a positive reporting culture with an increase in reporting throughout 2016/17 compared to 2015/16. The charts below provide a detailed breakdown of the number of incidents reported, the level of harm and also a comparison in the incident types. Medication administration incidents are the most reported incident type and with the development of the Medicines competency assessment framework will help support and lead to improvement.
- Near misses continue to be reported and the Medicines Optimisation Group is using this data to understand how this can improve learning.
- The Medication Safety Group will be merged and become Medicines Optimisation Group. It has monitored the trends and themes of medication incidents and the medication improvement plan. The plans going forward are:
  - Ongoing development of a robust communication route to ensure medicines safety messages reach the intended audience
  - Regional work is underway to devise our own regional tool to use instead of safety thermometers
  - Once the Medicines Code has been finalised, all medicines training will require updating and gaps in training identified to address changes in medicines code.
  - New ways to collect information on how involved patients feel around decisions with their medicines will been developed, and data will be collected in 2017.
Least Restrictive Practice

The Restrictive Practice Improvement plan continues to be monitored and updated during 2016/17 with 44 improvement actions identified since 2015/16 and are being progressed. The Key Achievements to date are:

- Rampton Hospital research project is now collating data regarding patient experience of restrictive practice following interviews.
- Forensic Services - Implementing the Long-Term Segregation guidance
- Proposed work on ‘Post Incident’ debrief in Forensic Services - diffusion for staff and patients. Currently being planned
- Ideal ward round project progressing in AMH. Wards for pilote have been identified.
- MVA Training and Development Strategy has been developed and implemented across Forensic and Local services. Focus will now shift to embedding and evaluation.
- Poster campaign has been rolled out.

The Trust wide Restrictive Practice e-Forms Design Group continues to meet and the following is planned:

1. Forms to record Rapid Tranquilisation and Seclusion and Long Term Segregation in RiO are ongoing
2. Wards to pilot the use of these forms have been suggested.
3. Ten HP 8” hand held devices have been purchased
4. Security testing has taken place on a device without a case and the device was approved. Further testing to take place on a device with a case.
5. Procurement is looking to source an additional 130 devices to support the further rollout across the Forensics Division.
Ulysses reporting system changes for falls came into effect on 1 April 2016 which led to improvements in reporting and learning since 2015/16. The significant increase in reporting is primarily driven by the introduction of a third party falls category on Ulysses. Falls incidents continue to be reviewed to establish whether any further changes are required.

There were no severe or catastrophic harms attributable to falls incidents reported 2016-17 and the above graphs providing a detailed breakdown of what was reported. 2% of patient falls were classed as ‘moderate’ harm and learning from these incidents have been shared via the Trust Falls Group which supports divisional learning.

Plans for next year include:

- Make sure everyone in our care is assessed for their risk of falls and actions taken to reduce risk of falls
- Increase reporting
- Improve inconsistency re severity of harm
- Develop use of case discussions to highlight lessons learnt
- Communicate lessons learnt widely across the Trust
- Get Guide to Action tools on RiO and System One
- Define 1:1 observations in relations to falls and develop a clinical decision tool
- Improve physical healthcare reviews of patients in AMH, Forensic Services, and Offender Health- Falls are often a symptom of an underlying health issue.
- Improve access to continual learning opportunities
During 2016/17 the Suicide and Self-harm Group has continued to monitor the Trust’s ambition ‘No incidents of suicide (or suspected suicide) among people with recent clinical contact and a 50% reduction in overall severity of self-harm incidents’. As a result the group has seen an improvement in the way self-harm incidents are reported and focused work on suicide since 2015/16. The following key achievements include:

- Forensic services - Self-harm audit has been formulated and being used at Rampton. This will then be rolled out to the rest of the Division. This will be followed by Depression audit.
- Local Partnership – Mental Health - Self harm audit and Depression re-audit are complete
- Listen Up research project complete and findings disseminated
- Roll out of amended Ulysses categories and initial data is available.
- Pilot underway of routine completion of Audit C and CHRISTO brief drug and alcohol assessment tools in Crisis Teams AMH.
- Ligature risk assessments in Hospices - LP have reviewed historic incidents and other issues. No risks have been reported.
- CAMHS crisis response team pilot up and running and evaluating well. Formal evaluation April 2017
- Criminal Justice Team have worked alongside Police to be compliant with NPCC Interim Guidance - Suicide Prevention Risk Management of Perpetrators of Child Sexual Exploitation
- Human Factors on RCA Investigations (EMAHSN) Project

Plans for the following year are:

- Task and Finish group to be established to look at suicide prevention training across the Trust, aligning to development of overarching strategy. Investigation into staff training needs and bespoke multi-faceted suicide and self-harm training alongside current internal training available.
- Restructuring of Local Partnerships Divisions- consideration of opportunities and implications for practice given 75% of suicides occur in people who are not in contact with MH services.
- Audits for Self-harm and Depression still to be programmed for Offender Health and Community Forensics
- AMH Contingency Safety Planning project and Piloting use of systematic measurement tool for Depression
- Street Triage Control Room Pilot has been evaluated. This has no recurrent funding at present. Discussions continuing with commissioners.
Quality Report 2016/17

CARING
Quality Priority 4 Improve experience through better management of complaints

<table>
<thead>
<tr>
<th>How we will monitor and measure the priority</th>
<th>Ambition</th>
<th>Current Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Complaints Management Improvement Plan will be developed and implemented to review structures, processes and outcomes</td>
<td>Our ambition is to have a complaints process that meets national best practice:</td>
<td>The Following graphs provide a summary of complaints received within Q4 2016/17. 235 new complaints were received and 41 complaints which had previously been responded to were re-opened. Overall during 2016/17 the Trust received a total of 877 formal complaints with 116 re-opened compared to 937 with 99 re-opened in 2015/16.</td>
</tr>
<tr>
<td>Analysis of complaints information by service area, in particular:</td>
<td>- Complainant at the centre</td>
<td></td>
</tr>
<tr>
<td>Reasons for complaint</td>
<td>- Easily understood and accessible</td>
<td></td>
</tr>
<tr>
<td>Complainant satisfaction with process</td>
<td>- Addresses concerns raised</td>
<td></td>
</tr>
<tr>
<td>Response times</td>
<td>- Responsive</td>
<td></td>
</tr>
<tr>
<td>% Upheld or upheld in part</td>
<td>- Focused on improvement</td>
<td></td>
</tr>
<tr>
<td>Number referred to the Parliamentary Health Service Ombudsman</td>
<td>- Integral part of feedback</td>
<td></td>
</tr>
<tr>
<td>Thematic review utilising human factors and triangulation with other forms of feedback</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Board ‘Lessons Learned’ Report – 6 monthly</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Monitored by:</strong> Board of Directors</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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- Complainant at the centre
- Easily understood and accessible
- Addresses concerns raised
- Responsive
- Focused on improvement
- Integral part of feedback

**Monitored by:** Board of Directors

**Complaint Outcomes Q4 2016-17**

<table>
<thead>
<tr>
<th>Service</th>
<th>% Upheld</th>
<th>% Upheld in Part</th>
<th>% Not Upheld</th>
</tr>
</thead>
<tbody>
<tr>
<td>LP Mental Health</td>
<td>10%</td>
<td>3%</td>
<td>87%</td>
</tr>
<tr>
<td>Forensic Services</td>
<td>16%</td>
<td>3%</td>
<td>81%</td>
</tr>
<tr>
<td>LP General</td>
<td>15%</td>
<td>4%</td>
<td>81%</td>
</tr>
<tr>
<td>Trust Total</td>
<td>10%</td>
<td>3%</td>
<td>87%</td>
</tr>
</tbody>
</table>

**Compliance with Response Times Q4 2016-17**

<table>
<thead>
<tr>
<th>Service</th>
<th>% Acknowledged in 3 days</th>
<th>% Closed in Timetable</th>
<th>% Closed in Timetable Agreed With Complainant</th>
<th>% Closed in Trust Standard of 25 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>LP Mental Health</td>
<td>96%</td>
<td>95%</td>
<td>96%</td>
<td>94%</td>
</tr>
<tr>
<td>Forensic Services</td>
<td>94%</td>
<td>99%</td>
<td>80%</td>
<td>99%</td>
</tr>
<tr>
<td>LP General</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Trust Total</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
</tr>
</tbody>
</table>

**Complaint Numbers** - 235 new complaints were received and 41 complaints which had previously been responded to were re-opened

**Response Times** - The current Trust Complaints Policy requires complaints to be acknowledged within 3 days and generally responded to within 25 working days unless complex or cross organisational.

**Complaint Outcomes** - These are the percentages of complaints investigated and does not include complaints not pursued

**Parliamentary and Health Service Ombudsman** - 6 complaints were referred to the PHSO in Q4 and the outcome of 7 previously referred was received. 2 was not upheld, 3 upheld in part and 2 had no further action by PHSO

CARING
Quality Priority 4 Improve experience through better management of complaints - continued
Quality Report 2016/17

Caring

Quality Priority 4 Improve experience through better management of complaints - continued

Trust Top Complaint Categories - Q4

<table>
<thead>
<tr>
<th>Complaint Category</th>
<th>LP Mental Health</th>
<th>Forensic Services</th>
<th>LP General</th>
<th>Trust Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access To Records</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Admission To Hospital Arrangements</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Appointment Arrangements</td>
<td>15</td>
<td>13</td>
<td>1</td>
<td>29</td>
</tr>
<tr>
<td>Assault/Physical Aggression/Threatening Incident</td>
<td>0</td>
<td>10</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Attitude Of Staff</td>
<td>30</td>
<td>38</td>
<td>1</td>
<td>69</td>
</tr>
<tr>
<td>Beds Management/Availability</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Cleanliness/Physical Environment/Amenities</td>
<td>1</td>
<td>6</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Communication With Other Services/Agencies</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Complaints Handling</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>4</td>
<td>6</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Consent To Treatment</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Discharge From Hospital Arrangements</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Equality &amp; Diversity</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Info To/Communication With Service Users/Careers</td>
<td>50</td>
<td>7</td>
<td>1</td>
<td>58</td>
</tr>
<tr>
<td>Length Of Time To Be Seen/Service Availability</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Medical Care</td>
<td>36</td>
<td>33</td>
<td>1</td>
<td>70</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>1</td>
<td>8</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Mental Health Act Issues</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Nursing Care</td>
<td>24</td>
<td>24</td>
<td>4</td>
<td>52</td>
</tr>
<tr>
<td>Patient Property/Expenses</td>
<td>0</td>
<td>7</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Policy/Procedure</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Privacy/Dignity</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Psychotherapy Care</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Quality/Accuracy Of Clinical Records</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Safe, Adequate, Coordinated Care</td>
<td>6</td>
<td>20</td>
<td>0</td>
<td>26</td>
</tr>
<tr>
<td>Security Services</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>197</td>
<td>188</td>
<td>10</td>
<td><strong>395</strong></td>
</tr>
</tbody>
</table>
## Quality Report 2016/17

### EFFECTIVE

<table>
<thead>
<tr>
<th>Quality Priority</th>
<th>Ambition</th>
<th>Current Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 Improve the health and quality of life of our patients and service users through implementation of a Clinical Outcomes Framework</td>
<td>To have a Trust clinical outcomes framework which demonstrates clinically effective care and treatment is being delivered resulting in positive outcomes for patients.</td>
<td>During 2015/16 the Trust identified dedicated project resource linked to the Vanguard Programme outcomes which was trialled by Monitor and an outline Clinical Outcome Framework was developed.</td>
</tr>
<tr>
<td>6 Improve outcomes for users of Trust services through effective monitoring and learning from deaths of patients who die whilst in receipt of services, or within six months of discharge.</td>
<td></td>
<td>In 2016/17 the clinical outcomes work has advanced is overseen by the Medical Director. The tools that will be used to collect the clinical reported outcome measure (CROM), patient reported outcome measure (PROM) have now been agreed a pilot of different PROM tools identified a goal based attainment tool that will be used a part of the care planning process and the HoNOS tool will be used for the CROM. Plans to roll out the PROM are now being developed and training requirements are being scoped. Work is progressing to identify the most effective way of reporting HoNOS scores for different services to demonstrate clinical effectiveness.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How we will monitor and measure the priority</th>
<th>Ambition</th>
<th>Current Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Progress with implementation of the Clinical Outcomes Framework</td>
<td>To have a Trust clinical outcomes framework which demonstrates clinically effective care and treatment is being delivered resulting in positive outcomes for patients.</td>
<td>During 2015/16 the Trust identified dedicated project resource linked to the Vanguard Programme outcomes which was trialled by Monitor and an outline Clinical Outcome Framework was developed.</td>
</tr>
<tr>
<td>Specific outcome measures to be monitored at Trust level in 2016/17 to be agreed.</td>
<td></td>
<td>In 2016/17 the clinical outcomes work has advanced is overseen by the Medical Director. The tools that will be used to collect the clinical reported outcome measure (CROM), patient reported outcome measure (PROM) have now been agreed a pilot of different PROM tools identified a goal based attainment tool that will be used a part of the care planning process and the HoNOS tool will be used for the CROM. Plans to roll out the PROM are now being developed and training requirements are being scoped. Work is progressing to identify the most effective way of reporting HoNOS scores for different services to demonstrate clinical effectiveness.</td>
</tr>
</tbody>
</table>

*Monitored by the Clinical Effectiveness Sub-Committee*
## How we will monitor and measure the priority

<table>
<thead>
<tr>
<th>Implementation of the Mortality Reporting Quality Improvement Plan</th>
<th>Ambition</th>
<th>Current Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Development and monitoring of Mortality Dashboards – (metrics to be agreed)</td>
<td>To reduce deaths that are considered to be preventable through implementation of best practice, clinically effective care</td>
<td>During 2015/16 Mazars prepared the Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust from April 2011 to March 2015 with an Expert Reference Group convened by NHS England. In response the Trust reviewed its mortality reporting and investigation process and established a Mortality Surveillance Improvement Plan. In 2016/17 the Mortality Surveillance Improvement Plan continues to be implemented.</td>
</tr>
<tr>
<td>Thematic review utilising human factors and triangulation with other sources of information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Board ‘Lessons Learned’ Report – 6 monthly</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Monitor by:** Trust CIRCLE

During 2015/16 Mazars prepared the Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust from April 2011 to March 2015 with an Expert Reference Group convened by NHS England. In response the Trust reviewed its mortality reporting and investigation process and established a Mortality Surveillance Improvement Plan.

In 2016/17 the Mortality Surveillance Improvement Plan continues to be implemented.

The Board received a paper which provided a summary on the National Quality Board (NQB) published National Guidance on Learning from Deaths. This guidance was launched at a national conference on 21st March and states that Boards should receive quarterly reports. The guidance consists of two main chapters – Mortality Governance and Bereaved Families and Carers, supported by 12 appendices.

A SIRI Policy has been written which incorporates reporting and reviewing all known deaths. It includes the introduction of a Death Investigation Decision Tree which includes the requirement to and a tool to undertake an Initial Death Review within three working days.

The guide will allow clinicians to determine whether the death meets the criteria to report the death as a SIRI, whether the death would benefit from a review but is not a SIRI or no review required. The decision to investigate or review will not be based on any early perceptions as to whether the death was considered to be unexpected or avoidable. These decisions can only be made after the investigation or review has been completed and therefore this has been incorporated into the revised SIRI/Death Review Policy.
RESPONSIVE

<table>
<thead>
<tr>
<th>Quality Priority</th>
<th>7 Ensure timely access to services which are provided from locations which meet service users clinical need</th>
</tr>
</thead>
<tbody>
<tr>
<td>How we will monitor and measure the priority</td>
<td><strong>Ambition</strong></td>
</tr>
<tr>
<td>Responsive Metrics for 2016/17:</td>
<td>Our ambition is to ensure all waiting time targets are met and negative feedback reduces. Patients are cared for in the most appropriate service to meet their clinical need.</td>
</tr>
<tr>
<td>• Monitor access targets – IAPT &amp; First Episode Psychosis</td>
<td></td>
</tr>
<tr>
<td>• Delayed Transfers of Care</td>
<td></td>
</tr>
<tr>
<td>• 28 day re-admission</td>
<td></td>
</tr>
<tr>
<td>• Length of stay</td>
<td></td>
</tr>
<tr>
<td>• Occupancy rate</td>
<td></td>
</tr>
<tr>
<td>• Out of area placements</td>
<td></td>
</tr>
<tr>
<td>• A&amp;E breaches</td>
<td></td>
</tr>
<tr>
<td>• Waiting times</td>
<td></td>
</tr>
<tr>
<td>Analysing relevant feedback – complaints &amp; patient surveys</td>
<td></td>
</tr>
</tbody>
</table>

*Monitored by the Finance and Performance Committee*
## WELL-LED

### Quality Priority 8
Ensure the Trust has a culture that encourages staff to have the ‘freedom to speak up’ (FTSU)

<table>
<thead>
<tr>
<th>How we will monitor and measure the priority</th>
<th>Ambition</th>
<th>Current Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific measures to be developed following the appointment of the new Local Freedom to Speak up (FTSU) Guardian.</td>
<td>For all concerns to be raised to help us to keep improving our services for all patients and the working environment for our staff. We want to investigate what staff say and provide access to the support they need.</td>
<td>During 2015/16 identified the role of FTSU Guardian and appointed in early 2016/17 for Nottinghamshire Healthcare NHS Foundation Trust. Since in post improvements to date includes:</td>
</tr>
<tr>
<td>Board ‘Lessons Learned’ Report – 6 monthly</td>
<td></td>
<td>FTSU Champions recruitment underway and to be completed by April 2017.</td>
</tr>
<tr>
<td>Top 20% Trusts with relevant national staff survey questions.</td>
<td></td>
<td>FTSU Guardian continues to help staff raise concerns in a confidential, supportive and anonymised manner; signposting appropriately.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Staff Voice” web page developed and now live focusing on helping to create an open culture which is based on listening and learning, not blaming, and to promote the benefits to staff, patients and the Organisation in speaking up.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>FTSU Guardian continues to offer training and dissemination on FTSU agenda through various outlets, inclusive of Trust Induction and Staff Forums.</td>
</tr>
<tr>
<td><strong>Monitored by:</strong> [Patient Safety Sub-Committee and the Workforce, Equality and Diversity Committee]**</td>
<td></td>
<td>Raising Concerns policy has been reviewed with input from FTSU Guardian and falls closely in line with recommendations from NHS Employers.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Collaboration with HR and Equality and Diversity Lead and Staff Side to review Bullying and Harassment Policy. It has been noted that difficulties have occurred in managing concerns pertaining to Bullying and Harassment cultures where the reporters do not wish to be identified for fear of reprisal, despite assurances.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Regular meetings held with members of the Executive Team to provide summary of work and key emerging themes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Work underway with Head of Equality and Diversity in order to engage BME staff in relation to their experience of speaking up in the Organisation.</td>
</tr>
</tbody>
</table>
Mortality Surveillance

The review commissioned by NHS England into the investigation of deaths at Southern Healthcare NHS Foundation Trust undertaken by Mazar’s was published in December 2015. Following this the Secretary of State for Health asked CQC to look at how acute, community and mental health trusts across the country investigate and learn from deaths. There was a particular focus on mental health and learning disabilities. This included all trusts submitting a Provider Information Request, visiting a sample of 12 trusts, involvement of more than 100 families and gathering information from charities, NHS professionals and other organisations. The review identified issues over five key areas:

- Involvement of families and carers
- Identification and reporting
- Decision to review or investigate
- Reviews and investigations
- Governance and learning

The Trust tracks mortality and produces a bi-annual report to the Board of Directors on mortality surveillance and learning from incidents. Over the last year the Trust has been extracting data from the Ulysses risk management system and clinical information systems such as RiO and SystmOne. This has identified discrepancies between the systems, in part due to the national issues identified by CQC. The Trust has been working with national and regional colleagues to consider these issues and influence potential national policy. The table below provides a breakdown of the Trust’s mortality rates over the past 3 years:

<table>
<thead>
<tr>
<th>TRUST</th>
<th>2014-15</th>
<th>2015-16</th>
<th>2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number of Deaths</td>
<td>629</td>
<td>533</td>
<td>617</td>
</tr>
<tr>
<td>Number of Unexpected Deaths</td>
<td>132</td>
<td>112</td>
<td>176</td>
</tr>
<tr>
<td>Number of Deaths regarded as a SIRI</td>
<td>67</td>
<td>87</td>
<td>98</td>
</tr>
<tr>
<td>Number of Deaths Degree of Harm 5</td>
<td>75</td>
<td>63</td>
<td>79</td>
</tr>
<tr>
<td>FORENSIC SERVICES - High, Medium, Low, Community Services</td>
<td>2014-15</td>
<td>2015-16</td>
<td>2016-17</td>
</tr>
<tr>
<td>Total Number of Deaths</td>
<td>2</td>
<td>11</td>
<td>4</td>
</tr>
<tr>
<td>Number of Unexpected Deaths</td>
<td>2</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Number of Deaths regarded as a SIRI</td>
<td>2</td>
<td>11</td>
<td>3</td>
</tr>
<tr>
<td>Number of Deaths Degree of Harm 5</td>
<td>1</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>FORENSIC SERVICES - Offender Health Services</td>
<td>2014-15</td>
<td>2015-16</td>
<td>2016-17</td>
</tr>
<tr>
<td>Total Number of Deaths</td>
<td>25</td>
<td>34</td>
<td>38</td>
</tr>
<tr>
<td>Number of Unexpected Deaths</td>
<td>15</td>
<td>19</td>
<td>27</td>
</tr>
<tr>
<td>Number of Deaths regarded as a SIRI</td>
<td>24</td>
<td>29</td>
<td>38</td>
</tr>
<tr>
<td>Number of Deaths Degree of Harm 5</td>
<td>11</td>
<td>18</td>
<td>25</td>
</tr>
<tr>
<td>LOCAL PARTNERSHIPS - General Health Services</td>
<td>2014-15</td>
<td>2015-16</td>
<td>2016-17</td>
</tr>
<tr>
<td>Total Number of Deaths</td>
<td>24</td>
<td>18</td>
<td>23</td>
</tr>
<tr>
<td>Number of Unexpected Deaths</td>
<td>13</td>
<td>8</td>
<td>18</td>
</tr>
<tr>
<td>Number of Deaths regarded as a SIRI</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Number of Deaths Degree of Harm 5</td>
<td>0</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>LOCAL PARTNERSHIPS - Mental Health Services</td>
<td>2014-15</td>
<td>2015-16</td>
<td>2016-17</td>
</tr>
<tr>
<td>Total Number of Deaths</td>
<td>578</td>
<td>470</td>
<td>552</td>
</tr>
<tr>
<td>Number of Unexpected Deaths</td>
<td>102</td>
<td>76</td>
<td>127</td>
</tr>
<tr>
<td>Number of Deaths regarded as a SIRI</td>
<td>61</td>
<td>45</td>
<td>54</td>
</tr>
<tr>
<td>Number of Deaths Degree of Harm 5</td>
<td>63</td>
<td>37</td>
<td>47</td>
</tr>
</tbody>
</table>
The Trust strengthened its governance and oversight of deaths through the establishment of Trust CIRCLE Group in November 2015. This has been further strengthened by the introduction of a weekly Serious Incident Review Group in November 2016, led by the Executive Medical Director which reviews all new serious incidents including deaths. Trust CIRCLE encompassed the role of a Mortality Surveillance Group to undertake in depth reviews of mortality data and review the outcome of the application of Human Factors Analysis and Classification System (HFACS) to investigations. HFACS enhances learning from serious incidents in healthcare and the Trust was involved in working with two human factors experts along with the other providers of mental health services in the East Midlands. To ensure that improvements are being made the Trust has developed a Mortality Improvement Plan based on the Mazar’s, CQC investigation and local improvement plans.

The Mortality Surveillance Group will also adopt a robust and effective methodology for case record reviews of all selected deaths, including engagement with the Learning Disabilities Mortality Review (LeDeR) programme; this process is more developed in acute trusts for which there is national guidance. There is currently no national guidance for mental health and community services, nor is this planned; however there has been some national work developing potential tools. Therefore, the Trust will consider these tools and will also work with other providers in the region to develop its approach. In addition, the Trusts will adopt the methodology developed by the LeDeR programme in those regions where the programme is available. This is a programme led by commissioners and it is anticipated will be rolled out across the county over the next few months, commencing initially in Bassetlaw.

Trust CIRCLE has agreed revised categories for reporting deaths on Ulysses which will be applied after the death has been reviewed or investigated by a smaller group of staff to improve consistency. The Serious Incidents Requiring Investigation (SIRI) Policy has been significantly revised and incorporates the Trusts approach to reporting and investigating deaths. This is in line with the National Guidance on Learning from Deaths produced by the National Quality Board in March 2017 which recommends having a clear policy for engagement with bereaved families and carers, having enhanced skills and training and the adequate governance arrangements and processes.
Quality Report 2016/17

Priorities for Quality Improvement 2017/18

Our ambition is that every person who uses our services receives the best health care possible every time they have contact with us. Listening to patients, their carer’s and families will assist us to understand their experience and will help us to achieve this ambition. Our staff are already recognised for delivering outstanding care and compassion for patients. We are determined to build upon this achievement and strive to deliver integrated care that is safe and effective every time. Our Quality Priorities for 2016/17 will continue to help us to achieve this ambition.

To agree our priorities for improvement for 2017/18 a number of consultation events were held. Through the Joint Health and Scrutiny Committee, attended by HealthWatch, the views of the wider public were considered. Views from our patients, carers, staff and other stakeholders were sought through the Council of Governors and staff members have been consulted via the Senior Nurse and Allied Health Professionals Advisory Council. In addition, Nottingham City Clinical Commissioning Group was consulted on behalf of all of our commissioners of services. The outcome of monitoring feedback from service user and carers also influenced the continuation and ongoing development of the priorities.

Monitoring Progress with Quality Priorities

The Board Committee with overall responsibility for monitoring the quality priorities is the Quality Committee. This committee, which meets six times per year, received during 2016/17 a regular Quality Priority Report to track progress with our ambition for each priority. These monitoring arrangements will continue in 2017/18.

The reports identify actual and potential underperformance to act as a trigger to ensure action is taken to improve performance against agreed trajectories. The Board of Directors also regularly monitors key performance indicators through the monthly Quality and Performance Report. This includes quality priority-related information such as incidents, CQC inspections, incidents, pressure ulcers, patient experience, quality impact of cost improvement programmes (CIPs) and workforce indicators such as safe staffing levels. The Board also receives regular service user and carer experience (SUCE) reports.

Quality Priorities 2017/18

The table below sets out our priorities, why we have chosen them and how, in addition to monitoring progress at the Quality Committee, they will be monitored and measured. Specific ambitions and trajectories for improvement, particularly relating to safety will be developed where appropriate and included in the Trust’s Quality Strategy and ‘Sign Up to Safety’ Campaign. The Trust, following consultation internally and with stakeholders is continuing with the quality priorities agreed for 2016/17.
<table>
<thead>
<tr>
<th>2017/18 Priorities</th>
<th>Our Ambition</th>
<th>How we will Measure the Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SAFE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. <strong>Reduce avoidable harm, with clear focus on:</strong></td>
<td><strong>Our ambition is to have no incidents causing severe harm or death and to reduce avoidable harm by 50%</strong>.</td>
<td><strong>Effective delivery of Safety Improvement Plans for each work stream, including one key action to deliver maximum impact</strong>.</td>
</tr>
<tr>
<td>1.1. <strong>Physical assaults</strong></td>
<td>Increase the reporting of these incidents</td>
<td><strong>To assess the impact of implementation of the Safety Improvement Plans some key metrics will be monitored:</strong></td>
</tr>
<tr>
<td>1.2. <strong>Pressure ulcers</strong></td>
<td></td>
<td>- % incidents causing moderate harm or above (assaults, medication errors, falls, self-harm)</td>
</tr>
<tr>
<td>1.3. <strong>Medication errors</strong></td>
<td></td>
<td>- % incidents high volume/low number of patients (assaults, falls, self-harm)</td>
</tr>
<tr>
<td>1.4. <strong>Patient falls</strong></td>
<td></td>
<td>- Number of suicides potentially preventable</td>
</tr>
<tr>
<td>2. <strong>Suicide prevention and reducing self-harm</strong></td>
<td></td>
<td>- Restrictive Practice metrics such as restraint including - prone, medication and mechanical and seclusion and long-term segregation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Number of Stages 3 &amp; 4 pressure ulcers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Number of repeated issues identified following investigations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Improvements in clinical risk assessment and management</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Run charts with key actions mapped and use of Statistical Process Control</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Metric to monitor accuracy of recording degree of harm to be developed</td>
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<td></td>
<td></td>
<td>Board ‘Lessons Learned’ Report – 3 monthly</td>
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<td><strong>Monitored by Trust CIRCLE</strong></td>
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<tr>
<td>3. <strong>Reduce restrictive practice to ensure the ‘least restrictive’ principle is applied for all patients</strong></td>
<td></td>
<td>These are also the Trusts ‘Sign up to Safety’ priorities</td>
</tr>
<tr>
<td>CARING</td>
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</tbody>
</table>
| **4. Improve experience through better management, understanding and response to issues raised through complaints** | Our ambition is to have a complaints process that meets national best practice:  
- Complainant at the centre  
- Easily understood and equally accessible for all, including seldom heard groups  
- Addresses concerns raised  
- Responsive  
- Focused on improvement  
- Integral part of feedback | Review of effectiveness Complaints Management Improvement Plan  
Analysis of complaints information by service area, in particular:  
- Reasons for complaint  
- Complainant satisfaction with process  
- Response times  
- % Upheld or upheld in part  
- Number referred to the Parliamentary Health Service Ombudsman  
- Triangulation of issues with other forms of feedback  
- Analysis of who complains to understand whether representative of patients and also seldom heard groups | Thematic review utilising human factors and triangulation with other forms of feedback (including compliments)  
*Monitored by the Patient Experience and Service Improvement Sub-Committee* |

<table>
<thead>
<tr>
<th>EFFECTIVE</th>
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| **5. Improve the health and quality of life of our patients and service users through implementation of a Clinical Outcomes Framework** | To have a Trust clinical outcomes framework which demonstrates clinically effective care and treatment is being delivered resulting in positive outcomes for patients. | Progress with implementation of the Clinical Outcomes Framework  
Year on year increase in the percentage of service lines with core outcomes identified/measured/used | Specific outcome measures to be monitored at Trust level in 2017/18 to be agreed.  
*Monitored by the Clinical Effectiveness Sub-Committee* |

|  | To reduce deaths that are considered to be preventable through implementation of best practice, clinically effective care. | Review of effectiveness of actions completed in the Mortality Reporting Quality Improvement Plan  
Development and monitoring of Mortality Dashboards – (metrics to be agreed)  
Thematic review utilising human factors and triangulation with other of information  
Compliance with the National Quality Board’s National Guidance on Learning from Deaths  
Participation and acting upon outcomes of the LeDeR programme for review of deaths of people with a learning disability | Board ‘Lessons Learned’ Report – 3 monthly  
*Monitored by Trust CIRCLE* |
### RESPONSIVE

7. **Deliver services that are responsive to patient’s needs, provided consistently across the Trust; providing the right care in the right place at the right time**

*This priority was chosen as feedback from service users and carers, as well as monitoring of waiting times and other access metrics, points to this being an area requiring quality improvement.*

Our ambition is to ensure all waiting time targets are met and negative feedback reduces. Patients are cared for in the most appropriate service to meet their clinical need.

**Responsive Metrics for 2017/18:**
- Monitor access targets – IAPT & First Episode Psychosis
- Delayed Transfers of Care
- 28 day re-admission
- Length of stay
- Occupancy rate
- Out of area placements
- A&E breaches
- Waiting times – referral to assessment and assessment to treatment
- Impact of Out of Area Transfers on quality of care

Analysing relevant feedback – complaints & patient surveys

*Monitored by the Finance and Performance Committee*

### WELL-LED

8. **Ensure the Trust has a culture that encourages staff to have the ‘freedom to speak up’**

*This priority was chosen as we want our staff to speak up about any concerns they have, feel they are listened to and their concerns acted upon.*

For all concerns to be raised to help us to keep improving our services for all patients and the working environment for our staff. We want to investigate what staff say and provide access to the support they need.

**Specific measures are being developed**

Top 20% Trusts with relevant national staff survey questions.

*Monitored by Trust CIRCLE and the Workforce, Equality and Diversity Committee*
**Statements of Assurance from the Board**

This section has a pre-determined content to allow comparison between Quality Reports from different organisations. The content and wording within the light blue boxes are requirements taken from The NHS Improvement’s Detailed Requirements for Quality Reports 2016/17. This incorporates the requirements for all trusts to produce a Quality Account as set out in The National Health Service (Quality Account) Regulations 2010 and additional requirements set by NHS Improvements for Foundation Trusts.

**Review of Services**

During 2016/17 Nottinghamshire Healthcare NHS Foundation Trust provided and/or subcontracted 143 relevant health services.

Nottinghamshire Healthcare NHS Foundation Trust has reviewed all the data available to them on the quality of care in 143 of these relevant health services.

The income generated by the relevant services reviewed in 2016/17 represents 89% of the total income generated from the provision of relevant health services by Nottinghamshire Healthcare NHS Foundation Trust for 2016/17.

**Participation in Clinical Audit**

During 2016/17 12 national clinical audits and 1 national confidential enquiry covered the relevant health services that Nottinghamshire Healthcare NHS Foundation Trust provides.

During that period Nottinghamshire Healthcare NHS Foundation Trust participated in 100% national clinical audits and 0% 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 Nottinghamshire Healthcare NHS Foundation Trust was eligible to participate in during 2016/17 are as follows:

- The National Prescribing Observatory for Mental Health (POMH) – 5 audits
- National Early Interventions in Psychosis (EIP) Audit
- Sentinel Stroke National Audit Programme (SSNAP) (Our Audit Ref D020)
- PLACE (Patient Led Assessments of the Care Environment) (Our Audit Ref D021)
- National COPD Pulmonary Rehab Audit (Our Audit Ref D059)
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) – Young People’s Mental Health (YPMH)
- National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)

The national clinical audits and national confidential enquiries that Nottinghamshire Healthcare NHS Foundation Trust participated in during 2016/17 are as follows:

- The National Prescribing Observatory for Mental Health (POMH) – 5 audits
- National Early Interventions in Psychosis (EIP) Audit
- Sentinel Stroke National Audit Programme (SSNAP) (Our Audit Ref D020)
- PLACE (Patient Led Assessments of the Care Environment) (Our Audit Ref D021)
The national clinical audits and national confidential enquiries that Nottinghamshire Healthcare NHS Foundation Trust participated in, and for which data collection was completed during 2016/17, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

<table>
<thead>
<tr>
<th>Audit Title</th>
<th>Cases Submitted</th>
<th>% of the number of registered cases required</th>
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<tbody>
<tr>
<td>POMH Audit Topic 11: Prescribing antipsychotic medication for people with dementia</td>
<td>120</td>
<td>100%</td>
</tr>
<tr>
<td>POMH Audit Topic 7: Monitoring of patients prescribed lithium</td>
<td>118</td>
<td>100%</td>
</tr>
<tr>
<td>POMH Audit Topic 16: Rapid tranquillisation or prescribing for depression</td>
<td>39</td>
<td>100%</td>
</tr>
<tr>
<td>POMH Audit Topic 1 &amp; 3: Prescribing for high dose antipsychotic drugs</td>
<td>380</td>
<td>100%</td>
</tr>
<tr>
<td>POMH Audit Topic 14: Prescribing for substance misuse : alcohol detoxification</td>
<td>9</td>
<td>100%</td>
</tr>
<tr>
<td>National Early Interventions in Psychosis (EIP) Audit</td>
<td>78</td>
<td>100%</td>
</tr>
<tr>
<td>Sentinel Stroke National Audit Programme (SSNAP)</td>
<td>155</td>
<td>100%</td>
</tr>
<tr>
<td>PLACE (Patient Led Assessments of the Care Environment)</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>National COPD Pulmonary Rehab Audit</td>
<td>Data collection underway</td>
<td>-</td>
</tr>
<tr>
<td>National Confidential Enquiry into Patient Outcome and Death (NCEPOD) YPMH</td>
<td>7</td>
<td>0%</td>
</tr>
<tr>
<td>National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)</td>
<td>25</td>
<td>100%</td>
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investigated by a smaller group of staff to improve consistency. The Serious Incidents Requiring Investigation (SIRI) Policy has been significantly revised and incorporates the Trusts approach to reporting and investigating deaths.

All homicides, suicides, unexpected deaths and near misses involving patients of the Trust are regarded as serious incidents and managed in accordance with national guidance and with agreed policies within the Trust and NHS England. The Trust therefore participates in this research and reports its investigations to the National Confidential Inquiry.

The distinctive feature of each inquiry’s contribution is the critical examination by senior and appropriately chosen specialists, into each incident. There are established arrangements for communicating lessons learned (both within the Trust and externally where appropriate), carrying out of gap analysis for any areas of concern, developing any additional action plans where applicable to meet the recommendations of the study and to ensure that there is a robust and expedient system for the dissemination of information.

The reports of 12 national clinical audits were reviewed by the provider in 2016/17 and Nottinghamshire Healthcare NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

As a result of participating in Prescribing Observatory for Mental Health (POMH) Audit programmes (and other programmes of work) the following actions have been taken:

**POMH Audit Topic 11: Prescribing antipsychotic medication for people with dementia**

– This audit standards have been derived from relevant recommendations in the NICE-SCIE Guideline on supporting people with dementia and their carers in health and social care. It looked at the prevalence of antipsychotic use in people with dementia who did not have a comorbid psychotic illness and were in contact with mental health services. The audit has led the way in highlighting areas of concern such as use of antipsychotics among people with dementia and monitoring side effects of psychotropic drugs. Through developing a range of resources that help prescribers improve their practice POMH has delivered real change for patients. The results of this audit will be discussed with the Mental Health Services for Older People Services and an action plan will be devised and shared with the Medicines Optimisation Group.

**POMH Audit Topic 16: Rapid tranquillisation or prescribing for depression**

In 2014, NICE advice was that ‘Rapid tranquillisation is when medicines are given to a person who is very agitated or displaying aggressive behaviour to help quickly calm them. For clinicians participating in the programme, information on their performance against such standards would allow them to reflect on their practice in relation to the management of acutely disturbed behaviour. But some of the clinical data relevant to the standards might not be documented in detail in the clinical records of patients. So rather than collecting such clinical data retrospectively, the audit proposes a prospective audit, whereby incident cases of pharmacotherapy for disturbed behaviour are identified promptly, the data is collected from clinical records and the staff involved are questioned soon after. The outcome of the audit is expected in June 2017.

**POMH Audit Topic 1 & 3: Prescribing for high dose antipsychotic drugs**

- There is considerable evidence for the effectiveness of antipsychotic drugs in the treatment of psychosis, but no evidence to suggest that doses of antipsychotics higher than the recommended dosages are more effective than standard doses in any clinical situation or patient group (Royal College of Psychiatrists, 2014). Those patients who are prescribed more than one antipsychotic concurrently are more likely to receive a high total antipsychotic...
dose and are at an increased risk of side-effects and tend to spend longer in hospital. This QIP initially addressed prescribing for patients on adult acute and psychiatric intensive care wards and, later, patients on forensic wards. This audit commenced in February 2017 and the Trust is awaiting the final report.

**POMH Audit Topic 7: Monitoring of patients prescribed lithium** - Lithium is used for the acute treatment of mania, to prevent relapse into mania or depression in bipolar disorder, and to augment antidepressants in treatment resistant depression. Its use for these indications is supported by NICE. Its side-effect profile is well established. This includes an increased risk of developing thyroid and kidney problems and thus all patients should have their thyroid and kidney function checked before starting lithium and then regularly throughout treatment. Lithium also has a narrow therapeutic range, that is, there is a small margin between an effective and a toxic dose. Importantly, dehydration and the concomitant use of some medicines can increase plasma lithium levels. It is therefore important that patients understand how to take lithium safely and that the level of lithium in the blood is monitored regularly. The Trust has recently received the outcomes of the audit and will review and produce an action plan for improvement.

**POMH Audit Topic 14: Prescribing for substance misuse: alcohol detoxification**

This audit seeks to determine the compliance with best practice in the prescription of medication in the treatment of substance misuse, more specifically, alcohol detoxification. The best practice standards outline the required documentation of physical healthcare details including blood tests relevant to alcohol dependence. They also outline the different treatment options available to those with alcohol dependence, and when they should be used or not. Treatment targets also looked at the diagnosis of alcohol detoxification treatment, the subsequent medication and referrals. Data collection for this audit completed in September 2016 and the two team who participated, Lucy Wade Unit and North Notts ID Team have reviewed the outcome. Due to the small sample size no specific actions have been identified.

As a result of participating in other national clinical audit programmes the following actions have been taken:

**National Early Interventions in Psychosis (EIP) Audit**

Improving access to evidence-based care for people with first episode psychosis is a national priority. A new Access and Waiting Time Standard has been set and additional funding has been made available to deliver better services. As part of this initiative, NHS England commissioned an audit to establish a baseline position regarding services’ ability to provide timely access to NICE recommended interventions across England.

In total 10 criteria were audited and the results indicate that the Trust exceeded the national findings in 6 areas. Areas of good practice where local performance was significantly (≥ higher than the national average include:

- Clozapine prescribing (+14%)
- Patients with first episode or suspected psychosis allocated and engaged within 2 weeks (+17%) and
- Patients looking for work are offered supported employment programmes (+24%)

There was one area where the Trust performed particularly poorly, scoring 0% compared to 41% nationally:

- Patients with first episode or suspected psychosis are offered CBTp
A monthly steering group has been set up to drive forward changes in EIP standards and an action plan has been devised which includes some of the following:

- A review of locality caseloads was undertaken against NICE standards with significant action taking place.
- Actions included the introduction of weekly triage, expanding referral routes through SPA & directly to EIP teams.
- It was also agreed that all clinical pathways would be reviewed and that all locality teams would include an EIP pathway, including older people services and CAMHS.

Development of a standardised clinical template as recommended by NICE and a flowchart has also been devised to assist in its completion.

**Sentinel Stroke National Audit Programme (SSNAP)**

Because so little is known about the organisation and structure of care received by stroke survivors after discharge from specialist acute inpatient services, SSNAP have made an effort to understand this by carrying out a post-acute organisational audit. This audit has been carried out in two phases, the first obtaining information from Clinical Commissioning Groups (CCGs) in England on what post-acute stroke services they commission (provide) and the second collecting structural data from all identified post-acute stroke services on the make-up of their service.

Data collection was completed by the Stroke Team in Nottingham West for the SSNAP audit in line with the 09/01/17 deadline. The Royal College of Physicians will provide the feedback report during March/April 2017.

**Patient Led Assessments of the Care Environment (PLACE)**

PLACE (Patient-led Assessments of the Care Environment) is a system for assessing the quality of the patient environment. They provide motivation for improvement by providing a clear message, directly from patients, about how the environment or services might be enhanced. They assess how the environment supports patient’s privacy and dignity, food, cleanliness and general building maintenance and also focus on the impacts of dementia. New for 2016 they include a focus on disability looking at the issues of access and mobility provided for disabled patients during their stay, and aspects relating to food and food service.

For 2016 in patient areas in General Services received a mixed report with:

- 2/4 areas achieving above the national average for Cleanliness.
- 3/4 areas achieving above the national average for Ward Food with 2 areas Bassetlaw Hospice and John Eastwood Hospice achieving 100% in this area.
- 3/4 areas achieving above the national average for Privacy, Dignity and Well Being.
- 4/4 areas achieving above the national average for Condition, Appearance and Maintenance.
- 2/3 areas achieving above the national average for the category of Dementia. (There is no national requirement for the Children’s Development Centre to report on this category).

It was highlighted that the current PLACE assessment tool is not conducive to the establishment of the Children’s Development Centre (CDC) and therefore by default would negatively impact on the available scores achieved. This is reflected in the scoring for CDC overall and it is recommended that further work is done with the City Hospital to address some of these issues as owners of the building and supplier of the catering arrangements.

A quality improvement plan containing 16 actions was developed to address minor issues
identified during the assessments. These actions included:

**Bassetlaw Hospice**
The hospice team have liaised with the charity administrator to schedule more frequent cleaning of the radiator grills at floor level.

**John Eastwood Hospice**
The hospice team have worked with catering staff to ensure patients are asked for a preference in relation to preferred temperature and all food is probed prior to leaving the kitchen to ensure this it is an appropriate temperature.
The audit identified dust at high levels prompting discussions with the house keeper. A follow up audit by the team found this to be no longer an issue. The issue of the use of green labels on cleaned equipment was raised and these have been added to cleaning rotas.
An issue raised about the bin in the reception area led to this being replaced with a lidded bin and also a further on site audit to ensure all waste is disposed of correctly and cost effectively. The Gardening team have ensured the pathways are all clear.

**Children’s Development Centre**
Minor maintenance issues have been raised with Carillion who provide the maintenance contract. These included the need for replacement of ceiling tiles and attention to water staining on one of the ceilings in the bedrooms. Carillion are completing a maintenance programme and these actions should be complete by 31/01/17.
Ridge carpets identified in the clinic and corridor have been taken up and replaced.
Recurring issues identified include old radiators which are difficult to clean and an issue with two therapy clinical areas do not facilitate privacy during treatment. Capital bids have been raised previously and been unsuccessful. Bids have been raised again and the outcome of this will be known by 31/03/17.

**Lings Bar Hospital**
It was noted poor lighting in patient’s toilets would pose a particular problem for patients with visual impairment and as a result of the audit the lighting has been replaced.
The hand wash basins on Castle Ward were noted as unclean and in poor condition. Deep cleaning has been arranged and the plugholes have been replaced.
Amendments have been to the menu in relation to meal choice.
A daily cleaning regime has been implemented with regards to the dining room floor.

For 2016 inpatient areas in Local Partnerships – Mental Health Services scored well with:

- 7/8 areas achieving above the national average for Food with Bracken House and 106/145 Thorneywood Mount achieving 100% in this area.
- 5/8 areas achieving above the national average for Privacy, Dignity and Well Being.
- 5/8 areas achieving above the national average for Condition, Appearance and Maintenance
- 7/8 areas achieving above the national average for Disability
- 3/3 areas achieving above the national average for the new category of Dementia.

All inpatient areas were required to complete a quality improvement plan which include actions such as the following:

- Introduce frequent environmental checklists for areas to be cleaned by nursing staff/environment coordinators.
- Directive given that all future furnishings being ordered or replaced should be wipeable.
- Labelling equipment when cleaned with green ‘ I am clean stickers’
National COPD (Chronic Obstructive Pulmonary Disease) pulmonary rehab audit

The core aim of the programme is to drive improvements in the quality of care and services provided for COPD patients. Through collecting and linking patient journey data it will enable the comparison of performance and practice, highlight variations in patient care and outcomes, and seek to innovatively drive up standards of patient care. The audit programme comprises five key work streams:

1. Primary care audit – collection of audit data from GP patient record systems.
2. Secondary care continuous audit – continuous audit of admissions to hospital with COPD exacerbation (began on 1 February 2017).
4. Organisational snapshot audits - snapshot audits of the resources and organisation of COPD services in secondary care and pulmonary rehabilitation (taking place in 2017).
5. Pilot data linkage – a pilot piece of work looking at linking the data across the patient journey.

This audit is not yet complete. Once the data has been submitted and final report published the Trust will ensure the recommendations are embedded into practice.

The reports of 170 local clinical audits were reviewed by the provider in 2016/17 and Nottinghamshire Healthcare NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Within our Forensic Services Division:

The reports of 66 local clinical audits were reviewed within Forensic Services during 2016/17.

The following are examples of actions taken to improve the quality of healthcare provided:

- Following an audit of the physical healthcare reports provided to Care Programme Approach (CPA) Planning meetings at Rampton Hospital, a new standard pro-forma was produced and piloted. The new version is now being used by the link physical health nurses to ensure that relevant and up to date information is being provided to CPA planning meetings.

- Audits of the Observations Procedure at Rampton Hospital led to a review of procedures and paperwork used in observations and the ward handover process. As part of the exercise a rationalisation of some documentation used across Forensic Services in relation to restrictive practices took place and in order to reduce the range and volume of documentation staff were required to complete, a single observation plan and record of interventions form has been put in place spanning intermittent observations, seclusion, long term segregation and mechanical restraint. Revisions to the daily handover book have also been initiated at Rampton.

- Pharmacists at Wathwood have developed an electronic on call log to improve the accuracy of recordings following a Clozapine Supplementary Stock audit.

- An audit of the use and completion of the Ward Round Template led to the inclusion
of Physical Health issues in the template at Wathwood.

- Information relating to the quarterly Pressure Ulcer audit within Offender Health is provided to the link nurses to highlight where there are gaps in compliance. The Tissue Viability Specialist Nurse has also provided some targeted training at individual prisons.

- Doctors and Physical Healthcare staff at Arnold Lodge have been reminded of the monitoring requirements for patients on Lithium.

Within our Local Partnerships Division – General Health Services:
There were a total of 40 different audit topics registered on the Audit Programme including audits looking at Infection Prevention and Control, Safeguarding, Continence, Documentation/Record Keeping Standards, Medicines Management, Dental, Podiatry and other service specific audits.

Excluding reports and actions received in relation to Documentation / Record Keeping Standards 48 audit reports have reviewed in the division with 322 actions identified from these on the QuIPTraK (the system used in General Health Services for the management of quality improvement plans)

For Documentation / Record Keeping Standards audits please note 230 reports have been received including 670 actions.

- **Dental – Do Not Attends for Adult Assessment Clinic at NUH** - Following this audit a number of processes have been introduced to minimize the number of ‘Do Not Attends’. Most importantly all non-attendees are to be followed up by a phone call to see how the service can work with carers and patients to further support them in attending these assessments.

  Community clinic referrals are also to discuss with carers and patients any issues in regards to being assessed at Nottingham University Hospitals, in particular, to stress if patient is unable to attend to let the team know in advance.

- **Antibiotic Use at Lings Bar Hospital** - This audit found the diagnosis and management of urinary tract infections is one particular area that could be improved upon. As a result of this audit refresher training will be provided to staff on the use of dipsticks on catheter urines and routine dip sticking by nursing staff.

  A “How To” folder including local guidance and documentation in relation to antibiotic use was also produced to be given to Locum Doctors and kept on the ward for other doctors to use.

- **Review of Nice Guidelines – QS9 Chronic Heart Failure in Adults** - As a result of this audit all patients will be given a follow up appointment at the time of medication changes to ensure all patients are reviewed within 2 weeks of any medication changes.

- **Benchmarking NICE guidelines on Idiopathic Pulmonary Fibrosis (IPF) with current service provision** - Following on from the audit the team will devise a specialist education session for patients to access specific pulmonary rehabilitation information. They will also use symptom questionnaires to document symptoms and psychosocial needs, improve existing links with secondary care and specialist
services, provide regular spirometry and oxygen assessments clinics and create a local support group.

- **Benchmarking NICE guidelines on Bronchiectasis with current service provision.** - As a result of the audit a specific care plan for the care of patients with Bronchiectasis will be developed.

**Within our Local Partnerships Division – Mental Health Services:**
Within the Local Services division a total of **64** clinical audits were completed in the year of 2016/17. The following examples describe some of the actions taken within the Division to improve the quality of services provided within the division:

- **Physical Examination and Assessment Audit – Inpatient** - Physical healthcare needs remain a priority within the Division and this re-audit looked at compliance with the standards set out in the Trust Policy. The audit found significant improvement had taken place in certain key areas; Physical examination being offered within 24 hours of admission; Clinician stipulating observations required and frequency of same. However further work is required to ensure further improvements take place and practice improves across all areas.

  Following this audit the Physical Healthcare Team revised their training programme with the aim of improving staff understanding of the core requirements in relation to physical health assessment and the management of long term conditions. They also delivered bespoke training to certain areas, such as the Mother and Baby unit, where the patient group has specific needs. Over the past year training has been rolled out to a mixture of staff groups across both inpatient and community settings. A further re-audit is planned for 2017/18 and moving forward learning from audits such as this will lie with the newly formed LP Physical Health Group which will have oversight of the audit reports and actions being taken to improve adherence to the Trust Physical Examination and Assessment Policy.

- **Do Not Attempt Cardio-Pulmonary Resuscitation - Re-Audit** - This re-audit took place in MHSOP and as a result all inpatient areas now carry out a weekly audit of all patients currently admitted with a DNACPR in place. This action has resulted in a significant improvement in the correct completion of the paperwork and adherence to the procedure outlined in Trust Policy.

- **Audit of QNIC standards on the assessment of health and social needs on admission in adolescent inpatient unit** - The QNIC standards set out a single channel for national and professional bodies to demonstrate and improve the quality of inpatient child and adolescent care. This audit found areas of good practice: the completion of risk assessments on admission and the commencement of a physical assessment within 4 hours of admission but there was also a degree of failure. In particular the documentation of reason for refusal is a concern and there also appear to be discrepancies in what is termed a full physical assessment of new inpatients. As a result of these findings, a new Pro-forma Flowchart was devised which outlined the standards that need to be met during the admission process. A re-audit is planned to measure the impact this has had on clinical practice.
Quality Report 2016/17

Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by Nottinghamshire Healthcare NHS Foundation Trust in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee **1373**.

Nottinghamshire Healthcare NHS Foundation Trust records the number of studies for each medical condition. This enables the Trust to monitor over-researched medical conditions and to ensure that there is an equal distribution of research being conducted over a variety of disease areas.

During 2016/17 there has been high numbers of studies approved relating to a broad range of topics; the majority of studies is within gender dysphoria, psychotic disorders, children/young people mental health and dementia. For those studies ongoing (opened before 2016/17), services with high research activity include ADHD, autism, suicide & self-harm and offender health. Our highest proportion of studies is with dementia Trust wide, which continues to support the Department of Health’s priorities. The Trust also undertakes a significant amount of research in health service delivery, which mainly includes staff as participants and our research in physical health conditions is also on the increase, for example stroke and cancer. Please note the recruitment number and the table below does not include staff studies, as the information requested is for patients recruited and also studies that have been approved by a research ethics committee. Research involving staff as participants are exempt from research ethics committee approval.

<table>
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<tbody>
<tr>
<td><strong>Total Non-Portfolio Open Studies</strong></td>
<td>48</td>
<td>39</td>
</tr>
<tr>
<td><strong>Total Portfolio Participant Identification Centre Studies</strong></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total Portfolio Open Studies (including ongoing)</strong></td>
<td>32</td>
<td>63</td>
</tr>
<tr>
<td><strong>Total Open Studies</strong></td>
<td><strong>81</strong></td>
<td><strong>104</strong></td>
</tr>
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Commissioning for Quality and Innovation (CQUIN)

A proportion of Nottinghamshire Healthcare NHS Foundation Trust income in 2016/17 was conditional upon achieving quality improvement and innovation goals agreed between Nottinghamshire Healthcare NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2016/17 and for the following 12 month period are available online at:


A CQUIN scheme is the locally agreed package of quality improvement goals and indicators, which in total, if achieved, enables the Trust to earn its full CQUIN payment. Commissioners and providers agree each year the detail of how national and local priorities will be measured and achieved. A series of milestones and targets are agreed in advance and each provider is required to submit evidence to commissioners at regular intervals.
Each clinical division have a set of agreed CQUIN targets which is monitored by the division and reported to the Trust Board of Directors every quarter. During 2016/17 there were 21 CQUIN targets across the three clinical divisions within the Trust. Performances against these are:

- **Forensic Services** – All 7 agreed CQUIN targets were achieved. 1 target in relation to discharge planning is awaiting clarification from commissioners.

- **Local Partnerships Division – General Health Services** – 4 out of 5 CQUIN targets were met. One was not met. This was ‘Improving the uptake of flu vaccinations for frontline clinical staff’. This was set at 75% for achievement by end of Quarter 3 16/17. The Trust failed to achieve this, with a 31.5% vaccination rate as of 31 December 2016.

- **Local Partnerships Division – Mental Health Services** – 6 out of 9 CQUIN targets were met. One target ‘Improving Physical Healthcare to Reduce Premature Mortality in People with an SMI - Cardio-metabolic assessment and treatment for people with psychosis’ is awaiting confirmation from commissioners. One target ‘Improving Physical Healthcare to Reduce Premature Mortality in People with an SMI - Communication with GPs’ was only partially met and one target Improving the uptake of flu vaccinations for frontline clinical staff’ was not met.

All unmet CQUIN targets are escalated within the relevant clinical division with actions identified for improvement. The division will also hold discussions with commissioners to agree further actions.

The monetary total for income in 2016/17 conditional upon achieving quality improvement and innovation goals was £8.3m (actual £7.1m). The monetary total for the associated payment in 2014/15 was £8,000k (actual £7,698k).
Care Quality Commission (CQC)

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. The CQC monitor, inspect and regulate services to make sure that health and social care providers meet fundamental standards of quality and safety, with the power to take action if care services are failing to meet those standards. The CQC also has a role in protecting the rights of vulnerable people whose rights are restricted under the Mental Health Act 1983, monitoring the use of the Mental Capacity Act and the Deprivation of Liberty Safeguards.

Nottinghamshire Healthcare NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is Good. Nottinghamshire Healthcare NHS Foundation Trust has no non-routine conditions on its registration.

The Care Quality Commission has taken enforcement action against Nottinghamshire Healthcare NHS Foundation Trust during 2016/2017.

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

The CQC assess all health and social care services against the following five key questions:

<table>
<thead>
<tr>
<th>Question</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are they SAFE?</td>
<td>By safe, they mean that people are protected from abuse and avoidable harm.</td>
</tr>
<tr>
<td>Are they EFFECTIVE?</td>
<td>By effective, they mean that people’s care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.</td>
</tr>
<tr>
<td>Are they CARING?</td>
<td>By caring, they mean that staff involve and treat people with compassion, kindness, dignity and respect.</td>
</tr>
<tr>
<td>Are they RESPONSIVE?</td>
<td>By responsive, they mean that services are organised so that they meet people’s needs.</td>
</tr>
<tr>
<td>Are they WELL-LED?</td>
<td>By well-led, they mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.</td>
</tr>
</tbody>
</table>

The Trust is registered with the CQC to provide regulated activities from 39 separate locations. (This is two fewer than 2015-16 given the loss of the contract for Mental Health Services at HMP Stocken and HMP & YOI New Hall from 1 June 2016 and 1 September 2016 respectively.)

In June 2014, the Trust received feedback from the CQC following a comprehensive inspection by the Chief Inspector of Hospitals. The CQC found that staff were ‘outstanding’ in their approach to patient care and rated the Trust as ‘Good’ overall. From this inspection the CQC raised 11 areas of non-compliance in eight core services and the Trust took prompt action to bring about the improvements required. The CQC has since undertaken follow up inspections at five of the eight core services and found that the compliance actions they made had been addressed. The Trust is anticipating a comprehensive inspection during 2017/18 when the CQC will follow up on the remaining three core services.

Following an inspection of HMP Lowdham Grange on 30/3/16 a warning notice was received in May and subsequently found to be met at a follow up inspection in August.
Rampton Hospital was also the subject of a focused CQC inspection in March 2016 after which enforcement action was taken in the form of a warning notice regarding observation practice. A follow up inspection by the CQC in August 2016 found the conditions of the warning notice had been met. The CQC also inspected the three High Secure hospitals in England between November 2016 and March 2017. The inspection of Rampton took place the week beginning 6th March and the Trust received a warning notice on 17 May 2017 instructing the Trust to improve staffing levels. The draft report for the inspection indicates that improvements are required and there is a plan to address this. The CQC undertook a total of eleven inspections, including three follow up inspections of Trust locations during the year 2016/17. Figure 1 illustrates the inspections that took place during 2016/17 with the subsequent outcomes and requirements.

**Figure 1:**

<table>
<thead>
<tr>
<th>Location</th>
<th>Review Date</th>
<th>Outcome</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rampton Hospital</td>
<td>18.03.16 &amp; 11.04.16</td>
<td>0 Requirement notice 1 Warning Notice</td>
<td>Warning Notice served 13 June 2016: • Patient observation system is not operating effectively. This places the safety of patients at risk.</td>
</tr>
<tr>
<td>HMP Lowdham Grange</td>
<td>30.03.16</td>
<td>0 Requirement notice 1 Warning Notice</td>
<td>Warning Notice served 09 May 2016: • Systems to ensure patients have timely access to health professionals are not operated effectively. • Systems to ensure that care is appropriate and meets the patient’s needs are not operated effectively. • Systems to ensure the proper and safe management of medicines and ensure that there are sufficient quantities of medication to meet patient needs are not operated effectively.</td>
</tr>
<tr>
<td>HMP Ranby</td>
<td>05.07.16</td>
<td>Requirement Notices made.</td>
<td>• Risks associated with the proper and safe management of medicines were not identified or mitigated effectively.</td>
</tr>
<tr>
<td>HMP Whatton</td>
<td>15.08.16 (not with CQC)</td>
<td>0 Requirement notice</td>
<td>None</td>
</tr>
<tr>
<td>HMP Lowdham Grange</td>
<td>18.08.16 (follow up)</td>
<td>0 Requirement notice</td>
<td>Report confirmed all actions have been taken to address the concerns identified in the S29A Warning Notice.</td>
</tr>
<tr>
<td>Rampton Hospital</td>
<td>25.08.16 (follow up)</td>
<td>0 Requirement notice</td>
<td>Report confirmed all actions have been taken to address the concerns identified in the S29A Warning Notice.</td>
</tr>
<tr>
<td>Adult Acute Wards (Highbury Hospital and Millbrook)</td>
<td>11.11.16</td>
<td>Requirement Notices made.</td>
<td>• The provider must ensure that ligature risk assessments are fully completed and that consideration is given to actions that could mitigate the risks further • The provider must continue to monitor and review bed usage and to take steps to improve the experience of patients.</td>
</tr>
<tr>
<td>HMP Ranby</td>
<td>07.12.16</td>
<td>Requirement Notices made.</td>
<td>Further improvements were required in medicine management</td>
</tr>
<tr>
<td>HMP Moorland</td>
<td>12.12.16 (follow-up)</td>
<td>0 Requirement notice</td>
<td>The CQC conducted a desk top follow up of compliance actions set at their inspection in February 2016 and found the service was compliant.</td>
</tr>
<tr>
<td>Rampton Hospital</td>
<td>06.03.17</td>
<td>Draft report received</td>
<td>Warning notice issued on 17/05/2017 The draft report has been issued for factual accuracy</td>
</tr>
</tbody>
</table>

Full inspection reports listing all requirement and warning notices and good practice recommendations can be accessed at the CQC website, [www.cqc.org.uk](http://www.cqc.org.uk)

Joint CQC and HMIP reports can be found at: [https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/](https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/)
**Data Quality**

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

Which included the patient’s valid NHS number was:
- 97.7% for admitted patient care;
- 100% for out-patient care; and
- Not applicable for accident and emergency care

Which included the patient’s valid General Medical Practice Code was:
- 99.7% for admitted patient care;
- 100% for out-patient care; and
- Not applicable for accident and emergency care.

**Information Governance Toolkit Attainment Levels**

Nottinghamshire Healthcare NHS Foundation Trust Information Governance Assessment Report overall score for 2016/17 was 87% and was graded *Green*.

A validation exercise was conducted on the Review of Information Governance Toolkit by Internal Audit 360 Assurance with their final report received in March 2017.

As a result, Internal Audit 360 Assurance was able to validate eleven of the twelve scores based on the evidence uploaded by the completion of their on-site review. They also reviewed the Trust's Information Governance Control Environment (as defined within requirement 101). From both of these contexts, 360 Assurance provided *Significant Assurance* that there is a generally sound system of control designed to meet the Toolkit’s objectives.

**Clinical Coding Error Rate**

Nottinghamshire Healthcare NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

Nottinghamshire Healthcare NHS Foundation Trust will be taking the following actions to improve data quality:
- Roles and Responsibilities for data quality have been defined and incorporated into the Trust Information Assurance Framework including those for Executive Directors.
- The Trust Information Assurance Framework has been written, consulted on and ratified by the Trust’s Executive Leadership Council and the Strategic Information Governance Group and is now incorporated into our operational policies and procedures for use by all staff.
- The Performance Indicator Assurance Process is embedded in the Trust Information Assurance Framework and the process continues to be used on an ongoing basis to review the data quality of the Monitor and main Trust KPIs in the Quality and Performance Report provided to the Trust Board.
National Quality Indicators

The Department of Health identified 15 indicators which should be included in Trust Quality Reports/Accounts, where they are applicable to services. Five of these indicators are relevant to Nottinghamshire Healthcare NHS Foundation Trust; in addition we have chosen to include the optional ‘Friends and Family Test’ indicator. The subject to limited assurance audit are marked with the symbol 🔴

🔴 CPA 7 Day Follow-up – The data made available to Nottinghamshire Healthcare NHS Foundation Trust by NHS Improvement with regard to the percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period.

The term ‘Care Programme Approach’ (CPA) describes the framework to support and coordinate effective mental health care for people with mental health problems in secondary mental health services. Although the policy has been revised over time, CPA remains the central approach for coordinating the care for people in contact with these services who have more complex mental health needs and who need the support of a multidisciplinary team.

Following up someone on care programme approach (CPA) within seven days of discharge from inpatient care reduces risk of harm and social exclusion and can maintain and improve access to care. Trusts must ensure that a minimum of 95% of inpatients on CPA are followed up within seven days of discharge from hospital.

Nottinghamshire Healthcare NHS Foundation Trust considers that this data is as described for the following reasons:

- Data is collected and analysed by the Trust Applied Information team before being released on the Trust reporting site.
- CPA 7 day follow up rates are scrutinised on a monthly basis at Directorate meetings and Divisional Business meetings.
- Directorate and ward level managers are required to monitor the CPA 7 day rate as one of part of their duties.
- Divisional performance heads are required to sign off CPA 7 data performance reports before inclusion into the Trust’s monthly Board of Directors Performance Report.

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

- Continuing to work closely with service users and their families in developing discharge care plans which support patients in a safe transition from inpatient care to life in the community.
- Nottinghamshire Healthcare NHS Foundation Trust has continued to achieve this target throughout the last three years, remaining consistently above the national average for levels of follow up care in the community.
Quality Report 2016/17

Crisis Team Gatekeeping Admissions: The data made available to Nottinghamshire Healthcare NHS Foundation Trust by the Information Centre, with regard to the percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team (CRHT) acted as a gatekeeper during the reporting period.

In a crisis resolution context within psychiatric care, a 'crisis' is defined as the breakdown of an individual's normal coping mechanisms. Crisis Resolution and Home Treatment is an alternative to in-patient hospital care for service users with serious mental illness, offering flexible, home-based care, 24 hours a day, seven days a week. These teams act as gatekeepers to acute in-patient services, and are measured against the 95% minimum gatekeeping target set in the Single Oversight Framework.

Nottinghamshire Healthcare NHS Foundation Trust considers that this data is as described for the following reasons:

- Crisis Resolution gatekeeping is an embedded and key process within the Trust before in-patient admission, evidenced through localised record keeping;
- Crisis Resolution gatekeeping levels are presented on a monthly basis at Board of Directors’ Meetings;
- Divisional Performance Heads are required to sign off Crisis Resolution data reports before inclusion in the Trust’s monthly Board Report.

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

- Improving the centralised management and recording of Crisis Resolution gatekeeping performance data through the development of bespoke reporting systems available on the Trust’s Rio clinical information system;
- Focusing on the data quality of Crisis Resolution gatekeeping at clinical team level where admission information is recorded onto Rio.
- The Trust has fully considered the Crisis Care Concordat making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously.

<table>
<thead>
<tr>
<th>7 Day Follow Up</th>
<th>Nottinghamshire Healthcare NHS Foundation Trust (NHS DIGITAL data)</th>
<th>Nottinghamshire Healthcare NHS Foundation Trust (local data taken from the Rio Clinical information System*)</th>
<th>National Average (NHS DIGITAL data)</th>
<th>Highest Performing Trust in any given Quarter (NHS DIGITAL data)</th>
<th>Lowest Performing Trust in any given Quarter (NHS DIGITAL data)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016/2017</td>
<td>98.8%</td>
<td>98.8%</td>
<td>96.6%</td>
<td>100%</td>
<td>73.3%</td>
</tr>
<tr>
<td>2015/2016</td>
<td>98.6%</td>
<td>98.6%</td>
<td>97.0%</td>
<td>100%</td>
<td>50%</td>
</tr>
<tr>
<td>2014/2015</td>
<td>98.5%</td>
<td>98.8%</td>
<td>97.2%</td>
<td>100%</td>
<td>90%</td>
</tr>
</tbody>
</table>

Monthly average performance against this target is shown in Part 3:
Re-admission Rates: The criteria as laid out by the Department of Health in regards to readmission rate reporting in Quality Accounts is based on data collected by the Health and Social Care Information Centre. This data collection is not directly applicable to mental health trusts due to the age related criteria not being relevant to mental health services. Nonetheless readmission rates are of concern to all health service providers including mental health services, and therefore the figures provided are those based on our own internal records.

Readmissions of patients to inpatient areas can be extremely distressing, leading to potentially harmful consequences for patients’ mental and physical wellbeing. NHS organisations endeavour to keep readmission rates as low as possible; however there can be a wide variation in readmission rates between similar NHS organisations. These variations can act as a trigger to look at practice within an organisation or geographical area. This could in turn help to prevent avoidable readmissions and lead to improved levels of care.

Nottinghamshire Healthcare NHS Foundation Trust considers that this data is as described for the following reasons:

- Data is collected in line with Trust reporting requirements.
- Instances of readmission within 28 days are investigated to ensure that each case is clinically appropriate.

Nottinghamshire Healthcare NHS Foundation Trust has taken the following actions to improve the percentage and so the quality of its services, by:

- Maintaining a focus on effective and therapeutic relationships between patient and its services to ensure we all illness and reducing readmission;
- Enabling patients making the transition from a structured hospital based environment to the community to have as positive and enabling experience as possible, providing support to reassure patients around the challenging aspects of greater personal involvement in the community.

0-15 years is not applicable, 16 years and over, see the table below:

<table>
<thead>
<tr>
<th></th>
<th>Nottinghamshire Healthcare NHS Foundation Trust (local data Rio Clinical information system)</th>
<th>Nottinghamshire Healthcare NHS Foundation Trust (NHS DIGITAL data)</th>
<th>National Average</th>
<th>Highest Performing Trust in any given Quarter</th>
<th>Lowest Performing Trust in any given Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016/2017</td>
<td>2.3%</td>
<td>Not Available</td>
<td>Not Available</td>
<td>Not Available</td>
<td>Not Available</td>
</tr>
<tr>
<td>2015/2016</td>
<td>3.7%</td>
<td>Not Available</td>
<td>Not Available</td>
<td>Not Available</td>
<td>Not Available</td>
</tr>
<tr>
<td>2014/2015</td>
<td>5.0%</td>
<td>Not Available</td>
<td>Not Available</td>
<td>Not Available</td>
<td>Not Available</td>
</tr>
</tbody>
</table>
Community Mental Health Survey - The data made available to Nottinghamshire Healthcare NHS Foundation Trust by the Picker Institute for the Trust’s ‘Patient Experience of Community Mental Health Services’ indicator score with regard to a patient’s experience of contact with a health or social care worker during the reporting period.

The summary of the results of the annual Community Mental Health Survey details how patients graded different aspects of their care. These results also enable each of the Trusts involved in the survey to assess their own findings and develop services accordingly.

Nottinghamshire Healthcare NHS Foundation Trust considers that this data is as described for the following reasons:

- The sample for the Trust-commissioned survey was collected and checked in line with the process approved by the Confidentiality Advisory Group (CAG), which provides independent expert advice to the Health Research Authority (HRA) and the Secretary of State for Health;
- Patients selected in the sample are informed of how their confidentiality will be protected. Details of how we do this are included in the letters patients receive alongside the questionnaires and published FAQs that support each survey. These documents tell patients how we apply data protection and ensure that personal data is kept confidential.

Nottinghamshire Healthcare NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, as follows:

- The Trust will continue to recognise the importance of working to individual strengths and aspirations, using recovery focused ways of working;
- All comments received via the community mental health survey will be entered and coded on the ‘Your Feedback Matters’ website, alongside comments received via the Feedback Survey and Patient Opinion. This will ensure that services are aware of this feedback and use it to inform service development/delivery, and they will be expected to report on any changes made as a result via their quarterly Involvement and reports, which in turn inform the assurance reports submitted to the Board of Directors;
- The Trust will continue to work in partnership with those using services, their families and carers (where appropriate), staff and membership, listening to individual lived experience and seeking to plan care in partnership. The Trust strives to provide as many diverse ways as possible to enable feedback from those using services and their carers.
- The Trust is committed to ensuring people’s experiences of care are positive. All services are expected to submit an Involvement and Experience report every quarter, detailing how they have used feedback to reflect on people’s experiences and improve services accordingly;
Quality Report 2016/17

<table>
<thead>
<tr>
<th>Patient Experience of Community Mental Health Services - rating</th>
<th>Nottinginghamshire Healthcare NHS Foundation Trust*</th>
<th>Highest Performing Trust</th>
<th>Lowest Performing Trust</th>
<th>National average: patients with a positive experience of Community Mental Health services (NHS DIGITAL data)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016/2017</td>
<td>7.3 (out of a possible 10)</td>
<td>7.5 (out of a possible 10)</td>
<td>6.1 (out of a possible 10)</td>
<td>6.5 (Out of a possible 10)</td>
</tr>
<tr>
<td>2015/2016*</td>
<td>34% (the lower the better)</td>
<td>N/A</td>
<td>N/A</td>
<td>36% (the lower the better)</td>
</tr>
<tr>
<td>2014/2015</td>
<td>7.2 (out of a possible 10)</td>
<td>7.5 (out of a possible 10)</td>
<td>6.5 (out of a possible 10)</td>
<td>66% positive</td>
</tr>
</tbody>
</table>

*Picker Institute for 15/16 Notts HC Foundation Trust results - this was a new sample survey taken from a different time period to that of the national Community Mental Health Services survey.

Patient Safety Incidents - The data made available to Nottinginghamshire Healthcare NHS Foundation Trust by the Information Centre 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.

A patient safety incident is any healthcare related event that was unintended, unexpected and undesired, and which could have or did cause harm to patients. It is recommended as a preferred term when considering adverse events, near misses and significant events to minimise confusion and help the formal reporting of relevant incidents.

All incidents graded as moderate harm to severe harm or death on the Trust’s incident reporting system (Ulysses) are validated to ensure they are graded correctly, as part of the Trust’s obligation under the Duty of Candour.

The Trust reported 12,897 Patient Safety Incidents (PSI) for 2016/17, of which 54 resulted in severe harm or death.

Never Events – The Trust reported no incidents for 2016/17.

Nottinghamshire Healthcare NHS Foundation Trust considers that this data is as described for the following reasons:

- The Ulysses electronic reporting system employed by the Trust enables a rapid and proactive reporting ethos with increased accountability at all levels;
- The Trust reports a range of incident data to the monthly Board of Directors ensuring openness and accountability, reflecting a reporting culture that is founded on continual learning and improvement through analysis and openness;
- The Trust reports regularly to the National Reporting and Learning System (NRLS) regarding any incident of patient safety whether actual or potential;
- The Trust reports all incidents of crime, including all violent incidents, to NHS Protect;
- Incidents involving staff absences of 7 days or more or other specified criteria are reported to the Health and Safety Executive (HSE) under the ‘Reporting of Injuries, Diseases and Dangerous Occurrences’ regulations (RIDDOR);
Quality Report 2016/17

- Serious incidents are reported to Commissioners via the Strategic Executive Information System (STEIS) system and are investigated fully. Where the investigation highlights recommendations for change, these are converted to action plans and are monitored to completion.

Nottinghamshire Healthcare NHS Foundation Trust has taken the following actions to improve the following incident rates, and so the quality of its services, by:

- Ensuring there is organisational learning from all incidents including serious incidents;
- Continuing to promote the national ‘Sign Up to Safety’ Initiative, with a particular focus on front line learning;
- Improving its performance in the monitoring and treatment of pressure ulcers;
- Providing a monthly supporting document for the National Safety Thermometer website published by the Department of Health, to present a balanced view of the Trust’s performance in relation to four key areas of patient health.

Data released by the National Reporting and Learning System (NRLS):

<table>
<thead>
<tr>
<th>Incident Data Reporting Periods</th>
<th>Notts HC Trust - incidents total (NRLS)</th>
<th>Notts HC Trust - Severe Harm/ Death incidents total (NRLS)</th>
<th>Notts HC Trust - Severe Harm/ Death incidents as a % of total incidents (NRLS)</th>
<th>National - Severe Harm/ Death incidents as a % of total incidents (NRLS)</th>
<th>National – highest level of Severe Harm/ Death incidents as a % of total incidents (NRLS)</th>
<th>National – lowest level of Severe Harm/ Death incidents as a % of total incidents (NRLS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr – Sept 2016 (NRLS)</td>
<td>6220</td>
<td>32</td>
<td>0.51%</td>
<td>1.11%</td>
<td>6.06%</td>
<td>0.26%</td>
</tr>
<tr>
<td>Oct15– Mar 2016 (NRLS)</td>
<td>5,555</td>
<td>24</td>
<td>0.43%</td>
<td>1.14%</td>
<td>6.01%</td>
<td>0.10%</td>
</tr>
<tr>
<td>Apr – Sept 2015 (NRLS)</td>
<td>5572</td>
<td>27</td>
<td>0.48%</td>
<td>1.02%</td>
<td>3.70%</td>
<td>0.09%</td>
</tr>
<tr>
<td>Oct14– Mar 2015 (NRLS)</td>
<td>5194</td>
<td>33</td>
<td>0.64%</td>
<td>1.06%</td>
<td>5.14%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Apr – Sept 2014 (NRLS)</td>
<td>5155</td>
<td>34</td>
<td>0.56%</td>
<td>1.01%</td>
<td>5.97%</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

The data released by the NRLS is part of a dataset that provides information on all trusts nationally; this takes a number of months of collation and preparation and the period April 2016 to September 2016 is the most recent set of data publicly available. Nonetheless, Nottinghamshire Healthcare NHS Foundation Trust submits data on a weekly basis to the National Reporting and Learning System and has, therefore, provided an accurate assessment of its performance at a local level in regard to Patient Safety Incident reporting.
<table>
<thead>
<tr>
<th>Patient Safety Incidents Reporting Periods</th>
<th>Data reported by the Trust to the National Reporting and Learning System:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nottinghamshire Healthcare NHS Foundation Trust – Rate of Patient Safety Incidents (number of incidents divided by total bed days of care) x 1000 bed days (Ulysses incident recording system and Rio Clinical information system data)</td>
</tr>
<tr>
<td>2016/2017</td>
<td>37.92</td>
</tr>
<tr>
<td>2015/2016</td>
<td>32.33</td>
</tr>
<tr>
<td>2014/2015</td>
<td>28.74</td>
</tr>
</tbody>
</table>
Further Quality Indicators

In addition to the requirement for the Trust’s external auditors to undertake a review of the content of the Quality Report, there is a requirement for two mandated indicators to be audited. An additional locally agreed indicator is also selected for audit by the Council of Governors.

The two mandated indicators are:

- Crisis Resolution Gatekeeping (covered in the previous section)
- Care Programme Approach 7 day follow-up (covered in the previous section)

The locally agreed indicator is:

- Safety Thermometer (see below)

Safety Thermometer

The NHS Safety Thermometer is the measurement tool for a programme of work to support patient safety improvement. It is used to record patient harms at the frontline, and to provide immediate information and analyses for frontline teams to monitor their performance in delivering harm free care. This information is shared with commissioners and is part of Local Partnership CQUIN.

The NHS Safety Thermometer records the presence or absence of four harms:

- pressure ulcers
- falls
- urinary tract infections (UTIs) in patients with a catheter
- new venous thromboembolisms (VTEs)

The Safety Thermometer is a point of care survey that is carried out on 100% of patients on one day each month. One of its most unique aspects is the concept of a 'harm free care' measure, the proportion of patients who are free from any of the harm measured. Using a composite measure such as this provides the Trust with a more positive view of the care we deliver, and ensures that we move away from thinking about harms with a silo mentality.

<table>
<thead>
<tr>
<th>Safety Thermometer Harm Free Care</th>
<th>Nottinghamshire Healthcare NHS Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016/2017</td>
<td>93.21%</td>
</tr>
<tr>
<td>2015/2016</td>
<td>93.46%</td>
</tr>
</tbody>
</table>
PART THREE: Review of Quality Performance 2016/17

Overview of Performance in 2016/17

This section provides information on performance against our quality and performance indicators agreed internally by the Trust, and also performance against relevant indicators and performance thresholds set out in Appendix 3 of NHS Improvement’s Single Oversight Framework (from October 2016), and the Monitor Risk Assessment Framework (pre October 2016).

The Trust has an established Performance Management Framework which includes a monthly Board Quality and Performance Report (QPR). The content of the QPR is reviewed and approved each year by the Finance and Performance Committee on behalf of the Board of Directors. This includes all Single Oversight Framework operational metrics, as defined within their Single Oversight Framework, and locally agreed indicators. This report provides performance information at Trust and Division level, and is structured around CQC’s five domains: Safe, Caring, Effective, Responsive and Well-Led.

Data Quality

Accurate information is fundamental to support the delivery of high quality care; we therefore strive to ensure all data is as accurate as possible. The Trust’s Performance Indicator Assessment Framework (PIAF) enables the Trust to ensure that each indicator on the Trust performance summary dashboard in the QPR is assessed against five dimensions of data quality, with an overall Red/Amber/Green (RAG) rating given as a summary of the quality of the indicator data (shown as circular symbols against each indicator on the QPR). Where an indicator has not yet been assessed, a grey symbol is used. These dimensions and the definitions of the RAG rating are outlined below.

<table>
<thead>
<tr>
<th>Data Quality Dimension</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completeness</td>
<td>Valid data – measures how much of the collected data can be used</td>
</tr>
<tr>
<td>Timeliness</td>
<td>Data entry – is all the data readily available at the time of calculation for the period being measured</td>
</tr>
<tr>
<td>Accuracy</td>
<td>Accurate recording of data, consistent interpretation of business rules when selecting values from lists and accurate calculation method for indicator construction</td>
</tr>
<tr>
<td>Audit</td>
<td>Has an audit, either local, internal or external, been carried out in the last 2 years and on either the system used to collect the data or on the specific indicator itself, and if so, what was the result</td>
</tr>
<tr>
<td>Validation</td>
<td>Divisions or other departments are monitoring the indicators locally and flagging up if there is an issue</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicator Data Quality RAG Rating</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue</td>
<td>Highly Significant Assurance (very robust)</td>
</tr>
<tr>
<td>Green</td>
<td>Significant Assurance (good enough)</td>
</tr>
<tr>
<td>Amber</td>
<td>Limited Assurance (significant issues)</td>
</tr>
<tr>
<td>Red</td>
<td>Very Limited Assurance (systemic issues, minimal confidence)</td>
</tr>
</tbody>
</table>

The PIAF also includes a glossary of all indicators, including definitions and any action required where an indicator’s data quality rating is rated as limited or very limited (amber or
red) to increase the data quality to significant assurance (green). The PIAF is included in the QPR each month.

The Trust has various information systems in which data is collected and from which performance against local and national indicators is calculated. These include nationally available systems:

- **RiO** – Clinical information system used by our mental health services from which data is used for CPA, readmissions, delayed transfers of care, crisis gatekeeping, early intervention in psychosis, and data completeness and outcome indicators
- **SystmOne** – Clinical information used in community services, used for community data completeness indicators
- **ESR** – Electronic staff record for sickness and appraisal rates
- **Integra** – Finance system for turnover and vacancy rates
- **PC-MIS** – for IAPT indicators
- **Ulysses** – for incident and complaint indicators

Some of the data from these systems is extracted into national datasets such as National Reporting and Learning System (NRLS) and the Mental Health Services Data Set (MHSDS).

In addition, the Trust utilises local reporting systems for patient experience, training and clinical supervision.

**Performance against Locally Agreed Quality and Performance Indicators**

The Trust has chosen to include performance against all the locally agreed quality and performance indicators reported to the Board of Directors, rather than specifically select three patient safety, three clinical effectiveness and three patient experience indicators. This was discussed and supported by stakeholders through the lead Clinical Commissioning Group and the Council of Governors.

Performance against all these indicators is included in the table below. Indicators which are governed using national definitions are marked with an asterisk (*). Where possible we have included benchmarking information to show how we compare to other NHS organisations. Each month where there is underperformance, exception reports are included in the QPR providing a rationale for under-performance and action being taken to improve. Areas for which there has been underperformance in 2016/17 relating to local indicators include:

- Staff Appraisals
- Complaints closed within agreed timescales in the last month
- Sickness and Absence
- Clinical Supervision
- 7 day follow-up
- Safety Thermometer
## Locally Agreed Quality and Performance Indicators

Numbers given at year’s end are the full year’s figures where appropriate, or the Trust’s latest performance levels for monthly targets.

<table>
<thead>
<tr>
<th>Indicator Set</th>
<th>Indicator Description</th>
<th>Local Data Source</th>
<th>2015/16</th>
<th>2016/17</th>
<th>Benchmarked performance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Safety</strong></td>
<td>Safety Thermometer All Harms - % Harm Free Care</td>
<td>NHS Safety Thermometer website</td>
<td>92.3%</td>
<td>92.2%</td>
<td>NHS DIGITAL March 2016 – National rate 94.1%</td>
</tr>
<tr>
<td></td>
<td>Total Sickness rate</td>
<td>Electronic Staff Records (ESR)</td>
<td>4.9%</td>
<td>5.4%</td>
<td>NHS DIGITAL November 2016 - National mental health trust rate - 6.0% / National rate 4.5%</td>
</tr>
<tr>
<td></td>
<td>Minimising mental health delayed transfers of care % (*superseding Mental Health Delayed Transfers of Care - % attributable to the Trust indicator used in 15/16)</td>
<td>Rio clinical information system</td>
<td>4.6%</td>
<td>3.3%</td>
<td></td>
</tr>
<tr>
<td><strong>Clinical Effectiveness</strong></td>
<td>Care Programme Approach - % patients having a review in last 12 months</td>
<td>Rio clinical information system</td>
<td>97.2%</td>
<td>97.1%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mandatory training %</td>
<td>HR Training Database</td>
<td>90.6%</td>
<td>88.2%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Annual Reviews carried out % (Staff Appraisals)</td>
<td>Rio clinical information system</td>
<td>86.2%</td>
<td>86.7%</td>
<td>Staff Survey 2016 - Trust 89% vs national average of 92%</td>
</tr>
<tr>
<td><strong>Patient Experience</strong></td>
<td>Friends and Family Test scores</td>
<td>Trust on-line Feedback site</td>
<td>97.0%</td>
<td>95.0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of new complaints received</td>
<td>Ulysses incident information system</td>
<td>937</td>
<td>876</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Service Quality Rating %</td>
<td>Trust on-line Feedback site</td>
<td>95.0%</td>
<td>94.0%</td>
<td></td>
</tr>
</tbody>
</table>
Quality Report 2016/17

Compliance with the NHS Improvement Single Oversight Framework (SOF)

The NHS Improvement Single Oversight Framework (SOF) became effective from 1st October 2016 replacing the Monitor Risk Assessment Framework and Well-Led Framework. The Trust is monitoring compliance with the new standards and range of local indicators to provide an overview of performance, quality and assurance within the Trust and escalate actual or potential underperformance.

There are five themes in the Single Oversight Framework:

- Quality of care (safe, effective, caring, responsive)
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

There is currently 1 indicator which is under target at Quarter 4 end 16/17.

**Single Oversight Framework (SOF) Operational Metrics: Patients requiring acute care who received a gatekeeping assessment by a crisis resolution and home treatment team in line with best practice standards (UNIFY2 and MHSDS)**

The Trust is at 92.7% for Quarter 4 end position against a target of 95%. The reporting position throughout Quarter 4 in Crisis Gatekeeping was affected by changes in how the Trust manages the reporting process, with a shortfall in the recording of these activities on the Crisis Gatekeeping teams’ records. This was an issue around reporting process rather than impacting directly on patient care.

This oversight has now been addressed, with compliance levels now being met.

There are currently 2 indicators waiting clarification from NHS Digital at Quarter 4 end 16/17.

**Single Oversight Framework (SOF) Operational metrics: Cardio-metabolic assessment and treatment for people with psychosis**

Cardio-metabolic assessment and treatment for people with psychosis is one of the national operational performance metric indicators as set out in the NHS Improvement Single Oversight Framework (SOF). Currently there is a lack of definition around how individual trusts can accurately collect and measure performance against this indicator. Clarity is being sought from NHS Improvement, but the Trust has yet to receive clear guidance in this regard; consequently the Trust is not in a position to give an accurate report of its level of compliance against this indicator at this point in time.

**Single Oversight Framework (SOF) Operational metrics: Priority metrics (Ethnicity, accommodation and employment status)**

The Trust has yet to be provided with full technical details of this indicator, and therefore is unable at present to replicate a calculation methodology or to estimate current performance. At the time of writing, no further details have been released and therefore we are still unable to interpret and calculate this indicator internally. Once details emerge, our intention will be to copy the methodology to be able to apply it to our data in order to report on a monthly basis, and we will compare our results to the external results when they start to be published, normally 3 months in arrears.
## Monitor / Single Oversight Framework

*(quarter positions given as national indicator measurements are quarterly)*

<table>
<thead>
<tr>
<th>Indicator Description</th>
<th>Local Data Source</th>
<th>Target</th>
<th>Quarter 4 position 2015/16</th>
<th>Quarter 4 position 2016/17</th>
<th>Average Monthly Performance 2015/16</th>
<th>Average Monthly Performance 2016/17</th>
<th>Benchmarked performance</th>
<th>Data Quality Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Programme Approach (CPA) patients - receiving follow-up contact within seven days of discharge</td>
<td>Rio clinical system</td>
<td>95%</td>
<td>98.1%</td>
<td>99.3%</td>
<td>98.6%</td>
<td>98.9%</td>
<td>(see page 41)</td>
<td>Green</td>
</tr>
<tr>
<td>Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams</td>
<td>Rio clinical system</td>
<td>95%</td>
<td>98.5%</td>
<td>92.7%</td>
<td>98.7%</td>
<td>96.4%</td>
<td>(see page 42)</td>
<td>Green</td>
</tr>
<tr>
<td>Early Intervention in Psychosis (EIP): People with a first episode of psychosis begin treatment with a NICE-recommended package of care within two weeks of referral (UNIFY2 and MHSDS) replacing Meeting commitment to serve new psychosis cases by early intervention teams</td>
<td>Rio clinical system</td>
<td>50%</td>
<td>n/a</td>
<td>75%</td>
<td>n/a</td>
<td>50.9%</td>
<td></td>
<td>Yellow</td>
</tr>
<tr>
<td>Improving access to psychological therapies (IAPT): people with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral</td>
<td>Rio clinical system</td>
<td>75%</td>
<td>83.8%</td>
<td>86.0%</td>
<td>81.0%</td>
<td>82.3%</td>
<td></td>
<td>Yellow</td>
</tr>
<tr>
<td>Improving access to psychological therapies (IAPT): people with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral</td>
<td>Rio clinical system</td>
<td>95%</td>
<td>98.8%</td>
<td>95.8%</td>
<td>98.5%</td>
<td>98.9%</td>
<td></td>
<td>Yellow</td>
</tr>
<tr>
<td>Mental health data completeness: identifiers</td>
<td>Rio clinical system</td>
<td>97%</td>
<td>98.9%</td>
<td>98.5%</td>
<td>98.9%</td>
<td>98.8%</td>
<td></td>
<td>Green</td>
</tr>
</tbody>
</table>
Annex 1 - Statements of Assurance from Other Bodies

Nottingham City Clinical Commissioning Group

‘NHS Nottingham City Clinical Commissioning Group (CCG) is the lead commissioner for Nottinghamshire Healthcare NHS Foundation Trust on behalf of a number of commissioners. In this role the CCG is responsible for monitoring the quality and performance of services at Nottinghamshire Healthcare NHS Foundation Trust throughout the year. As this Quality Account relates to the whole of Nottinghamshire Healthcare NHS Foundation Trust the CCG is satisfied that the information contained within this quality account in relation to mental health and learning disabilities services for children and adults is consistent with that supplied to us throughout the year.

Our 2016/17 contract and service specifications with the Trust detailed the level and standards of care expected and how we would measure, monitor, review and manage performance. Monthly Quality and Contract Review meetings are held with the Trust and it is through this arrangement along with visits to services and continuous dialogue as issues arise that the accuracy and validity of this Quality Account has been checked by the CCG.

Commissioners acknowledge the hard work and commitment of Nottinghamshire Healthcare NHS Foundation Trust staff to ensure patients remain at the centre of care. As healthcare commissioners we are dedicated to commissioning high quality services from our providers and are encouraged that the Trust are focused on patient safety, patient experience and clinical effectiveness. Nottinghamshire Healthcare NHS Foundation Trust has worked constructively with commissioners and other partners to respond to commissioning intentions and develop integrated care pathways to support the reduction of health inequalities and improve the health of the local community.

Achievement of 2016/17 priorities include a reduction in moderate harm incidents including suicide and self-harms, physical assaults, medication errors and falls, plus a reduction in acquired avoidable pressure ulcers prevalence. Overall there has also been a reduction of severe and catastrophic incidents. Commissioners support the continued focus on the six safety priority areas of restrictive practices, suicide and self-harm, assaults and violence, medication errors, pressure ulcers and falls.

The Quality Account reflects the ongoing commitment to improving experience through better management, understanding and response to issues raised through complaints. Monitoring access targets through a detailed review of feedback will improve services for patients. The CCG acknowledges the work that will be undertaken in relation to this issue including encouraging feedback from seldom heard groups. This remains a priority with a view to providing details of actions to be taken based on the patient demographics identified.

Commissioners support the Trust’s approach to reducing clinical variation in order to improve outcomes for all patients and are pleased to see this included as part of the priorities which will be reviewed in year.

The CCG would like to see progress in understanding the impact of delays in accessing care and treatment on patients and is pleased to see the exploration of potentially undertaking harm reviews to fully understand how this affects patients. Commissioners are supportive of improvements that are being made by the Trust following development
of a Mortality Improvement Plan based on the Southern Healthcare NHS Foundation Trust review undertaken by Mazar’s, CQC investigation and local improvement plans. The CCG is pleased to see Nottinghamshire Healthcare NHS Foundation Trust is engaged with the Learning Disabilities Mortality Review (LeDeR) programme.

The Trust recognises that there are still improvements to be made and Commissioners expect to see progress against the quality priorities for 2017/18 with Nottinghamshire Healthcare NHS Foundation Trust detailing the impact on patients and actions being taken to address issues and reduce harm.

We will continue to work with Nottinghamshire Healthcare NHS Foundation Trust in 2017/18 to assure ourselves of the continual quality of the services provided and to monitor achievement of targets, indicators and priorities’.

**Joint Statement from Healthwatch Nottingham and Healthwatch Nottinghamshire**

As the independent watchdog for health and social care in Nottingham City and Nottinghamshire, we work to ensure that patient and carer voices are heard by providers and commissioners. We are grateful to be given the opportunity to view and comment on the Quality Report.

We consider that we have a good working relationship with the Trust. The Trust’s Head of Involvement and Experience sits on the Healthwatch Nottinghamshire Advisory Group. We are pleased that our Chief Executives continue to meet regularly with the Trust to discuss comments that we receive from local people. We feel this is a good forum to look at the quality of the patient experience of the Trust’s services, and feel that responses we receive are useful. The trust also receives monthly reports and informatics dashboards as part of Healthwatch Nottingham & Healthwatch Nottinghamshire’s Information Sharing Protocols.

Healthwatch would like to highlight a number of recognised successes presented in the Account and to seek assurance and guidance from the Trust in addressing under performance and the areas of concern that remain.

**Successes**

Over the past 12 months the Trust appears to have shown continued commitment to patient safety through the use of the ‘Sign up to Safety Plan’. We are pleased that the Trust encourages the reporting of incidents and concur that the rise in reported incidents reflects the successful implementation of this initiative.

We were impressed by the proactive and swift response of the Trust to the Healthwatch Nottingham and Nottinghamshire’s recommendations from our Insight report on mental health crises in seldom-heard communities. Indeed, both Healthwatches have found the Trust to be proactive in their relationship with us. For example, the Chief Executive Ruth Hawkins instigated a ‘sign off’ process in which Nottinghamshire Healthcare NHS Foundation Trust responds to Healthwatch feedback.

**Improvements/Concerns**

We were surprised that the Mental Health Crisis Care Concordat was not mentioned in the draft report. As the provider of community and inpatient mental health services in Nottinghamshire, we expected that examples of collaborative working with local organisations and future plans to ensure positive patient experiences for individuals in crisis would be emphasised. We were encouraged by the Trust including reference to the
Mental Health Crisis Concordat following discussion at the Joint Health Scrutiny Quality Account Study Group.

Presentation of the Quality Account

Healthwatch Nottingham and Nottinghamshire believes that patient engagement is an important element and with regards patient experience, we are delighted to see large amounts of patient feedback received by the Trust. However there is little information in the Quality Account that tells us what patients, carers and services users have said about the services that the Trust provides. Moreover it is unclear how this feedback is used to improve services and patient experience. It is also difficult to see from the report how the views of patients and services users have influenced its development and draft content.

Comments received by Healthwatch Nottingham and Nottinghamshire

During 2016/17 we collected 622 experiences about services that the Trust provides (see the dashboard overleaf for an overview of our data). All of our data is thematically coded and we used 75 codes in total - 37 of which were positive and 38 were negative. Most experiences have been collected through Patient Opinion and 91% of these are positive. It is important to note that, in contrast, 65% of experiences that came directly to Healthwatch were negative. It is important to note that the percentage of negative experiences shared directly with Healthwatch in 2015/16 was 79%. We can clearly see that experiences that are not shared directly with us are overwhelmingly positive, and this highlights the need for the Trust to continue working with us to ensure that experiences from multiple sources are considered when improving services and patient experience.

Looking at the service types and sentiments, negative experiences can be attributed to the mental health services that the Trust provides. We are pleased that our data show three of the five most prevalent positive themes to relate to staff interaction, and feel that the Trust should be commended for this.

Actions / Recommendations

Healthwatch Nottingham and Nottinghamshire seeks clarification on the following:
1. Continued commitment to the ‘Sign up to Safety’ campaign in 2017/18.
2. Commitment to sustain improvements in Mental health crisis resolution.
3. More information regarding how patient experiences are used to improve services.
4. We hope to continue to regularly engage with the Trust to address patient feedback.

Healthwatch welcomes improvements in a number of the priority areas set for 2016/17, but we also recognise the challenges still faced by the Trust. We look forward to seeing further improvements in 2017/18. We will continue to work with the Trust, to monitor any issues which arise, and ensure that we represent the views of local people.
Nottinghamshire Healthcare Trust
1st April 2016 - 31st March 2017

Experiences collected
622
Identifiable services reviewed
75

Note: this does not include experiences collected through ongoing Question of the Moment or Insight Projects

Source of experiences and sentiment

<table>
<thead>
<tr>
<th>Source</th>
<th>Number</th>
<th>Negative</th>
<th>Positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthwatch direct</td>
<td>69</td>
<td>65%</td>
<td>35%</td>
</tr>
<tr>
<td>Patient Opinion</td>
<td>541</td>
<td>9%</td>
<td>91%</td>
</tr>
<tr>
<td>Online monitoring</td>
<td>11</td>
<td>64%</td>
<td>36%</td>
</tr>
<tr>
<td>Information sharing</td>
<td>1</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>All sources</td>
<td>622</td>
<td>16%</td>
<td>84%</td>
</tr>
</tbody>
</table>

Services and sentiment

Themes of reviews

Top five positive themes
- Treatment and care - Effectiveness - ... 33%
- Staff - Compassionate 20%
- Staff - Positive 20%
- Unspecified - Positive 12%
- Staff - Communication ... 10%

Top five negative themes
- Administration - Communication - Negative 3%
- Staff - Compassionate care - Negative 3%
- Treatment and care - Patient choice - Negative 2%
- Facilities and surroundings - Negative 2%
- Treatment and care - Effectiveness - Negative 2%
Joint Nottingham and Nottinghamshire Health Scrutiny Committee

The Joint Health Scrutiny Committee welcomes the opportunity to comment on the Nottinghamshire Healthcare Trust Quality Account 2016/17. Our comment focuses on the areas in which we have engaged with the Trust during 2016/17.

As in previous years, the Committee has found the Trust open and willing to engage with scrutiny during the year. This reflects the Trust’s efforts to be open and learn from feedback, complaints and patient safety incidents. The Committee is encouraged by work to develop a culture of reporting incidents, including near misses, and has received reassurance from the Trust that staff are supported in both reporting incidents and how incidents are responded to and learnt from. The Committee also supports the continued focus on improving complaints management.

More generally, the Committee welcomes the Trust’s deliberate approach of largely retaining the same improvement priorities as last year so as to maintain a focus on the same issues and allow sufficient time to deliver sustained improvement.

During the year the Committee has reviewed development of local transformation plans for improving children and young people’s mental health in Nottingham City and Nottinghamshire County. The Committee was encouraged by the progress being made against these transformation plans. However, it is recognised that it takes time for change to be made and concerns remain about waiting times from referral to treatment in community child and adolescent mental health services (CAMHS). The Committee would like to see the continued implementation of transformation plans translate into shorter waiting times for treatment in both the City and County and will follow this up during 2017/18. The Committee is looking forward to the opening of the new inpatient CAMHS and perinatal health facility during the forthcoming year and hopes that this will reinvigorate the service as a whole.

More widely than CAMHS, the Committee strongly supports the Trust’s continued focus on improving waiting times for all services and it is appropriate that the ambition is to ensure that all waiting time targets are met.

Council of Governors

The Council of Governors welcomes the opportunity to comment on the Trust’s Annual Quality Account for 2016/17. Governors have a prime role in holding Non-Executive Directors to account for the performance of the Board of Directors, with a particular focus on quality. As part of the Council’s newly developed governance structure it meets monthly to hold the trust to account on its performance and strategic direction. Within the last 12 months governors, with the information available to them, have done the following:

- Discussed and challenged the Trust Quality Priorities
- Identified a local quality performance indicator for the Trust to audit
- Directly challenged Non-Executive Director’s around quality issues
- Received regular performance reports and provided open challenge and scrutiny at its Council of Governors meetings
- Regular observers of the Quality Committee and the Board of Directors meeting where assurance was sought

The Council of Governors are aware of the developing Sustainability and Transformation Plans and are mindful of the difficult financial challenges facing the Trust and the wider
NHS. With these developing initiatives the Council of Governors maintain that quality of services provided by the Trust are a priority and will continue to seek assurance and challenge on behalf of its members and the public.

Overall the Council of Governors are assured by the performance of the Trust and will continue to challenge and scrutinise over the next 12 months and beyond.
Annex 2 – Statement from Directors

Statement of Directors’ Responsibilities in Respect of the Quality Account

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

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

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2016/17 and supporting guidance;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2016 to [the date of this statement]
  - Papers relating to Quality reported to the board over the period April 2016 to March 2017
  - Feedback from the commissioners dated 22/05/2017
  - Feedback from governors dated 04/05/2017
  - Feedback from local Healthwatch organisations dated 04/05/2017
  - Feedback from Overview and Scrutiny Committee dated 04/05/2017
  - The trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 30/08/2016;
  - The 2016 national patient survey 22/12/2016;
  - The 2016 national staff survey 30/03/2017
  - The Head of Internal Audit’s annual opinion over the trust’s control environment dated 15/05/2017;
  - CQC Inspection Reports dated –
    - Rampton Hospital 18.03.16, 11.04.16, 25.08.16 & 06.03.17
    - HMP Lowdham Grange 30.03.16
    - HMP Ranby 05.07.16 & 07.12.16
    - HMP Whatton 15.08.16
    - HMP Lowdham Grange 18.08.16
    - Adult Acute Wards (Highbury Hospital and Millbrook) 11.11.16
    - HMP Moorland 12.12.16
- the Quality Report presents a balanced picture of the NHS foundation trust’s performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
• there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
• the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
• the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

........................................Date................................................Chairman

........................................Date................................................Chief Executive
## Glossary and Definitions for Audited Indicators

### Crisis Gatekeeping

<table>
<thead>
<tr>
<th><strong>Indicator Description:</strong></th>
<th>The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment team (CRHT) acted as a gatekeeper during the reporting period.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator/Value:</strong></td>
<td>The number of admissions to the trust’s acute wards that were gate kept by the CRHT during the reporting period.</td>
</tr>
<tr>
<td><strong>Denominator:</strong></td>
<td>The total number of admissions to the trust’s acute wards.</td>
</tr>
<tr>
<td><strong>Target:</strong></td>
<td>$\geq 95%$</td>
</tr>
</tbody>
</table>

#### Additional Information:
Numerator and denominator clinical information are taken from the RiO clinical information system.

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

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

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

#### Criteria:
- The indicator is expressed as proportion of inpatient admissions gate-kept by the crisis resolution home treatment teams in the year ended 31 March 2016;
- The indicator should be expressed as a percentage of all admissions to psychiatric inpatient wards;
- Patients recalled on Community Treatment Order should be excluded from the indicator;
- Patients transferred from another NHS hospital for psychiatric treatment should be excluded from the indicator;
- Internal transfers of service users between wards in the trust for psychiatry treatment should be excluded from the indicator;
- Patients on leave under Section 17 of the Mental Health Act should be excluded from the indicator;
- Planned admission for psychiatric care from specialist units such as eating disorder unit are excluded;
- An admission should be reported as gate-kept by a crisis resolution team where they have assessed* the service user before admission and if the crisis resolution team were involved** in the decision-making process which resulted in an admission;
* An assessment should be recorded if there is direct contact between a member of the team and the referred patient, irrespective of the setting, and an assessment made. The assessment is made via a phone conversation or by any face-to-face contact with the patient.

** An involvement will include Crisis team members having a direct contact with the patient via phone, face to face or assessment carried out by other disciplines such as A&E liaison teams which counts as crisis gate keeping.

Where the admission is from out of the Trust’ area and where the patient was seen by the local crisis team (out of area) and only admitted to this trust because they had no available beds in the local areas, the admission should only be recorded as gate-kept if the CR team assure themselves that gatekeeping was carried out

<table>
<thead>
<tr>
<th>Care Programme Approach (CPA)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicator Description:</strong></td>
</tr>
<tr>
<td>Patients receiving follow-up contact within seven days of discharge from mental health services (CPA and Care Pathway).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Numerator/Value:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of people under adult mental illness specialties on CPA who were followed up (either by face-to-face contact or by phone discussion) within seven days of discharge from psychiatric inpatient care.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Denominator:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The total number of people under adult mental illness specialties on CPA who were discharged from psychiatric inpatient care.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Target:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red: &lt;90% Amber: ≥90% Green: ≥95%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Additional Information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>For a small number of records, the final CPA Level is not determined within the 7 days after discharge. Although operationally any patients with a potential change are followed up as if they were on CPA, if the CPA Level is not finalised before a) data flows into the monthly Q&amp;P Report and b) quarterly externally, it is possible that our final actual numbers of included patients are slightly higher than reported.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Criteria:</th>
</tr>
</thead>
<tbody>
<tr>
<td>For data in the last 2 years, although numerator and denominator numbers have increased slightly, this issue has not changed the overall percentage figure in any significant way therefore still significant assurance provided.</td>
</tr>
</tbody>
</table>
**Safety Thermometer**

**Indicator Description:**
The NHS Safety Thermometer is the measurement tool for a programme of work to support patient safety improvement. It is used to record patient harms at the frontline, and to provide immediate information and analyses for frontline teams to monitor their performance in delivering harm free care. The NHS Safety Thermometer records the presence or absence of four harms:

- pressure ulcers
- falls
- urinary tract infections (UTIs) in patients with a catheter
- new venous thromboembolisms (VTEs)

**Numerator/Value:**

**Pressure Ulcers** - The Safety Thermometer asks you to record the patient's worst old pressure ulcer and worst new pressure ulcer. An 'old' pressure ulcer is defined as being a pressure ulcer that was present when the patient came under your care, or developed within 72 hours of admission to your organisation. A 'new' pressure ulcer is defined as being a pressure ulcer that developed 72 hours or more after the patient was admitted to your organisation. To collect the data, you should examine the patient for any skin damage and ask them about any skin damage they have experienced as well as consulting their notes or handover documents. In each of the 'old' and 'new' pressure ulcer columns, record the category of the worst pressure ulcer the patient has.

**Falls** - The Safety Thermometer asks you to record the severity of any fall that the patient has experienced within the previous 72 hours in a care setting (including home if the patient is on a district nursing caseload). A fall is defined as an unplanned or unintentional descent to the floor, with or without injury, regardless of cause (slip, trip, fall from a bed or chair, whether assisted or unassisted). Patients 'found on the floor' should be assumed as having fallen, unless confirmed as an intentional act.

**Catheters & UTIs** - The Safety Thermometer asks you to record information about any UTI treatment and Urinary Catheterisation. In the 'UTI' column, record whether or not the patient is being treated for a UTI. If the patient is being treated for a UTI, the Safety Thermometer asks you to record whether treatment started before or after the patient was admitted to your organisation. If treatment for the UTI started before the patient was admitted to your organisation, record as 'Old UTI' in the 'UTI' column. If the treatment for the UTI started whilst the patient was under your care, record as 'New UTI'. Otherwise, if the patient is not being treated for or diagnosed with a UTI, select 'No UTI'. The Safety Thermometer also asks you to record any information about an indwelling Urethral Urinary Catheter. If the patient has, or has had, an indwelling urethral urinary catheter at any point in the last 72 hours, record the number of days that it has been in place. If the patient is long term catheterised choose the number of days the patient has been catheterised not the number of days the latest catheter has been in place. There are four options for recording this information available on the drop down menu on the survey form; ‘1-28 days’, ‘28+ days’, ‘days unknown’ and ‘no catheter’. If the patient does not have an indwelling Urethral Urinary Catheter and has not had one at any point in the last 72 hours, record ‘No catheter’.

**VTE Risk Assessment** - The Safety Thermometer asks you to record whether or not a patient has a documented risk assessment for VTE. This information is required for all surveyed patients. There are three options for recording this information on the drop down menu: Yes, No and N/A. If the patient has a documented risk assessment for VTE then select ‘Yes’, if not, select ‘No’. If the question is not appropriate for the patient or setting, select N/A.

**Denominator:** The total number of surveys carried out within the month.

**Target:** 95% Harm Free Care
**Additional Information:**
The process in which the Trust collates and submits ST data to NHS Digital is as follow:

1. Local Partnerships Division has Clinical Leads for both mental health and general health who will send a reminder via email to relevant Heads of Services of the date for data collation.

2. District Nurses within all general health localities and Ward Managers within Mental Health Services Of People (MHSOP) wards will collate data on the pre-determined day of the month, normally the third Wednesday of the month.

3. Upon completion of the data collection, all data is captured on to the electronic *NHS Safety Thermometer: Front Line* data survey spreadsheets. All data is then validated by the Heads of Service/Ward Manager prior to being sent through to the Clinical Lead for validating.

4. Once the data is validated each locality will send the ST data via email to the Head of Risk and Assurance within the agreed submission period. The MHSOP wards have a shared drive and the Local Partnerships Performance Team will fetch and check the data and then send through to the Head of Risk and Assurance, again within the agreed submission period.

5. The Head of Risk and Assurance will ensure that all teams have submitted data. By using the ‘Dashboard’ function within the spreadsheet, any anomalies will be queried with the appropriate team and then will prepare the surveys for merging.

6. The Head of Risk and Assurance will provide a final check and will use the ST 12.74 Installer to merge all ST data.

7. Once merged the Head of Risk and Assurance will use the ST Data Submission Key provided by NHS Digital to upload the Trust data to the NHS Digital website before the final submission date.

8. The Head of Risk and Assurance will circulate the Trust return along with the ST receipt to the Clinical Leads for information.

We have been engaged by the Council of Governors of Nottinghamshire Healthcare NHS Foundation Trust to perform an independent assurance engagement in respect of Nottinghamshire Healthcare NHS Foundation Trust’s Quality Report for the year ended 31 March 2017 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance (the “specified indicators”) marked with the symbol A in the Quality Report, consist of the following national priority indicators as mandated by Monitor (operating as NHS Improvement) (“NHSI”):

<table>
<thead>
<tr>
<th>Specified Indicators</th>
<th>Specified indicators criteria (exact page number where criteria can be found)</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% enhanced Care Programme Approach (CPA) patients receive follow-up contact within seven days of discharge from hospital.</td>
<td>The performance indicator is on page 159 and the criteria are set out on page 187.</td>
</tr>
<tr>
<td>Admissions to inpatient services had access to crisis resolution home treatment teams.</td>
<td>The performance indicator is on page 160 and the criteria are set out on page 186.</td>
</tr>
</tbody>
</table>

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 specified indicators criteria referred to on pages of the Quality Report as listed above (the "Criteria"). The Directors are also responsible for the conformity of their Criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the "Detailed requirements for quality reports for foundation trusts 2016/17" issued by NHSI.

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 for foundation trusts 2016/17";
- 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 for foundation trusts 2016/17".

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2016/17"; 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 inconsistent with the following documents:

- Board minutes for the financial year, April 2016 and up to the date of signing this limited assurance report (the period);
- Papers relating to quality report reported to the Board over the period April 2016 to the date of signing this limited assurance report;
Feedback received on Nottinghamshire Healthcare Trust Quality Account Corroborative Statement 2016/17 from NHS Nottingham City Clinical Commissioning Group (CCG) received on 22/05/2017;

Feedback from Governors dated 04/05/2017;

Joint Statement from Healthwatch Nottingham and Healthwatch Nottinghamshire – dated 04/05/2017;

Joint Nottingham and Nottinghamshire Health Scrutiny Committee - May 2016, dated 04/05/2017;


The patient survey: Involvement, experience and volunteering: National Community Mental Health Survey 2016, dated 22/12/2016;

The National NHS Staff Survey 2016, dated 30/03/2017;


The Head of Internal Audit Opinion from 360 Assurance for the Nottinghamshire Healthcare NHS Foundation Trust 2016/17 dated 15/05/17; and

Bassetlaw New Model Update dated 28/07/2016; Agency Use and Self Certification dated 30/11/2016; Nursing, Quality & Patient Experience Directorate Tissue Viability - Update and Ambition 22/12/2016; Mortality Surveillance and Learning from Incidents dated 01/02/2017.

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 applied 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 & Ireland) 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 Nottinghamshire Healthcare NHS Foundation Trust as a body, to assist the Council of Governors in reporting Nottinghamshire Healthcare 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 2017, 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 Nottinghamshire Healthcare 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 for foundation trusts 2016/17";
- 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 assessment criteria set out in the FT ARM and "Detailed requirements for quality reports for foundation trusts 2016/17" and the Criteria referred to above.

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.

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 Nottinghamshire Healthcare 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 2017:

- 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 for foundation trusts 2016/17";
- 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 for foundation trusts 2016/17".

PricewaterhouseCoopers LLP
Donington Court
Pegasus Business Park
Castle Donington
East Midlands
DE74 2UZ

Date: 30 May 2017

The maintenance and integrity of the Nottinghamshire Healthcare 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.