Southern Health NHS
NHS Foundation Trust

QUALITY REPORT AND QUALITY ACCOUNT 2013/14

Contents

Statement on Quality from Katrina Percy, Chief Executive Officer of Southern Health NHS Trust

Our vision at Southern Health is to build a sustainable, person centred health and care system through delivery of high quality services that put patients, service users and their families at the centre of everything we do. I am therefore pleased to be able to summarise the Trust's view on the quality of its services during 2013/14.

Before doing so, I would like to personally thank everyone who has worked for the Trust in the past twelve months for their hard work, dedication and commitment. I see and hear of staff going the extra mile for our patients each and every day. Although I see all the complaints made to the Trust I also receive many letters from grateful patients and carers praising the care and compassion shown by staff and I would like to take this opportunity to express my thanks to staff for their dedication and loyalty.

Southern Health has faced significant quality challenges in some of its services in 2013/14 and it is important to me we are open and honest about this in our Quality Report and Account. Southern Health is one of the largest providers of mental health, community, learning disability and social care services in the country and from 1 November 2012 includes the services formerly known as Oxfordshire Learning Disability Trust. We provide services across some 170 sites and it is a matter of major regret that a small number of these locations have been found to be unsatisfactory by external inspection.

Care Quality Commission (CQC) inspections found some of the former Oxfordshire Learning Disability Services and one Adult Mental Health unit did not meet all the Essential Standards of Quality and Safety and issued warning notices. We took immediate action to rectify the problems and put plans in place to drive long term sustainable improvements and I am very pleased that on re-inspection by CQC the warning notices for all sites/sites re-inspected so far have been lifted. However we are not complacent and we know there is more to do.

On April 23rd 2014 the health sector regulator, Monitor announced its decision to take enforcement action against Southern Health. We have been under investigation by Monitor following a CQC inspection at our learning disability inpatient unit at Slade House in Oxford in September 2013. We have agreed with Monitor that we need to do a number of things to demonstrate improvements. These are:

- Deliver our improvement plan for our learning disability services
- Address the action plans for CQC warning notices across all of our services
- Deliver improvements in our quality governance and Board governance

Monitor's role is to protect the interests of patients, and we take their concerns extremely seriously. Over the coming weeks our focus will be on ensuring we make the improvements needed, to reassure both Monitor and our patients and their families about the quality of care we provide across all of our services day in, day out. I fully understand why Monitor has raised their concerns and I welcome the

opportunity to work with them to demonstrate that the issues they have identified are not an ongoing cause for concern.

Despite these challenges we have made a number of quality achievements this year:

- We successfully achieved 6 of the 10 quality improvement priorities we set last year. For those we did not meet, we are planning further work this year to build on the partial successes achieved.

- Over 96% of patients would recommend our services to friends and family;

- We are in the top 20% nationally for well-structured appraisals for staff;

- Healthcare acquired infections remain very low with cases of C. Difficile falling to their lowest level with only 3 this year;

- We achieved all of the Monitor access to care and outcome standards to improve patient experience;

- CQC carried out 41 unannounced inspections this year and assessed xx outcomes, with the Trust being fully compliant with 76% of these;

- We launched our new Recovery College this year which embeds the principles of recovery in mental health services and has been a huge success with our patients and the local community.

I am also incredibly proud the Trust won the Leadership Innovation category in the first ever Guardian Healthcare Innovation Awards this year; we see the continual investment and development of our staff and building strong leadership as key to the delivery of quality care for patients. I am delighted that we have several individual staff and teams shortlisted for awards, including the West Hampshire Community Diabetes team in the British Medical Journal awards and 'bank nurse of the year' body awarding?

The Board approved its new Quality Governance Strategy 2014-2016 "Getting it right first time, every time". The Strategy sets out how our patients and staff will become our leaders in patient safety, improving the effectiveness of care and ensuring we act on patient experience. The Trust continues to work to ensure the recommendations of the Francis Report following the inquiry into events at Mid Staffordshire NHS Foundation Trust and the Department of Health's response 'Patients First and Foremost' are implemented in full.

Finally, the Council of Governors, Board of Directors, our senior managers, clinical leaders and I are committed to delivering a programme of continuous quality improvement during 2014/15. We will ensure quality improvement and standards of care always have our full attention and will continue to respond promptly and positively to any initiatives which help us maintain a strong and clear focus on quality. Above all we value the feedback of patients and their carers, family and friends to guide us in improving the quality of our services.

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

[signed]

Katrina Percy
Chief Executive Officer, Southern Health NHS Foundation Trust
Xxxxx 2014

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

Southern Health NHS Foundation Trust is one of the largest providers of mental health, community, learning disability and social care services in the country. This year almost 8000 dedicated staff enabled us to treat or support approximately 255,000 people through providing 1,510,760 community contacts, 282,031 outpatient appointments and 235,257 occupied bed days across Hampshire and beyond.

Developing our priorities for 2014/15

Our Quality Account includes series of improvement indicators which have been selected in consultation with stakeholders and approved by the Trust Board. Every Quality Account must contain a minimum of three indicators each for patient safety, clinical outcomes and patient experience. We emphasise that the chosen indicators form only a small sample of all the quality improvement activities being undertaken across the Trust and that quality of care is widely reviewed and monitored at team, service, divisional and Board level.

The information we have used to identify the annual priorities includes:

- What patients tell us about our services and how we can improve;
- What our commissioners have told us is important for us to provide to their patients;
- What our Governors have told us is important to them;
- What staff have told us is important to them;
- Consultation with Healthwatch organisations;
- What we have learnt from reviewing our performance and the quality of our services and where improvements are required; and
- Review of national priorities as identified in the NHS Operating Plan.

We have a Quality Improvement Plan which provides detail of the action we will take to meet the quality improvement priorities with progress being monitored by Quality Improvement and Development Forum, Quality and Safety Committee and the Board and included in the Quality Account for 2014/15.

These priorities reflect our Quality Governance Strategy 2014- 2016 which supports delivery of the Trusts vision and values and overarching Clinical Strategy and sets out our approach to continually improving the quality of care for our patients, users, their families and carers. It will be formally launched in 2014/15.

Detail of the priorities for improvement for 2014/15 is included later in this section.

A review of our performance for clinical quality

The tables below summarise some of the quality information we regularly review as part of quality performance monitoring and includes the indicators chosen for 2013/14. The acquisition of Oxford Learning Disabilities Trust (OLDT) in November 2012 impacts on direct comparison of performance data.

Patient Safety

	2011/12	2012/13	2013/14	2013/14 target	Met/not met	comments
Serious Incidents Requiring Investigation	390	353	389			Trend being monitored
Never events	1	0	0			Remain rare
Healthcare associated infection Clostridium difficile	7	5	3			Steady reduction from 27 in 2009/10
Suicide (includes patients discharged within 12 months)	47	34	43			Numbers are within national benchmarking
Attempted suicide	12	6	14			Numbers are within national benchmarking
High harm falls	31	31	22	To reduce	✓	**Achieved** 90% inpatients have falls care plans
Pressure ulcers grade 3 (avoidable and unavoidable)	141	144	143			
Pressure ulcers grade 4 (avoidable and unavoidable)	95	101	134			
Avoidable Pressure ulcers grade 3 and 4 in community care teams	149	166	124	<116	x	Prioritised for 14/15. Nationally PU reduction is challenging
Medicines review within 24 hours	tbc	tbc	tbc	80%	x	Prioritised for 14/15.

Clinical outcomes

	2011/12	2012/13	2013/14	2013/14 target	Met/not met	comments
Violence and aggression incidents resulting in physical injury	736	627	864	532	x	Prioritised for 2014/15. Increase may reflect nature of caseloads in former OLDT

Use of track and trigger early warning system (clinical audit)	75% (community hospital)	n/a	91%	90%	✓	**Achieved**
Outcome frameworks	n/a	n/a	5	5	✓	**Achieved**
Dementia friendly environments in Community Hospitals	n/a	n/a	100%	100%	✓	**Achieved**
% of patients receiving a 7 day follow up	95.4	96.9	97.0	95.0		Met Monitor target
% crisis resolution teams acted as gatekeeper	97.9	97.4	99.7	95.0		Met Monitor target
Readmission rates within 28 days to hospital	10.2	8.7	7.4			Downward trend

Patient experience

	2011/12	2012/13	2013/14	2013/14 target	Met/not met	comments
Total complaints	342	398	470			Increase being monitored
Total concerns	544	475	488			
Total compliments	854	1511	1732			Doubled since 2011/12: approx. 4 times complaints
Patient experience surveys: recommend trust to family and friends	tbc	tbc	96.1% (90.6% for mental health services)	95% (75% for mental health services)	✓	**Achieved**
Patient experience surveys: support for carers	tbc	84.9%	87.6% (67.5% for mental health services)	95% (75% for mental health services)	x	Carers survey launched early 2014
Duty of Candour	n/a	n/a	100%	100%	✓	**Achieved** being open principles in place

2.1 Priorities for Improvement 2014/15

The priorities for improvement for 2014/15 are shown below. We have included information about why these indicators are important and how we plan to manage and measure progress towards these our aims.

Priority 1: Improving Patient Safety 2014/15

Priority 1.1 Reduce the number of pressure ulcers			
Aim To share and implement learning across the Trust to reduce pressure ulcers	**Why is this important?** Pressure ulcers can be painful and increase the risk of associated infection for a patient. We want to minimise this risk and any potential harm to the patient by doing all we can to prevent pressure ulcers developing. We were successful in reducing pressure ulcers in some of our divisions this year and want to repeat a similar indicator for 2014/15 with learning and good practice being shared across the whole Trust, resulting in fewer pressure ulcers.	**Our aims for 2014/15** To share and implement learning from regional initiatives which are reviewing good practice, developing evidence based guidance and targeted outcomes for pressure ulcer reduction. To share learning and good practice from teams who have successfully reduced numbers of pressure ulcers to all teams across the Trust. To raise awareness of pressure ulcer causes, prevention and signs of tissue damage to patients, carers and staff with person specific concerns identified and advice given. To reduce number of new avoidable grade 3 and 4 pressure ulcers.	**How we will measure progress** SPC charts for grade 3 and 4 avoidable pressure ulcers acquired in our care in community services in 2014/15 will show a reduction when compared to SPC charts for 2012/13 and 2013/14.
Priority 1.2 To improve the management of incidents of violence and aggression			
Aim To improve the management of incidents of violence and aggression so that patients are cared for in safe environments which use least restrictive interventions	**Why is this important?** We aim to support patients with Mental Health problems to recover in safe, calm and therapeutic inpatient environments, and to engage patients to work in collaboration with us. We know that patients experiencing Mental Health distress can sometimes express this through violent or aggressive behaviour. Our aim is to work with patients to manage their distress and avoid violence and aggression wherever possible. If it occurs we want to address it in a way that is safe for all concerned, and maintains the dignity	**Our aims for 2014/15** To minimise the use of Restrictive Practice in working with patients who exhibit violence and aggression. To introduce a framework for Positive Behavioural Support (PBS), this will include the introduction of Behavioural Support Plans. To improve environments thereby minimising the negative impact of	**How we will measure progress** We will develop an audit and assurance programme to measure standards which are required to minimise the use of restrictive practice. We will undertake an audit against the standards to identify how we are progressing our annual plan to promote SAFER services and minimise restrictive practice.

	and respect for the individual, and minimises the use of coercion (including restraint and seclusion). We aim to respond proactively to the Department of Health objectives outlined in their publication *'Positive and Proactive: Reducing the need for Restrictive Interventions' (April 2014).*	oppressive environments on how patients behave and recover.	We will report on our progress. Our report will show that we are using evidence based interventions to minimise the use of restrictive practices. We will highlight areas of exceptional or good practice and also where we have made improvements to environments. We will include stories and perspectives from those who use our services around how we are working in a safe and therapeutic way.
Priority 1.3 To improve medicines reviews for people			
Aim To improve the medicines review of patients being admitted to our inpatient units/hospitals	**Why is this important?** Patients are often taking medicines before being admitted to our inpatient units/hospital and then may be prescribed more medicines. The National Institute for Health and Clinical Guidance (NICE) found medication errors most commonly occurred at the time of admission. We aim to check that medicines prescribed on admission correspond to those that the patient was taking before admission. This will ensure safe care and reduce any potential harm to the patient from taking the wrong medicine. We did not consistently meet our target across all inpatient sites in 2013/14 and are therefore repeating a similar indicator for 2014/15.	**Our aims for 2014/15** To increase the percentage of patients who have their medicines reviewed by a pharmacist within 48 hours of admission using Q1 figures from 2014/15 as a baseline. To continue the roll out of updated training for nurses started in 2013/14. To use the new monthly medicine reconciliation report to identify trends in performance with action taken to ensure progress against target.	**How we will measure progress** Data from Q1 2014/15 on the percentage of patients admitted to our inpatient units/hospitals who have level 2 medicine reconciliation completed by a pharmacist/pharmacy technician within 48 hours of admission to be used as a baseline. Progress to be shown by an increase from this baseline on the percentage of patients admitted to our inpatient units/hospitals who have level 2 medicine reconciliation completed by a pharmacist/pharmacy technician within 48 hours of admission by the end of March 2015.

Priority 2: Improving Clinical outcomes 2014/15

Priority 2.1 Holistic care planning for people			
Aim To improve holistic assessment and care planning for patients	**Why is this important?** Our services are caring for patients who are increasingly unwell, many of whom have long term conditions and complex needs. A first step in our care is to complete a holistic assessment of all needs and to work in partnership with the patient and their carers to develop care plans that are centred on their needs and include goals important to them. We will work in partnership to review progress against the care plan and ensure it is leading to improved outcomes for the patient and their carers and continues to be focused on what is important to them. Evidence demonstrates effective care planning ensures better continuity of care, clinical outcomes, safety and experience for the patient. We want to ensure we have an effective care planning process in place across trust.	**Our aims for 2014/15** • To work collaboratively with patients and their carers to develop holistic, patient-centred care plans. • The plans will be goal orientated, and address all identified care needs with evidence that progress against the care plans are monitored and that they lead to improved outcomes for the individual. • To demonstrate we have effective care planning process in place by auditing community services: ○ All patients on caseload have appropriate assessment and related care plan which include patient identified goals and outcomes. ○ Care plans for patients diagnosed with dementia reflect management of condition. ○ Evidence that action plans had led to changes and improved patient care.	**How we will measure progress** • Clinical audit of community team's caseload with audit tool to include key questions as shown in the aims. • Audit results to show how many teams were compliant with set standards. • First audit results to be the baseline for the year with improvement in standards being met shown in subsequent audits throughout the year.
Priority 2.2 Learning from information about quality of care			
Aim To improve and learn from data about quality of care including analysis of	**Why is this important?** We want to learn from the information we have about the quality of care we are providing to patients, identifying and acting on key themes where we could do better and which will lead to improvements in quality of care.	**Our aims for 2014/15** • Implement the Quality & Organisational Learning Strategies across the Trust.	**How we will measure progress** • Track progress with implementation of the Strategies at the Quality Improvement & Development Forum.

incidents, serious incidents requiring investigation and complaints.	We want to be an organisation which encourages a culture of active review and learning across our services and which supports staff to make changes where appropriate to ensure improved quality of care. This is a new indicator this year.	• Embed triangulation of information and thematic analysis within divisions. • Learning is shared and changes embedded across the trust.	• Quarterly reporting to identify how learning has been shared from key themes following analysis of data. • We will look at the number of repeat complaints of same theme in a team or division within 3 month period to see if these are decreasing. • We will look at the number of repeat SIRIs of same theme in a team or division within 3 month period to see if these are decreasing.
Priority 2.3 Learning from deaths			
Aim To learn from and take action from reviewing suicides and unexpected deaths	**Why is this important?** Tragically, some of the patients in contact with Mental Health services die by suicide. Sadly, some of the patients supported within our community hospitals die. While the numbers are small, it is a priority for us to ensure that we learn from each incident, and take action to ensure that the learning is shared across our services, and that it results in improvements in the quality of care.	**Our aims for 2014/15** Thematic review of all deaths with a thorough, open and transparent process of investigation, reporting and acting on any learning to arise. Wherever possible to involve the families in this process and share investigation outcomes with them. To benchmark our Mental Health services against data produced by the National Confidential Enquiry into Suicides. To develop and implement metrics, both quantitative and qualitative, which will help us better understand mortality in community services and support benchmarking with other Trusts.	**How we will measure progress** • Evidence of learning shared and action plan tracked • Benchmarking numbers of patients dying by suicide in the Trust against national averages. • Development and use of mortality metrics in community services.

Priority 3: Improving Patient Experience 2014/15

Priority 3.1 Improve the experience people have of our services			
Aim To improve the experience patients have of our services	**Why is this important?** Seeking and acting on patients feedback is key to improving quality of healthcare services. A patient experience survey offers the opportunity to patients to give their views on the care or treatment they have received. This feedback, alongside other information, will be used to identify and tackle concerns at an early stage, improve the quality of care we provide and provide more positive experience of our care.	**Our aims for 2014/15** To improve levels of positive feedback on patient experience surveys from 2013/14 baseline. To increase number of patient experience surveys returned from 2013/14 baseline. Narrative reports published on Trust website to show changes made to services as result of people's feedback.	**How we will measure progress** All positive responses (i.e. top two) to survey question 'How would you rate your experience of our service overall? Improve results in 2014/15 from 2013/14 baseline. Increase numbers of surveys returned in 2014/15 from 2013/14 baseline. Narrative reports published on Trust website to show changes made to services as result of patient feedback.
Priority 3.2 Support carer involvement and listen to their feedback			
Aim To learn from feedback from carers as to how we can improve our services	**Why is this important?** Carers often provide key support to patients we are providing services for and can help to improve or maintain a patient's health and well-being. We want to provide appropriate support and information to enable carers to do this effectively. We have therefore developed a carer's feedback questionnaire which focuses on how carers feel about the support and recognition they have received as a carer. We will use this feedback to identify areas where we can improve our services.	**Our aims for 2014/15** To roll out new carers feedback questionnaire across the Trust in 2014/15. To analyse feedback results and make changes to practice as needed. Ensure carers feel adequately supported.	**How we will measure progress** All positive responses (i.e. top two) to three questions on the carer survey: 'When I am in contact with your services and/or staff, I feel welcome'. 'Staff recognise me as a carer of the person who will be using the service'. 'How likely would you be to recommend this service to friends or family, if they needed similar care or treatment? Narrative reports to show changes made to services as result of carer's feedback.
Priority 3.3 Use feedback from complaints to improve our services			
Aim Demonstrate to complainants we have acted on their experience to improve our services	**Why is this important?** We want to be an organisation which listens to patients and their families and acts when they say we have not got things right. National reviews, including the Francis, Berwick, Clwyd reports recommend that it is good practice to	**Our aims for 2014/15** To introduce in April 2014 a process to feedback to complainants 6 months after the complaint had been resolved what actions or changes in practice have been made as a result of their complaint.	**How we will measure progress** Number of complaints Number of complaints where there were actions Number of complaints where complainant

	let complainants know it was worth telling us about their experience and that we have taken actions as a result of their feedback.	To contact 100% of those applicable From October 2014 to publish on the Trust's website a summary of actions or changes in practice have been made as a result of complaints received by the Trust	would like a response Number of complainants contacted at 6 months with target of 100% Summary of actions taken in response to complaints published on the Trust's website NB: initial results due October 2014

2.2 Statements of assurance from the board

These are nationally mandated statements which provide information to the public which is common across all quality accounts. They help us demonstrate:

- We are actively measuring clinical processes and performance.
- We are involved in national projects and initiatives aimed at improving quality, for example, recruitment to clinical trials or through establishing quality improvement and innovation goals with commissioners using the Commission for Quality and Innovation (CQUIN) payment framework.
- We are performing to essential standards (CQC) as well as going above and beyond this to provide high quality care.

Review of services

During 2013/14 Southern Health NHS Foundation Trust provided and/or sub-contracted 47 relevant health services. Southern Health NHS Foundation Trust has reviewed all the data available to them on the quality of care in 47 of these relevant health services.

The income generated by the relevant health services reviewed in 2013/14 represents xxxx per cent of the total income generated from the provision of relevant health services by Southern Health NHS Foundation Trust for 2013/14.

Clinical audits and national confidential enquiries

Clinical audit supports the Trust's overall aim to provide high quality and safe services; it helps to embed clinical quality within services and deliver demonstrable improvements in patient care through the development and measurement of evidence based practice.

During 2013/14 5 national clinical audits and 2 national confidential enquiries covered relevant health services that Southern Health NHS Foundation Trust provides.

During that period Southern Health NHS Foundation Trust participated in 60% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Southern Health NHS Foundation Trust was eligible to participate in during 2013/14 are as follows:

National Audit /Confidential Enquiry	Eligible
Elective Surgery (National PROMS Programme – eligible for hernia surgery only)	✓
National audit of Schizophrenia	✓

National comparative audit of blood transfusion (eligible for consent audit only)	✓
Prescribing Observatory for Mental Health (POMH-UK)	✓
Sentinel Stroke National Audit Programme (SSNAP)	✓
National Confidential Enquiry into Suicide and Homicide for people with Mental Illness	✓
National Confidential Enquiry: Gasterointestinal Haemorrhage	✓

The national clinical audits and national confidential enquiries that Southern Health NHS Foundation Trust participated in during 2013/14 are as follows:

National Audit /Confidential Enquiry	**Participated in**
Elective Surgery (National PROMS Programme – eligible for hernia surgery only)	✓
National audit of Schizophrenia	✓
National comparative audit of blood transfusion (eligible for consent audit only)	✓
Prescribing Observatory for Mental Health (POMH-UK)	x
Sentinel Stroke National Audit Programme (SSNAP)	x*
National Confidential Enquiry into Suicide and Homicide for people with Mental Illness	✓
National Confidential Enquiry: Gasterointestinal Haemorrhage	✓

The Trust has recently subscribed to the Prescribing Observatory for Mental Health (POMH-UK) and will be participating in audits led by POMH-UK in 2014/15.

*The Trust currently completes the Sentinel Stroke National Audit Programme (SSNAP) as a local audit but does not submit audit results to the national programme. A process to submit results nationally is being put in place for 2014/15.

The national clinical audits and national confidential enquiries that Southern Health NHS Foundation Trust participated in, and for which data collection was completed during 2013/14, 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.

National audit /Confidential enquiry	**% of required cases submitted**
Elective Surgery (National PROMS Programme – eligible for hernia surgery only)	100%
National audit of Schizophrenia	51%
National comparative audit of blood transfusion (eligible for consent audit only)	100%
National Confidential Enquiry into Suicide and Homicide for people with Mental Illness	100%
National Confidential Enquiry: Gasterointestinal Haemorrhage	data collection is underway

The reports of 0 national clinical audits were reviewed by the provider in 2013/14 and Southern Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

The Trust has registered to receive the results of the Elective Surgery (hernia) audit and will review the results once received and take action as appropriate.

The national audit report (part two) on schizophrenia is yet to be published. The submission rate for this audit was low with some of the random sample of patients chosen for audit having been discharged or died since audit selection took place.

The national comparative audit of blood transfusion report is yet to be published.

The reports of 66 local clinical audits were reviewed by the provider in 2013/14 and Southern Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Audit title	Actions
Health Records – Paper Records Including Quality Aspects - Physiotherapy	All staff to familiarise themselves with the requirements as defined in SHFT Record Keeping Policy and to document; • the service user's perception of their needs • the service user's expectation of intervention • that the clinical impression has been discussed with the patient • that the goals have been agreed with the patient
Choking Screening	• Review and develop staff knowledge in screening for risk of choking in patients with learning disabilities. • To use choking screening assessment tool and specific dysphagia assessment tool. • To ensure relevant information is available when patient is admitted.
Antenatal and Postnatal Care and Perinatal Mental Health	• To review perinatal mental health guideline and RiO Standard Operating Procedure V1.7 [p94] to ensure consistency with recording processes. A family health assessment to be completed at the initial contact with the mother. • All mothers, where a mental health concern is identified, should be assessed for risk of self-harm and this should be documented. • Where a risk of self-harm is identified an action plan should be documented in the RiO record.
Antipsychotic Medication in Dementia	• Consultants /Registrars to discuss and document risks with family member in clinic, CPA or family meeting. • Doctors, nurses and therapists to seek out, implement and document alternative treatments for behavioral, psychological treatments in dementia.
Urinary Catheter Insertion and Ongoing Care	• Meatus to be cleaned with sterile normal saline prior to catheter insertion and urinary catheters should be inserted using an aseptic technique. • All staff who catheterise patients are trained in correct procedures. Antibiotic prophylaxis to be considered for patients who experience trauma during catheterisation. • Reflux of urine is associated with infection and consequently drainage bags should be positioned in a way that prevents back flow

Audit title	Actions
	of urine. • Urine samples should be obtained from the sampling port using an aseptic technique.
Asepsis in Theatre	• To maintain optimal oxygenation during surgery ensure haemoglobin saturation of 95% is maintained. (NICE 2008). • All patients to have temperature measured and documented before the administration of anaesthesia, and then measured and documented every thirty minutes until the end of the procedure. (AFPP 2011). • If detergent and water are used for cleaning, the surface must be physically dried before re-use.
Nasoendoscope Decontamination	• All patients about to undergo surgery or endoscopy should be asked if they have ever been notified as being at increased risk of CJD or vCJD and the response recorded in the patient's notes. • Follow updated decontamination policy in correct storage of nasoendoscopes and maintenance of dirty to clean flow of medical devices. • When/if area is due for refurbishment consider having separate areas dedicated for decontamination. • All work surfaces to be clean and free from clutter. • PPE should be worn as per the SOP for nasoendscope decontamination.

Clinical research

The Trust considers research a critical component of a successful NHS provider organisation. It is our vision that all patients have the opportunity to participate in research.

We aspire to:

- Embed a culture in the organisation that ensures research is a core part of clinical services;
- Embed a culture of evidence based clinical practice;
- Be seen as a leader and host to research in mental health, learning disability and community services;
- Encourage clinical academics, studentships and practitioner researchers; and
- Continue to attract nationally and internationally recognised and funded research, ensuring that we can continue to deliver significant and relevant research for Southern Health NHS Foundation Trust into the future.

The research department supports research in dementia, mental health and community services, such as stroke, diabetes, tissue viability, MSK, Parkinsons and respiratory. Jointly, with the University of Southampton, we host the Memory Assessment and Research Centre (MARC), which is internationally renowned for its research activity into dementia. In 2013/14 we received a certificate of recognition from the National Institute of Health Research (NIHR) for maximising research and we also met our activity targets.

In 2013/14 we hosted 94 clinical research studies (57 Portfolio and 37 Non-portfolio).

The number of patients receiving relevant health services provided or sub contracted by Southern Health NHS Foundation Trust in 2013/14 that were recruited during that period to participate in research approved by a research ethics committee was 528.

Increasing Patient and Public Involvement (PPI) in research is central to the Research Business Plan. We launched a major PPI in research initiative in March 2013. We have and will continue to engage service users, carers and members of the public in research.

R&D will be expanding in estate and infrastructure to develop a clinical trials facility and increase uptake of clinical trials.

Commissioning for Quality and Innovation Framework (CQUIN)

A proportion of Southern Health NHS Foundation Trust income in 2013/14 was conditional upon achieving quality improvement and innovation goals agreed between Southern Health NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2013/14 and for the following 12 month period are available electronically at: www.gov.uk/government/news/commission-for-quality-and-innovation-scheme-data-available

In 2013/14 income totalling xxxxxxx(available 1.6.14) was conditional upon Southern Health NHS Foundation Trust achieving quality improvement and innovation goals. In 2012/13 income totalling xxxxxxxx was conditional upon Southern Health NHS Foundation Trust achieving quality improvement and innovation goals, of which payment of xxxxxxx were received.

Our CQUIN schemes for 2013/14
Insert table – figures available end April

Care Quality Commission registration and actions

Southern Health NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered in full with no conditions.

The Care Quality Commission has taken enforcement action against Southern Health NHS Foundation Trust during 2013/14.

Southern Health NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during 2013/14.

The Trust's Quality and Risk Profile (QRP) formulated by the CQC at the end of February 2013 identified the Trust as being at low risk of non-compliance against each of the Essential Standards of Quality and Safety. The QRP is currently being phased out as CQC start their Intelligent Monitoring.

Southern Health NHS Foundation Trust has 51 locations registered with CQC under the Health and Social Care Act (2008) and is compliant with the registration requirements; however in-year inspections by CQC found several units which were not compliant with all Essential Standards of Quality and Safety.

Each Clinical Division is required to have in place local arrangements for reviewing compliance with the CQC Essential Standards of Quality & Safety; expectations are twofold: Divisions must have a systematic way of monitoring evidence of compliance with each of the essential standards for each team/service through the use of the CQC Provider Compliance Assessments and secondly, Divisions must also have local arrangements in place for site visits, peer reviews, mock inspections, etc, to ensure information on PCAs is accurate and standards are being met.

During the spring and summer of 2013/14 inspection toolkits and PCA guidelines were provided to all Divisions and a number of CQC workshops held across the Trust and attended by over 300 staff. Divisional compliance is monitored by the Quality Improvement & Development Forum and details of local monitoring arrangements were requested from Divisions on three occasions during 2013/14.

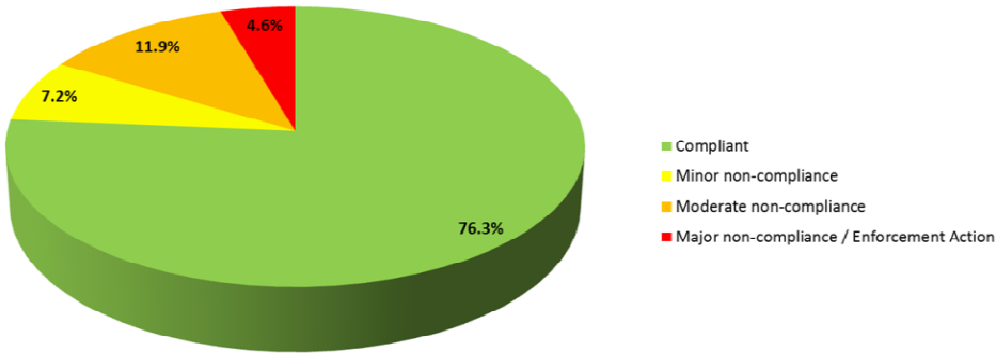
The Chief Operating Officer requested details of each Divisions CQC monitoring arrangements in April 2013, more in-depth detail was requested by the Governance Department in August 2013 and all Divisions were required to complete a modified version of the Monitor Quality Governance Framework in November 2013. The QGF was modified to include additional questions specifically about CQC compliance and serious incident management and reporting.

A central programme of validation of the evidence provided in support of Divisional QGFs is taking place during March to May 2014 following which a report on the status of Divisional Governance arrangements will be presented to the Trust Board and to each Division.

From 1 April 2013 to 31 March 2014 the Trust was inspected by the Care Quality Commission (CQC) against the Essential Standards of Quality and Safety on 41 occasions.

Number of CQC Essential Standards Inspections	**Number of inspections found to be fully compliant**	**Number of inspections found to be non-compliant**
41	24	17

CQC have concentrated their inspections on the Trust's mental health, learning disability and social care services with a total of 194 Outcomes inspected during this period. The chart below details the percentage of these outcomes found to be compliant.



Of the 17 inspections identified as not meeting essential standards, 38 compliance actions and 10 enforcement actions have been issued. The level of concern relates to the potential impact on patients and service users of non-compliance with the standard.

Compliance actions		Enforcement actions	
Minor concern	**Moderate concern**	**Moderate concern**	**Major concern**
15	23	2	8

The Enforcement Actions have resulted in nine Warning Notices being issued against the Trust;

- Six at Slade House, Oxford (John Sharich House and the Short Term Treatment & Assessment Team (STATT));
- One at Antelope House, Southampton;
- One at Piggy Lane, Oxfordshire; and
- One at Postern House, Wiltshire.

Plans were implemented on the day of the inspection at each location to address the issues raised and this has meant that several concerns had been resolved prior to CQC's reports being published. CQC have subsequently returned to Slade House to re-inspect and three of the Warning Notices have been lifted. They have also re-inspected Antelope House and have lifted this warning notice. Further warning notices should be lifted following CQC draft report on Slade received 28.4.14.

Analysis of all inspections of Trust services has identified three outcomes where the majority of non-compliance concerns have been identified:

- Outcome 4 – Care & Welfare of People who use the Service;
- Outcome 9 – Management of Medicines; and
- Outcome 16 – Assessing and Monitoring the Quality of Service Provided.

The same issues have been found in more than one unit including:

- Care planning and assessment of the physical health needs of mental health patients, including their medication needs;
- Care plans not reflecting the needs of the person;
- Medicines management on inpatient wards;
- Audits and matron walk rounds not reflecting what is actually seen on units; and
- Actions not being taken following routine assurance checks.

A Trust CQC Steering Group was established in November 2013 to direct, advise and support Divisions to ensure frontline services remain compliant with the Essential Standards. Based on the analysis of inspections above, the priorities for the CQC Steering Group in its 2014/15 work plan will be:

- Establishing baseline compliance statement for every ward/unit/team in the Trust against the current Essential Standards;
- Scrutiny of divisional assurance processes to ensure routine monitoring of quality and standards of care are in place;
- In-depth review of Trust compliance against Core Standards where non-compliance issues have emerged; and
- Review of Action Plans monitoring arrangements at Divisional level to ensure these are implemented effectively and signed off by Divisional Directors.

CQC is developing new approaches to inspections for each care sector which they plan to implement in October 2014. The Trust has asked to be one of the first Trusts inspected under the new mental health and community services regime.

Quality of data

Southern Health NHS Foundation Trust submitted records during 2013/14 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

- which included the patient's valid NHS Number was:
  99.7% for admitted patient care;
  99.9% for outpatient care; and
  97.0% for accident and emergency care.

- which included the patient's valid General Practitioner Registration Code was:
  99.9% for admitted patient care;
  99.9% for outpatient care; and
  98.4% for accident and emergency care.

Southern Health NHS Foundation Trust Information Governance Assessment Report overall score for 2013/14 was 80% and was graded green satisfactory.

Southern Health NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2013/14 by the Audit Commission. A scheduled audit in February 2014 has been postponed until April 2014.

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

- Significant work has been undertaken and will continue to ensure the data quality underpinning our reported performance is of a sufficiently high standard this year;
- The Trust has achieved this through a dedicated data quality work programme that has supported clinicians to ensure the data held within our Electronic Patient Record is robust and updated in a timely manner; and

- As such the Trust ensures clinical data is used to report performance, avoiding the need for manual collection of performance information.

2.3 Reporting against Core Indicators

From 2012/13 NHS foundation trusts are required to report against a core set of indicators relevant to the services they provide, for at least the last two reporting periods, using a standardised statement set out in the NHS (Quality Accounts) Amendment Regulations 2012. The data is presented in the same way in all quality accounts published in England so that readers can make a fair comparison between trusts.

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

As required by point 26 of the NHS (Quality Accounts) Amendment Regulations 2012, where the necessary data is made available by the Health and Social Care Information Centre, a comparison is made of the numbers, percentages, values, scores or rates of each of the NHS foundation trust's indicators with
a) the national average for the same; and
b) those NHS Trusts and NHS Foundation Trusts with the highest and lowest of the same.

Our Patients on a Care Programme Approach who were followed up within 7 days of discharge
The data made available to the National Health Service Trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period.

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

Inconsistences in the approach to reporting of this indicator were identified and Southern Health NHS Foundation Trust has taken the following actions to improve the indicator and so the quality of services,

- Re-affirmed guidance based on Monitor criteria to clinical services regarding documentation in the patient electronic record
- Clinical services completed data quality review of this indicator with audit of 7 day follow up data to be completed on regular basis within services

Indicator	Percentage of patients on Care Programme Approach (CPA) who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period.		
	Apr 2011- Mar 12	Apr 2012- Mar 13	Apr 2013- Mar 14
Southern Health	95.4%	96.9%	97.0%
Average Trust Score			For Dec 2013-Jan 2014 74.7%
Highest Scoring Trust			
Lowest Scoring Trust			

Our crisis resolution teams
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period.

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

The Southern Health NHS Foundation Trust has taken the following actions to improve the indicator and so the quality of services, by reviewing information per team and identifying areas where improvements may be made. These are further detailed in our Performance reports to Board.

Indicator	The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper.		
	Apr 2011- Mar 12	Apr 2012- Mar 13	Apr 2013- Mar 14
Southern Health	97.9%	97.4%	99.7%
Average Trust Score		97%	
Highest Scoring Trust		100%	
Lowest Scoring Trust		20%	

Our readmission rate for children and adults
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients aged-

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

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

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

The Southern Health NHS Foundation Trust has taken the following actions to improve the indicator and so the quality of services, by reviewing our discharge procedures and analysing information to identify areas for improvement with action plans developed as required. These are further detailed in our Performance reports to Board.

Indicator	The percentage of patients aged 0-15 years readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.		
	Apr 2011- Mar 12	Apr 2012- Mar 13	Apr 2013- Mar 14
Southern Health	0.0%	0.0%	0.0%

Average Trust Score			
Highest Scoring Trust			
Lowest Scoring Trust			

Indicator	The percentage of patients aged 16 or over years readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.		
	Apr 2011- Mar 12	Apr 2012- Mar 13	Apr 2013- Mar 14
Southern Health	10.2%	8.7%	7.4%
Average Trust Score			
Highest Scoring Trust			
Lowest Scoring Trust			

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

The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.

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

The Southern Health NHS Foundation Trust has taken the following actions to improve the indicator and so the quality of services, by developing a workforce strategy and action plan based on key findings from the staff survey. These are further are detailed in our Performance reports to Board.

Indicator	The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.		
	Apr 2011- Mar 12	Apr 2012- Mar 13	Apr 2013- Mar 14
Southern Health	63%	62%	61%
Average Trust Score		60%	59%
Highest Scoring Trust	Not available		
Lowest Scoring Trust			

Patient experience of community mental health services

The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to 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 Southern Health NHS Foundation Trust considers this data is as described for the following reasons, taken from national dataset using the data provided.

The Southern Health NHS Foundation Trust has taken the following actions to improve the indicator and so the quality of services, by analysing results from the patient survey and discussing with service users and carers improvements to be made. These are further detailed in divisional action plans and Performance reports to Board.

Indicator	Patient experience of contact with a health or social worker		
	2011-12	2012-13	2013-14
Southern Health	Not available	8.9	8.0
Average Trust Score	Not available		
Highest Scoring Trust		9.1	9.0
Lowest Scoring Trust		8.2	8.0

Our rate of patient safety incident reporting

The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care 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 patent safety incidents that resulted in severe harm or death.

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

The Southern Health NHS Foundation Trust has taken the following actions to improve the indicator and so the quality of services, by rolling out a training programme to staff on accurate completion of incidents including correct categorisation, auditing random samples of incidents for accuracy and feedback to managers on the timely review of incidents. These are further detailed in our incident reports to Board.

Indicator	Number of patient safety incidents reported to the National Reporting and Learning Service.		
	Apr 2011- Mar 12	Apr 2012- Mar 13	Apr 2013- Mar 14
Southern Health	5704	5106	7586
Average Trust Score			
Highest Scoring Trust			
Lowest Scoring Trust			

Indicator	i)Number and ii)percentage of such patient safety incidents that resulted in severe harm or death.		
	Apr 2011- Mar 12	Apr 2012- Mar 13	Apr 2013- Mar 14
Southern Health	1.26%	i) 118 ii) 1.94%*	i) 58 ii) 0.8%
Average Trust Score		Oct 2012-Mar 2013	

		1.3%	
Highest Scoring Trust			
Lowest Scoring Trust			

*these are updated figures and so are different to those reported in the 2012/13 Quality Report.

Friends and Family Test
Southern Health NHS Foundation Trust currently provides all physical health community patients with the option of completing a Friends and Family survey. During 2013/14 a total of 28,014 surveys were responded to with 96.2% of patients saying they would recommend our services to friends and family.

Part 3: Other Information

Progress made in meeting our priorities for improvement in 2013/14
In the 2012/13 Quality Report we set out specific areas for improvement based on the three dimensions of quality identified by Lord Darzi and chosen following feedback from our patients, stakeholders and staff. These priorities for quality improvement are chosen to be representative of our work on continually improving the quality of care we provide and there are many other areas of quality improvement across the Trust – these priorities are just a selection. We have monitored and reported to the Board our performance against these priorities throughout the year.

In 2013/14 as in previous years, we set ourselves challenging and aspirational targets to support the three dimensions of quality:

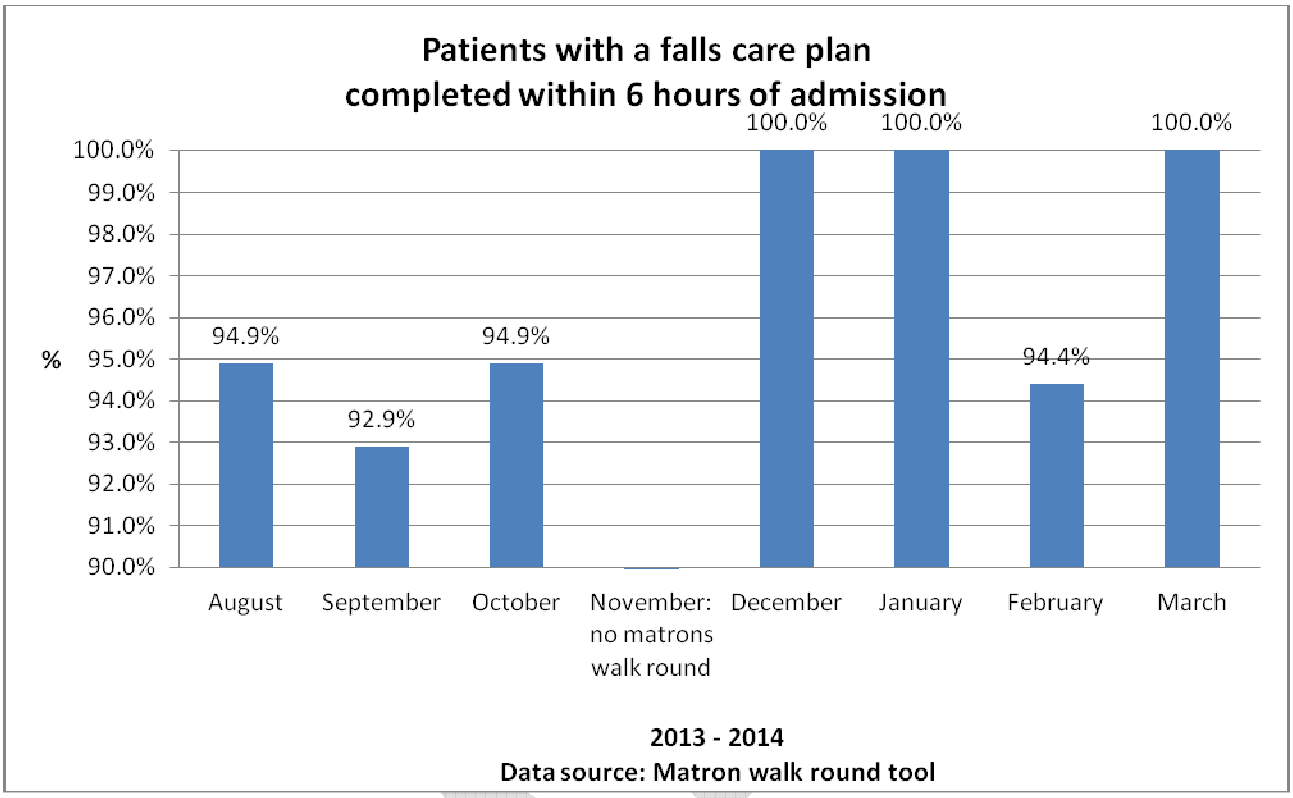
- Improving patient safety;
- Improving clinical outcomes; and
- Improving patient experience.

Priority 1: Improving Patient Safety

1.1 To reduce the risk of falls by ensuring 90% of inpatients in Community Hospitals and Older People's Mental Health wards at risk of falling have a falls care plan completed within 6 hours of admission

Our aim
Falls are one of the highest reported patient safety incidents in our inpatient settings, and although most do not result in serious harm, we recognise that any fall can lead to loss of confidence and increased length of stay in hospital. We want therefore to ensure patients are safe in our care and that we minimise the risk of falling by completing a falls care plan on admission.

What we have achieved
We have achieved this target. Results from a check of patient's records by the matron when doing a quality focused walk round of the ward found over 90% of patients had a falls care plan completed within 6 hours of admission.



- There has been a 29% reduction in 2013/14 in the number of patients who have had a fall which resulted in major surgery, for example, a broken hip, with 22 incidents compared to 31 in 2012/13. This means 9 fewer patients experienced pain, distress and an acute hospital admission.

What we did in 2013/14 and future plans

- We identified a staff member on each ward to be a 'falls champion' who works closely with the falls prevention team to analyse trends in falls and share learning with actions taken as required. These can be quite simple, for example, providing slippers for patients with inappropriate footwear.

- We continued the development of falls training making the Royal College of Physicians e-learning programme, 'preventing falls in hospital' available on our website for all staff to use.

- Following the successful pilot of a new inpatient falls care plan which provides clear guidance to staff in screening and assessing people at risk of falling, we are rolling out the new falls care plan across the whole Trust.

- Clinical audits showed an increase in the numbers of patients with a falls care plan completed within 6 hours of admission in community hospitals with the percentage rising from 80% in April to 93% when re-audited in November. There was a dip in audit results on Older People's Mental Health wards from 89% in April to 73% in November. The falls team are working closely with these ward staff to ensure that falls care plans are completed.

- This indicator has been met and so is not repeated in 2014/15, although work programmes to reduce falls will continue.

1.2 Numbers of avoidable grade 3 and 4 pressure ulcers acquired whilst in our care to reduce by 30% from baseline prevalence identified in each Integrated Service Division.

Our aim

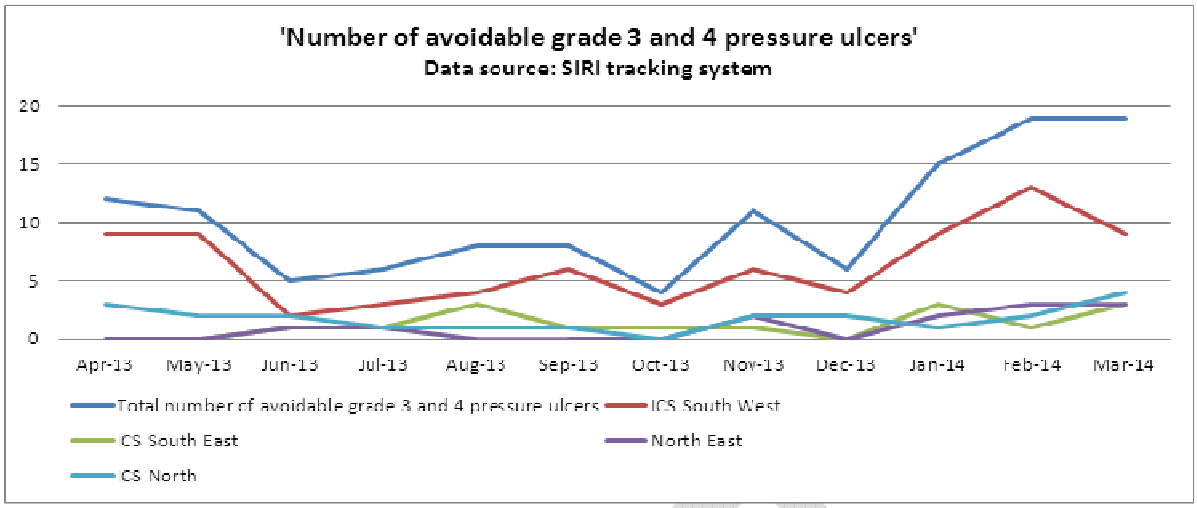
Pressure ulcers are wounds that develop when constant pressure or friction on one area of the body damages the skin. They can be painful and lead to an increased risk of infection. Pressure ulcers are graded using the European guidance system from grade 1 to 4 with 4 being the most serious. The number of patients who develop pressure ulcers while in our community hospitals has reduced significantly over the past two years, while numbers have remained essentially the same for patients cared for by our community teams in their own homes. We want to see a similar reduction for these patients and ensure they are safe in our care. We have therefore repeated a similar indicator from last year.

What we have achieved in 2013/14 and future plans

We have partially achieved this target with a 30% reduction in avoidable grade 3 and 4 pressure ulcers in two divisions with community care teams in South East and North Hampshire successfully meeting the target.

Every grade 3 and 4 pressure ulcer is investigated by a senior staff member with support from the tissue viability team to identify causes and contributory factors. Six key themes have been identified, which mirror national trends; documentation, staff/patient/carer education, communication between multidisciplinary teams and agencies, equipment and staff factors such as leadership, vacancy rates and use of key workers. A Trust wide pressure ulcer reduction plan has taken these key themes into consideration with specific work undertaken during the year to address these issues.

Numbers across the Trust were on a downward trend in quarters 1-2 but there has been significant rise in quarter 4, mostly in West Hampshire. The West division has seen an increase in the numbers of patients who at the end of their life are choosing to die at home and who are at increased risk of pressure ulcers. There are also recruitment pressures across the Trust with difficulties filling vacancies which reflect the national picture.



Avoidable grade 3 and 4 pressure ulcers			
Division (community care teams)	**Target** (based on 2013/14 figures from Pressure Ulcer report)	**Actual**	**30% reduction achieved**
South East	36	15	
Southampton and West	51	76	
North	24	21	
North East	6	12	

What we did in 2013/14 and future plans

- We have implemented a Trust wide plan to reduce numbers of pressure ulcers which includes sharing learning from analysis of the causes of pressure ulcers and actions to be taken. A key focus is to embed learning from divisions who have successfully reduced pressure ulcers to all clinical teams and ensure learning is sustained over time.

- A clinical academic fellow has been appointed to complete a four year study into the role of nursing and other staff in pressure ulcer reduction.

- A flow chart has been developed to help staff identify that they have taken all the necessary actions to avoid pressure ulcers developing.

- In November, pressure ulcer prevention week saw the launch of 'spot the signs' and a patient specific leaflet 'how to prevent pressure ulcers' aimed at supporting discussion of key issues with patients and carers.

- Training is provided by the tissue viability team to all relevant staff including primary care and residential home staff. They have also introduced a very successful telephone support line to give advice and support.

- We will engage in new initiatives, for example 'stamp out sores' campaign, in collaboration with our commissioners, acute hospitals and others to reduce pressure ulcers in 2014/15.

- We are repeating a similar indicator for 2014/15.

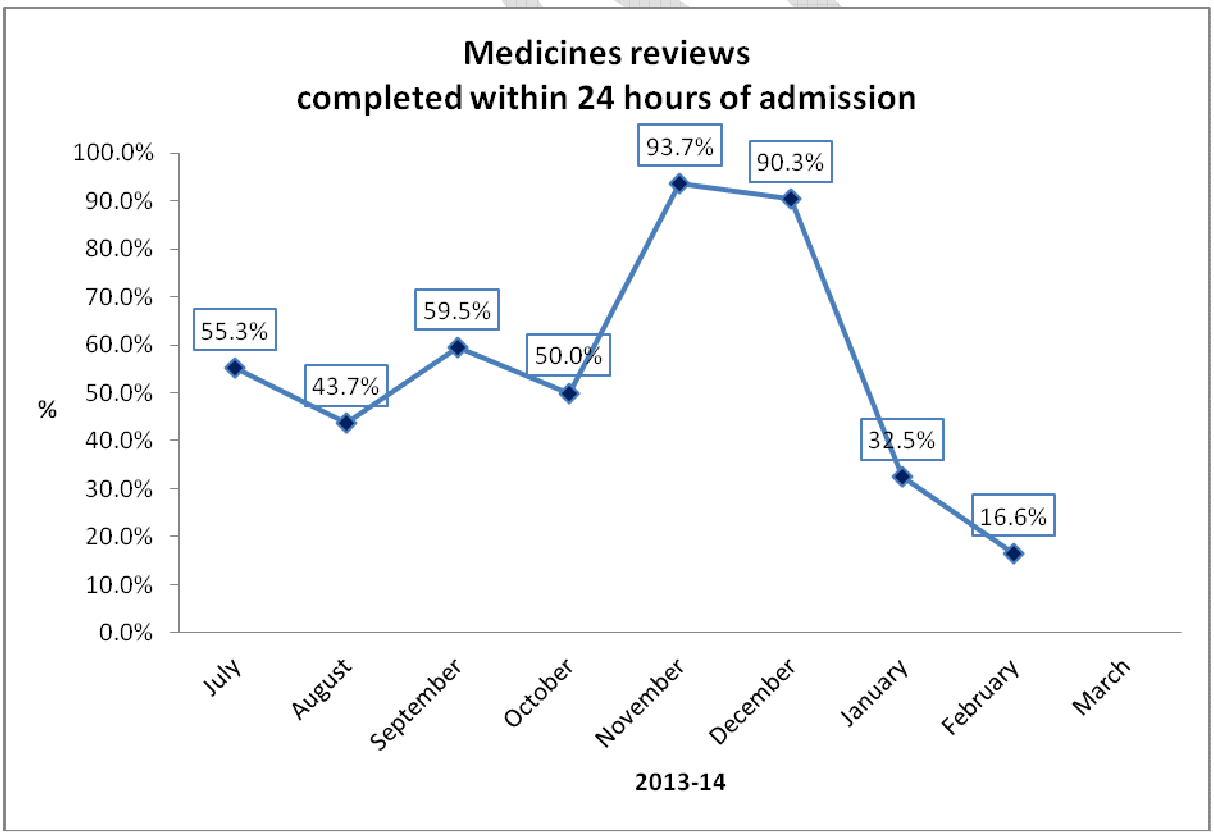
1.3 80% of inpatients have their medicines reviewed within 24 hours of admission

Our aim

We aim to review the medicines patients are taking when admitted to our inpatient units to ensure safe care and reduce any potential harm to the person from taking the wrong medicines. Last year we found variability between services in their ability to carry out medicines reviews within the set time frame and so repeated a similar indicator this year to ensure that medicine reviews are available to all inpatients in a timely way.

What we have achieved

There have been technological difficulties with the web based data collection system which makes it difficult to interpret the results. Manual data collection in November and December resulted in a large increase in reported results which may represent a more accurate picture of medicines reviews within 24 hours of admission and would mean that the target was achieved.



Feb/March data needs to be added

What we did in 2013/14 and future plans

- We introduced a web based data collection system so that data can be collated and analysed centrally with the aim to identify trends across inpatient sites and highlight areas of underperformance which can be targeted. However there have been technological difficulties with the system which are being resolved so that collation of data is accurate.

- Current training programmes have been updated with particular focus on junior doctor training.

- A proposal for increased pharmacy capacity was presented to the Board in January with agreement reached for additional funding for the pharmacy team enabling recruitment of additional staff so as to provide more effective medicines cover across the whole Trust.

- We are repeating a similar indicator in 2014/15 to confirm that medicines reviews are being completed within best practice time frames.

Priority 2 Improving Clinical Effectiveness

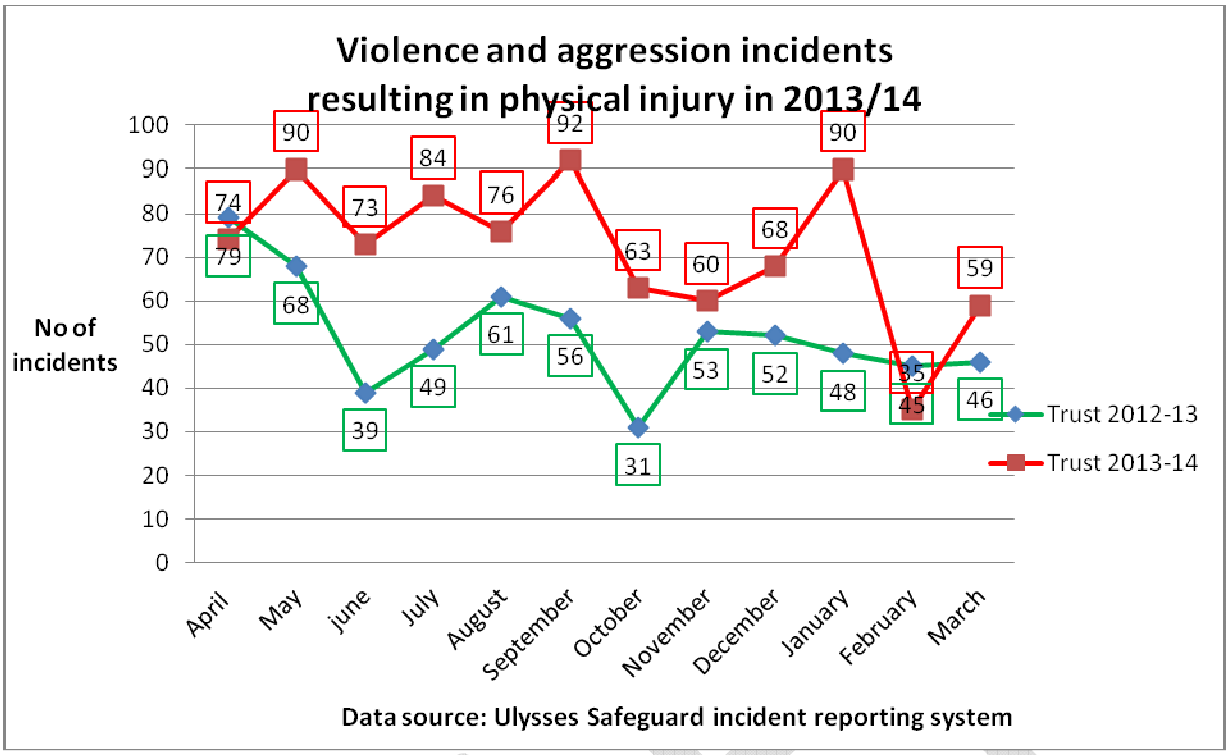
2.1 Improve therapeutic interventions in Mental Health and Learning Disabilities services to reduce patient violent and aggressive incidents which result in physical injury by 10%.

Our aim

Patients experiencing mental health distress can at times express this through violent or aggressive behaviour. Our aim is to work with them to manage their distress and avoid violent behaviour wherever possible. If it occurs we want to address it in a way that is safe for all concerned and minimises the use of coercion.

What we have achieved

We have not achieved this target. It was an ambitious one as a 14.8% reduction in violent and aggressive incidents resulting in physical injury as defined by the National Reporting and Learning System was achieved last year. We are also now including incidents occurring in the former OLDT which makes the target even more ambitious. Although the reduction target is not being met, there are downward trends in Mental Health, Learning Disabilities and OPMH services, with the exception of a spike in January 2014. These spikes can reflect the admission of an individual patient with challenging behaviour to an inpatient unit.



What we did in 2013/14 and future plans

- We reviewed the data on violent and aggressive incidents in monthly meetings to identify trends or hot spots and found no unexplained spikes or variation in incidents which would cause concern. It is anticipated that trends will remain flat on the basis of the increased acuity of patients in inpatient units.

- One OPMH ward are piloting the use of a new lighting system specifically designed to foster calmness and reduce violent and aggressive incidents. This pilot will be evaluated as to the benefits of using such lighting more widely across the trust.

- A working group has been set up in mental health services to embed recovery principles in acute care with a focus on initiatives such as increased use of peer support workers which research has shown helps reduce violent incidents and 'No Force First' principles where de-escalation techniques are used to prevent violent and aggressive incidents.

- We have developed a SAFER programme which will continue into 2014/15 and is focused on providing safe environments and minimising the use of restrictive practice. The programme has several measures and includes refining our training to reflect the current evidence base, development of 'safe wards', reduction in the use of seclusion and developing peer support workers.

- We are introducing a framework for Positive Behavioural Support which will include the introduction of Behavioural Support Plans. These will focus specific care and support to address challenging behaviour or violent and aggressive behaviour.

- We will improve environments so that we minimise the negative impact of oppressive environments on how patients behave and recover.

- We will continue to focus on the minimising of violence and aggression in our inpatient areas and have included in our priorities for 2014/15.

2.2 Prevent patients and service users deteriorating unexpectedly by using the track and trigger tool as an early warning system for 90% of appropriate patients and service users.

Our aim

Early warning systems help staff recognise the early warning signs of possible deterioration in a patient's vital signs so that prompt action can be taken to ensure appropriate treatment is given. We therefore developed a 'track and trigger' early warning system whose roll out to all services in 2012/13 took longer than anticipated and so we did not meet the quality improvement priority last year regarding its use. We want to identify early signs of deterioration so we can best help patients and so repeated the priority for 2013/14.

What we have achieved

We have achieved this target. Clinical audits have shown an increased use of the track and trigger observation charts during 2013/14 with the latest audit in November 2013 reporting 91% of appropriate patients were assessed using the track and trigger observation charts.

Clinical audit results in use of an early warning system/track and trigger system			
	Sept 2011 (modified early warning system)	March 2013 (track and trigger)	Nov 2013 (track and trigger)
Community Hospitals	75%		
All services		69%	91%

There have been no reported deaths in community hospitals in 2013/14 where the early signs of deterioration have been missed.

What we did in 2013/14 and future plans

- We continued the roll out to all clinical services of 'track and trigger' observation charts to monitor patient's vital signs as part of an early warning scoring system to detect clinical deterioration.

- We have reviewed and revised the Physical Assessment and Monitoring Policy to make guidance clearer to staff, particularly for mental health and learning disabilities teams where the monitoring of the physical health needs of patients is less well established.

- We have provided a training programme in physical assessment and monitoring for all new starters with a set of clinical competencies to be achieved within first 6 weeks. Bespoke training has been delivered to junior doctors.

- Throughout the year we monitored use of 'track and trigger' as part of the matron quality walk round and found variability across divisions in their use of the 'track and trigger' observation charts. Targeted support has been given to teams where the use of this early warning system is less well embedded. Latest matron walk round results for February and March 2014 show 93.9% and 92.0% of patients respectively have been assessed using track and trigger observation charts.

- The Trust's resuscitation group is currently reviewing the 'track and trigger' system in the light of a revised national early warning system (NEWS) and will make recommendations for revision as appropriate.

- In our priorities for improvement in 2014/15 we will look at learning from analysing deaths which will include consideration of effective use of early warning systems.

2.3 Five Outcome Frameworks will be introduced to demonstrate improved clinical outcomes for patients/service users.

Our aim

We want to move away from counting activities as a measure of performance to focus instead on what we need to do to ensure a positive clinical outcome is achieved for every patient we care for. We want to develop 'Outcome Frameworks' which gather all aspects of service delivery that need to be in place in order to ensure positive outcomes for patients. This was a new indicator for 2013/14.

What we achieved

We have achieved this target with five Outcome Frameworks developed with clinical services and populated with key information to support their planning for service improvements and improved clinical outcomes for patients.

What we did in 2013/14 and future plans

- The Service Improvement Project manager led on this project and developed a project plan to meet this indicator. She worked closely with a small number of clinical services to identify factors that are necessary to have in place in order to achieve the desired outcomes for patients. For example, the prevention of health crises for patients seen by the community care teams included measures about how well the patient was able to manage their own condition. It included information about whether the patient had been given information which was relevant and helpful, how confident the patient felt in managing their own condition and whether the patient had been involved in planning their own care.

- Information on many measures has been collated into outcome frameworks so that clinical services can now be supported to review and interpret the data and use to plan for service improvement. The frameworks will support services to plan for

positive clinical outcomes and identify any key issues which need to be addressed to achieve the best care for patients.

- This indicator has been met and will not be included in 2014/15 priorities for improvement, however the project is continuing next year and will embed the use of existing outcome frameworks within services and develop further frameworks.

2.4 All Community Hospitals and Older People's Mental Health wards will provide dementia friendly environments.

Our aim

We want the Trust to be a dementia friendly organisation and to provide appropriate dementia friendly environments for all inpatients in Community Hospitals so that their stay in hospital is as comfortable as possible. Clinical audit in 2012 found there were some areas where we could improve to meet the needs of patients with dementia. This was a new indicator for 2013/14.

What we have achieved

We have successfully completed the project plan developed to achieve this indicator and are pleased with progress made. However we are aware of some of the actions required following a CQC inspection of an Older People's Mental Health ward and will continue to support dementia friendly initiatives.

What we did in 2013/14 and future plans

- Key staff attended King's Fund training on providing dementia friendly environments with information cascaded to clinical teams.

- We successfully piloted use of dementia leads for each ward who led on dementia friendly objectives for their area with dementia lead programme being extended to all wards.

- We have worked collaboratively with key partners to develop a dementia friendly strategy and to drive work streams in education, environment and awareness. The Trust's dementia lead is working with local county councils and acute hospitals to scope and develop training and education provision.

- Observational audits in the community hospitals found evidence of good practice in providing dementia friendly environments with clear signs in place, date information and clocks in all of the bays, and that staff were welcoming and spoke in a calm and professional manner to patients with dementia. These observational audits will be repeated in 2014/15.

- Fleet Hospital is working with Alzheimer's UK and patient/carer's associations to become part of a dementia friendly community.

- Romsey Hospital has been redecorated to be a dementia friendly environment.

- This indicator has been met and will not be included in 2014/15 priorities for improvement, however we will continue with work already started with key partners to ensure dementia friendly initiatives are successfully continued.

Priority 3: Improving Patient Experience

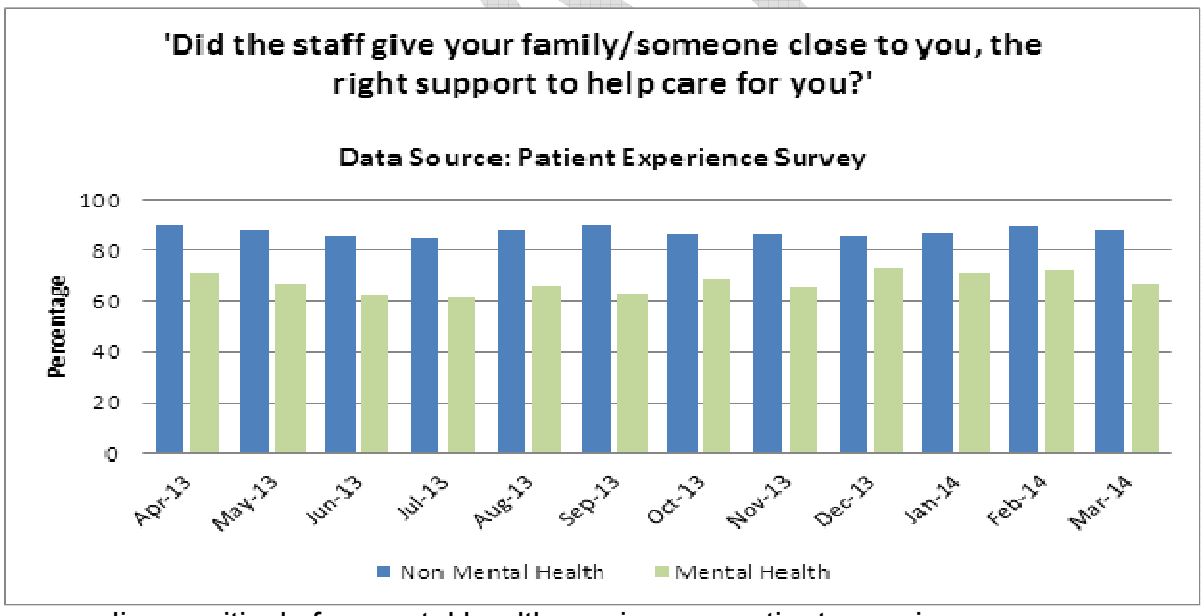
3.1 95% (75% in mental health services) positive response to the question 'did the staff give your family/someone close to you the right support to help care for you?' on our patient experience surveys.

Our aim

We recognise the importance of families or someone close to the patient in helping care for them. Our patient experience surveys in 2012/13 showed lower positive responses to our support for carers than other survey questions. We wanted to improve our carer support, leading to improved experience of our service. This was a new indicator for 2013/14.

What we have achieved

We have not quite achieved the target we set ourselves with 87.6% of patients responding positively in non-mental health services and 67.5% of patients



responding positively for mental health services on patient experience surveys. Different targets for mental health services are set internally to take into account the different nature of their caseload.

What we did in 2013/14 and future plans

- We have carer forums and drop in meetings for people and their relatives with advice and information given and signposting to local voluntary support groups and national helplines.

- We involve carers as much as possible in the care planning for their relatives so that we are choosing goals that are important to the patient and their carers and are designing our services to meet their needs.

- We provide facilities for carers to stay overnight in hospital where possible when a relative is close to the end of life.

- We involve carers in planning for the discharge of their relative from inpatient settings so that the most appropriate care is available for the patient when they leave.

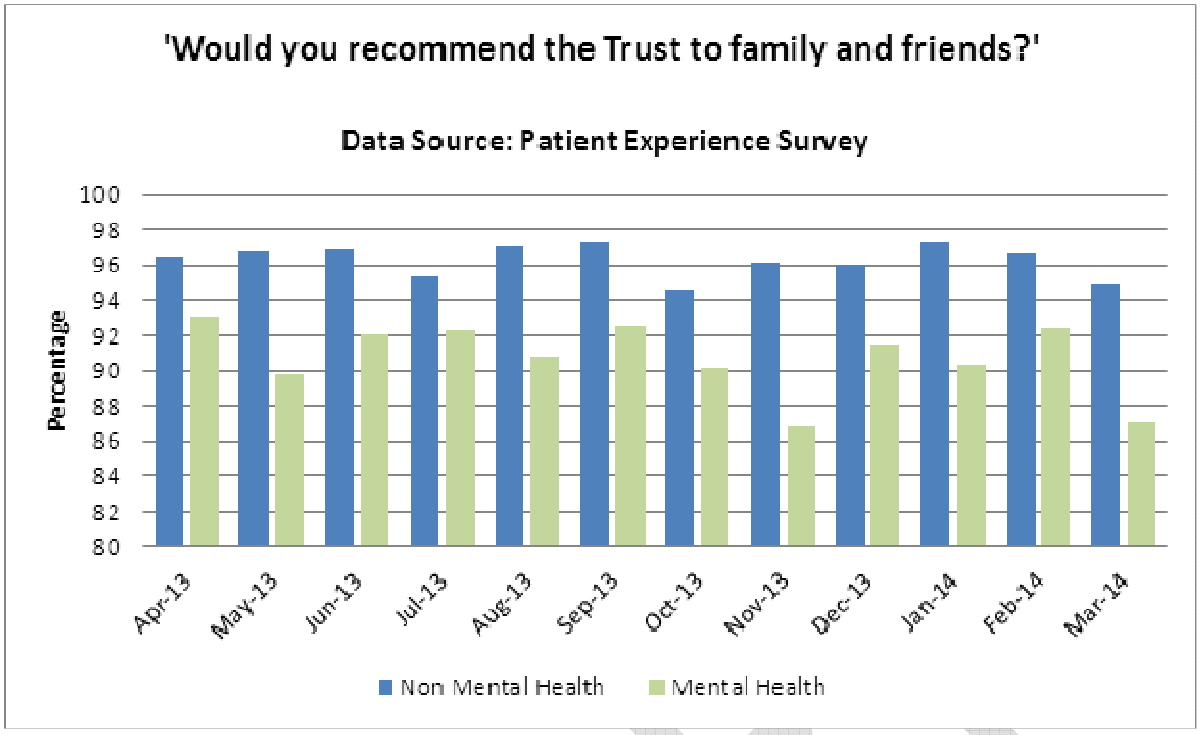
- A specific carer's survey was launched in February 2014 with roll out across the whole Trust over the coming months. It is a little early for results but once received the divisions will use the feedback to help shape our support for carers and patients.

- Supporting carers and listening to their feedback to improve services is one of our priorities for improvement in 2014/15.

3.2 Achieve 95% (75% for Mental Health services) excellent in the Friends and Family Test

Our aim
We believe patients should be at the heart of everything we do and should drive the design and delivery of our care to them. We want to use their feedback to identify and implement service improvements so that we are continually improving the experience people have of our services.

What we have achieved
We used the question 'How likely are you to recommend our services to friends and family if they needed similar care or treatment?' on our patient experience surveys as the measure. We have different targets for mental health services as explained above. We achieved this target with 96.1% of patients responding positively in non-mental health services and 90.6% in mental health services.



What we did in 2013/14 and future plans

- We review patient's feedback within divisional and team meetings and take action to address issues raised, for example, we bought name badges for staff as patients commented they could not read staff ID badges easily.

- We have launched new patient experience surveys for our learning disabilities and social care divisions.

- We have implemented actions to increase the numbers of surveys returned.

- We will continue to seek patient's feedback so we can improve their experience of our services and have included a similar indicator for 2014/15.

3.3 100% compliance with Duty of Candour obligations for suspected or actual patient safety incidents that result in severe harm or death

Our aim

We want to be open with patients and their carers when something has gone wrong with their care and to apologise and ensure lessons are learned. We want to be an organisation where patients have trust in the services we are providing.

What we have achieved

We have achieved this target. Quarterly audits of serious incidents have shown that staff apologise and give a full explanation to patients and their carers on those occasions, which do not happen often, where something has gone wrong with their care.

We have tried our best to contact a carer or next of kin for these discussions but on 6 occasions this year have been unable to either identify or involve a carer or next of kin.

What we did in 2013/14 and future plans

- Every serious incident is reported by staff on the Ulysses Safeguard reporting system and investigated by a senior manager who looks at the underlying causes and contributory factors and makes recommendations for actions and learning. These aim to reduce the likelihood of a similar incident occurring in the future. Prompt questions to ascertain staff were being open and discussing with patients and carers when something has gone wrong with their care were added to the incident reporting and investigation documentation and audited on a quarterly basis by the Serious Incident Manager.

- From April 2014 the paper based audit system will be replaced by electronic reporting which will make it easier to analyse information, identify trends and share learning.

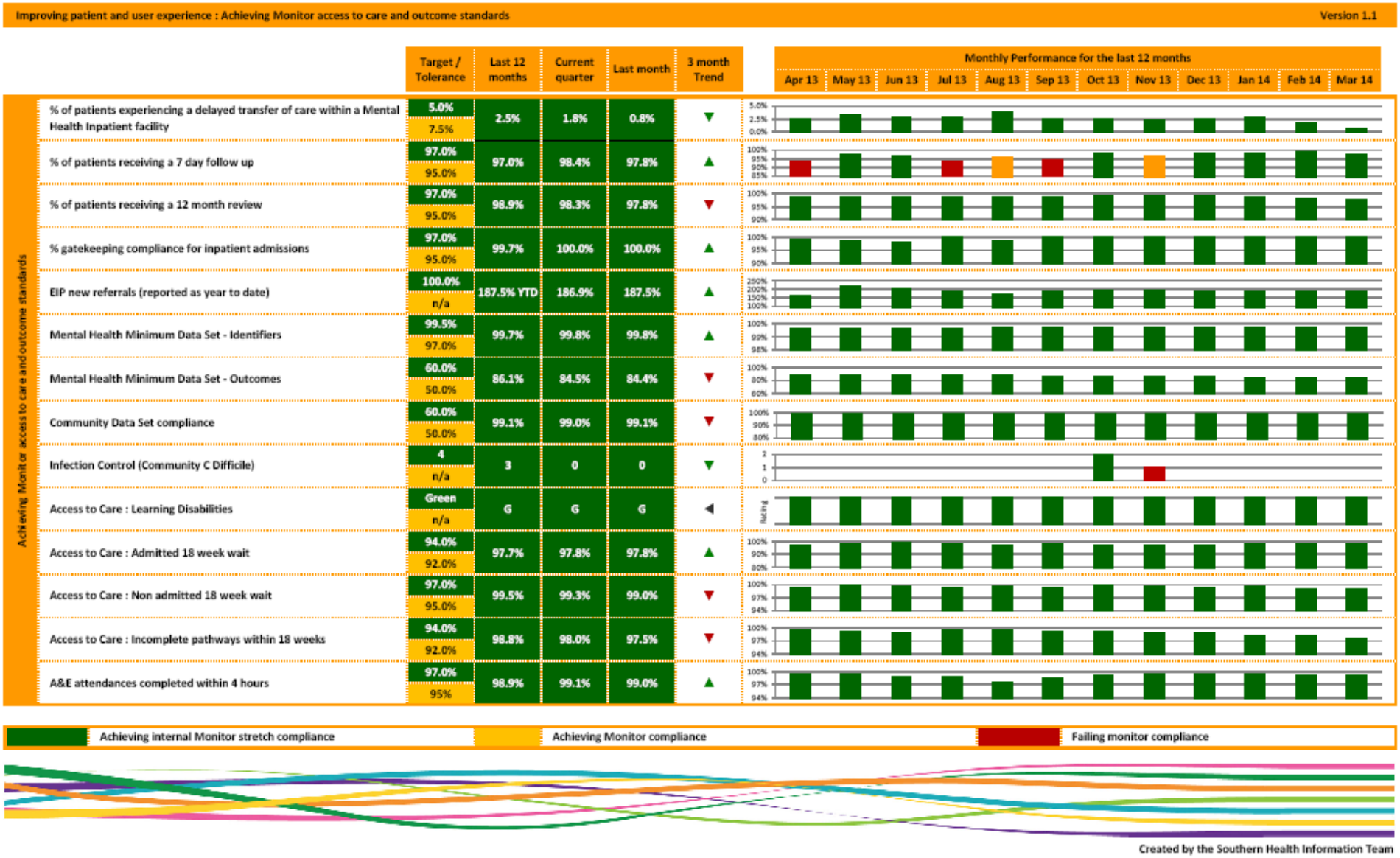
- The principles of duty of candour have been highlighted in induction training and incorporated into specific training on serious incidents.

- We will revise the existing 'Being Open' policy to encompass the principles of duty of candour and the Francis Report recommendations.

- We will continue to embed the principles of being open in everyday practice but will not include as a specific indicator in 2014/15.

Performance against key national priorities

The dashboard with relevant indicators and performance thresholds set by Monitor for 2013/14 shows the Trust was compliant with all 14 Monitor non-financial indicators by year end. 13 of these indicators were met throughout the whole year with only one indicator, percentage of patients receiving a 7 day follow up, showing inconsistent achievement. Focused work within clinical services to provide 7 day follow ups have resulted in thresholds being met December onwards.


Improving patient and user experience : Achieving Monitor access to care and outcome standards
Version 1.1
Target / Tolerance
Last 12 months
Current quarter
Last month
3 month Trend
Monthly Performance for the last 12 months
Apr 13
May 13
Jun 13
Jul 13
Aug 13
Sep 13
Oct 13
Nov 13
Dec 13
Jan 14
Feb 14
Mar 14
Achieving Monitor access to care and outcome standards
% of patients experiencing a delayed transfer of care within a Mental Health Inpatient facility
5.0%
7.5%
2.5%
1.8%
0.8%
% of patients receiving a 7 day follow up
97.0%
95.0%
97.0%
98.4%
97.8%
% of patients receiving a 12 month review
97.0%
95.0%
98.9%
98.3%
97.8%
% gatekeeping compliance for inpatient admissions
97.0%
95.0%
99.7%
100.0%
100.0%
EIP new referrals (reported as year to date)
100.0%
n/a
187.5% YTD
186.9%
187.5%
Mental Health Minimum Data Set - Identifiers
99.5%
97.0%
99.7%
99.8%
99.8%
Mental Health Minimum Data Set - Outcomes
60.0%
50.0%
86.1%
84.5%
84.4%
Community Data Set compliance
60.0%
50.0%
99.1%
99.0%
99.1%
Infection Control (Community C Difficile)
4
n/a
3
0
0
Access to Care : Learning Disabilities
Green
n/a
G
G
G
Access to Care : Admitted 18 week wait
94.0%
92.0%
97.7%
97.8%
97.8%
Access to Care : Non admitted 18 week wait
97.0%
95.0%
99.5%
99.3%
99.0%
Access to Care : Incomplete pathways within 18 weeks
94.0%
92.0%
98.8%
98.0%
97.5%
A&E attendances completed within 4 hours
97.0%
95%
98.9%
99.1%
99.0%
Achieving internal Monitor stretch compliance
Achieving Monitor compliance
Failing monitor compliance
Created by the Southern Health Information Team

Board Leadership, assurance and governance

The Board's vision for quality is aligned with the Trust's strategic vision, core values and business strategy which is being finalised for both the two and five year operational plans to be submitted to Monitor this year.

At each board meeting, directors review measures which indicate how the organisation is performing in relation to quality, safety, clinical performance, finance and workforce. The Board has been clear throughout the year that any examples of poor quality or performance must be tackled swiftly and purposefully. Following the CQC inspections which resulted in enforcement actions to some of our inpatient sites, the Board initiated an external review by Deloitte of both corporate and quality governance structures within the Trust. Although their report is generally positive, a number of recommendations are made to strengthen the infrastructure, systems and procedures across the Trust and divisions so that poor performance and quality are identified quickly with actions taken to resolve immediately. Further details are given below.

All Non-Executive directors take an active and challenging role at the Board and board committees.

Independent Governance reviews by Deloitte

In January 2014 Deloitte concluded an independent Board Governance and Quality Governance Reviews of the Trust. Their reports convey a balanced perspective and identified many positives in relation to the organisation:

- *Board Governance* - findings from the Board Governance review were grouped around two themes: Board leadership, capability, roles and responsibilities and Board processes and systems. The report stated the most significant governance issue for the Trust being the risk associated with maintaining Board oversight and control during a period of significant change as the Trust moves towards greater divisional autonomy. It acknowledged the Trust is making significant progress but further work is required to finalise management structures, strengthen risk registers, streamline reporting, get the right balance for divisional accountability/corporate control and generally manage the cultural transition. The report recommended the Board as a whole needs greater oversight of this transformation than it has at present. Twenty-nine recommendations were made in relation to this and other issues pertaining to Board sub-committee portfolios and Executive responsibilities.

- *Quality Governance* - The report made 26 recommendations themed around each of the Monitor Quality Governance Framework domains and key risks identified included a lack of implementation of the Trust's Quality Strategy due to its recent release, the need to finalise the updated Risk Management Strategy and Policy, the completeness of divisional risk registers and lack of structured reporting in relation to the quality impact of CIPs. The report noted positively that the Quality and Safety Committee functioned well and brought effective challenge on quality however the quality governance structures and systems in the newly formed divisions were still in varying stages of development and will take time to become fully embedded.

Deloitte also found several areas of good practice in relationship to quality and quality governance including:

- An innovative programme of combined leadership development and behaviour based appraisals which are focused upon improving patient experience, care and the working environment;
- The development of a performance management framework into Divisions which are supported by integrated performance dashboards and information;
- Staff were positive about communications at the Trust; and
- A defined divisional leadership team who are positive about the devolved accountability structure as well as the degree of collaboration and support from the Executive members of the Board.

The Trust Board accepted the Deloitte findings and recommendations and approved the management response and action plans at the Board in March 2014. Many Deloitte actions align with the outputs of the Risk Management Development Programme which was procured and commenced prior to the receipt of Deloitte's reports.

Learning Disability Services

Following the death in July 2013 of a patient in one of the Trust's non-Hampshire Learning Disability Services, the Trust commissioned an independent investigation from Verita.

In September 2013 the unit where the patient died was inspected by CQC and failed all the outcomes against which it was assessed. Since then a number of non-Hampshire Learning Disability Services have also been inspected and serious concerns identified in some of these inspections. Of the nine warning notices issued against the Trust, eight relate to the non-Hampshire Learning Disability Services.

The Verita investigation was completed in February 2014 and concluded that actions which should have been taken to manage and minimise the risk to the patient were not taken and the patient's death was therefore preventable. The Trust has publicly accepted the findings and recommendations, published the report and apologised to the family of the young man who died. Thames Valley Police are still considering the findings from the report however the Health and Safety Executive have advised they will be taking no further action.

Since the patient's death the Trust has put in place a number of measures to improve the clinical systems and processes in the non-Hampshire Learning Disability Services to safeguard patients and increase and strengthen clinical leadership in these units. MBI Health is also working with the Learning Disability Management Team to review the model of care and implement a comprehensive plan of action to further strengthen safety and quality in the coming months.

Concerns about the quality governance and assurance arrangements in the non-Hampshire Learning Disability Services and the wider Trust, have been raised by commissioners, the NHS England Regional and National Teams. The Trust has been the subject of local Quality Surveillance meetings, invited to attend two Risk Summits chaired by NHS England, and a Board to Board meeting with our largest

commissioner, West Hampshire Clinical Commissioning Group. Throughout the Trust has been commended on its openness about the challenges it faces and for its co-operation with stakeholders in the quality surveillance process; at each meeting the Trust has shared its improvement plans in Learning Disabilities and for the wider Trust to enable these to be challenged and scrutinised and to date no significant concerns have been raised; formal feedback relating to the outcome of the last Risk Summit in March is awaited.

The Trust Chief Executive Officer and the Chief Operating Officer/Deputy Chief Executive met with the Chief Executive of the CQC and, Regional Director in March 2014. This was a constructive meeting where the Trust shared good practice as well as discussed the Trust's highest risk areas and actions being taken to address these. In February 2014 the Chief Executive Officer also met the CQC Chief Inspectors of Hospitals, Mental Health and Social Care to discuss their concerns about the number of adverse indicators that they had noted from the organisation, particularly in the non-Hampshire Learning Disability Services. The Chief Executive Officer shared the summary findings from the external governance review into Board Governance and Quality Governance processes and agreed to share the outcome of these reviews and the Trust's response to the recommendations. Professor Sir Mike Richards will be writing to the Trust formally following this meeting.

Monitor has considered all of the above intelligence and on April 23rd issued the Trust with enforcement actions due to governance failures. We take Monitor's decision very seriously and over the coming weeks our focus will be on making sure we make the improvements needed.

Quality Governance Strategy

Our Quality Strategy was approved by the Trust Board in September 2013 and has since been revised to become the Quality Governance Strategy 2014-2016 "Getting it right first time, every time". This document sets out a number of patient-centred quality improvement goals for Southern Health Foundation Trust over the next two years; at its centre is the promotion of a culture of continuous improvement where every member of staff has the pride, compassion, confidence and skills to champion the delivery of safe and effective care.

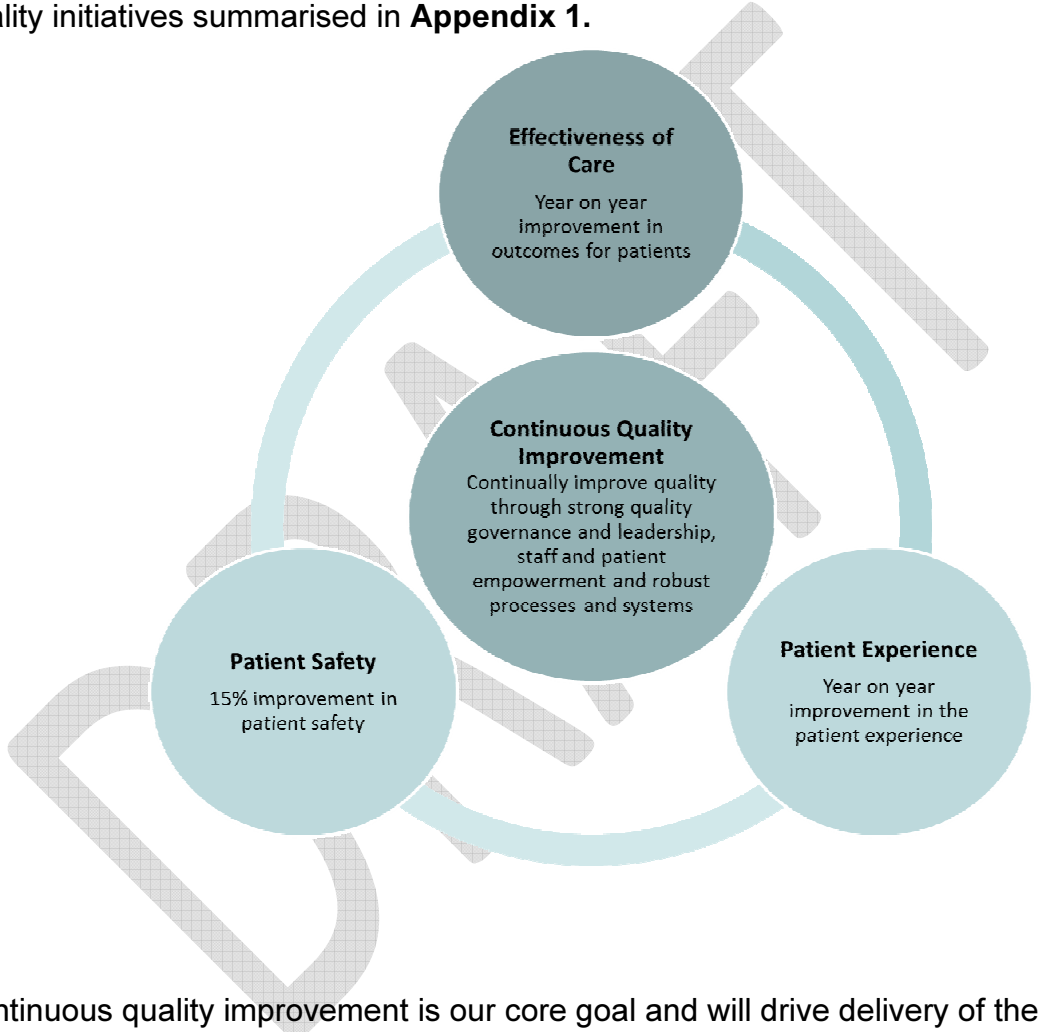
The aims of the Quality Governance Strategy are to:-

- Support the development of a culture of continuous improvement which results in higher satisfaction and experience for patients, carers and their families
- Engage every member of staff because they all must contribute to a quality experience and continuous improvement
- Set goals and priorities for improvement based on the NHS definition of quality
- Set out our approach to quality improvement which is based on evidence of what works in world class organisations
- Set out how we will measure and publish our progress

Our vision for quality ***to get it right first time, every time*** supports the Trust's overall aim of providing high quality and safe care.

This means giving the correct treatment at the appropriate time, to a high standard with minimal complications; it involves ensuring we have appropriate end-to-end care pathways with a referral system designed to allow the right patient to be seen by the right person at the right place at the right time leading to improving patient outcomes and satisfaction. It means doing this first time and every time for every patient.

To achieve this we have set ourselves four quality goals for the next three years. These goals are supported by a set of principles and the principles underpin our quality initiatives summarised in **Appendix 1.**



Continuous quality improvement is our core goal and will drive delivery of the others because process improvement and target based approaches alone have not been successful in enabling the Trust to deliver the level and scale of quality improvement it aspires to.

A cultural change which places emphasis on empowering frontline staff to make continuous changes in their clinical practice within the context of the delivery of the Clinical Strategy is needed. This will enable the Trust to aim high and deliver high and achieve maturity as recognised provider of high quality and safe care by its patients, service users, staff and stakeholders.

Organisational learning

We recognise the importance of organisational learning in developing safe effective services and the sharing of good practice. The Organisational Learning Strategy has been refreshed and will be implemented in 2014/15 across the Trust. A planned programme of work includes refinement of formal meeting and reporting structures so as to share good practice and learning opportunities, with reports being shared widely in the Trust and strengthening informal opportunities for discussion and enquiry of the data available. Divisional and frontline themes for learning and quality improvement are already being shared with Mental Health and TQtwentyone divisions each using key learning points from a review of all information about quality to share monthly top-tips posters for their staff.

We have implemented a programme of work to ensure we learn from all available information and feedback about our services, including complaints, incidents, clinical audits, CQC and mock CQC inspections and performance indicators. These have influenced the selection of some of our quality indicators for 2014/15. Information is triangulated from a wide range of indicators, to identify themes where action may be needed or good practice shared across the Trust in Trust-wide and divisional reviews.

Risk Management Development Programme

In November 2013 the Trust went out to competitive tender for independent risk management support to assist us in developing our whole-organisation approach to risk management and the Board Assurance Framework from January and throughout 2014. The programme objectives are to:

- Engage the Trust Board in the development and use of the Board Assurance Framework (BAF) for 2014/15; ensuring the BAF has the right focus and the Board is sighted on the right risks;
- Enhance the presentation and reporting of the Assurance Framework in readiness for a new BAF to Board early the 2014/15 financial year;
- Improve engagement of the Trust's clinical services in the organisations approach to risk management for the purpose of ensuring risk management is embedded in the day to day business of delivering high quality services and ensuring the risk register is relevant, reliable and fit for purpose;
- Ensure the Trust's approach to risk management and framework is robust and follows best practice by supporting the review of the Risk Management Strategy and Policy and suite of supporting documents.

The Risk Management Programme has been designed to support the Trust in addressing the challenges that have arisen during 2013/14 in relation to risk management; specifically the programme will address recommendations in the Risk Management and BAF Internal Audit and recommendations from the Deloitte Reviews.

The Chief Operating Officer/ Deputy Chief Executive is lead executive for this piece of work as it aligns with the Trust annual business cycle including strategic objective identification schedule, risk identification and risk appetite articulation for 2014/15.

Baker Tilly were awarded the contract and commenced work in January 2014; the Project Plan was reviewed by the Audit, Assurance and Risk Committee on 6th March 2014 and a programme board convened to oversee the work and will include the Lead Director and a Non-Executive Director and programme progress and key findings will be reported to this Board. Work with clinical divisions has commenced, and the first session held with the full Trust Board to agree the high level strategic risks for 2014/15.

Workforce

We have continued to equip our leaders with the capability and confidence to deliver our Strategy and Business Plan which aims to enhance quality, safety and clinical outcomes across the organisation. Over the past 12 months the 'Going Viral' leadership programme has coached, developed and supported 481 staff to deliver the attitudes, values and behaviours expected from our workforce.

We continue to place great emphasis on ensuring our staff have the appropriate knowledge, attitude and skills to provide safe and effective care. This year has seen the development of a new analytics report (first release February 2014) which provides monthly compliance statistics on statutory and mandatory training requirements. The report is accessible via the Trust's data warehouse and enables all managers to assess their team's compliance with training requirements.

During 2013/14 our range of statutory and mandatory training sessions exceeded 30,000 attendances. Accessibility to electronic training resources as a suitable alternative to face to face attendance has continued to be promoted. Over the past 12 months our workforce accessed electronic assessments on 17,699 occasions with 87% resulting in a pass. Calculations demonstrate that this has generated a saving of £541,000 when compared to the costs associated with attendance at face to face training. These savings endorse our aim of working smartly to eliminate wasteful activities thereby enabling our staff to spend time on things that really count. The continued promotion and uptake of e-assessments during 2013/14 has contributed to the achievement of a predicted year end increase of 11.32% compliance with statutory and mandatory training.

We have recognised the diverse nature of the services we provide and have effectively utilised our Continuing Professional Development budget to meet the specialist needs of our Bands 5-9 workforce in line with divisional workforce strategies. This year we have supported our staff to access a range of educational courses which include relevant courses in neurological, physiological and psychological interventions.

This year saw the implementation of a project to address the recommendations of the Cavendish review. We will be introducing a competency based induction framework for our support workers to ensure they have been trained to a specific set of standards and have the skills, knowledge and behaviours to provide compassionate and high quality care and support.

Safeguarding

Safeguarding describes Southern Health's responsibility to work in partnership with other agencies to prevent abuse and neglect of vulnerable adults and children and to deal with it effectively if it does occur. The Trust is a member of Local Safeguarding Boards for Children and Adults and follows the Multi Agency procedures. The safeguarding focus within the Trust is 'Think Family' to ensure staff consider all individuals who may need safeguarding in a situation and not just the adult or child for whom the original concern was raised. The corporate safeguarding team has been further strengthened in the Trust with the appointment of a Named Doctor for Safeguarding Children and a Named Doctor for Safeguarding Adults. The corporate safeguarding team work in an integrated way to support sharing expertise and skills to benefit staff/patients/service users.

The Trust is committed to ensuring adequate preventative measures are in place to reduce the risk of abuse. This includes having appropriate policies, staff training, supervision, management and leadership arrangements in place and clearly defined professional boundaries. The 'Think Family' approach is reflected in both the Safeguarding and Communications Strategies, workforce development and responding to incidents.

An appropriately skilled workforce is considered key to reducing risk of abuse or neglect. Safeguarding training has been reviewed across the Trust to ensure effective high quality training is accessible to all staff. All incidents where safeguarding concerns are reported are investigated with the Trust focused on learning and sharing widely any lessons learned thereby reducing future risk. Trust safeguarding dashboards have been developed which enable monitoring of themes and trends and support a proactive approach.

The Trust ensures all staff see safeguarding as their responsibility and divisions have identified internal lead governance structures that feed in to Trust safeguarding assurance. Action plans developed by services to address any identified shortfalls to meet the recommendations from the Winterbourne Review and Saville case are monitored through divisional governance structures and the Trust Safeguarding Forum.

Infection Prevention and Control

We take the risk of infection very seriously and work hard to maintain our low infection rates. We have our own dedicated infection prevention and control team who work with all staff to ensure the risk of infection is kept as low as possible for all patients and service users. All staff must undertake regular training in infection prevention, control and hand hygiene. There is an extensive audit programme to monitor clinical practice and ensure high standards are maintained.

We have very low rates of healthcare acquired infection with *Clostridium difficile* infection numbers reducing year by year:

Number of positive cases of C difficile –community hospitals					
Year	2009/10	2010/11	2011/12	2012/13	2013/14
Number	27	14	7	5	3

The team monitors other infections such as MRSA, MSSA and *Escherichia coli* and also any outbreaks of infection which occur in inpatient areas. These do not happen very often, but when they do occur, we investigate to see if there was anything that could have been done differently to prevent the infection. Any learning from these incidents is shared with staff.

The team work closely with other departments such as Estates and Facilities to ensure high standards of cleanliness are maintained and also to ensure that any new builds or refurbishments comply with national guidance in infection prevention and control.

Serious incidents

These are rare and unintended events that can cause significant harm or distress. If it happens as a result of failure in care or treatment, we want to understand why and how, and to make sure it doesn't happen again. We do this by:

- Ensuring staff know what to do in the event of a serious incident by having policies and procedures in place;
- Ensuring investigating officers are fully trained to identify root causes of incidents and actions which will make a difference to patient and service user outcomes;
- Ensuring that staff involved in serious incidents attend panels with senior managers to discuss root causes, review action plans and share learning in a constructive manner;
- Ensuring through our audit of action plans that improvements have been made and learning from incidents has been embedded into practice and shared across the organisation; and
- Ensuring that staff are aware of their responsibilities in being open with patients, services users and their carers to discuss openly with them serious incidents resulting in harm when things may have gone wrong.

The table below shows the number and type of serious incidents reported by Southern Health in 2011/12, 2012/13 and in 2013/14.

Total	**2011/12**	**2012/13**	**2013/14**
Infection Control (outbreaks, C-Diff, MRSA bacteremia, legionella)	14	↓ 9	→ 9
Information Governance	2	↑ 3	↓ 0
Pressure Ulcers Grade 3 (total:avoidable/unavoidable)	141	↑ 144	↓ 143
Pressure Ulcers Grade 4 (total:avoidable/unavoidable)	95	↑ 101	↑ 134
Slip/Trips/Falls	31	→ 31	↓ 22
Unexpected Deaths	7	↓ 5	→ 5
Homicide	1	→ 1	↓ 0
Suicide by Outpatient	44	↓ 33	↑ 42
Suicide by Inpatient (includes those on home leave, AWOL)	3	↓ 1	→ 1
Attempted Suicide (self harm)	12	↓ 6	↑ 14
Serious Inpatient Incident (surgical error)	6	↓ 3	↓ 1
Safeguarding (inc: allegations against staff)	11	↓ 9	↓ 8
Grade 0 (used historically when severity of incident not	6	↓ 0	→ 0

clear initially)			
Other (AWOL, Lapsed Registration, undocumented patient outcomes, medication, choking, fire and serious assault by patient)	17	⬇ 5	⬆ 10
Total	390	⬇ 353	⬆ 389

Overall the numbers of serious incidents reported have increased by 10% in 2013/14 bringing these in line with 2011/12 figures, although it must be noted that we are now a larger Trust since the acquisition of OLDT.

There are decreasing numbers of SIRIs reported in several categories:

- Infection control
- Information Governance
- Slips/Trips/Falls (high harm)
- Unexpected deaths
- Surgical errors
- Safeguarding

There are two categories showing an increase:
Suicides – we have looked at these sad incidents and have found no trend or theme, with the increase in numbers in line with national benchmarked figures.
Grade 3 and 4 pressure ulcers – show an increase of 12% in total figures but pleasingly there has been a decrease of 3% in avoidable pressure ulcers.

The Trust has participated in NHS England initiatives for pressure ulcers and suicides. This has enabled the sharing of SIRI learning from these two key areas to support the reduction of pressure ulcers and to enable organisational bench marking for key learning from suicides.

Supporting patients and service users

All people should be treated with compassion, dignity and respect in a clean, safe and well managed environment. We view excellent customer service as integral to achieving these standards and have a dedicated Complaints and Patient Advice and Liaison Services (PALS) team who are the first point of contact for people who require advice or information about any of our services and which also manages complaints.

In 2013/14 the Trust received 470 formal complaints, 488 concerns that were dealt with informally and 1732 compliments. The majority of compliments were praising staff for their clinical care and attitude.

The most common complaint categories reflect the national picture and are the same as reported in 2011/12 and 2012/13 within the Trust:

- Clinical and nursing care 31% (145);
- Attitude 18% (84); and
- Communication 16% (75);

We want to understand reasons and trends underlying complaints so that we can change and improve our services. We therefore analyse all complaints and found the next most common categories were:

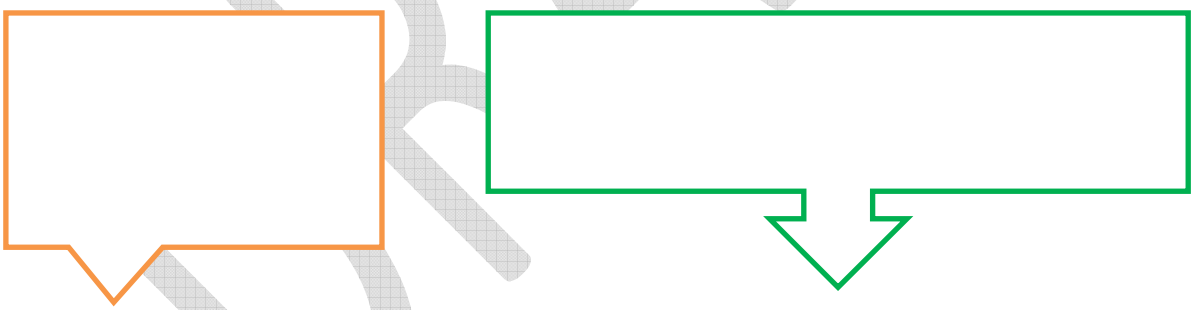
- Access to services 8% (39);
- Appointment 4% (20); and
- Medication and Prescribing 3% (15).

The majority (25) of complaints about access to services were from Mental Health services with most reflecting a mismatch between service users and carer's expectations and the redesigned community services. The remaining 12 complaints were about a variety of issues across a number of different services with no particular themes identified.

Complaints about appointments were again across a variety of services, the majority relating to outpatient appointments and orthopaedic/physiotherapy.
Complaints about medication and prescribing have been about changes to medication, side effects and differences of opinion about which medication should be given.

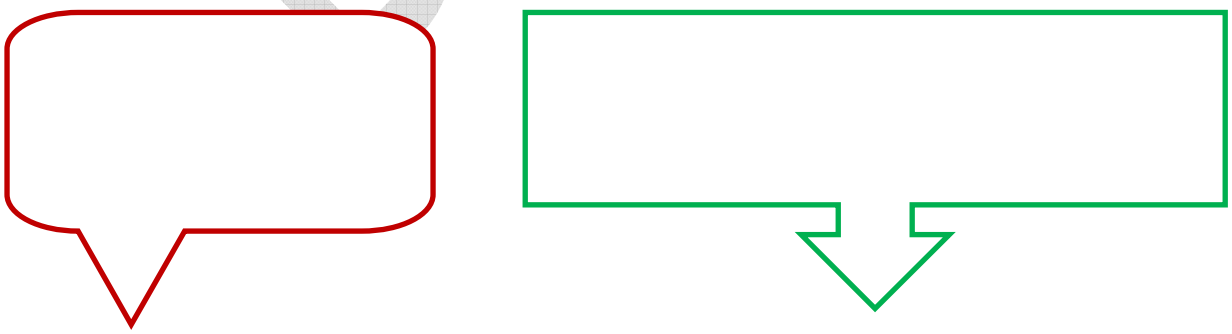
Overall numbers of complaints are small with 0.03% of total contacts for the year resulting in a formal complaint compared with 0.09% leading to a compliment, therefore people are three times more likely to compliment our services.

The Complaints and PALS team work closely with clinical services to review complaints and concerns and identify themes and share learning to improve quality of services with some examples given below:



You said:

We apologised, listened and took action:



You said:

We apologised, listened and took action:

You said: We apologised, listened and took action:

In 2013/14 the Trust has been made aware of 19 complainants who have referred their complaints to the Parliamentary and Health Service Ombudsman, compared to 17 last year. Of the 19, eight have been closed with no further action and 11 are on-going.

We have reviewed the recommendations from national reviews including the National Complaints report, Berwick, Keogh and Francis reports and have already developed and started to implement a programme of actions based on their recommendations.

Conclusion

We recognise that we have faced significant quality challenges in a small number of units this year and have worked hard to rectify problems and put plans in place to drive long term sustainable improvements.

However this should not detract from the many advances we have made in the quality of services this year. We will continue to work with all our key stakeholders including patients to continue improving to achieve high quality performance in all services.

ANNEXES

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

Annex 2 Statement of directors' responsibilities for the quality report

Annex 3 External Auditors' Limited Assurance Report

Annex 4 Data definitions

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

Feedback from our local Clinical Commissioning Groups (CCGs)

To be inserted

Feedback from Healthwatch

To be inserted

Feedback from Overview and Scrutiny Committees

To be inserted

Feedback from Southern Health Governors

To be inserted

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

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

Monitor 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 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 2013/14;
- 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 2013 to June 2014;
- Papers relating to Quality reported to the Board over the period April 2013 to June 2014;
- Feedback from commissioners dated *xx/xx/20xx;*
- Feedback from governors dated *xx/xx/20xx;*
- Feedback from local Healthwatch organisations dated *xx/xx/20xx;*
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated *xx/xx/20xx;*
- Latest national patient survey xx/xx/20xx;
- Latest national staff survey *xx/xx/20xx;*
- The head of internal audit's annual opinion over the Trust's control environment dated *xx/xx/20xx;* and
- CQC quality and risk profiles dated *xx/xx/20xx*.

- The quality report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- The performance information 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 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 Monitor's annual reporting 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
NB: sign and date in any colour except black

…… Date …… Chairman

…… Date …… Chief Executive Officer

Annex 3: External Auditors' Limited Assurance Report

To be inserted

Annex 4: Data definitions

PwC tested the following indicators

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

Detailed descriptor
The proportion of those patients on Care Programme Approach (CPA) discharged from inpatient care that are followed up within 7 days.

Data definition
All patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within 7 days of discharge. All avenues need to be exploited to ensure patients are followed up within 7 days of discharge. Where a patient has been discharged to prison, contact should be made via the prison in-reach team.

Exemptions

- Patients who die within 7 days of discharge may be excluded;
- Where legal precedence has forced the removal of the patient from the country;
- Patients transferred to NHS psychiatric inpatient ward
- CAMHS (Child and Adolescent mental health services) are not included.

The 7 day period should be measured in days not hours and should start on the day after discharge.

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

Minimising delayed transfer of care

Detailed descriptor
The number of Delayed Transfers of Care per 100,000 population (all adults – aged 18 plus).

Data definition
Number of patients (acute and non-acute, aged 18 and over) whose transfer of care was delayed, averaged over the quarter. The average of the three monthly Sit-Rep figures is used as the numerator. The denominator is average number of occupied bed days.

A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed.

A patient is ready for transfer when:
i) a clinical decision has been made that the patient is ready for transfer AND
ii) a multi-disciplinary team decision has been made that the patient is ready for transfer AND
iii) the patient is safe to transfer.

To be effective, the measure must apply to acute beds, and to non-acute and mental health beds. If one category of beds is excluded, the risk is that patients will be relocated to one of the 'excluded' beds rather than just discharged.

Accountability
The ambition is to maintain the lowest rate of delayed transfers of care. Good performance is demonstrated by a consistently low rate over time, and/or by a decreasing rate. Poor performance is characterised by a high rate, and/or by an increase in rate.

Local Indicator

Safety incidents involving severe harm or death

Indicator description
Patient safety incidents reported to the National Reporting and Learning Service (NRLS), where degree of harm is recorded as 'severe harm' or 'death', as a percentage of all patient safety incidents reported.

Indicator construction
Numerator: The number of patient safety incidents recorded as causing severe harm/death as described above.

The 'degree of harm' for PSIs is defined as follows;
'severe' – the patient has been permanently harmed as a result of the PSI, and
'death' – the PSI has resulted in the death of the patient.

Denominator: The number of patient safety incidents reported to the National Reporting and Learning Service (NRLS).

Indicator format: Standard percentage.