Portsmouth CITY COUNCIL

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NOTICE OF MEETING

HEALTH OVERVIEW & SCRUTINY PANEL

TUESDAY, 6 DECEMBER 2016 AT 9.30 AM

THE EXECUTIVE MEETING ROOM - THIRD FLOOR, THE GUILDHALL

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If any member of the public wishing to attend the meeting has access requirements, please notify the contact named above.

Membership

Councillor Jennie Brent (Chair)
Councillor David Tompkins (Vice-Chair)
Councillor Alicia Denny
Councillor Leo Madden
Councillor Gemma New
Councillor Lynne Stagg
Councillor Brian Bayford
Councillor Gwen Blackett
Councillor David Keast
Councillor Mike Read
Councillor Elaine Tickell
Councillor Philip Raffaelli

Standing Deputies

Councillor Dave Ashmore
Councillor Ben Dowling
Councillor Hannah Hockaday
Councillor Lee Hunt
Councillor Ian Lyon

(NB This agenda should be retained for future reference with the minutes of this meeting.)

Please note that the agenda, minutes and non-exempt reports are available to view online on the Portsmouth City Council website: www.portsmouth.gov.uk

A G E N D A

1 Welcome and Apologies for Absence

2 Declarations of Members' Interests

3 Minutes of the Previous Meeting (Pages 5 - 12)

The minutes from the meeting held on 4 October 2016 are attached for approval.

4 Solent NHS Trust - Kite Unit, Falcon House and update on CQC inspection (Pages 13 - 64)

Kite Unite Report - Sarah Austin, (Chief Operating Officer and Commercial Director) Lesley Munro (Operations Director, Adults Southampton) and Sallyann Smith (Clinical Manager, Solent Neurological Rehabilitation Services) will present and answer questions on the attached report.

Falcon House report - Sarah Austin (Chief Operation Officer and Commercial Director) and Mark Paine (Service Transformation Manager (Child & Families) will present and answer questions on the attached report.

CQC inspection - Sarah Austin (Chief Operation Officer and Commercial Director) will answer questions on the attached presentation.

5 Learning Disability Transforming Care (Pages 65 - 70)

Beverley Meeson, West Hampshire CCG will provide an update of the Transforming Care Partnership within the Southampton, Hampshire Isle of Wight and Portsmouth (SHIP) area, and will answer questions from the Panel.

Mark Stables, Service Manager Integrated Learning Disability Service, will then present his report on what is happening locally in terms of transformation of Learning Disability Services and will answer questions from the panel.

6 Southern Health - update (Pages 71 - 92)

Julie Dawes Interim CEO and Mark Morgan, Director of Operations for MH, LD and Social Care will introduce the report and answer questions from the panel.

7 Portsmouth Safeguarding Adults Board Annual Report (Pages 93 - 112)

Robert Templeton, PSAB Chair will present and answer questions on the attached report.

8 CQC update (Pages 113 - 128)

Anne Davis, Inspection Manager will present and answer questions on the attached report.

9 Dates of Future Meetings.

For Members to note the dates of future meetings for 2017 as follows. All meetings will start at 9:30am:

24 January
7 March

6 June
19 September
21 November

Members of the public are now permitted to use both audio visual recording devices and social media during this meeting, on the understanding that it neither disrupts the meeting or records those stating explicitly that they do not wish to be recorded. Guidance on the use of devices at meetings open to the public is available on the Council's website and posters on the wall of the meeting's venue.

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HEALTH OVERVIEW & SCRUTINY PANEL

MINUTES OF THE MEETING of the Health Overview & Scrutiny Panel held on Tuesday, 4 October 2016 at 9.30 am in The Executive Meeting Room - Third Floor, The Guildhall

Present

David Tompkins (acting Chair)
Gwen Blackettl
Alicia Denny
Leo Madden
Philip Raffaelii
Lynne Stagg
Elaine Tickell

1. Welcome and Apologies for Absence (AI 1)

Councillors Jennie Brent and Gemma New sent their apologise for absence.

2. Declarations of Members' Interests (AI 2)

No interests were declared.

3. Minutes of the Previous Meeting (AI 3)

RESOLVED that the minutes of the meeting held on 26 July 2016 were agreed as a correct record.

4. Systems Resilience Group Plan - Update (AI 4)

Sue Damarell-Kewell, Programme Director introduced the report and added that:

- Monthly updates on the Systems Resilience Group are sent to the HOSP.
- The name of this group has changed to the Accident & Emergency Delivery Board and will contribute to improving delivery at A&E and across the board.
- The focus is on what happens now and in the future to ensure services are sustainable.
- It will ensure that senior leadership is in place as well as a leadership and development programme.

Rob Kemp, Area Manager, South West Hants, South Central Ambulance Service explained that:

- It is essential that all partners work together.
- The accurate early navigation of a patient to a safe, appropriate place is essential to their whole care pathway. If they are navigated to the wrong place at the start, they could end up at completely the wrong place.
- 50% of callers to the 111 or 999 service are directed to alternative places rather than the hospital through the hear and treat or see and treat processes. Some patients with non-serious complaints are transported to the hospital because alternatives are not available.
- The ambulance crews in this area do not have access to a directory of services yet.

- Regular reviews of the outcomes for callers are carried out.
- Forecasts of potential demand and types of conditions over winter have been calculated and staff rotas and processes aligned accordingly.

Rob Haigh, Executive Director, Emergency Care, Portsmouth Hospitals' NHS Trust added that:

- This has been one of the busiest summers for the Emergency Department.
- Overall attendance has increased by approximately 2% and elderly and frail attendees have significantly increased.
- The safety of patients remains a priority.
- The four hour target is important so that patients are treated appropriately and swiftly.
- The ED's four-hour performance has improved only minimally.
- Nationally the majority of ED are struggling to meet the four hour admission target.
- The ED's senior team has highlighted areas where improvements can be made in the processes and also infrastructure; work is underway to implement these.
- The NHS Improvement Team changed the ED's risk rating the previous week which means that it will have a more traditional overseeing role.
- The CQC made an unannounced two-day visit the previous week. Initial verbal feedback was that the the safety of patients had improved. However, the full written feedback is awaited.
- A significant number of patients are stranded in acute hospital beds because there is no alternative. This term covers both medically fit and delayed discharge patients. The trust takes a hands-on approach to managing these patients and is working constructively with its partners in social care, community care and mental health teams.
- The Frailty Interface Team prevents 5-6 admissions a day. This success has been recognised nationally.

Suzanne Hogg, lead for the integrated discharge services work stream explained that:

- The integrated discharge service went live last week and the five teams are now co-located at QA.
- The Discharge to Assess Model is being implemented in line with recommendations by the Emergency Care Improvement Programme. The process starts when the patient is assessment fit rather than wait until they are medically fit. This would ensure that access to support and assessments are in place when required and that the patient does not stay in a hospital bed longer than necessary. The longer a patient stays in bed the higher the risk that they decondition physically, mentally and socially and the less likely it is that they will be able to return to their homes.

In response to questions, they clarified the following points:

Experienced clinicians sit in on calls to 111 and 999 to aid with the Hear & Treat process. If there is any doubt as to the severity of the symptoms an ambulance is despatched. On the previous Sunday 18% of calls were heard and treated.

Sussex has an older population and is also a net importer of care. Providing care for older patients with more cognitive and physical conditions is a national issue. Screening for early stages of dementia is essential to prevent progressive decline.

There are many outstanding services at QA including cardiac and neonatal services. The excellent reputation encourages people from outside the catchment area to go there.

The Emergency Department is the new name for the Accident & Emergency Department. The brand ED is recognised by everyone and people frequently use it even though other alternatives are available.

Although the ED's performance has improved, there is still a way to go.

A programme for effective, community based care is essential. It is important that there are community hubs to treat minor illnesses and ailments.

The Sustainability Transformation Plan will review the needs and capacity of the Hampshire and Isle of Wight area.

Ambulances are permitted to use bus lanes in Portsmouth which enables them to reach emergencies quickly despite traffic congestion. The service is talking to other local authorities that do not currently permit this.

The Risk Summit reviewed the evidence that indicated real improvement had been made in patient safety at the QA's front door.

Queen Alexandra Hospital does not yet know whether the CQC has sufficient assurance to lift he enforcement notice. The initial feedback highlighted areas that were of concern e.g. outlying patients being treated in areas which did not normally provide that level of care. This was already on PHT's radar.

The issue of stranded patients continues to have a negative impact on the flow of the hospital.

Frail and older people fare better in their own environment. The IDS team are very positive about the new model of working which focuses on the re-ablement of patients.

There are social worker vacancies as it is proving challenging to recruit the right calibre and there is a national shortage. However, the panel was assured that work was continuing to try to fill the vacant positions.

There were high levels of waste in the discharge assessment process across Hampshire and Portsmouth. The new model of working is more collaborative and reduces duplication.

As shown on the data provided for this meeting, bed occupancy can be over 100% in a day because one bed can be used by more than one person in 24 hours.

A shortage of free beds can mean that fewer surgical interventions are carried out.

When Rob Haigh was trained it was normal for a patient to remain in hospital for 10-14 days after having their gall bladder removed. Now similar patients can stay between 12 and 14 hours.

One advantage of the assessment process starting sooner in the patients' journeys will be the identification of patients with cognitive impairment which will enable the appropriate level of assessment to be in place. Cognitive deconditioning is a significant contributory factor in delays to hospital discharges.

The government's approach to screening for dementia and care is an important factor in the wellbeing of the population.

The panel congratulated the officers for listening to their staff and for the improvements made across the board. Members agreed that information on this plan continue to be sent monthly and include both graphs and narrative.

RESOLVED that the panel continue to receive regular updates on the Systems Resilience Group Plan.

5. South Central Ambulance Service - update (AI 5)

Rob Kemp, Area Manager, South West Hants introduced the report and explained that:

- There has been an Increase in activity for 111 and 999 services locally and nationally. Reasons for this could include the increase in frail and elderly patients and freshers' week. Demand is expected to level off before increasing again in Winter.
- Locally the service receives an average of 2,000 calls per week.
- Patients classed as Green 30 are less poorly, but are often frail.
- The graph on page 35 of the information sent out with the agenda, shows a breakdown of long waits for green 20 and red 2 category calls. The left hand axis refers to the former category and the right hand one to the latter.
- Dispatched ambulances can be diverted to more urgent calls if required.
- Regular reviews are carried out into the treatment received for all calls and outcomes.
- The single highest risk identified is staff recruitment and retention.
- The service is prepared for the expected pressures in winter with amendments made to processes and staff rotas.
- A staff-led review of rotas is being carried out linked to best practice. This will include the removal of 12 hour shifts.
- Electronic Patient Records have been introduced. The service should be able to access the directory of services shortly.

- SCAS is a key part of the SRG team.
  Work carried out with a number of care and residential homes to build their resilience has proved successful resulting in a 30% decrease in calls from homes.
- As part of the Vanguard programme, paramedics work with GPs and undertake some visits under the guidance of GPs.

In response to questions from the panel, the following points were clarified:

- The clinician intervenes to decide on the necessary response to a 111 call that becomes a 999 caller not the system.
- Welfare checks are undertaken for patients waiting for an ambulance. Staff call the patients to check on their symptoms and can upgrade their response category if necessary. If they are upgraded, the clock does not restart.
- Ambulances are rotated for use in rural and city areas to balance out the mileage used. Different makes of vehicles are purchased so that if one has a manufacturer's fault, they are not all affected. There is a replacement programme in place. Some vehicles with lower mileage ones can be 59 or 60 plates and most others are newer. There are regular service checks plus six-weekly safety checks.
- They are fine with the fact that the use of jumbulances is prohibited at QA hospital. Handover delays at the ED may prevent an ambulance crew responding to another call. The jumbulance is used in Oxfordshire.
- It is sometimes difficult to determine if a call is a hoax. If there is any doubt, an ambulance is despatched.
- Levels of violence towards paramedics has remained stable over the last two years. There has been a decrease in calls from the night time economy since 2005. Most assaults are from vulnerable patients who have mental health issues. Staff are well trained in how to manage conflict and diffuse situations.

The patient congratulated SCAS for its recent CQC Good rating following an inspection.

RESOLVED that the update be noted.

6. Emergency Department, Queen Alexandra Hospital - update. (AI 6)

Peter Mellor, Director of Corporate Affairs introduced the report. As the department had been discussed under the previous item, there were no further questions.

7. Portsmouth Hospitals' NHS Trust - update (AI 7)

Peter Mellor, Director of Corporate Affairs introduced the letter from the Chief Executive which included a finance overview and added the following further information:

- The winter pressures may jeopardise the trust's ability to deliver its savings target.
- When hospital beds are taken up by stranded patients, fewer surgical interventions can be carried out. This has a negative impact on referral to treatment times and the trust's income.

- Applications have been received for the position of the new Chief Executive and a short list will be drawn up shortly. If the new Chief Executive is already working in the NHS, it may take up to six months before they can start work at Queen Alexandra Hospital.
- The flu strain currently in Australia is vigorous and as there is a tendency for them to come this way, he encouraged everyone to have their flu vaccinations.

In response to questions, he explained that:

- The new junior doctors' contract will be implemented. In his view, the British Medical Association made a strategic error when they tried to persuade members to move to a 5 day work to rule. This caused them to lose public and senior doctors' support.
- All trusts have been given some sustainability and transformation support. Portsmouth Hospitals' NHS Trust will receive £14.6m payable in arrears at the end of each quarter if targets are met. The targets for quarters 3 and 4 are at risk because of operational pressures.
- A significant amount of work has been carried out reviewing internal processes to make efficiencies. There have been no redundancies and there is no intention to make any. However, there have been changes to staff rotas which will result in positive impact for patients.
- Head hunters were engaged to assist with the recruitment of the new Chief Executive. NHS Improvement will be involved in the shortlisting of candidates and sit on the interview panel along with non-executive directors of the trust. Shortlisted candidates will present to a series of groups who will feedback to the interview panel. Portsmouth City Council could be represented on these groups.

8. St Mary's NHS Treatment Centre - update. (AI 8)

In response to questions from the panel, Penny Daniels, Hospital Director and Paul Fisher Service Manager explained that:

- Up to 200 patients a day are seen.
- They anticipate approximately 40 patients a day would previously have gone to the Guildhall Walk Healthcare Centre. They have not mapped where their patient group live.
- The waiting time is variable. The four hour target to be seen only once or twice a month and more often than not this is due to external factors such as awaiting patient transport or waiting to speak to a specialist at the acute trust who maybe in theatre at the time of the call.
- Feedback is gathered from every patient and collated monthly. Approximately 90% would recommend the unit to friends and family.

RESOLVED that the update be noted and that details of where patients travel from to reach the unit be brought to a future meeting.

9. Portsmouth Clinical Commissioning Group - update (AI 9)

Dr Elizabeth Fellows, CCG Governing Board Chair introduced the letter that had been sent to the panel. Then in response to questions from the panel she, Katie Hovenden, Director of Primary Care and Tracy Sanders, Chief Strategic Officer explained that:

- The Sustainability Transformation Plan (STP) brings together the activity that is planned across the area with one aspect involving smarter working between QA, Southampton General Hospital, Lymington Hospital and St Mary's Hospital on the Isle of Wight through the establishment of a Solent acute alliance.
- There will be an opportunity for consultation regarding any substantive changes set out within the STP.
- Future anticipated changes to the population has been estimated and incorporated into plans to inform how resources are allocated.
- Following the decision by Portsmouth City Council to cease funding to the Portsmouth Counselling Service, the CCG has provided non-recurring funding via a voluntary sector grant scheme. This has provided time for the organisation to look at their future model and sources of funding. Conditions of the grant include for all organisations to have a clear exit strategy for when the funding comes to an end. Unfortunately the Charity has not been able to find alternative funding sources during this period and is therefore proposing to close.
- Patients can access NHS counselling services through the Talking Change Programme which is provided by Solent NHS Trust. This service is funded for self referrals and s free to users. .
- A coalition of community pharmacies had written to the General Medical Council and the Care Quality Commission expressing their concern about the establishment and use of an internet pharmacy by a local GP practice group.
- NHS England is the commissioner of community pharmacy services and not the CGG and is responsible for ensuring that they fulfil their contractual obligations.
- The CCG has spoken to the practice involved to remind them of the risk of potential conflicts of interests.

RESOVLED that the update be noted.

The meeting ended at 11.40 am.

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Chair

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Solent NHS
NHS Trust

Briefing for Portsmouth Overview and Scrutiny Committee – December 2016
Proposal to relocate the Kite Unit from St James' Hospital, Portsmouth to Western Community Hospital. Southampton

1. Introduction

The Kite Unit, situated on the St James' Hospital site in Portsmouth, provides specialist neuropsychiatric and neuro behavioural services to people from a very wide area. The Unit on the St James' Hospital campus currently caters for level 1a and 1b acuity Neuro rehabilitation patients. This includes individuals with a brain injury whose impairments are largely in the cognitive, behavioural or mental health spectrum. Staff at the Kite Unit provide intensive and clinically specialised support for those who have a neurological condition which, when combined with other health and/or psychiatric needs, create significant difficulties or leads to the presentation of challenging behaviour. This cannot be provided in a community setting due to the complex needs of this particular group of patients.

The facility consists of 10 beds and the average length of stay is between 6 and 9 months.

Over time, it has become apparent that the current building which houses the Kite Unit, on the St James' site, is no longer fit-for-purpose. To ensure we can continue to deliver the very best possible care to our service users, we have considered alternative accommodation for the Unit.

Following an options appraisal it has become apparent that the option, which provides the maximum benefit to service users and staff, is to relocate the unit to the Western Community Hospital in Millbrook, Southampton.

This paper outlines the proposal to relocate services from the Kite Unit at St James' hospital in Portsmouth to the Western Community Hospital (WCH) in Southampton, and in doing so create a dynamic Neurological Rehabilitation Hub at the WCH. The WCH already houses core Neurological rehabilitation services including Snowdon ward, a 14 bedded neurological rehabilitation unit and specialist community and early supported discharge services. Rehabilitation , botulinum, orthotic and spasticity clinics also run from this site. Creation of the hub will allow for effective cross fertilisation of ideas amongst professionals to improve patient care.

2. Background to the proposal

The proposal to relocate the Kite Unit is built on a number of elements:

(i) Meeting quality standards

Whilst staff at the Kite Unit always maintain a high level of care for their patients, a previous inspection by the Care Quality Commission (2014) highlighted that the building which currently houses the Unit is not fit for purpose.

The presence of potential ligature points, the inhibited lines of site within the facility and ensuring compliance with single sex guidance has been the subject of on-going remedial works.

Providing safe, quality services is our highest priority. Whilst we have done everything we can to ensure a safe and equitable environment for our patients, the extent of works required, and the physical layout of the building, makes addressing these issues any further challenging.

In addition, whilst steps have been taken to ensure provision of compliant single sex accommodation, the layout of the building is inflexible and does not allow clinicians to maximise their estate resource, resulting in the inability to take more than two female patients at any time.

(ii) Development of a regional neuro rehabilitation service

It is our intention to be at the forefront of neurological rehabilitation provision across the Wessex region. There is a proven need for additional acute complex and specialist rehabilitation beds in Wessex and the region requires more musculoskeletal rehabilitation facilities, as well as viable neurological psychiatric facilities. We already deliver some of this provision and have the optimum clinical skills to develop a comprehensive regional neurological rehabilitation facility. To establish such a service requires the centralisation of existing services to create a specialist hub on which to develop and build further capacity.

The two options considered:

1) **Do nothing** – Continue to deliver neurological rehabilitation services from the Kite Unit on the St James' site.

   Whilst this option saves on capital expenditure, it fails to deliver the necessary environmental improvements required to safely develop the Unit and accommodate increasing demand for this kind of neurological rehabilitation service. The current estate also doesn't allow the service to develop in line with patient feedback i.e. patients have requested gym which would aid their recovery.

2) **Move the Unit to the Western Community Hospital site**

   The empty ward at the Western will involve some capital expenditure, but it will provide a fit for purpose location that can accommodate increasing demand for services and establish a clinical platform on which to develop a regional neurological rehabilitation hub. The Western Community Hospital also provides a better rehabilitative environment. As stated above, key clinical services have their base at WCH and there are rehabilitation facilities and clinics that can be accessed by Kite unit patients to enhance and optimise their rehabilitation journey.

3. Benefits of the proposal

- The co-location of the Kite Unit with Snowdon, Solent's 14-bedded neuro rehab unit, will facilitate improved efficiency, productivity and enhance clinical expertise and skills through improved supervision, training and operational cover.

- The estate will allow greater capacity flexibility of access. The service will no longer need to limit the number of female patients being admitted to two and will be able to accommodate up to 12 patients at a time.

- The Western Community Hospital offers a better environment for the rehabilitation of service users. The proposed ward for relocation has been used for older people with behavioural concerns

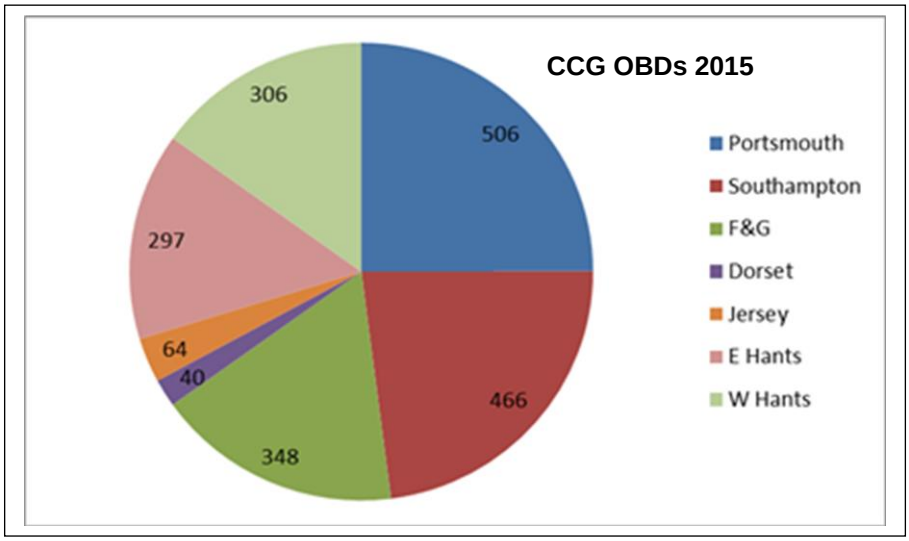
and so is an ideal environment for the client group as many anti-ligature features required are already in place. Patients will also have access to rehab gymnasiums and garden areas on the WCH site.

- The co-location would enable Solent to strategically develop the service as a specialist regional neurological rehabilitation hub. The creation of a HUB of service activity, and the creation of a platform and critical mass, gives a concentration of significant clinical weight. This will allow Solent to develop further service collaborations.

4. Impact on referrers, patients and carers

The services that Kite provide are predominantly commissioned by the following clinical commissioning groups (CCGs): Portsmouth, Fareham and Gosport Commissioning Group, Southampton, Dorset and North Hampshire

The pie chart below outlines the occupied bed days (OBD) of the Unit by respective CCGs for 2015. Patients are referred from across Hampshire, with a minority from Dorset and Jersey for specialist treatment.



	2015 number of patients by CCG	2016 to date (end Oct) number of patients by CCG
Southampton	4	3 (166 OBD)
East Hampshire	5	1 (305 OBD)
Portsmouth	7	3 (499 OBD)
West Hants	4	4 (642 OBD)
Jersey	1	0
Fareham and Gosport	3	1 (167 OBD)
Dorset	1	2 (276 OBD)
North East Hants	1	1 (32 OBD)
North Hants	0	1 (61 OBD)
Surrey Downs	0	1 (34 OBD)

5. Communication and engagement

We are proactively communicating and engaging about the move to ensure key stakeholders and local people and are heard when developing our proposals.

Our plan for communications and engagement has been shared with Healthwatch organisations in Southampton, Portsmouth and Hampshire. Further meetings were held with Healthwatch Southampton and Healthwatch Portsmouth to develop the plan.

Our programme of work so far has included engaging with current service users, their families and carers, and staff through a variety of means including group and face-to-face conversations. We have also informed key stakeholders about the move and have invited them to meet with us to discuss in more detail. We will continue with our engagment activity, including engaging with our membership base (7,000 public members) and members of the public.

6. Proposed timeframe

A draft project plan has been developed and high level timescales scoped:

Solent internal assurance and support	July – September 2016
Engagement and communication phase	September – End of project
Potential relocation	May-June 2017

8 Recommendations

Solent NHS Trust requests support for the recommendation to relocate the Kite Unit from St James' Hospital site in Portsmouth to the Western Community Hospital site in Southampton.

Subject: Battenburg Clinic / Falcon House Estates Rationalisation and creation of a Portsmouth Better Care Centre

1. **Purpose:**

To inform and seek views from HOSP on the proposal to relocate children and family services from the Solent NHS Trust owned Falcon House building on the St James' Hospital Campus in Portsmouth to the Battenburg Avenue site in Portsmouth, and in doing so create a co-located Better Care Centre for Child & Family Services.

2. **Anticipated Benefits**

It is anticipated the delivery of this relocation will achieve or contribute to the following proposed outcomes:

- Support integration of service lines and promote joined up working
- Promote more integrated working within services and drive efficiencies
- Contribute to the creation of a more financially sustainable staff structure
- Provide an improved and safer more compliant family environment
- Reduce the estate footprint and associated costs by vacating surplus property
- Deliver part of 16 / 17 Child and Family Service Portsmouth Business Plan

3. **Rationale for the development of a Portsmouth Solent NHS Trust Children and Families Better Care Centre**

Solent's Children and Families Service Vision and Strategy

Solent NHS Trust's Children and Families Service has a strategic vision to reduce health inequalities and improve child health outcomes.

There is increasing demand and complexity in presentations to the Service. The number of families in the most vulnerable and complex categories persist.

The current Children's Service Business Plan 2016/17 proposes to address this by delivering the right service, in the right place, at the right time, by the right person

- Integrated teams, that are trained and competent in the interventions they deliver in homes, schools, colleges and community assets;
- Working with our partners to achieve early intervention;
- The desired outcome will be that children, young people and their families will report that the service they received was what they needed, when they needed it and that they were treated with respect.

To achieve improved care for our service users we are developing integrated pathways.

Integration will be achieved through;

- Developing a Single Point of Access (SPA) which provides triage to enable enquirers to be directed to the most appropriate service to meet their needs, allowing early assessment, consistent operations standards and daily access to close connected children service pathways.
- An integrated 'front door' which simplifies referrals into Children Services Solent, using a multi-disciplinary team to triage and allocate work, enabling specialist supervision and support to staff in locality teams.
- Creating an integrated Better Care Centre for children & families in Portsmouth that brings together, in one place, the more specialised services we provide, such as CAMHS, Community Paediatric, Specialist Health Visiting and Paediatric Therapy services. Providing enhanced opportunities for multi-disciplinary assessment and treatment.
- Integrated Better Care locality teams delivering integrated care pathways for health and early intervention services.

4. Current Service Provision

Currently Portsmouth CCG's commissioned Child and Adolescent Mental Services (CAMHS) operate from Falcon House on the St.James' Hospital campus. This service includes a successful CAMHS Single Point of Access (SPA) process that offers clinically led triage for referrals into CAMHS.

A space utilisation study of the clinical rooms used at Falcon House has shown that these rooms are used for 47% of the possible time for clinical work in a typical week.

Portsmouth's CCG commission the Community Paediatric Medical Service, Paediatric Therapy services and Specialist Health Visiting services all of whom operate from the Battenburg Child Development Centre Clinic. (BCDC)

A space utilisation study of the clinical rooms used at BCDC has shown that these rooms are used for 25% of the possible time for clinical work in a typical week.

With some adaptations to clinical rooms at the BCDC site and the creation of a more open plan hot-desking environment for administrative functions, the BCDC site has the capacity to host all of these services and consequently support the development of integrated service delivery and pathways.

We are not expecting any adverse effect on car parking in the immediate vicinity as parking for staff and clients will be managed on site.

5. Solent NHS Trust's Strategic, Economic and Financial Rationale for Change

One of the key drivers for this proposal is the need to demonstrate financial responsibility and sustainability and seek reductions in the cost of Estate in support of this. This proposal seeks:

- To enable identified Child & Family Better Care Centre services to operate in an integrated manner as a result of the long term Child & Family service line development plan and structural service transformation that has been evolved over the last 2 years

- To comply with the broader Portsmouth Estates Rationalisation (Phase 2) work that is being undertaken, namely the rationalisation of estates owned by Solent NHS Trust on the St.James' Hospital campus
- To deliver Solent East Child and Family Service identified Cost Improvement Plans
- To support delivery of the NHS 5 year Forward View (holistic patient centred community care provision)
- To support the delivery of Estate Rationalisation through improved utilisation of existing Estate

10 year financial modelling

The table below shows a summary of the General Economic Model (GEM) for this business case, it shows the impact on the Income and Expenditure Account.

Option 1 will lead to an annual saving from 2017-18 onwards of initially £165k with margin increases each year after that. The aggregate saving over the first 10 years will be £1.468m.

Trust Name:	**Solent NHS Trust**										
Scheme Name:	**Falcon House Relocation to Battenburg Clinic - Portsmouth Estates rationalisation**										
Project Stage:	**Summary Business Case**										
Summary I&E Impact		**Total Cost 000s**	**Mar-16 000s**	**Mar-17 000s**	**Mar-18 000s**	**Mar-19 000s**	**Mar-20 000s**	**Mar-21 000s**	**Mar-22 000s**	**Mar-23 000s**	**Mar-24 000s**	**Mar-25 000s**
Option 0	Do Nothing - Remain in Current Falcon House Building	5,352	478	490	502	514	527	541	554	568	582	597
Option 1	Relocate to Battenburg Clinic	3,884	655	325	333	341	349	358	367	376	385	395
Net impact (I&E)												
Option 1	Relocate to Battenburg Clinic	(1,468)	177	(165)	(169)	(173)	(178)	(182)	(187)	(192)	(197)	(202)

6. Stakeholder Engagement

All internal and external stakeholders have been identified and a stakeholder engagement plan has been created to share plans and seek views of staff, service users, local residents, referring agencies, external partners and other interested parties. The engagement plan is available should this be required. Initial feedback from engagement activities is attached to the report.

7. Timeframe

The high level timeline for this project is;

August 2016	Business Case Approved
September – Dec. 2016	Stakeholder Engagement Period
October 2016	Estates Project Team initiated to deliver the project
January 2017 – May 2017	Redesign and building programme
June 2017	Launch of new Integrated Centre for Children at Battenburg Clinic

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Portsmouth Children's Better Care Centre Stakeholder Engagement

Responses to Survey Monkey (been open to staff for 63 days)

27 Responses at 21st Nov. 2016

Question 1	Tell us who you are?	Number
	Parent / carer	
	Child / Young person	
	Education Rep	
	Social Care Rep	
	GP/ healthcare representative	26
	VCS Rep	
	Member of the Public	
	Other	1 (staff)
	Total	

Question 2	What do you like about the way services are delivered at Falcon House?	Number of comments
Facilities	• Client friendly environment / welcoming / child centred / user friendly • Purpose-built • Always able to book a room • Range of therapy rooms / meeting rooms • Lay out works • Spacious • Outdoor play space • Spacious waiting area - good for anxious clients / parents	18
Location	• Convenient • Parking • Quiet / peaceful / nice • Secure	8
Staff	• Staff working together / in one place • Reception welcoming • Able to contact colleagues • Have their own space	5

Question 3	What do you like about the way services are delivered at Battenburg CDC?	Number of comments
Facilities	• Spacious • Good rooms with appropriate equipment • Inviting for staff • Child friendly / centred • Clinical & office facilities in one place - is efficient • Quiet small office spaces for dictation	9

Location	• easy accessible • Central to the community • free parking • Accessible for the north of the City / whole city • Not a hospital	8
Staff	• Multi-agency / disciplinary base • good liaison / communication between professionals • Decreases feelings of isolation • Services in one place working together • Joined up working / joint appointments - eg between therapies and specialist HVs • Staff & admin together	11

Question 4	What are the most important things that make attending appointments a good experience for children, young people and their parents/carers?	Number of comments
Appointments	• short waiting time • flexible appointment times / out of usual hours • privacy • on time / don't change • timely support • seeing the right professional • clear plans of what next for the child	14
Facilities	• Free / easy parking • Clean • accessible building • Waiting area good / well designed • modern • quiet spaces for clients • child friendly • indoor & outdoor play spaces • Suitable for all ages • spacious rooms • good therapy equipment / toys • Welcoming environment / inviting / non clinical	33
Location	• Accessible by public transport • central • easy to find / easy access	7
Staff	• Friendly / Welcoming • seeing right person at right time • Consistency of staff • Reception staff friendly • trusted professionals • happy staff • joined up services / teams • understand children's needs / communicative/ caring / knowledgeable/kind	21

Question 5	What improvements could be put in place to make children's and parents' experience even better at our new Centre?	Number of comments
Facilities	• Waiting area - adequate seating, age appropriate, light bright, children's artwork, information, stimulating but calming, teenage appropriate • Friendly, inviting environment, non-clinical - delivery rooms 'softened' not surrounded by medical equipment • Board to notify of waiting times • clinical Staff able to use office space for admin • More clinic rooms - so equipment doesn't need to be moved • Better IT • Good disabled access - children with complex needs • Same as Falcon House now • Outdoor therapeutic play area • Quiet rooms for dictation • Sufficient rooms of varying sizes for groups and meetings - e.g. TAC meetings • WIFI in waiting rooms for children & parents • Consulting rooms with comfy sofas for parents & children to sit close together • New centre needs to mirror what is available at Falcon House	20
Location	• adequate parking - big impact on clients attending if not good parking access • on public transport routes	4
Organisation	• Not too many appointments / clinics at same time • Better Booking systems - messaging clients & staff in timely fashion • easy for parents to contact the professionals • Open for early evening appointments • One point of contact	5
Staff	• Welcoming reception • Appropriate staffing levels • Admin / staff knowledgeable about clinical roles & services provided - additional training for them • Good liaison between clinical staff • Appropriate levels of admin support to clinicians	6

Question 6	The change of location of CAMHS clinics to the Battenburg Child Development Centre site will have an impact on me, my child or my organisation.	Number	impact
Strongly agree		52%	
agree		30%	
disagree		11%	
strongly disagree		7%	

Comments:			
facilities	• used to hot desking , just need good IT & appropriate chairs • The location itself will not be a problem so long as the facilities are available • Need to learn lessons about Southampton CAMHS move to avoid low morale	3	neutral
Organisation	• Improved opportunities for joint working / joint clinics, improved integrated between services e.g. CAMHS and therapies, CAHMHS on same site • Improved info sharing • Opportunities for relationship building and improved communications, professional discussions facilitated • Will provide high level service wherever we work	13	positive impact
Location	• Easier for staff that live outside of city or closer for them		
facilities	• Increased use of clinical rooms / pressure on booking rooms • Availability of hot desks / admin space (a concern) • Disruption during building works • Parking - pressure on spaces • Space for resources	27	negative impact
Organisation	• Less space to meet quietly with clients • Effect on working in a bigger admin team • Changes could have impact on families (no defined) • teams not able sit together		
Staff	• More change for staff		

Question 7	Solent NHS Trust Children & Families will be able to provide a better service for families by developing an integrated clinical delivery centre.	Number
Strongly agree		22%
agree		48%
disagree		22%
strongly disagree		7%
Comments:		
Neutral	• Unsure, will have to wait and see • Potentially but it depends on how teams work together it's not just about being in one place • Communication and referral pathways are key to this working - not just about co-location • Can't comment as don't know what it will look like • Would be useful to include Social Care staff • An integrated service (not a centre) will be efficient and better • The 2 locations provide excellent facilities, the delivery site would need to be increased in size to not loose facilities	

Positive	• Range of integrated clinical staff • shared experience and skills • quicker response • more joined up working • better communication & info sharing • As long as integrated teams are set up so that it works in practice • Fully support integration and the benefits for families • Being in one place saves money therefore staff • On the whole feel positive • Looking forward to closer working relationships with colleagues • Families have asked for a one stop shop • Joint clinics with a range of health staff • Fewer barriers between health care working
Negative	• Parking inadequate, space at a premium - not set up for mental health services • Concerns about enough space • Co-location does not improve the patient experience

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Solent NHS
NHS Trust

CQC inspection report
Report to Portsmouth HOSP

Honesty Everyone counts Accountable Respectful Teamwork

Solent NHS Trust:
Great care at the heart of our community

What are we proud of?

Solent NHS
NHS Trust

- Our ‘Outstanding’ LD services
- Our caring and compassionate staff
- Our research activities
- The way we work with other organisations
- Our work around new models of care
- How we learn from mortality reviews
- Our innovative practices
- Our Tulip Clinic
- Our end of life care services
- The feedback from parents and carers

Heat maps

Solent Community Services

Solent NHS Trust

	Safe	Effective	Caring	Responsive	Well-led		Overall
Community health services for adults	Requires Improvement	Good	Good	Good	Good		Good
Community health services for children, young people and families	Inadequate	Requires Improvement	Good	Requires Improvement	Requires Improvement		Requires Improvement
Community health inpatient services	Good	Good	Good	Good	Good		Good
End of life care	Good	Good	Good	Good	Good		Good
Sexual Health	Good	Good	Good	Good	Good		Good
Overall	Requires Improvement	Good	Good	Good	Good		Good

Solent Mental Health Ratings

Solent NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units (PICU's)	Requires Improvement	Good	Good	Good	Good	Good
Long stay/rehabilitation mental health wards for working age adults	Requires Improvement	Good	Good	Good	Good	Good
Wards for older people with mental health problems	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Community-based mental health services for adults of working age	Good	Good	Good	Good	Good	Good
Mental health crisis services and health-based places of safety	Good	Good	Good	Good	Requires Improvement	Good
Specialist community mental health services for children and young people	Inadequate	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Community-based mental health services for older people	Requires Improvement	Requires Improvement	Inspected but not rated	Good	Requires Improvement	Requires Improvement
Community mental health services for people with a learning disability or autism	Good	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding
Community Substance Misuse	Inadequate	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement

Heat map – Primary Care Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Portswood Solent GP Practice	Good	Good	Good	Good	Requires improvement	Good
Adelaide Health Centre	Good	Good	Good	Good	Good	Good
Royal South Hants Hospital - Nicholstown	Requires improvement	Good	Good	Good	Requires Improvement	Requires Improvement

Heat map – Overall Trust Rating

	Safe	Effective	Caring	Responsive	Well led		Overall
Overall	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement		Requires Improvement

End of Life Care

	Safe	Effective	Caring	Responsive	Well-led	Overall
End of life care	Good	Good	Good	Good	Good	Good

- Good leadership, strong vision and focus on patient centred care
- Safety rated as good
- Effective care and treatment
- Evidence-based practice.
- Effective multidisciplinary working
- The care provided was good.
- Patients were truly respected and valued as individuals and were empowered partners in their care.
- Feedback from patients, relatives and carers was consistently positive and there were many examples of staff going 'above and beyond' when delivering care

However

- Need to monitor rapid discharge of those expressing wish to die at home
- Review quality of MCA assessments *
- Improve record management *

Community health inpatient services

Solent NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health inpatient services	Good	Good	Good	Good	Good	Good

- Staff understood their responsibilities to raise concerns and report incidents, and evidence learning occurred as a result.
- Staffing levels were sufficient to provide safe care.
- Staff provided care and treatment that took account of nationally recognised evidence based guidelines and standards.
- Patient pain was managed effectively, and patient's varied dietary and nutritional needs were met.
- The trust took part in national and local audits to measure and promote improved outcomes for patients.
- Staff had a good understanding of their responsibilities to the Mental Capacity Act and applied it appropriately when caring for patients who had reduced capacity and cognition.
- There was a strong emphasis on multidisciplinary working across all inpatient wards.
- Nursing and medical staff were caring, compassionate and patient centred in their approach..
- There was a clear governance framework to monitor quality, performance and risk at ward level

However

- Pressure from PHT on admission criteria in Spinnaker
- Time to complete mandatory training
- Medicine * and equipment storage
- Access to social services
- Access to interpreter services *

Community health services for adults

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community Health Services for Adults	Requires Improvement	Good	Good	Good	Good	Good

- Responsive teams working collaboratively to meet their patients' needs.
- They provided care close to or within the patients' home environment, thus reducing hospital admissions.
- Staff used comprehensive holistic patient risk and care assessments,
- Patient and their families received compassionate, focused care, which respected their privacy and dignity. Without exception, patients we spoke with praised staff for their kindness, caring and empathy.
- Most formal patient feedback was positive, although where there were complaints; clear action plans were in place.
- Community services for adults provided care based upon the latest national guidance from the National Institute for Health and Care Excellence (NICE).
- Well-established multidisciplinary team (MDT) working across all the teams we visited.
- Staff had mandatory training and most had had appraisals and access to personal development.
- The trust had actively engaged staff in agreeing values to support the trust vision and strategy.

However

- City differences and inequity
- Staffing pressures - need to ensure safe levels *
- Pressure ulcer rates *
- Using the new health record and access to IT equipment *
- Wheelchair provision and access to community equipment *
- Staff awareness of and use of duty of candour *
- All facilities have emergency alarms *

Acute wards for adults of working age and psychiatric intensive care units (PICU's)

Solent NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units (PICU's)	Requires Improvement	Good	Good	Good	Good	Good

- Comprehensive and mostly person-centred assessments on admission.
- Physical health assessments took place on admission.
- Good multidisciplinary team input in to patient care from a number of professionals across both wards.
- Mental Health Act documentation was complete across both wards. Staff adhered to the principles of the Code of Practice.
- Patients told us staff were caring. They had access to advocacy and information on their rights.
- We observed warm and professional actions on both wards despite the staff being under pressure.
- Patients could access information easily about treatment and support.
- Patients' needs were respected with regard to food, cultural and their spiritual needs. There was good access to interpreters
- Managers were available to staff. Despite the high acuity of patients and increased risks in previous months, staff had maintained fairly good morale and told us they felt supported by their leaders.

However

- Potential ligature points in the enclosed gardens of both wards. *
- On Maple ward there was no clear segregation of male and female bedrooms. *
- Reporting safeguarding concerns on Maple ward in care plans *
- Time for training and supervision
- DTOCs; forensic and housing

Community-based mental health services for adults of working age

Solent NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community-based mental health services for adults of working age	Good	Good	Good	Good	Good	Good

- Managers were aware of staff caseloads and adjustments were made to take account of the complexity of patients.
- Patients who required regular blood checks to ensure maintenance of therapeutic levels of medicines, attended clinics run by the "wellbeing" staff.
- Care plans were up to date, personalised, holistic, recovery orientated and included evidence of ongoing physical care, informed consent and appropriate consideration of mental capacity.
- Staff had a very good understanding of the needs of their individual patients.
- Staff were committed to patient care and care was patient centred.
- Staff were responsive to patients' needs and able to demonstrate how they could draw on increased support from colleagues if required.
- There were clear care pathways dealing with access and discharge to the community teams.
- Staff were overwhelmingly positive about the culture of the teams which they described as mature, supportive and very open. They also felt supported by line managers and colleagues.

However

- L shaped interview rooms and lack of visibility
- More break away training

Long stay / rehabilitation mental health wards for working age adults

Solent NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay/rehabilitation mental health wards for working age adults	Requires Improvement	Good	Good	Good	Good	Good

- Staffing levels were good and there was a good sense of relational security.
- Good morale amongst the staff, and a sense of team spirit. Leadership and development were encouraged and there was a team approach to service development.
- The ward was clean. Furnishings were in good order and the ward was well maintained.
- Staff used de-escalation techniques to reduce the need for restraint.
- Patients had a comprehensive assessment on admission, which included mental and physical health. On-going assessment was evident.
- Staff received management and clinical supervision, staff appraisals were carried out.
- There were good working relationships with the community teams and the acute and PICU wards that were located on site.
- All patients we spoke with told us that staff were caring and kind.
- Patients told us they were included in discussions and decisions relating to their care and treatment, and we observed a strong culture of promoting independence and rehabilitation.
- The ward had had a sufficient number of beds to meet the needs of patients from the catchment area. Discharge was well planned.
- Staff told us they felt supported by their immediate managers.
- Morale was high, with a low turnover of staff. There were opportunities for staff to develop their skills.

However

- Non collapsible curtain rail remove and complete all other anti-ligature work *
- Mandatory training missing elements

Mental health crisis services and health-based places of safety

Solent NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Mental health crisis services and health-based places of safety	Good	Good	Good	Good	Requires Improvement	Good

- There was a range of psychological therapies available to patients using the crisis and home treatment service.
- Staff of the crisis and home treatment service told us they were well supported and had a good induction to the services.
- Patients we spoke with told us that the staff were respectful and staff reported morale as high.
- The crisis team had daily multidisciplinary meetings (Monday to Friday) to discuss patients and update risk assessments. Detail and quality was good in most of the care records we reviewed.
- The crisis team had access to a full range of mental health professionals and had non-medical prescribers.
- The crisis team had capacity to respond to routine and urgent referrals and all patients were visited within target times.
- Staff acted in a kind and respectful manner with patients. The patients we spoke with all said staff were supportive.
- All staff we spoke with were enthusiastic and caring.
- Patients were involved in recruiting staff. And could give feedback as part of a patient forum.

However

- Address deviation from multi agency policy on HBPOS *
- HBPOS stark
- Governance systems to monitor care in HPBOS *
- Time for training and development *
- Copies of care plans for clients

Specialist community mental health services for children and young people (Portsmouth)

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for children, young people and families	Inadequate	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

- Risk assessments, care plans, crisis plans all comprehensive
- Supportive staff
- Good team working including multiagency
- Foster and parent feedback positive
- Staff spoke respectfully of young people
- Portsmouth CAMHS was well staffed with a 2% vacancy rate
- Clear arrangements for cover arrangements for sickness, leave, vacant posts to ensure patient safety.
- Crisis plans were completed and well integrated into their work.
- Mandatory training 95%

However

- More user involvement in service needed
- Internal waits
- Risk assessments, crisis plans, care plans completed *
- Training to undertake the role*
- Access to unsafe areas*
- Effective governance systems including waiting list management *

Community health services for children, young people and families

Solent NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for children, young people and families	Inadequate	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

- There is a well -established children's outreach assessment and support team (COAST) service in Southampton and Portsmouth.
- The interactive "Trache bus" is an innovative service which was available to children living in Portsmouth.
- In the clinics, medicines such as vaccines were stored safely and in line with guideline to maintain the cold chain.
- There was an effective process for safeguarding children which included safeguarding supervisions for staff.
- Staff adhered to infection control procedures to minimise of the risk and spread of infection.
- Records were stored safely and securely, although access to records was variable due to IT issues
- The duty of candour process was applied as required which included evidence of action taken information being shared with the relevant people.

However

- Urgent equipment such as suction machine must be available in schools *
- Medicines are administered and stored safely in special schools and protocols followed *
- Staffing is reviewed and there are adequate staff to deliver the healthy child programme, health visiting and school nursing services. *
- Robust processes are developed for identifying risk and monitoring quality across all services particularly school nursing.*
- Staff receive training and appropriate supervision and their competencies are assessed re extended roles*

Wards for older people with mental health problems

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for older people with mental health problems	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement

- Staff were caring and committed to delivering a positive patient experience. Patients told us that they felt safe on the ward.
- Physical health monitoring was completed on admission and routinely thereafter. Care plans were up to date, comprehensive and patient focused.
- Best practice with regards to prescribing was being adhered to. Covert medication was being managed well.

However

- Safeguarding procedures were not always being adhered to with regards to patient on patient assaults. *
- Staff did not know where the ligature cutters were or what they were used for. *
- Some ligature risk and control measures were missing from the annual audit tool.
- Staff were not adhering to best practice with regards to mixed sex environments or following local safety procedures- there was no separate female lounge in the smaller eight bedded area. *
- Confidential information was not stored securely. *
- Mandatory training issues
- There was a lack of oversight by senior staff on the ward with regards to resuscitation procedures, safeguard reporting and managing mixed sex environments. *

Community - based mental health services for older people

Solent NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community-based mental health services for older people	Requires Improvement	Requires Improvement	Inspected but not rated	Good	Requires Improvement	Requires Improvement

- Patients were seen within six weeks of referral in accordance with the guidance from the National Institute for Health and Care Excellence.
- The team took a proactive approach to re-engaging with people who do not attend appointments
- The waiting areas and clinic rooms were welcoming and comfortable
- We saw the information pack that staff gave to people using the memory clinic. It contained a good range of literature, including information how to complain
- We observed some examples of reasonable adjustments that staff had made so there was disabled access
- The carer we spoke with told us they knew how to complain. They were able to describe the complaints procedure and all said they felt confident that staff would act upon this if needed
- Caring not rated……. We observed warm interactions with a patient and carer in the clinic setting and staff demonstrated professionalism
- We spoke with one patient and their carer, they were very positive about the treatment they received and described staff as very helpful friendly and polite.

However

- Carry out physical health checks in line with guidance *
- The staff member who managed the memory service had a caseload of over 600 patients. Therefore, patients did not receive six monthly reviews of their medication in line with national guidance. *
- Staff did not follow the trust's policies and procedures when managing medicines. Therefore, staff did not manage medicines in line with current legislation and guidance, including those related to storage and transportation.
- Staff told us that they managed risk and investigated incidents. However, at the time of the inspection staff could not provide any records of risk assessments, incident reports or audits of these records..
- Leadership to have access to policies procedures and documents *
- Electronic care records were of inconsistent quality.
- Care records did not describe how staff involved patients in making decisions about their care
- Statutory and mandatory training issues
- The clinic did not have hand-washing sinks in the consultation rooms and had not completed an environmental risk assessment

Community Substance Misuse

Solent NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community Substance Misuse	Inadequate	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

- There was emergency equipment that staff regularly checked and emergency procedures in place.
- Although staff in the Southampton service did not document interventions clearly, we did see some positive outcomes for clients in some of the care records.
- Clients in both services had good initial assessments, risk assessments, access to psychosocial interventions and social support in both locations.
- Most clients told us they felt respected and the teams were caring.
- Staff attitudes were positive towards clients in both locations.
- We observed kind and respectful interactions between staff and clients.
- Clients told us they understood their rights regarding confidentiality and sharing of information.
- We saw good examples of client involvement in recovery care plans in both locations.

Community Substance Misuse

Solent NHS Trust

However there are a range of concerns about the Southampton service despite the Portsmouth service performing well.

- The trust must ensure that staff in the prescribing services review prescriptions regularly and policies are in place clearly outlining staff responsibilities in this.*
- The trust must ensure that staff are supported effectively to monitor and manage caseloads.*
- The trust must ensure that staff complete all safe storage visits for clients with children, and embed a system to identify which new clients starting treatment need a home visit. *
- The trust must ensure that all clients have a prescribing care plan in place.*
- The trust must ensure that there are sufficient staffing levels to safely manage and review clients who are in receipt of prescriptions.*
- The trust must ensure that both services have signed patient group direction forms (PGD).*
- The trust must ensure that staff undertake clear discharge planning for all clients accessing the
- prescribing service. This includes those clients who routinely do not attend appointments or who disengage.*
- The trust must ensure that managers add all risk items to the service risk register on an on going basis.*
- The trust must ensure that staff attend mandatory training.*

Community mental health services for people with a learning disability or autism

Solent NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community mental health services for people with a learning disability or autism	Good	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding

- Staff truly respected and valued service users' as individuals and aimed to empower them to achieve what they wanted to.
- All staff had a focus on the individual in what they did, with an ethos of enabling service users'.
- The service was focussed on the needs of the people using it and valued their participation in their care. Leadership within the service drove a positive, valuing and learning culture that staff thrived in.
- The service was innovative in developing new approaches to care and was responsive to the needs of service users'. These were developed collaboratively with people using the service.
- Capacity and consent were carefully considered in all interventions. Interventions followed best practice guidance and latest research which the service regularly reviewed.
- Governance arrangements were exemplary. The service had excellent learning from complaints and incidents
- The service continually reviewed best practice and national guidance and how it could be applied to the service. The service worked hard to gain feedback from people using the services in different ways and then acted on it.

However

- Could improve consistency of risk assessments

Solent NHS Trust

Take more opportunities to share and learn between cities

Review of resource to deliver Healthy Child Programme

Ensure training methods always appropriate and accessible

Improve the involvement of service users

Improve access to forensic services

Improve standards of OPMH services

Supporting staff and managing workload

Deliver improved substance misuse services

Action taken / action plans

A number of action plans were put in place immediately after the Inspection in July.
These were specifically related to:

- Substance Misuse
- CAMHS (Southampton but with applied learning)
- Brooker Ward
- 136 suite
- Mary Rose School

Verbal feedback during the inspection initiated a number of action plans under weekly monitoring.
The final reports also contain additional must/should actions that are now being actioned and tracked

Multi-agency opportunities for learning

- Caseloads/ demand and capacity - health visiting, school nursing, OPMH community, SMS Soton, Paed continence., CAMHs waits, Spinnaker pressure
- Staffing pressures of above impacting on time for learning and supervision and time for case conferences
- DTOCs and delays in fast track and access to DoLs
- Differential commissioning; 136, EoL
- Wheelchairs and access to community equipment
- Complex commissioning structure; Soton SMS
- Forensic provision

Today you would see

Solent NHS Trust

A growth in our learning culture as a result of our CQC experience

A sense of pride

Staff settled into new locations	**Successful bid for sexual health services**	**Cohort 2 of Quality Improvement Programme**
Improved staff engagement (3.82/5)	**Great Place to Work Programme**	**Expanded and advanced staff communication**
Less vacancies	**Sound finances**	**Improved IT functionality**

Solent NHS Trust

Solent's vision is to provide great care, be a great place to work and deliver great value for money

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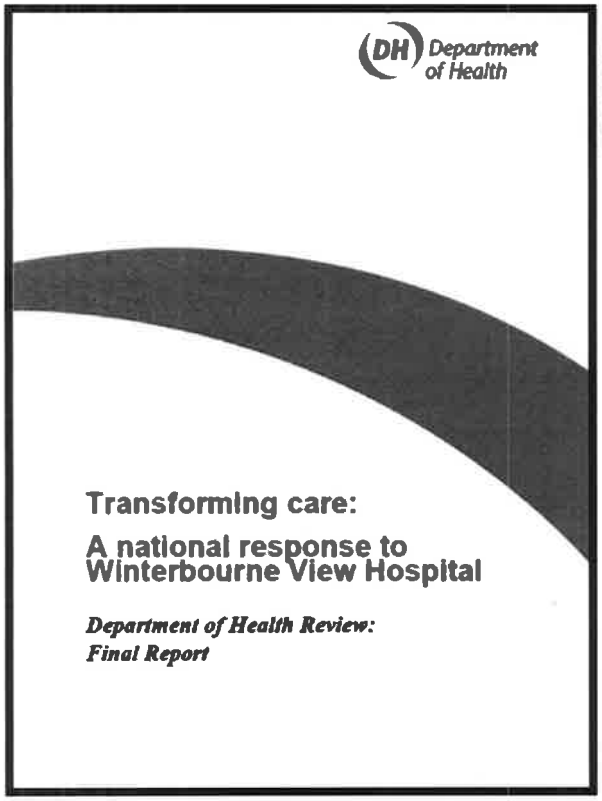
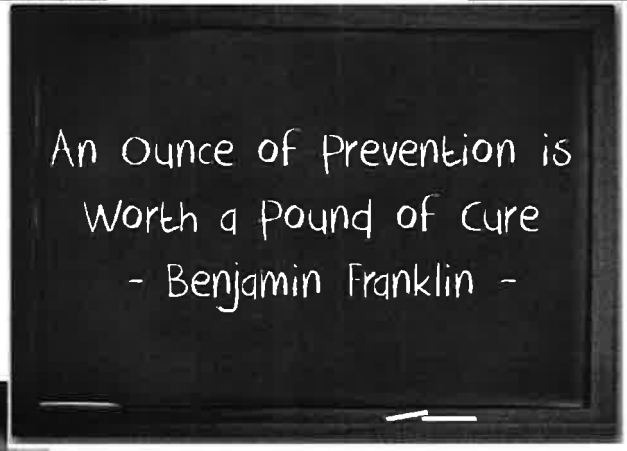
Southampton, Hampshire, Isle of Wight & Portsmouth Transforming Care Partnership



Our Ambitions



What are we doing in Portsmouth? - Transformation Programme

There are 6 key elements of the Transformation programme - all overlap and together offer a coherent approach. It will deliver cost effectiveness and better outcomes for people.

Not Using Hospitals

- We have 7 people in hospital (specialist hospitals)
- By March 2017 we expect to have only 2 people in hospital
- We have a team to support and keep people in the community
- We know who is a risk of admission and we support them more closely

Health

- We have an excellent Liaison Team at Q A hospital
- Every G P surgery has a Link Nurse
- Health facilitation training is available to all providers
- There is a local “health equalities” plan across all health service
- We support people to have Health Action Plans

Day Services

We have de- commissioned 66% of the in-house service and much of the independent sector provision and re commissioned services that focus on the 4 Preparing for Adulthood outcomes:

- Work
- Health
- Independence/Learning
- Relationships and Community

We have replaced 'block contracts' where we agree to pay a provider a fixed amount with individual budgets so people can change their service and the money moves with them. This approach works together with the introduction of a named worker for all service users and a focus on a support plan that identifies clear long and short term, aspirational outcomes for people. We have moved from a Supermarket model of provision where Day Centres try and do everything to a High Street Model where you go to a particular place for a particular purpose and the focus is on independence and personal development.

We are currently reviewing services for people who would be described as 'at risk' under Transforming Care. We will look to integrate into other services where we can and provide specialist provision where we are unable to.

Transition

Transition is a perennial concern for young people and their families. Since the Children's Act statements have been replaced by Education Health and Care Plans which from the age of 14 should focus on the 4 Preparing for Adulthood outcomes. We have dedicated Transition Workers within the integrated Team and as a National Demonstration site are tackling 3 issues:

- Making sure that EHC Plans identify and support achievement of aspirational PfA outcomes.
- Using information from planning to inform commissioning particularly for people who may 'fall between stools' for example people with autism
- Working with Colleges to make sure transition in and out of College is smooth and that we work together under the umbrella of the EHCP

The re-design of Day Services supports the PfA focus

Housing and Support

In 2013 we set a target to reverse the residential care/supported living ratio 40(SL)/60(Res Care) and we have done that. But often Supported Living is only understood as a service type and we need to make sure that people have as much choice and control as possible and that they are supported to be independent. The Local Government Association is clear that pressure on LD budgets is greater than on any other Care Sector and that the only sustainable approach to tackle this is by supporting people to be independent and part of their Communities

We are addressing 4 key questions

- How do we expand the range of housing and support options?
- How do we support people to explore what is right for them?
- How do we decide what is 'good' and how will we measure it?
- What are the rules around development?

We have had 2 stakeholder conferences to look at this and work is being led by a sub group of the Partnership Board that service users and carers are part of.

Our excellent collaborative relationship with Housing means that we can provide changing options and currently 5 significant housing developments are underway

Respite

Currently the basic offer is Russets a residential Care Home. It is expensive, it doesn't reflect the range of respite options that people want and it is expected to accommodate emergency placements and a range of needs often which are incompatible. So we are looking to move from a one stop shop to offer a menu

- Gig buddies
- Outreach Support
- Holidays
- Shared Lives

We have converted 2 houses to support emergency placements and provide for people who need a smaller quieter environment. This will be financed by ceasing independent sector respite, reducing cost of staffing that was required because of the unsuitability of Russets for some and by use of Russets by other Agencies.

Integration

We have an exceptionally able and committed integrated team made up of Nurses, Social Workers, Psychology, Occupational Therapists, Speech and Language Therapy, Psychiatry. Integration is often a challenge but works well. CQC have just rated the Service 'Outstanding' which they have stated is not the case in any LD Team in the UK. We have introduced single line management and a Named Worker system. This reflects an asset based approach. Using a Support Planning tool the Team developed, we focus on key outcomes - the things that matter to us all and proactive engagement and planning. This has meant we spend less time attending to what is not working. It also means that when opportunities occur because of the relationship and knowledge the Named Worker has referrals are readily forthcoming.

Collaboration

The sixth theme is about doing things together. In terms of Carers - for example - we provide regular meetings and Newsletters. Carers welcome the Named Worker approach and the consistency of someone they know. All new contracts require that providers involve Carers and Service Users is measuring the quality of that service and support Carers and Service users to have their say. We have recently trained Service users and Carers to 'enter and View' for example Stakeholders are also involved in the design of services whether that's sitting down with architects plans or advising re colour schemes and furnishings.

We also see providers as partners and have a provider forum and maintain regular contact. We encourage Named Workers to get to know providers well.

This all comes together in the Partnership Board which has a very collaborative feel and which monitors the transformation programme as well as being the conduit for stakeholder views.

Mark Stables 23.11.16

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Southern Health NHS
NHS Foundation Trust

Portsmouth City Council
Health Overview and Scrutiny Panel
November 2016

Southern Health NHS Foundation Trust: Update on progress following the Mazars & CQC reports

Background

Southern Health NHS Foundation Trust provides Mental Health, Learning Disability, Community and Social Care services in Hampshire and Learning Disability services in Oxfordshire.

The independent Mazars review in December 2015 found that the Trust's processes for reporting and investigating deaths of people with learning disabilities and mental health needs could have been better, and that families weren't always involved as much as they could have been.

The report looked at the way the Trust recorded and investigated deaths of people with mental health needs and learning disabilities who had been in contact with Southern Health at least once in the previous year, over a four-year period from April 2011 to March 2015. The report did not consider the quality of care provided by the Trust to the people we serve.

In January 2016 the Care Quality Commission (CQC) undertook a follow-up inspection of Southern Health NHS Foundation Trust. This was to review the actions taken since the CQC's comprehensive inspection of the Trust in October 2014 and to examine the Trust's processes for investigating and reporting deaths following the publication of the Mazars report in December 2015.

On 6 April 2016 the CQC announced that it had issued the Trust with a warning notice, highlighting further improvements that needed to be made to our governance arrangements. The full CQC inspection report was published on 29 April.

During September 2016 the CQC undertook a follow up inspection, and the Trust has since been informed that the CQC intend to lift the warning notice.

Mazars report: actions and progress (Appendix A)

SIRI process

- A new oversight process for serious incidents requiring investigation has been established. This new process has greater oversight from the Trusts Executives, including formal sign off of each report, which has led to improvements in the quality of the investigation reports.
- A central investigation team now takes the lead on investigating serious incidents. The team have been fully trained using external experts.
- A new policy for investigating patient deaths has been implemented and this is now reported to commissioners in the weekly governance flash reports.

As a result, SIRI completion rates within the 60 days have improved from approximately 20% in February 2016 to 94% in September 2016. It should be noted, however, that bereaved families are not always able to participate in investigations whilst still grieving. It is important that families are able to input into investigations when they are ready to do so, even if it's outside the 60-days timeframe.

Deaths are now subject to a review within 48 hours with a target of 95%. An audit is performed every month to evidence the rationale for the decision to report as a serious incident or not. CCGs now receive initial reports at 72 hours post incident; these address the immediate actions to address risks.

Patient and Family Engagement

- A Family Liaison Officer has been recruited (starting in December) to support families throughout the serious incident investigation process, and a member of the public has been recruited to attend the Mortality Working Group.
- The Trust has commissioned an independent review of family involvement in investigations conducted following a death at Southern Health. The review highlighted the lack of communication with families as a key issue, and identified the need for a culture change across the organisation towards recognising the importance of family involvement in the care of loved ones. The Trust is currently developing an action plan to address the recommendations made in the report, which will be shared with families and wider stakeholders within the next few weeks.
- Julie Dawes, Interim CEO, is currently meeting with families who feel very strongly about the Trust in order to listen to their individual concerns and understand their individual stories and backgrounds.
- An Interim Head of Patient Engagement and Experience has been appointed to oversee and co-ordinate the development of local and Trust-wide plans for patient involvement.
- A review of the way the Trust is handling complaints is being conducted, with members having been invited to become part of the review group to share their experiences with the Trust and help redesign the process.
- During November, the Trust supported the national #hellomynameis campaign with its own campaign to embed the practice of introducing themselves to patients, carers and colleagues amongst all staff across the Trust.

CQC report: actions and progress (Appendix B)

During September the CQC undertook a follow up inspection across many of our sites and we have been told by the CQC that the warning notice will be lifted.

The most recent National Community Mental Health survey, which is conducted annually amongst patients and staff across the UK, shows that Southern Health has made significant progress in many areas, including crisis care and support and wellbeing. Our rating of the overall experience is above the national average.

A new project management approach to monitoring and reporting progress against the delivery plans has been set up, enabling the Trust to track progress much more efficiently. Detailed action plans are included as appendices C and D.

In recent weeks, efforts by the Trust have focused on embedding stringent quality management processes across the Trust, and on developing consistent and sustainable patient, family and staff engagement in all Divisions that are aligned to central activities.

Estates improvements

Following the appointment of a ligature manager, who oversees and advises on ligature risks and addressing these appropriately, site specific environmental work plans have been developed for all MH/LD inpatient units, which include actions arising from ligature risk assessments, site visits, and staff feedback. On their recent visit, the CQC acknowledged that there was a good working relationship between Estate and clinical staff and that information sharing had improved.

The majority of patient safety risks specified in the CQC report have been addressed, including the installation of anti-roll guttering on the roof of Melbury Lodge. Further work on Kingsley Ward at Melbury Lodge commenced on 14 November to improve patient safety and experience.

Quality Improvement Strategy

- Southern Health NHS Foundation Trust has begun to implement a one-year Quality Improvement Strategy developed to align quality priorities with the Trust Operational Plan.

- A new Divisional Quality Performance Reporting framework has been launched to ensure clear ward to Board visibility of quality performance. A Trust-wide Quality & Safety Pack, which reports against the key CQC questions (safe, effective, caring, responsive, well-led), shows Trust quality and safety measures in detail down to Directorate level across the Trust. This is supported by a new quality meeting structure and agenda framework and a senior nurse weekly ‘Back to the floor’ programme.
- Furthermore, a new Business Partner approach is being introduced to the Central Quality Governance Team to strengthen the links and accountability lines between the central team and divisional quality structures, with roles currently being recruited to.

Staff engagement

We have put a number of initiatives in place to support staff through this challenging time and increase staff engagement.

- Our ‘Your Voice’ facility gives staff the opportunity to contact the executive team with questions, concerns or suggestions (anonymously if desired) and receive a reply within seven days. Responses are made public.
- We have also appointed a Freedom to Speak Up Guardian – an independent role dedicated to supporting the Trust to become a more open and transparent place to

work by listening to staff and supporting them to raise concerns. Our aim is to create an open and listening culture where patient and staff views contribute to the running of the organisation.

- A review of staff feedback mechanisms is underway to determine whether there are sufficient processes in place for staff to escalate matters beyond their line manager.
- We have increased 'back to the floor' days by senior managers and are reviewing our supervision policy.
- Our Interim CEO Julie Dawes has put in place a series of dedicated events across the Trust aimed at listening to staff's views and concerns and answering questions.

Leadership

Following the announcement in August that Katrina Percy was to take on a regional strategic advisory role, we received correspondence from the public, patients and families expressing their concerns. Both the Trust and NHS Improvement believed it was no longer possible for Katrina to continue in her new advisory role and we worked with NHS Improvement to come to a settlement where Katrina left Southern Health on 7 October with immediate effect, to pursue other opportunities.

In September Tim Smart took the decision to resign from his post as Interim Chair for personal reasons.

On 3 November Alan Yates was appointed as Interim Chair of Southern Health. Alan has a 36 year track record of leading NHS providers of mental health and community services and has been working closely with us as Improvement Director since April 2016. As Interim Chair, Alan will lead an important review of our clinical services. The review will consider how our services need to change in the future to best meet the needs of the people we serve. We are working together with people who use our services, their families and our staff to ensure that a range of views and ideas are heard.

Julie Dawes, who joined the Trust as Director of Nursing and Quality in May 2016, has since stepped up as Interim CEO until a new substantive CEO has been recruited. Julie is supported as and when required by Dr Matthew Patrick, Chief Executive Officer at South London and Maudsley NHS Foundation Trust, and Jon Allen, Non-Executive Director and former Director of Nursing at Oxford Health.

The executive team led by Julie Dawes is committed to having an open and listening culture where patient, staff and member/governor views contribute to the running of the organisation.

The current leadership team at Southern Health:

- Chris Gordon, Chief Operating Officer, and Sandra Grant, Director of People and Communications, are both currently on secondment. Chris is working with NHS Improvement but is still involved in our incident review processes during this period. Sandra is leading on strategic workforce development across the region as part of the emerging Sustainability and Transformation Plan (STP) for Hampshire and the Isle of Wight.

- Jane Pound, a highly experienced human resources professional, is acting Director of People and Communications during this period.
- Sara Courtney is acting up as Director of Nursing and AHPs whilst Julie fills the Chief Executive role.
- Mark Morgan (Director of Operations MH, LD and Social Care) and Paula Anderson (Director of Finance) have joined the team on a permanent basis.
- Chris Ash will concentrate on Strategy, particularly leading STP and Better Local Care, Gethin Hughes will become Director of Operations over both ISDs and Children's Services, and Paul Streat will concentrate on Corporate Governance.
- Dr Lesley Stevens retains her position as Medical Director.

Future work

A four month review into our clinical services began in October 2016. The purpose of this is to understand how our services should be configured to best meet the needs of local communities in the future. We are working together with people who use our services, their families and our staff to ensure that a range of views and ideas are heard.

This work will focus on our mental health and learning disability services. We are also making sure that these services will fit together with our physical health community services, and our partnerships with other organisations, such as Better Local Care.

We will use what we learn to make a plan for the future, called a Clinical Services Strategy. We will publish this in February 2017 and then put the plan into action. Our plan might lead to Southern Health transforming into something new and different; the most important thing is that we do what is right for the people who use our services and their carers.

To help us do this work, we have partnered with experts from a company called Deloitte LLP and Northumberland Tyne and Wear NHS Foundation Trust (NTW). NTW is an organisation providing similar kinds of care to us and rated 'outstanding' by the Care Quality Commission.

As part of this project we want to listen to the views of a variety of people, including health workers and experts. Just as importantly, we want to hear from people who use the services, as they are experts in the experience they have had. We have run a number of workshops and canvassed views through a questionnaire, and there will be further opportunities for people to get involved during consultation and implementation.

Kerstin Mordant
External Communications Manager

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Serious Incidents and Mortality Improvement Action Plan

Southern Health NHS
NHS Foundation Trust

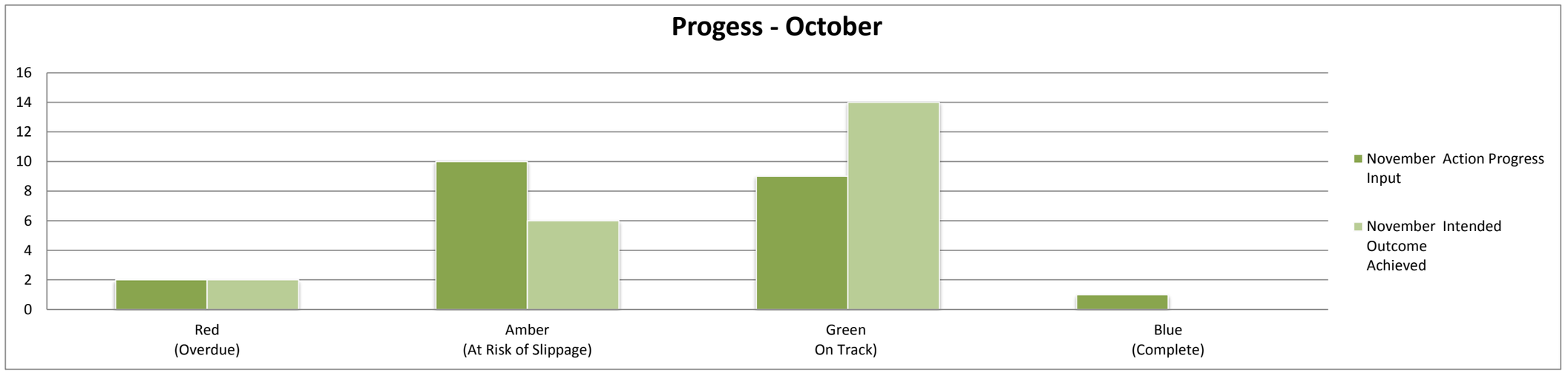
Version No 16.0

Date 17/11/16

Leads Helen Ludford, Associate Director of Quality Governance
Mehreen Arshad, Programme Lead (Quality and Improvement Planning)

Completion 72%

RAG status	July		August		September		October		November	
	Process Input	Outcome Achieved	Process Input	Outcome Achieved	Process Input	Outcome Achieved	Process Input	Outcome Achieved	Process Input	Outcome Achieved
Red (Overdue)	6	6	5	5	3	3	3	4		
Amber (At Risk of Slippage)	0	0	0	0	0	0	0	0		
Green On Track)	5	47	5	48	7	48	7	23		
Blue (Complete)	53	11	54	11	54	13	55	38		
TOTAL	64	64	64	64	64	64	65	65	0	0


Progess - October
16
14
12
10
8
6
4
2
0
Red
(Overdue)
Amber
(At Risk of Slippage)
Green
On Track)
Blue
(Complete)
November Action Progress Input
November Intended Outcome Achieved

Theme	Mazars Recommendations	SHFT Actions	Responsible Lead	Divisional Responsible Lead	Executive Accountability	Process Completion Date	Process Status	Expected Outcome	Outcome Progress Update	Evidence of Outcome Achieved	Measuring Success Date	Outcome Evidence
Board Leadership and Oversight	1. The Board needs to address the culture of lack of review and reporting of unexpected deaths, ensure staff at all levels recognise the need for timely, high quality investigation, how to include families and to ensure learning is demonstrated. a. The Board needs to ensure the processes of reporting and investigating unexpected deaths are consistent and robust throughout the organisation and to improve the quality of investigations and the involvement of families in those investigations. The Trust needs to prioritise the review of deaths as part of a wider mortality review process making better use of data available. b. The Board needs to understand and make full use of the data available and the underlying information required for assurance that unexpected deaths are being properly identified and investigated.	1.1a The Board will address the culture to stimulate improvement in the reporting of deaths and the recognition for high quality and timely investigations by launching the new procedure - Procedure for Reporting and Investigating Deaths - in all types of Trust-wide communications, discussing the process at all executive roadshows and cascade training through all the Trust managers. This is supported by the Trust-wide bulletin, an executive level video on the internet and executive level site visits. 1.1b Cultural change to continue to be addressed through the Trust-wide 'Viral' programme of events advertised by LEaD - this will make reference to the Mazars review and the behaviourally requirement to learn from incidents which have been investigated in a timely manner with the production of a quality report. 1.1c Clinical leadership will adopt 'Back to the Floor' visits on Thursday mornings overseen by the Chief Nurse. This will provide the opportunity for face to face discussions with staff, patients and their relatives regarding improvement activities and actions.	Anna Williams, Company Secretary and Head of Corporate Governance (1.1a) Emma McKinney, Associate Director of Communications (1.1a & 1.1b) John Monahan, Talent and Business Development Partner (1.1b) Paula Hull, Divional Director of Nursing (1.1c) Debra Moore, Deputy Director of Nursing MH/LD (1.1c)	N/A	Sara Courtney, Acting Chief Nurse (1.1a & 1.1c)	30.06.16	Evidence obtained: Communication of new process cascading through the Trust, bulletin, video and executive site visits (1.1a) Viral programme of events (1.1b) Communication related to 'Back to the Floor events' (1.1c)	Engagement of all clinical staff at all levels in the mortality reporting procedure. Investigations and the involvement of families. Through the collection of positive evidence the outcome will be achieved.	Weekly Flash report in place 20% audit undertaken each month and reported to the Mortality Working Group and Quarterly to SOG (1.1a) External review of family involvement commissioned due to report end of September 2016 (1.1b & 1.1c) Focused question included in the AMH peer review tool (1.1a, 1.1b & 1.1c) Back to the Floor events occurring every Thursday morning (1.1c)	Compliance to the death reporting procedure numerically monitored by the Flash report. (1.1a) Compliance to the death reporting procedure Qualitatively monitored through the monthly 20% audit. (1.1a) Quality audit of the investigations to ascertain that families and loved ones were involved in investigations where is was appropriate and they wished to be.(1.1b & 1.1c) From the information ascertained via the peer review reports - focused question related to the death reporting procedure to which individuals positively describe the process. (1.1a, 1.1b & 1.1c)	30.10.16	Evidence required: Minutes of TEG to confirm that the Flash report and mortality is discussed (1.1a) Compliance to reporting. monitored by the Flash and Tableau reports and actively discussed with Divisions where action is required. (1.1a) Results of the monthly 20% IMA audit which review quality. (1.1a, 1.1b & 1.1c) Results of the external enquiry around family involvement. (1.1b & 1.1c) Results of the SI report audit to support whether families where involved in investigations where appropriate. (1.1b & 1.1c) Results of the peer review 1 to 1 staff questions related to the mortality process (1.1a, 1.1b & 1.1c)
		1.2a The Board will lead in forming a structure for mortality oversight within the Trust. A Serious Incident Oversight and Assurance Committee (SIOAC) will be formed (Board sub-committee) to monitor mortality and the implementation of the Serious Incident and Mortality Improvement Plan. 1.2b Formal reporting will be provided to the SIOAC - Serious Incident Trajectory Report, Mortality Flash Report and the Mortality Process Audit Report. The SIOAC will hear reports on a monthly basis, agenda coordinated by the Chair. The Chair will report to the Board on a monthly basis.	Anna Williams, Company Secretary and Head of Corporate Governance (1.2a & 1.2b)	N/A	Julie Dawes, Acting Chief Executive Officer (1.2a & 1.2b)	29.02.16	Evidence obtained: Terms of Reference for SIOAC (1.2a & 1.2b) Meeting invitations (1.2a & 1.2b) Circulation / Meeting attendance request (1.2a & 1.2b)	Increased Board oversight by monitoring the implementation of the action plan and gaining assurance from the evidence of implementation and change. NED Chair to report to the Board.	Meeting in place with Executive membership, meets a minimum of monthly and scrutinises evidence submitted against the actions on the plan. SIOAC meeting weekly. 04.08.16 Outcome evidence obtained	Minutes of the meeting will provide assurance of the scrutiny applied to ensure that the changes within the action plan are implemented and embedding. (1.2a & 1.2b) Serious Incident and Mortality feature within the Board papers and minutes and is clearly an improvement priority for the Trust. (1.2a & 1.2b)	31.07.16	Evidence required: SIOAC agendas x 3 (1.2a & 1.2b) SIOAC minutes x 3 (1.2a & 1.2b) Chairs report to the Board - Board Papers x 3 (1.2a & 1.2b)
		1.3a A Trust-wide Mortality Working Group to be formed to report to the SIOAC which, under Executive Chair, monitors the performance of the Divisional Mortality Meetings and assures that the death reporting procedure supported by the Ulysses system is embedding. 1.3b The meeting is supported by Terms of Reference and: 1.3c There is Divisional attendance.	Helen Ludford, Associate Director of Quality Governance (1.3a and 1.3b)	Mary Kloer, Clinical Services Director (AMH) Mayura Deshpande, Clinical Services Director (Specialised Services) Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Peter Hockey, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Liz Taylor, Associate Director of Nursing (Childrens and Families) (1.3c - all leads are responsible for Divisional attendance)	Lesley Stevens, Medical Director (1.3a and 1.3b)	29.02.16	Evidence obtained: Terms of Reference (1.3b) Meeting invitations (1.3a) Circulation / Meeting attendance request (1.3a)	That there is Trust-wide forum to monitor and challenge the activities of the Divisional Mortality Meetings to provide assurance that all deaths are being investigated correctly.	Mortality Working Group in place and meets monthly. 04.08.16 Outcome evidence obtained	Minutes of the meeting will provide assurance of the scrutiny applied to ensuring that the changes within the action plan are implemented and embedding. (1.3a, 1.3b & 1.3c) Results of the qualitative monthly audit will feature as a standing agenda item and stimulate discussion which will promote improvement. (1.3a & 1.3c) Key performance indicator - that audit will show that in 95% of death reviews through IMA and the 48 hr panel process the decision to investigate and at what level is correct. (1.3a & 1.3c)	31.07.16	Evidence Required: Terms of Reference for the Mortality (1.3b) Working Group Agendas of the Mortality Working Group x 3 (1.3a) Minutes of the Mortality Working Group x 3 (1.3b) Attendance register for the Mortality Working Group (1.3c) Results of the Mortality IMA audit (1.3a)
		1.4a Weekly 'flash' report to be developed to describe the status and timelines for every SIRI investigation inclusive of deaths - this will be embedded into the Trust BI System. 1.4b The Flash report will be circulated to the Executive team and all Divisional leads accountable for ensuring that investigations are completed to timescales. The detail in the report will contain the stage the investigation is at and whether it has been rejected by the quality assurance panel at corporate level. 1.4c This will be discussed by the Executive team each week at the Wednesday meeting.	Helen Ludford, Associate Director of Quality Governance (1.4a & 1.4b) Anna Williams, Company Secretary and Head of Corporate Governance (1.4c)	N/A	Julie Dawes, Acting Chief Executive Officer (1.4a, 1.4b & 1.4c)	31.12.15	Evidence obtained: Flash report (1.4a) Flash report circulation list (1.4b) TEG minutes (1.4c)	That there is weekly executive oversight of the operational procedure compliance data for mortality, serious incident, complaints and risk data. This will enable a 'real time' executive overview of 'hot spot' areas of concern where compliance to process is not being maintained for further investigation and director level resolution.	The Flash report is provided to TEG each week and discussed by the executives. Chris Gordon draws executive attention to 'hot spot' areas with the relevant divisional director and requests further assurance of improvement at the following meeting or further insight into why improvement cannot be made or is slow. There is also an assurance of immediate patient safety given. 21.07.16 Flash report now fully embedded in Tableau - real-time daily reporting. 04.08.16 Outcome evidence obtained	This will be evidenced through position monitoring of the compliance to the process behind incident, serious incident, risk and complaints by the executive team. (1.4a, 1.4b & 1.4c) The TEG minutes will provide an indicator that a worsening position is developing and a related action to deal with this. (1.4c)	31.07.16	Evidence Required: Flash report (1.4a) TEG minutes (1.4c) Trust dashboard related to reduction in overdue serious investigation (1.4c)
		1.5a Lead Investigators to be appointed for each Division who will track compliance to timescales and support investigators to achieve this. 1.5b Job Description to be standardised with a 20% Corporate and 80% Divisional governance focus and: 1.5c An initial priority objective to deliver clearance of any SIRI backlogs which will be evidenced in the Flash report.	Helen Ludford, Associate Director of Quality Governance (1.5a, 1.5b & 1.5c)	Paula Hull, Deputy Director of Nursing ISDs John Stagg, Associate Director of Nursing, LD TQ21 Carol Adcock, Associate Director of Nursing, AMH Nicky Bennet, Associate Director of Nursing, Specialised Services Liz Taylor, Associate Director of Nursing, Childrens and Families (1.5a -all leads are responsible for Divisional recruitment)	Sara Courtney, Acting Chief Nurse (1.5a, 1.5b & 1.5c)	30.11.15	Evidence obtained: Job Description for Lead Investigators (1.5b) Demonstration of individuals in post (1.5a)	That there is competent expertise at divisional level to monitor performance against the national framework criteria and through a process of support, education and feedback increase the quality of the investigation reports. Completion / submission of a quality investigation becomes standard Trust practice.	Key Performance Indicator monitored monthly and report to executive level within the trajectory and mortality and serious incident management papers supplied to Board sub-committees. As of 31st May the Trust reached a position of 87% compliance to the 60 days timeframe and 100% clearance of the historical SI backlog. Predicted 94% target achievement by 30th June 2016. 21.07.16 Compliant to 100% submitted within 60 days.	Dashboard results supporting the Key Performance Indicator of submission of a quality investigation report within 60 working days. Achievement will 90% and above sustained for a 6 month period. (1.5a & 1.5c)	30.11.16	Evidence Required: Dashboard of performance for a 6 month period demonstrating 90% compliance with submission of a quality investigation within 60 days (1.5a, 1.5b & 1.5c)
		1.6a Executive support to be sought and agreed to ensure that investigators are given sufficient time to investigate serious incidents as part of their job plans. 1.6b If improvement trajectories are not being met a divisional review of capacity will take place.	Helen Ludford, Associate Director of Quality Governance (1.6a)	Paula Hull, Deputy Director of Nursing ISD's John Stagg, Associate Director of Nursing, LD TQ21 Carol Adcock, Associate Director of Nursing, AMH Nicky Bennet, Associate Director of Nursing, Specialised Services Liz Taylor, Associate Director of Nursing, Childrens and Families (1.6a & 31.6b - all leads are responsible for investigator capacity issues in their relevant Divisions and for escalation to their Director when issues arise)	Mark Morgan, Director of Operations AMH, LD & TQ21 Gethin Hughes, Director of ISDs, OMPH and Childrens and Families (1.6a & 1.6b - Divisional Director have ultimate responsibility and accountability for ensure that investigator capacity in their Division is 'fit for purpose')	30.11.15	Evidence obtained: WTE centralised lead investigators in post for each Division - mapping document (1.6a) Registers of trained investigators in each Division (1.6a) Flash report - weekly compliance review (1.6a & 1.6b) Serious Incident trajectory report provided to SIOAC and monthly dashboard of compliance to 60 days (1.6b)	That there is competent expertise at divisional level to monitor performance against the national framework criteria and through a process of support, education and feedback increase the quality of the investigation reports. Completion / submission of a quality investigation becomes standard Trust practice.	Key Performance Indicator monitored monthly and report to executive level within the trajectory and mortality and serious incident management papers supplied to Board sub-committees. Director escalation of failure to reduce the SI backlog in AMH resulted in increased investigator capacity and this is now being monitored monthly. 21.07.16 Trajectory monitored on a weekly basis, capacity in place to cover demand.	The trajectory report provided to SIOAC and the Flash report provided to the business and reviewed at TEG will assure that there are processes in place to monitor compliance to the 60 day submission of quality reports to reach a target of submission of 90% and above to this standard. (1.6a & 1.6b)	31.07.16	Evidence required: Flash report - weekly compliance review (1.6a & 1.6b) Serious Incident trajectory report provided to SIOAC and monthly dashboard of compliance to 60 days (1.6b) TEG minutes (1.6a)
		1.7a Serious Incident Investigation Training to include the National timescale requirement. Clarify and agree with Commissioners the reporting and achievement of the 60 day SIRI timescale includes/does not include Commissioner sign off. Obtain written agreement to enable benchmarking to other Trusts.	Helen Ludford, Associate Director of Quality Governance (1.7a)	N/A	Sara Courtney, Acting Chief Nurse (1.7a)	30.06.16	Evidence Required: Extract from the Serious Incident Framework 2015 plus training requirement from the Questions and Answer document 2016 (1.7a) Written agreement and clear definition of the 60 days pathway from the Commissioners - quality investigation to be undertaken, produced and submitted - 60 days provider, 20 days for Commissioner sign off and closure (1.7a)	The Trust training is compliant to the national framework requirements and that there is a clear understanding between the Trust and the Commissioners regarding the monitoring of the compliance to this framework. Completion / submission of a quality investigation becomes standard Trust practice.	Discussions have taken place with the Commissioners to define the national framework guidance of 'submission of a quality report within 60 days'. 21.07.16 Raised as an outstanding issue at the Quality Oversight Committee. 04.08.16 Written agreement received from the Commissioners	Dashboard results supporting the Key Performance Indicator of submission of a quality investigation report within 60 working days. Trust to achieve 90% and over, sustained for a 6 month period. (1.7a) Framework checklist to be utilised at each SI panel - divisional, corporate and CCG closure panels: supplied as evidence of recognised good practice proven by recorded observation (1.7a)	30.11.16 (6 months following first achievement of above 90%)	Evidence Required: Minutes of the Strategic Oversight Group June 2016 (1.7a) Dashboard of performance for a 6 month period demonstrating 90% compliance with submission of a quality investigation within 60 days (1.7a) Evidence proved by recorded observation that the Framework checklist is used at all SI closure panels - internal and external (1.7a)

Theme	Mazars Recommendations	SHFT Actions	Responsible Lead	Divisional Responsible Lead	Executive Accountability	Process Completion Date	Process Status	Expected Outcome	Outcome Progress Update	Evidence of Outcome Achieved	Measuring Success Date	Outcome Evidence
		1.8a Provide Investigator Training to Divisional Lead Investigation Officers and those staff who undertake Investigating Officer roles. The course will be advertised and booked through the LEaD training system. The training will be a two day 'face to face' course and meet the requirements of the 2016 Serious Incidents Framework questions and answers publication, NHS England. This training will include: All related SHFT policies NPSA guidance tools on report writing in training Root cause analysis tools and how to use these to extract a root cause National Serious Incident Framework guidance inclusive of timescales Requirement for reporting deaths in detention Duty of Candour inclusive of involving families and other parties within investigations Human Factors Complaints management Ulysses system training Legal and inquest overview 1.8b A register of active trained Investigating Officers will be keep to ensure that supervision is provided and their is capacity within the Divisions to undertake all of the investigations required.	Kay Wilkinson, SI and Incident Manager Helen Ludford, Associate Director of Quality Governance (1.8a)	Sara Courtney, Associate Director of Nursing East ISD Paula Hull, Associate Director of Nursing West ISD John Stagg, Associate Director of Nursing, LD TQ21 Carol Adcock, Associate Director of Nursing, AMH Nicky Bennet, Associate Director of Nursing, Specialised Services Liz Taylor, Associate Director of Nursing, Childrens and Families (1.8b - all Divisional ADoNs are responsible and accountable for ensuring that registers are kept and capacity issues are escalated)	Sara Courtney, Acting Chief Nurse (1.8a)	31.04.16	Evidence obtained: Course programme and timetable (1.8a) Course attendance register (1.8a) Divisional investigating officers registers (1.8b)	Trained investigators within the Trust to meet the requirements of the 2016 update to the Serious Incident Framework NHS England incorporated in the questions and answers document. Outcome - increase the quality of the investigations and compliance to the 60 day submission of a quality report requirement.	Divisional registers created. 21.07.16 Course capacity increased by another 70 places per annum, 140 places offered in total.	Register of trained investigators for all Divisions who have attended the trained which is offered via LEaD every 6 months - 2 day course. (1.8a & 1.8b) Compliance to the 60 day target via monitoring of the Key Performance Indicator of submission of a quality investigation report within 60 working days. 90% achievement to be sustained over a 6 month period. (1.8a & 1.8b)	30.11.16	Evidence Required: Dashboard of performance for a 6 month period demonstrating 90% compliance with submission of a quality investigation within 60 days (1.8a & 1.8b) Divisional investigating officers registers (1.8b)
		1.9a Quality of the investigation reports will be monitored through the Divisional and Corporate Panels with executive Chair. Feedback will be provided at the panel on the standard of the report. The panels will utilise the 'checklist' from the National Framework document to aid the judgement on quality. 1.9b Corporate Panels booked weekly but can be increased as per demand. 1.9c Learning from serious incidents will take place in a timely manner as a result of improved lessons learnt, recommendations and actions.	Kay Wilkinson, SI and Incident Manager (1.9a, 1.9b & 1.9c)	N/A	Sara Courtney, Acting Chief Nurse (1.9a & 1.9b)	31.01.16	Evidence obtained: Quality checklist used at all Corporate panels including of the grading tool and the National Framework checklist document arranged with the CCGs. (1.9a) Corporate panel diary and schedule (1.9b)	The quality of the reports will improve through a process of the panels applying scrutiny and challenge to ensure that all elements of the national checklist are included. This will in turn ensure that the improvement lessons learnt from serious incidents will be shared in a timely way from which changes can be made in practice, for example policy changes to prevent recurrence.	Quality checklist utilised at all panel meetings used in coordination with National checklist and the grading tool. The quality checklist is loaded on to the Ulysses system as a record of the decision making at the Corporate panel.	Increase in quality with 85% of reports gaining Corporate Panel approval on 1st hearing. (1.9a) Managed Corporate Panel capacity which meets the demand. (1.9b) Policy and procedures changes resulting from serious incidents (1.9c) Please note timescale for outcome for action 1.9c, Policy and procedures changes resulting from serious incidents is 31.10.16	31.07.16 31.10.16	Evidence required: Dashboard indicator monitoring the investigation reports which gain Corporate Panel approval on the 1st hearing - target 85%. (1.9a) The trajectory report supplied to SIOAC provides assurance of activities to enable the Corporate Panel capacity to be increased during period of high demand. (1.9b) Policy and procedures changes resulting from serious incidents (1.9c)
		1.10a The involvement of families within investigations is of paramount importance. Early conversations with family members will ensure that the correct information is ascertained and that their questions are included as part of the investigation. The 48 hr mortality panel as part of the death process includes defining of family members, establishing their involvement in the process and participation in the investigation. 1.10b This will be assured through the audit of the process with the results being feedback to the Head of Patient Engagement and Experience.	Helen Ludford, Associate Director of Quality Governance (1.10a) Chris Woodfine, Head of Patient Engagement and Experience (1.10b)	Mary Kloer, Clinical Services Director AMH Mayura Deshpande, Clinical Services Director, Specialised Services Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Peter Hockey, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Liz Taylor, Associate Director of Nursing Childrens and Families Jennifer Dolman, Clinical Services Director, LD (1.10a - all Divisional leads are responsible for the 48 hr panels which will include addressing family involvement)	Lesley Stevens, Medical Director (1.10a & 1.10b)	31.01.16	Evidence obtained: Death reporting process includes guidance on defined family involvement which is discussed as the 48 hr panel (1.10a) Ulysses 48 hr panel questionnaire includes a check for family involvement (1.10a) The IMA / 48 hr panel audit has a specific question to test family communication (1.10b) Terms of reference for external review (1.10b)	Increased involvement of families in the investigation process will ensure that the investigation is holistic involving the opinions, views and questions of loved ones and where there has been an act or omission of care the Trust says it is sorry and learns from the events. The long term outcome is for SHFT to be evidenced as a Trust who is open and honest and keen to work in partnership with families for service improvement and redesign.	The death / mortality reporting process includes guidance on family involvement and there is a field on the 48 hr panel questionnaire related to this. The IMA / 48 hr panel audit is underway - 20% sample across all Divisions on a monthly basis. External review commissioned and commenced.	The external review into the quality of the experience of Duty of Candour / family involvement in SIRI investigations. To be completed and reported by 30.10.16. This will review the involvement of families and enable to the Trust to evidence improvement and plan further improvement actions. (1.10b) The Trust will self-monitor the inclusion of families where appropriate through monthly audit of 48hr panel this will provide internal evidence that the process is being correctly followed (1.10a & 1.10b) Please note timescales - Internal review through audit - 30.06.16 External review through commissioned enquiry 30.09.16 Internal thematic review due for completion 30.09.16	30.06.16 30.09.16	Evidence obtained: Monthly IMA / 48 hrs panel results produced and improvement activities to be discussed at MGW - audit results and MGW minutes this will provide evidence that discussions with families have occurred early on in the investigation process (1.10a &1.10b) Result of external review and related improvement plan (1.10b) Internal thematic review of Serious Incidents will prove that families have been included in 100% of investigations where appropriate and they wish to be involved (1.10b)
		1.11a Identify and deliver appropriate training for all non clinical Trust Board members to ensure they are able to interpret mortality data.	Anna Williams, Company Secretary and Head of Corporate Governance (1.11a)	N/A	Julie Dawes, Acting Chief Executive Officer (1.11a)	30.06.16	Required Evidence: Schedule for Board training in relation to mortality data interpretation (1.11a)	To be able provide Board members with the additional skills to interpret and scrutinise mortality data which is presented to them. Scrutiny and challenge will lead to improvement.	Training has been delivered by Simon Beaumont.	Scrutiny and challenge regarding mortality to be evidenced in the Board minutes and resulting actions. (1.11a)	30.10.16	Required evidence: Board papers and minutes where mortality has been presented and discussed (1.11a)
Board Leadership and Oversight	2. The Board or its sub-committees should receive regular reports of all incidents of deaths. The report should: a. provide data on all deaths of people using a Mental Health or Learning Disability service including service users of the social care service - TQ21. b. outline how many unexpected deaths there have been and in which areas. c. outline how many IMAs have been written as a result and how many have progressed to CIR and then onto SIRI. d. include a summary of how many deaths are 'pending' for the purposes of investigation with a reason why. This would make the decision-making more transparent as regards to delays in reporting to StEIS. e. provide information to enable trends to be identified and for Board members to become familiar with the information f. provide information which includes the categorisation of all deaths reported to Ulysses g. provide data at least twice a year on all deaths. Themes should be reported on which covers at least the previous 6 quarters (or a sufficient number to provide a reasonable sample from which to identify themes). This is particularly important for the Learning Disability arena where numbers of deaths in each quarter will be low and in areas that may not meet SIRI criteria e.g. non-suicide Mental Health deaths.	2.1a Weekly 'flash' report to be developed to describe the status and timelines for every SIRI investigation inclusive of deaths - this will be embedded into the Trust BI System. 2.1b The Flash report will be circulated to the Executive team and all Divisional leads accountable for ensuring that investigations are completed to timescales. The detail in the report will contain the stage the investigation is at and whether it has been rejected by the quality assurance panel at corporate level. 2.1c This will be discussed by the Executive team each week at the Wednesday meeting.	Helen Ludford, Associate Director of Quality Governance (2.1a & 2.1b) Anna Williams, Company Secretary and Head of Corporate Governance (2.1c)	N/A	Sara Courtney, Acting Chief Nurse (2.1a, 2.1b & 2.1c)	31.12.15	Evidence obtained: Flash report (2.1a) Flash report circulation list (2.1b) TEG minutes (2.1c)	That there is weekly executive oversight of the operational procedure compliance data for mortality, serious incident, complaints and risk data. This will enable a 'real time' executive overview of 'hot spot' areas of concern where compliance to process is not being maintained for further investigation and director level resolution.	The Flash report is provided to TEG each week and discussed by the executives. Chris Gordon draws executive attention to 'hot spot' areas with the relevant divisional director and requests further assurance of improvement at the following meeting or further insight into why improvement cannot be made or is slow. There is also an assurance of immediate patient safety given. 21.07.16 All Flash reports now embedded into Tableau. 04.08.16 Outcome evidence obtained	This will be evidenced through position monitoring of the compliance to the process behind incident, serious incident, risk and complaints by the executive team. (2.1a, 2.1b & 2.1c) The TEG minutes will provide an indicator that a worsening position is developing and a related action to deal with this. (2.1c)	31.07.16	Evidence Required: Flash report (2.1a) TEG minutes (2.1c) Trust dashboard related to reduction in overdue serious investigation (2.1c)
		2.2a The Board will lead in forming a structure for mortality oversight within the Trust. A Serious Incident Oversight and Assurance Committee (SIOAC) will be formed (Board sub-committee) to monitor mortality and the implementation of the Serious Incident and Mortality Improvement Plan. 2.2b Formal reporting will be provided to the SIOAC - Serious Incident Trajectory Report, Mortality Flash Report and the Mortality Process Audit Report. 2.2c Oversight of Serious Incidents is through the Quality and Safety Committee (QSC) (Board sub-committee) to which the Quarterly Serious Incident and Incident Report is provided. These reports will include the elements stated within the recommendation.	Anna Williams, Company Secretary and Head of Corporate Governance (2.2a & 2.2c) Helen Ludford, Associate Director of Quality Governance (2.2b)	N/A	Julie Dawes, Acting Chief Executive Officer (2.2a, 2.2b & 2.2c)	29.02.16	Evidence obtained: Terms of Reference for SIOAC (2.2a) Meeting invitations (2.2a) Circulation / Meeting attendance request (2.2a & 2.2c) SIAOC agenda / papers (2.2b)	Increased Board oversight by monitoring the implementation of the action plan and gaining assurance from the evidence of implementation and change. NED Chair to report to the Board.	Meeting in place with Executive membership, meets a minimum of monthly and scrutinises evidence submitted against the actions on the plan. 04.08.16 Outcome evidence obtained	Minutes of the meeting will provide assurance of the scrutiny applied to ensure that the changes within the action plan are implemented and embedding. (2.2a) Serious Incident and Mortality feature within Board sub-committee papers (2.2b & 2.2c) Serious Incident and Mortality feature within the Board papers and minutes and is clearly an improvement priority for the Trust. (2.2a)	31.07.16	Evidence required: SIOAC & QSC agendas x 3 (2.2a, 2.2b & 2.2c) SIOAC & QSC minutes x 3 (2.2a, 2.2b & 2.2c) SIOAC Chairs report to the Board - Board Papers x 3 (2.2a, 2.2b & 2.2c))
		2.3a The Quality Governance team to provide a monthly report to the Medical Director and the Chief Nurse on Mortality and Serious Incidents for inclusion in the Board report to provide oversight and assurance.	Helen Ludford, Associate Director of Quality Governance (2.3a)	N/A	Sara Courtney, Acting Chief Nurse (2.3a) Lesley Stevens, Medical Director (2.3a)	30.01.16	Evidence obtained: Monthly COO and Director of Patient Safety and the Director of Nursing reports (2.3a)	Monthly oversight of mortality and serious incidents to be included in the Board report for assurance.	Monthly reports provided to the Director of Nursing and COO and Director of Patient Safety.	Detailed assurance narrative featuring within the Board report.(2.3a)	30.09.16	Evidence required: Board report x 3 (2.3a)
		2.4 a Each Division will provide mortality data inclusive of all elements of the recommendation in the report submitted to their monthly Divisional Performance Review (DPR).	Julie Giles, Performance Manager (2.4a)	Paula Hull, Deputy Director of Nursing ISD's John Stagg, Associate Director of Nursing, LD TQ21 Carol Adcock, Associate Director of Nursing, AMH Nicky Bennet, Associate Director of Nursing, Specialised Services Liz Taylor, Associate Director of Nursing, Childrens and Families (2.4a - Divisional Leads are responsible for the reporting which is associated with their DPR)	Mark Morgan, Director of Operations AMH, LD & TQ21 Gethin Hughes, Director of ISDs, OMPH In Patients, East and West ISD's and Childrens and Families (2.4a - Each Divisional Director is accountable for their own Division)	31.07.16	Evidence required: DPR papers from each Division (2.4a)	Divisions will own their mortality and serious incident data reporting these aspects for challenge and scrutiny as part of the Divisional Performance Review. Improvement activities will be captured within their improvement plans.	Mortality and serious incident management is discussed at DPR and is reported within the body of the reports. 04/08/16 Evidence has been provided by the performance team of inclusion at DPR. The system is changing to MOM's (monthly operational meetings) and the Governance Business Partner is included in the ToR's to ensure that the action is covered.	Divisional Performance Review reports and associated minutes will ensure that management of mortality is a key focus for improvement. (2.4a)	30.09.16	Evidence required: DPR minutes where mortality and serious incident improvement and assurance has been discussed (2.4a) Peer review reports where understanding of the mortality / death process is discussed with staff members (2.4a)
Board Leadership and Oversight	3. The 2015/16 Annual Report should provide a more transparent breakdown of deaths including a analysis of the themes that occur for people with Mental Health and Learning Disability challenges.	3.1a A review of the annual report should be undertaken to establish which inclusion around mortality can be made. Inclusions into the Quality Account will be the priority for improvement in year 2016/17 related to mortality and undertaking investigations.	Anna Williams, Company Secretary and Head of Corporate Governance Tracey McKenzie, Head of Compliance, Assurance and Quality (3.1a - joint responsibility)	Gina WinterBates, QG Business Partner ISD's Enzani Nyatoro, QG Business Partner MH	Sara Courtney, Acting Chief Nurse (3.1a)	31.07.16	Evidence required: 2015/16 Annual Report which includes the Quality Account (3.1a) 2016/17 Quality Account priorities (3.1a)	Openness and transparency within the annual Quality Account as to the priority for improvement linked to mortality and serious incident management.	Analysis could not be provided for 2015/16 however this has been highlighted within the Quality Account as a priority for 2016/17. 2015/16 report on track to be published 30 June 2016. 04.08.16 Combined Annual Report and Quality Account published.	Quality Account publication will result in clear transparency of improvement indicators for 2016/17. (3.1a)	31.07.16	Evidence required: 2015/16 Annual Report which includes the Quality Account (3.1a) 2016/17 Quality Account priorities (3.1a) both to be published on NHS Choices as of 30.06.16 Schedule of monitoring QA priority related to Mortality /Serious Incident Improvement (3.1a)

Theme	Mazars Recommendations	SHFT Actions	Responsible Lead	Divisional Responsible Lead	Executive Accountability	Process Completion Date	Process Status	Expected Outcome	Outcome Progress Update	Evidence of Outcome Achieved	Measuring Success Date	Outcome Evidence
Board Leadership and Oversight	4. There is clear national and Trust policy guidance on reporting and investigating deaths. Trust policy includes a full set of templates and processes - the Board should ensure these policies are being followed and templates being used.	4.1a Serious Incident Management policies and procedures to be rewritten to reflect the National Framework inclusive of flowcharts to assist staff. The Trust will follow the guidance of the newly created Procedure for Reporting and Investigating Deaths which is inclusive of flowcharts to assist staff in their decision making. Staff will be able to refer to both of these documents: The Procedure for Reporting and Investigating Deaths is prescriptive of what deaths to report and how to do it. The Serious Incident policy and procedure describes what a serious incident is and provides guidance of how to report with the support of the centralised team. The policy makes reference to the use of the NHS England Serious Incident Framework within the decision making. Decision making will be quality assured by the central governance team and audited through the IMA / mortality audit.	Thomas Williams, Ulysses Systems Developer Kay Wilkinson, SI and Incident Manager (4.1a - joint responsibility) David Batchelor, Compliance Officer (4.1a - review evidence)	Mandy Slaney, Lead IO AMH Eileen Morton, Lead IO AMH Georgie Townsend, Lead IO Childrens and Families and West ISD Angela O Brien, Lead IO East ISD Nic Cicutti, Lead IO LD & TQ21 (4.1a - responsible for assuring the promotion and monitoring of the policy an procedure use in Divisions)	Sara Courtney, Acting Chief Nurse (4.1a)	31.01.16	Evidence obtained: Serious Incident Management Policies and Procedures rewritten(4.1a) Procedure for Reporting and Investigating Deaths created (4.1a)	Staff will undertake serious incident investigations in line with Trust policies and procedures which in turn aligns with national guidelines to ensure that there is a robust decision making process that reflects the accuracy of undertaking investigations and is quality assured through the Ulysses System. The overarching outcome will ensure that all deaths will receive the correct level of investigation, which is robust and quality assured through the correct sign-posting for staff.	All rewritten and newly developed policies and procedures published. Monthly audit of 20% of mortality incident reports established and undertaken by clinical staff. 21.07.16 Q2 audit increased to 50% of mortality reviews due to continuing underperformance on the KPI / 95% target.	Audit of the decision making process as to the level of investigation required will prove in 95% of cases the decision was correct. Please note timescale for outcome for action Peer review reports to provide assurance that staff know about the death reporting and serious incident procedures and how to use them. (4.1a) is 31.10.16	31.08.16 31.10.16	Evidence required: Compliance to the procedure via the mortality Flash report (4.1a) Achievement of 95% correct clinical decision to investigate a death and at what level, assurance gained by audit (4.1b) Peer review reports to provide assurance that staff know about the death reporting and serious incident procedures and how to use them. (4.1a)
		4.2a Create an investigation template for the Ulysses Safeguard system to guide investigators with the process of report writing and ensure that additional tools / supplementary documents can be stored with the investigation. The use of prescribed electronic tools will ensure that all elements of the investigation are accurately recorded which ensure the richness in the quality of the investigation report. 4.2b Include scenario based system use within the Investigating Officers training to ensure that all investigators are trained to use the system embedded templates. Support to be provided by the Lead Investigating Officers.	Thomas Williams, Ulysses Systems Developer (4.2a) Kay Wilkinson, SI and Incident Manager (4.2b)	Mandy Slaney, Lead IO AMH Eileen Morton, Lead IO AMH Georgie Townsend, Lead IO Childrens and Families and West ISD Angela O Brien, Lead IO East ISD Nic Cicutti, Lead IO LD & TQ21 (4.2a - all are responsible for assuring that Divisional Investigation Officers are trained to use the system correctly)	Sara Courtney, Acting Chief Nurse (4.2a & 4.2b)	31.01.16	Evidence obtained: Investigation Template (ERCA) within Ulysses Safeguard system developed (4.2a) All investigating officers receive systems training and further 1 to 1 support from their Central Lead Investigating Officer (4.2b)	The template will aid in producing high quality investigation reports with the necessary appendices added to ensure richness and accurate recording of data and information. Quality investigations will be produced within the required national timescale and also ensure that lessons are learnt and practice changes are made to prevent recurrence.	31.01.16 All new serious incident investigations completely systems based - ERCA on Ulysses Safeguard 30.03.16 System based tracking module implemented	Compliance to use of the standard system checked at each Corporate Panel. Bi-annual audit to be undertaken. (4.2a & 4.2b) Please note timescale for outcome for action Policy and procedures changes resulting from serious incidents is 31.10.16	31.08.16 31.10.16	Evidence required: Audit of the Serious Incident investigation reports to assure that the Ulysses template in being used and completed correctly, quality indicator (4.2a & 4.2b) Policy and procedures changes resulting from serious incidents (4.2a)
		4.3a The Board are to be assured of the use of the system and embedded templates through the reports which include the audit of the death reporting process and the Corporate SI Panel monitoring that all investigation reports post 01.01.16 are embedded into the Ulysses system.	Thomas Williams, Ulysses Systems Developer Kay Wilkinson, SI and Incident Manager (4.3a - joint responsibility)	Mandy Slaney, Lead IO AMH Eileen Morton, Lead IO AMH Georgie Townsend, Lead IO Childrens and Families and West ISD Angela O Brien, Lead IO East ISD Nic Cicutti, Lead IO LD & TQ21 (4.3a - all are responsible for assuring that their respective Divisions use the Ulysses ERCA for all investigation report)	Sara Courtney, Acting Chief Nurse (4.3a)	31.01.16	Evidence obtained: Report style checked at every Corporate SI Panel for compliance with the Ulysses system. (4.3a)	Board assurance of the correct use of the Ulysses system with embedded investigation templates which support SI investigation processes. The outcome will lead to a quality investigation if all aspects of the template are completed.	31.01.16 All new serious incident investigations completely systems based - ERCA on Ulysses Safeguard 30.03.16 System based tracking module implemented 31.05.16 As the backlog in now cleared all reports are generated through the ERCA built into the Ulysses Safeguard system.	Audit of the compliance to the use of Ulysses and review of the quality to be included in Board reports. (4.3a & 4.3b)	31.08.16	Evidence Required: Audit of the Serious Incident investigation reports to assure that the Ulysses template in being used, completed correctly and the Board have been assured of this (4.3a & 4.3b)
Monitoring mortality and unexpected deaths / attrition	5. Unexpected deaths should be defined more clearly. We suggest the Trust uses, as a starting point, the classification outlined in this report to identify the potential need for review or investigation in each case. In particular, the definition of an 'unexpected death' needs to be refined to be more applicable to the circumstances of people with a Learning Disability regardless of setting.	5.1a Through consultation with the Clinical Leadership of each division create a Trust-wide Procedure for Reporting and Investigating Deaths which clearly defines the reporting criteria, review process as to what level of investigation should be undertaken and involves families. 5.1b Monitoring of this procedure will be through the Mortality Working Group under executive chair which reports to Serious Incident Oversight and Assurance Committee SIOAC (Board sub-committee). 5.1c Audit of the process is to be shared with the CCG commissioners on a quarterly as an assure of how the decision to investigate deaths and at what level is made. This information is reported internally on a monthly basis.	Helen Ludford, Associate Director of Quality Governance (5.1b & 5.1c) Thomas Williams, Ulysses System Developer (5.1a)	Mary Kloer, Clinical Services Director AMH Mayura Deshpande, Clinical Services Director, Specialised Services Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Peter Hockey, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Liz Taylor, Associate Director of Nursing (Childrens and Families) Jennifer Dolman, Clinical Director (LD) (5.1a & 5.1b - all are responsible for assuring that their respective Divisions use the procedure appropriately and have a member on the MWG)	Sara Courtney, Acting Chief Nurse (5.1a, 5.1b & 5.1c)	31.12.15	Evidence obtained: Procedure for Reporting and Investigating Deaths written and published (5.1a) MWG membership, Terms of Reference and agenda (5.1b) Audit tool created , audit completed on 20% of reported deaths per month (5.1c)	The procedure will enable all deaths to be reviewed, reporting and a decision made as to whether an investigation is required by senior clinicians. This will provide assurance that all deaths which require investigation will be recognised and families will be notified and included at the earliest opportunity.	01.06.16 Compliance to procedure 100% Audit result 83%	Compliance to the procedure will be monitored through the weekly Flash report. (5.1a) Detail of the decision making will be through monthly audit of 20% of the reports. (5.1c) SIOAC papers will demonstrate monitoring of compliance to the procedure (5.1b)	30.09.16	Evidence required: Mortality audit results above 90% correct decision making as to the level of investigation and compliance to the procedure at 90% (5.1a and 5.1c) Assurance evidence obtained demonstrated to the Board through SIOAC papers (5.1b)
Monitoring mortality and unexpected deaths / attrition	6. The Trust should develop a Mental Health and Learning Disability Mortality Review Group which includes reviewing unexpected deaths which do not constitute a serious incident. Clear terms of reference should be developed. This group should serve a number of purposes: a. to provide oversight of all deaths occurring amongst the Trusts Mental Health and Learning Disability service users b. develop a mortality dashboard which is provided to stakeholders and reported in the annual report that provides a full picture of all deaths, themes, CIRs and serious incidents c. monitor causes of deaths amongst its service users by using the 2013/14 MHMDS data release to see if the ICD 10 chapters show any trend d. provide an evidence base to share with Local Authority commissioners and other providers highlighting themes that are arising relating to social care and other agencies issues e. to ensure that liaison with acute provider colleagues can take place at a clinical and managerial level where the Trust has concerns raised with it about care in acute settings f. should include a GP as part of its membership g. the formation and progress of this new group should be monitored at Board level h. the group must aim to improve the transparency of reporting levels of unexpected deaths.	6.1a ALL Divisions inclusive of Mental Health and Learning Disability to introduce regular Mortality Review Meetings (minimum of once a quarter) to review and identify learning from ALL deaths (not just SIRIs)	Helen Ludford, Associate Director of Quality Governance (6.1a)	Mary Kloer, Clinical Services Director (AMH) Mayura Deshpande, Clinical Services Director (Specialised Services) Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Peter Hockey, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Liz Taylor, Associate Director of Nursing (Childrens and Families) Jennifer Dolman, Clinical Director (LD) (6.1a - each lead responsible for the meeting in their Division)	Lesley Stevens, Medical Director (6.1a - for ensuring Divisional clinical leadership) Chris Gordon, COO and Director of Patient Safety (6.1a - for devising process and supporting tools)	30.01.16	Evidence obtained: SharePoint site of planned Mortality Meetings (6.1a)	Increased oversight of deaths of service users and patients in receipt of care from SHFT will prove valuable data for scrutiny of the clinical model and care delivered.	All Divisions have Mortality Meetings in place. 21.07.16 Concerns have been raised regarding the attendance at the AMH Mortality Meeting this will be explored at the MWG.	Robust evidence of mortality review recorded through the minutes of the meetings which are shared through a central SharePoint site which are auditable. (6.1a) Audit of these minutes will prove that there is a richness of clinical discussion occurring about causes of deaths and improvements which could be made. (6.1a)	30.09.16	Evidence required: Audit of the contents of the SharePoint site record of Mortality Meetings (6.1a)
		6.2a Terms of Reference and standardised agenda inclusive of case study review to be drawn up by the Governance Workstream of the Quality Programme and implemented within each group.	Helen Ludford, Associate Director of Quality Governance (6.2a)	N/A	Chris Gordon, COO and Director of Patient Safety (6.2a)	30.01.16	Evidence obtained: Terms of Reference (6.2a) Standardised agenda (6.2a)	Consistent approach to the review of deaths through Mortality Meetings across the Trust.	Standardised Terms of Reference and Agendas in place.	Robust evidence of mortality review recorded through the minutes of the meetings which are shared through a central SharePoint site which are auditable. (6.2a) Audit of these minutes will prove that there is a richness of clinical discussion occurring about causes of deaths and improvements which could be made. (6.2a)	30.09.16	Evidence required: Audit of the contents of the SharePoint site record of Mortality Meetings (6.2a)
		6.3a Divisional Mortality Meetings to be chaired by the senior clinician in a senior leadership role. 6.3b The Senior Clinician Chair should attempt to recruit membership from primary care (GP), external stakeholders such as the Local Authority and a representative for patients this should be supported by the Head of Patient Engagement and Experience.	Chris Woodfine, Head of Patient Engagement and Experience (6.3b)	Mary Kloer, Clinical Services Director (AMH) Mayura Deshpande, Clinical Services Director (Specialised Services) Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Peter Hockey, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Jennifer Dolman, Clinical Services Director (LD & TQ21) Liz Taylor, Associate Director of Nursing (Childrens & Families) (6.3a & 6.3b - each lead responsible for the actions in their Division)	Lesley Stevens, Medical Director (6.3a & 6.3b - for ensuring Divisional clinical leadership)	30.01.16	Evidence obtained: Terms of Reference (6.3a) Standardised agenda (6.3b)	Consistent approach to the review of deaths through Mortality Meetings across the Trust managed by a Senior Clinician with the skills to applied scrutiny and challenge. Non SHFT attendees should bring a further aspect of check and challenge based on the external view point of the wider health economy.	All Chairs defined as Senior Clinicians.	Robust evidence of mortality review recorded through the minutes of the meetings which are shared through a central SharePoint site which are auditable. (6.3a) Non SHFT attendees should be clearly auditable within the minutes.(6.3b)	30.09.16	Evidence required: Audit of the contents of the SharePoint site record of Mortality Meetings (6.3a & 6.3b)

Theme	Mazars Recommendations	SHFT Actions	Responsible Lead	Divisional Responsible Lead	Executive Accountability	Process Completion Date	Process Status	Expected Outcome	Outcome Progress Update	Evidence of Outcome Achieved	Measuring Success Date	Outcome Evidence
		6.4a Divisional Mortality Meetings to report into the Mortality Working Group under Executive Chair which in turn reports through to the Serious Incident Oversight and Assurance Committee (Board sub-committee). 6.4b Themes and trends should be escalated and consideration for 'deep dive' thematic analysis to be undertaken. On completion findings should be shared with external stakeholders where appropriate.	Helen Ludford, Associate Director of Quality Governance (6.4a) Tracey McKenzie, Head of Compliance and Assurance (6.4b)	Mary Kloer, Clinical Services Director AMH Mayura Deshpande, Clinical Services Director, Specialised Services Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Peter Hockey, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Jennifer Dolman, Clinical Services Director (LD & TQ21) Liz Taylor, Associate Director of Nursing (Childrens and Families) (6.4a & 6.4b) - each lead responsible for the reporting and thematic analysis in their Division)	Lesley Stevens, Medical Director (6.4a & 6.4b)	31.10.16	Evidence obtained: Terms of Reference (6.4a) Standardised agenda (6.4a) Evidence required: Completed thematic analysis linked to mortality (6.4b)	Upward reporting of the mortality review process from Division to Board provides a richness of information to provide assurance or the requirement for further check and challenge.	SharePoint in place for the collection of the documentation related to all levels of mortality meeting. 23.08.16 Schedule for the presentation of thematic reviews in development by the MWG. 30.08.16 Recovery plan for action 6.4b submitted to SIOAC and action timescale approved for change - reset at 31.10.16	Robust evidence of mortality review recorded through the minutes of the meetings including the Mortality Working Group which are shared through a central SharePoint site.(6.4a) Bi-annual audit of the minutes to be reported to the SIOAC will provide assurance that mortality and serious incidents are being scrutinised and lesson learnt throughout the Trust.	30.09.16	Evidence required: Audit of the contents of the SharePoint site record of Mortality Meetings (6.4a) Audit of the minutes of the SIOAC (6.4a) Thematic review reports and documented changes to practice (6.4b)
		6.5a Data for Mortality Meetings to be produced by the Ulysses systems analyst (monthly). Data Quality Audit to be implemented for cross checking Ulysses data against Tableau live data to ensure all deaths are accurately recorded and included in Divisional Mortality Reviews	Simon Beaumont, Head of Informatics Thomas Williams, Ulysses Systems Developer (6.5a - joint responsibility)	N/A	Sara Courtney, Acting Chief Nurse Paula Anderson, Chief Finance Officer (6.5a - joint accountability)	30.01.16	Evidence obtained: Screen shot of mortality data reports on Tableau (6.5a)	Consistent data set to guide the discussion at the Mortality Meetings.	Data published to Tableau the trust BI system.	Robust evidence of mortality review recorded through the minutes of the meetings including the Mortality Working Group which are shared through a central SharePoint site which are auditable. (6.5a) Bi-annual audit of the minutes will ensure that this is being utilised appropriately at the meetings to highlight themes for further investigation. (6.5a)	30.09.16	Evidence required: Audit of the contents of the SharePoint site record of Mortality Meetings (6.5a) Audit of the minutes of the SIOAC (6.5a) Thematic review reports and documented changes to practice (6.5a)
		6.6a All Divisions to use 'Hot Spots', 'Learning Matters' and 'Could it happen here?' templates to share thematic review findings and enhance organisational, divisional and team learning. This should include learning from family involvement.	Tracey McKenzie, Head of Compliance and Assurance (6.6a)	Mandy Slaney, Lead IO AMH Eileen Morton, Lead IO AMH Georgie Townsend, Lead IO Childrens and Families and West ISD Angela O Brien, Lead IO East ISD Nic Cicutti, Lead IO LD & TQ21 (6.6a responsible for their allocated Division)	Lesley Stevens, Medical Director Sara Courtney, Acting Chief Nurse (6.6a - joint accountability)	31.03.16	Evidence required: Publications for the Divisions - Hotspots, Learning Matters and Could it Happen Here (6.6a)	Evidence of divisional learning which should reduce the risk of potential recurrence of the incident when the root cause describes a SHFT related failing.	Publications present in all division accept the East ISD. 21.07.16 Further check underway with the East ISD to assess compliance	Reduction in themed root causes which described a SHFT related failing over a 12 month period, data provided by audit. (6.6a)	31.12.16	Evidence required: Results of audit tracking the themes from root causes (6.6a)
Thematic reviews	7. A template for a thematic review should be produced. All thematic reviews should be undertaken in an agreed format which meets best practice standards and includes follow up, evaluation and demonstration of lessons learned and practice change.	7.1a Creation and publication of a template to support thematic review this will be implemented through the Mortality Working Group for mortality related reviews and will be implemented through the Clinical Audit Facilitator responsible for Trust-wide thematic reviews. 7.1b Pilot use in the divisions and promote via the Mortality Working Group.	Tracey McKenzie, Head of Compliance and Assurance (7.1a & 7.1b)	N/A	Sara Courtney, Acting Chief Nurse (7.1a & 7.1b)	31.03.16	Evidence obtained: Thematic review template (7.1a) Mortality Working Group minutes (7.1b)	Consistent documentation support thematic review to ensure that quality reports are received from which improvement actions can be easily extracted.	Template piloted and shared with the Commissioners for opinion. Piloted and launched in the Trust. 21.07.16 Evidence of discussing thematic reviews at the Mortality Meetings has not been obtained and this will be discussed at the MWG 04.08.16 Discussed at the MWG, thematic template to be reicirculated, East ISD and West ISD have both commenced a thematic review 30.08.16 Recovery plan for action 7.1a & 7.1b submitted to SIOAC and action timescale approved for change - reset at 31.10.16	Quality thematic reports which can be shared as learning throughout the Trust. (7.1a) Reduction in incidents with identical root causes to be evidenced by audit. (7.1b) Please note detail behind timescale: 30.06.16 31.12.16 - for audit to prove reduction in incidents with identical root causes (7.1b)	31.10.16 31.12.16	Evidence required: Mortality Forum minutes - presentation of a thematic review (7.1a & 7.1b) Audit of root causes to prove reduction (7.1a & 7.1b) (results not expected until 31.12.16)
Thematic reviews	8. There should be further work undertaken to establish whether all deaths of people over the age of 65 are being appropriately reported and investigated - in particular amongst inpatients.	8.1a The Procedure for Reporting and Investigation Deaths includes the reporting of all Older Persons Mental Health (OPMH) inpatient deaths. A 48 hour panel is to be established with Senior Clinical Chair at Divisional to decide the level of investigation which is require for each death on a case by case basis. Panel decision to reported within the Ulysses system as per process.	Thomas Williams, Ulysses System Developer (8.1a)	Sarah Constantine, Clinical Services Director, OPMH inpatients and East Division Gina WinterBates, QG Business Partner, OPMH (8.1a)	Lesley Stevens, Medical Director (8.1a)	29.02.16	Evidence obtained: Procedure for Reporting and Investigating Deaths created and in use within OPMH (8.1a)	All OPMH inpatient deaths are reviewed inline with the SHFT procedures and reasons not to investigate are clearly defined by the 48 hour panel.	Senior clinical chair for each 48 hr mortality review panel. Monthly IMA / Mortality process is covering OPMH investigations. 21.07.16 Evidence of discussing thematic reviews at the Mortality Meetings has not been obtained and this will be discussed at the MWG 04.08.16 Discussed at the MWG, thematic template to be reicirculated, East ISD and West ISD have both commenced a thematic review 30.08.16 Recovery plan for action 8.1a submitted to SIOAC and action timescale approved for change - reset at 31.10.16	Improved levels of investigation into OPMH inpatient deaths over a 12 month period evidence by audit and thematic review. (8.1a) Please note detail behind timescales: 30.06.16 - Externally commissioned thematic review 31.01.17 - Audit after 12 month working under the new process to assess the level of reporting	31.10.16 31.01.17	Evidence required: Thematic review results (8.1a) Audit of all reports deaths (8.1a) - evidence not due until 31.01.17 Monthly audit of 20% of the mortality / death reports / IMA which is inclusive of OPMH
Thematic reviews	9. The Trust, CCG and local authority should undertake a retrospective review of all Learning Disability unexpected deaths regardless of place of residence with particular reference to: a. the quality, timing and follow up of dysphagia assessments b. the level of support provided by hospital liaison services and the challenges faced in acute liaison c. the decision-making process for PEG insertion d. the hydration and nourishment of service users refusing to eat e. delays in decision-making for treatment - including primary care, decisions by care staff and responses in A&E and on wards f. the inclusion of carers and families in investigations	9.1a Engage all stakeholders in a workshop to discuss the appropriateness, the capacity for and ownership of the terms of reference for retrospective and forward planned thematic review. 9.1b SHFT to commission an external appreciative enquiry into the experience of families in the investigation process over the last 2 years.	Helen Ludford, Associate Director of Quality Governance (9.1a) Chris Woodfine, Head of Patient Experience and Engagement (9.1b)	Mary Kloer, Clinical Services Director AMH Mayura Deshpande, Clinical Services Director, Specialised Services Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Peter Hockey, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Jennifer Dolman, Clinical Services Director (LD & TQ21) Liz Taylor, Associate Director of Nursing (Childrens and Families) (9.1a & 9.1b - responsible for Divisional participation in thematic reviews)	Sara Courtney, Acting Chief Nurse (9.1a) Lesley Stevens, Medical Director (9.1b)	29.02.16 (9.1a) 31.08.16 (9.1a) 01.06.16 (9.1b)	Evidence required: Workshops with CCG Commissioners to discuss multi-agency retrospective and forward planned thematic review (9.1a) Commissioning documents for external appreciative enquiry (9.1b)	That joint thematic reviews are commissioned correctly and involve all providers of care to the cohort of patients.	This is a joint action which SHFT are working with the commissioners to achieve. SHFT has commissioned an external appreciative enquiry into the experience of families in the investigation process over the last 2 years as this has been deemed as extremely important for guiding improvement activities.	Meetings to be held to discuss any joint thematic reviews that are to be jointly commissioned and Terms of reference shared. (9.1a) Results of the appreciative enquiry (9.1b)	30.09.16	Evidence required: Report from externally commissioned thematic review.(9.1a) Outcome of wider stakeholder discussion re thematic review. (9.2b)
Thematic reviews	10. The Trust and CCG should undertake thematic reviews in Mental Health on a number of the issues raised in this review, including: a. A joint review of the circumstances of death of people with serious mental illness on long term antipsychotic drugs encompassing a review of safeguarding alerts, self neglect and physical health management. b. A joint review of all deaths relating to people with a drug related death in conjunction with local providers encompassing a review of referral processes between agencies. c. A joint review with the CCG of recent cases of death relating to serious eating disorders to understand how services need to improve by	10.1a Engage all stakeholders in a workshop to discuss the appropriateness, the capacity for and ownership of the terms of reference for retrospective and forward planned thematic review.	Helen Ludford, Associate Director of Quality Governance (10.1a)	Mary Kloer, Clinical Services Director AMH Mayura Deshpande, Clinical Services Director, Specialised Services Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Peter Hockey, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Jennifer Dolman, Clinical Services Director (LD & TQ21) (10.1a - responsible for Divisional participation in thematic reviews)	Sara Courtney, Acting Chief Nurse (10.1a) Lesley Stevens, Medical Director (10.1a)	29.02.16 1st workshop 30.09.16 2nd workshop	Evidence required: Workshops with CCG Commissioners to discuss multi-agency retrospective and forward planned thematic review (10.1a)	That joint thematic reviews are commissioned correctly and involve all providers of care to the cohort of patients.	This is a joint action which SHFT are working with the commissioners to achieve.	Meetings to be held to discuss any joint thematic reviews that are to be jointly commissioned and Terms of reference shared. (10.1a)	30.09.16	Evidence required: Report from externally commissioned thematic review (Carolan report) .(10.1a)
Thematic reviews	11. The Trust should provide staff with regular training and guidance to help them manage physical health conditions of long-term mental health service users. Diabetes management stands out as an area for greater awareness from a number of cases we reviewed.	11.1a Review the content of the five day physical health course which LEaD provide. Course content and learning outcomes which will be reviewed. 11.1b Ensure that there is the correct percentages of staff attending from each service. 11.1c Attendance data recorded per service. 11.1d Review published Physical Assessment and Monitoring Procedure for Mental Health and Learning Disability Services which includes a reference to diabetic monitoring. 11.1e The physical health monitoring policy will be reissued to all clinical staff within the Adult Mental Health division (AMH), Learning Disabilities (LD) and Older Persons Mental Health (OPMH)	Bobby Moth, Associate Director of LEaD Steve Coopey, Head of Clinical Development (11.1a, 11.1b and 11.1c)	Carol Adcock, Associate Director of Nursing AMH (11.1a, 11.1b & 11.1c) Mary Kloer, Clinical Services Director AMH (11.1a, 11.1b & 11.1c) Kate Brooker, Associate Director AMH (11.1a, 11.1b, 11.1c, &11.1d) John Stagg, Associate Director of Nursing LD (11.1a, 11.1b & 11.1c)	Mark Morgan, Director of Operations AMH, LD & TQ21 Sara Courtney, Acting Chief Nurse (11.1a, 11.1b & 11.1c - joint accountability)	31.07.16	Evidence required: Course content and learning outcomes (11.1a) Percentages of for the staff who have undertaken it by service (11.b) Attendance registers (11.1c)	All AMH services will have staff who are competent in managing physical health care needs of the individual service users. Reduction in the rate of physical health management featuring as a contributory factor in SI investigation reports.	11.1a Course content currently being reviewed by the ADoNs from AMH and a LEaD representative. Additional options being scoped alongside the 5 day course. Alternatives are physical health specialist subject sessions and e learning. Subject matter inclusive of diabetes and respiratory. 11.1b & 11.1c Training records being obtained by Louise Hartland LEaD. 04.08.16 Input evidence request made for information - meeting was held with ADoNs to discuss e learning and shorter course options	Divisional and service level training records to that staff have been trained. (11.1b & 11.1c) Achieve of 90% compliance to clinical audit of physical health needs. (11.1a) Physical health audit to be undertaken in Q3. Audit of SI contributory factors to be undertaken in Q2. (11.1a)	30.11.16	Evidence required: Course attendance records - site / service percentage (11.1b & 11.1c) Results of the physical health audit of AMH sites (11.1a) Audit of SI reports proving a reduction in physical health contributory factors (11.1a) Review published Physical Assessment and Monitoring Procedure for Mental Health and Learning Disability Services which includes a reference to diabetic monitoring (11.1d)

Theme	Mazars Recommendations	SHFT Actions	Responsible Lead	Divisional Responsible Lead	Executive Accountability	Process Completion Date	Process Status	Expected Outcome	Outcome Progress Update	Evidence of Outcome Achieved	Measuring Success Date	Outcome Evidence
Thematic reviews	12. The Trust should undertake thematic reviews of the issues raised in the review, including: a. Medical input and senior medical oversight b. The role of the care co-ordinator c. The need for pharmacy colleagues to be more explicitly involved in cases involving drug toxicity and polypharmacy.	12.1a Review the themes which the Mortality Report suggests require further investigation such as, the role of the care coordinator. Undertake review and report the findings and the actions taken to Quality and Safety Committee. The requirement for thematic reviews will be discussed at the Divisional and Corporate panels and will be specifically aimed at the themes resulting from the Serious Incidents. By undertaking thematic reviews quality improvement plans will be created that will lead to improvement.	Mayura Deshpande, Associate Medical Director, Patient Safety and all Clinical Service Directors (12.1a)	Mary Kloer, Clinical Services Director AMH (12.1a)	Lesley Stevens, Medical Director (12.1a)	31.10.16	Evidence required: Minutes of a meeting where these issues have been discussed (12.1a)	The quality of care will improve through the outcomes of thematic review and the development of quality improvement plans. Thematic review will include expert opinion such as, pharmacist where necessary.	04.08.16 Raised at the MWG 01.08.16 - schedule of thematic reviews to be created 30.08.16 Recovery plan for action 12.1a submitted to SIOAC and action timescale approved for change - reset at 31.10.16	Thematic review reports will provide the evidence base for quality improvement activities at service level which will be documented in improvement plans.(12.1a)	30.11.16	Evidence required: Thematic reviews which do include clinical expert opinion and role scrutiny (12.1a) Serious investigation reports which contain expert opinions (12.1a) Quality Improvement plans which have been developed from thematic reviews (12.1a) Policy and procedures changes resulting from thematic reviews (12.1a)
		12.2a Provide evidence of thematic review to the CCG commissioners through CQRM's and SOG.	Tracey McKenzie, Head of Compliance and Assurance (12.2a)	Mary Kloer, Clinical Services Director AMH Mayura Deshpande, Clinical Services Director, Specialised Services Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Peter Hockey, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Jennifer Dolman, Clinical Services Director (LD & TQ21) (12.2a - responsible for Divisional participation in thematic reviews)	Mark Morgan, Director of Operations AMH, LD & TQ21 Sara Courtney, Acting Chief Nurse (12.2a - jointly accountable for ensuring thematic reviews take place and are shared)	31.10.16	Evidence required: Thematic review template (12.2a) Completed thematic review (12.2a)	The Trust will share the results of thematic review in an open and transparent style with Commissioners to stimulate discussion regarding changes in service provision for patient and service users where necessary. This will result in dynamic service transformation which will improve outcomes for patients.	Template for thematic review developed and circulated Trust-wide. 30.08.16 Recovery plan for action 12.2a, completed thematic review, submitted to SIOAC 31.08.16 - action timescale extended to 31.10.16	Thematic review reports will provide the evidence base for quality improvement potential for the wider health economy therefore evidence of sharing and the associated quality improvement activities discussed with be evidenced through minutes. (12.2a)	30.11.16	Evidence required: Thematic reviews which have been undertaken (12.2a) Minutes of meetings where thematic reviews have been discussed (12.2a)
Thematic reviews	13. A regular review of all sudden deaths of OPMH inpatients should be carried out. This should include a review of whether care treatment decisions are taken quickly enough, whether cooperation and liaison with acute medical staff is adequate and whether staff feel confident in managing and identifying sudden physical deterioration including CPR.	13.1a The Procedure for Reporting and Investigation Deaths includes the reporting of all OPMH inpatient deaths. 13.1b A 48 hour panel is to be established with Senior Clinical Chair at Divisional to decide the level of investigation which is require for each death on a case by case basis. Panel decision to reported within the Ulysses system as per process. 13.1c Within the Terms of Reference for investigations physical health deterioration with be explored.	Helen Ludford, Associate Director of Quality Governance (13.1a)	Sarah Constantine, Clinical Services Director, OPMH inpatients and East Division (13.1b & 13.1c)	Chris Gordon, COO and Director of Patient Safety (13.1a & 13.1b) Lesley Stevens, Medical Director (13.1c)	30.06.16	Evidence obtained: Procedure for Reporting and Investigating Deaths created (13.1a) Ulysses template for mortality 48 hour panel in OPMH (13.1b) Ulysses incident report for OPMH with physical health related Terms of Reference (13.1c)	All OPMH inpatient deaths are reviewed inline with the SHFT procedures and reasons not to investigate are clearly defined by the 48 hour panel. Physical health concerns will feature as part of the panel discussion.	Senior clinical chair for each 48 hr mortality review panel. Procedure for Reporting and Investigating Deaths published - includes the requirement for OPMH.	Improved levels of investigation into OPMH inpatient deaths over a 12 month period evidence by audit. (13.1a & 13.1b) Reduction in contributor factors associated with the management of physical health will be seen over a year an evidenced by audit. (13.1c)	31.12.16	Evidence required: Audit of 12 months of OPMH related serious incident investigation reports to prove a reduction in physical health related contributory factors. (13.1a, 13.1b & 13.1c)
Reporting and Identifying Deaths	14. The Trust should review the way that deaths are categorised under the incident reporting policy so that: a. All relevant deaths are re-graded accurately before and after investigations have taken place (14.1a, 14.2a, 14.2b) b. All relevant deaths are reported on regardless of impact grading to ensure that deaths have greater prominence in the Trust's reporting systems. (14.3a) c. Accurate information is provided for future Trust Mortality Reviews. (14.4a) d. That immediate work with the NRLS team is undertaken to ensure the changes to the local risk management system map as expected to NRLS and on to CQC. (14.5a)	14.1a Re-write SHFT incident policy to include enhanced information on impact grading as defined by the National Reporting and Learning Service (NRLS). This is a national requirement and processes need to be correct to gain accurate benchmarking data.	Kay Wilkinson, SI and Incident Manager (14.1a)	N/A	Sara Courtney, Acting Chief Nurse (14.1a)	30.03.16	Evidence obtained: Serious Incident Management Policies and Procedures rewritten (14.1a)	Monitoring our accurate reporting to the NRLS will enable SHFT to accurate benchmarking against other Trusts within the sector to ascertain that improvements made through learning from serious incidents has resulted in less harm being experienced by our patients.	Policy re-written and published.	Benchmarking NRLS data should evidence that SHFT is not a data outlier. Please note NRLS data is published 6 months in arrears therefore improvement cannot be measured until the April 2017 publication. (14.1a)	01.04.17	Evidence required: Screenshot evidence of uplift of to the NRLS (14.1a) Published NRLS data April 2017 (14.1a)
		14.2a Create a Corporate Panel tool that records the impact grading which is applied to the investigation at the point of final sign off by the panel under the executive director Chair. 14.2b Serious Incident support officers to update the impact grade in the Ulysses system following panel.	Kay Wilkinson, SI and Incident Manager (14.2a & 14.2b)	N/A	Sara Courtney, Acting Chief Nurse (14.2a & 14.2b)	30.03.16	Evidence obtained: Corporate tool which records impact grading (14.2a) Corporate panel SOP which required the officers to update the impact grade (14.2b)	Monitoring our accurate reporting to the NRLS will enable SHFT to accurate benchmarking against other Trusts within the sector to ascertain that improvements made through learning from serious incidents has resulted in less harm being experienced by our patients.	Tool created and is in use at each Corporate Panel.	Benchmarking NRLS data should evidence that SHFT is not a data outlier. . Please note NRLS data is published 6 months in arrears therefore improvement cannot be measured until the April 2017 publication. (14.2a & 14.2b)	01.04.17	Evidence required: Published NRLS data April 2017 (14.2a & 14.2b) Audit of corporate panel grading tool results with comparison to the uplifted reports to StEIS with provide assurance of accurate grading (14.2 & 14.b)
		14.3a Through consultation with the Clinical Leadership of each division create a Trust-wide Procedure for Reporting and Investigating Deaths which clearly defines the reporting criteria, review process as to what level of investigation should be undertaken and involves families. 14.3b Monitoring of this procedure will be through the Mortality Working Group under executive chair which reports to Serious Incident Oversight and Assurance Committee (Board sub-committee).	Helen Ludford, Associate Director of Quality Governance Thomas Williams, Ulysses System Developer (14.3a & 14.3b)	Mary Kloer, Clinical Services Director AMH Mayura Deshpande, Clinical Services Director, Specialised Services Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Peter Hockey, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Jennifer Dolman, Clinical Services Director (LD &TQ21) Liz Taylor, Associate Director of Nursing (Childrens and Families) (14.3a & 14.3b - responsible lead for their own Divisions)	Sara Courtney, Acting Chief Nurse (14.3a & 14.3b)	31.12.15	Evidence obtained: Procedure for Reporting and Investigating Deaths written and published (14.3a) MWG membership, Terms of Reference and agenda (14.3b) Audit tool created , audit completed on 20% of reported deaths per month (14.3b)	The outcome will be that all reportable deaths are reviewed by a consistent process defined by procedure and that families are included in investigations where appropriate and their questions answered in an open and transparent manner.	01.06.16 Compliance to procedure 100% Audit result 83%	Compliance to the procedure will be monitored through the weekly Flash report. (14.3a) Detail of the decision making will be through monthly audit of 20% of the reports. (14.3b) SIOAC papers will demonstrate monitoring of compliance to the procedure (14.3b)	30.09.16	Evidence required: Mortality audit results above 90% correct decision making as to the level of investigation and compliance to the procedure at 100% this audit will also demonstrate the involvement of families (14.3a & 14.3b) Assurance evidence obtained demonstrated to the Board through SIOAC papers (14.3a & 14.3b)
		14.4a The death reporting procedure is to be supported by the Safeguard Ulysses system enabling accurate and auditable extractions of mortality information. Supporting data input screens to be developed and users to be educated.	Lottie Turner, Practice Development Lead East ISD Thomas Williams, Ulysses System Developer (14.4a - joint responsibility)	N/A	Chris Gordon, COO and Director of Patient Safety (14.4a)	31.12.15	Evidence obtained: Screenshots of the Ulysses System for mortality reporting and 48 hour panels (14.4a)	SHFT will be compliant to providing easily extractable for any Mortality Review which includes auditable recording of reporting deaths and decision making as to whether an investigation is required. This will enable accurate benchmarking and provide public reassurance of improvement in process which is compliant to the national guidance .	01.06.16 Compliance to procedure 100% Audit result 83%	Compliance to the procedure will be monitored through the weekly Flash report. Detail of the decision making will be monitored through monthly audit of 20% of the reports. (14.4a)	31.04.16	Evidence obtained: Flash report compliance to the procedure (14.4a) Monthly audit of 20% of the mortality 48 hr panel information (14.4a)
		14.5a Governance team to meet with the NRLS centralised team to ensure that the SHFT impact grading and uplift processes are occurring within the required criteria. This upload is electronic supported through a system extraction of all patient safety incidents. The information is onwardly shared with the CQC.	Ryan Taylor, Head of Incident Management and Patient Safety Thomas Williams, Ulysses System Developer (14.5a - joint responsibility)	N/A	Sara Courtney, Acting Chief Nurse (14.5a)	30.03.16	Evidence obtained: Minutes to support meeting with NRLS to verify Trust procedure for uplift (14.5a)	Monitoring our accurate reporting to the NRLS will enable SHFT to accurate benchmarking against other Trusts within the sector to ascertain that improvements made through learning from serious incidents has resulted in less harm being experienced by our patients.	01.06.16 NRLS uplift undertaken on the 18th of each calendar month. NRLS team have reviewed SHFT process and agreed it as accurate.	Assurance that SHFT is managing the national NRLS uplift process correctly demonstrated by uplift confirmation messages directly from the NRLS. (14.5a)	31.04.16	Evidence obtained: System confirmation messages of successful uplift to the NRLS (14.5a)
Quality of Investigation Reporting	15. The Serious Incident investigation process needs a major overhaul in the Trust. Improvements are needed in: a. Separation of people responsible for quality assurance and those undertaking investigations. This would enable training in review processes and quality assurance to be targeted at senior staff and in investigation techniques at a dedicated group of investigators. (15.5a, 15.5b, 15.5c, 15.5d) b. Quality assurance processes including independent review and sign off (15.5a, 15.5b, 15.5c, 15.5d, 15.6d) c. Achieving high professional standards in written presentation (15.1a, 15.2b, 15.3a, 15.3b, 15.3c, 15.4a)	15.1a Rewrite of SHFT Serious Incident Management policy and procedures to be more inclusive of flowchart to provided guidance to staff.	Kay Wilkinson, SI an incident Manager (15.1a)	N/A	Sara Courtney, Acting Chief Nurse (15.1a)	30.03.16	Evidence obtained: Serious Incident Management Policies and Procedures rewritten (15.1a)	Clear instruction about reporting and managing serious incidents will improve compliance to reporting and the quality of the investigation.	Updated policy and procedure published	Compliance to policy and procedure to checked by audits: mortality IMA monthly audit and the bi-annual SI report audit. From the information ascertained via the peer review reports - focused question related to the death reporting procedure and serious incident management.	30.09.16	Evidence required: Extract from peer review results - specific question about mortality reporting (15.1a) Monthly 20% audit of the mortality reports and 48 hr panel information (15.1a)
		15.2a Recruit centralised Serious Incident Investigator team to be known as the Divisional Lead Investigation Officers.	Helen Ludford, Associate Director of Quality Governance (15.2a)	Paula Hull, Deputy Director of Nursing ISD's John Stagg, Associate Director of Nursing, LD TQ21 Carol Adcock, Associate Director of Nursing, AMH Nicky Bennet, Associate Director of Nursing, Specialised Services Liz Taylor, Associate Director of Nursing, Childrens and Families (15.2a - responsible for the Lead IO's for their Division)	Sara Courtney, Acting Chief Nurse (15.2a)	30.11.15	Evidence obtained: List of Lead IO's in post per Division (15.2a)	That there is competent expertise at divisional level to monitor performance against the national framework criteria and through a process of support, education and feedback increase the quality of the investigation reports. Completion / submission of a quality investigation becomes standard Trust practice.	Key Performance Indicator monitored monthly and report to executive level within the trajectory and mortality and serious incident management papers supplied to Board sub-committees.	Dashboard results supporting the Key Performance Indicator of submission of a quality investigation report within 60 working days. (15.2a)	30.06.16	Evidence obtained: Dashboard demonstrating to Trust's performance against submitting quality reports within 60 days (15.2a)

Theme	Mazars Recommendations	SHFT Actions	Responsible Lead	Divisional Responsible Lead	Executive Accountability	Process Completion Date	Process Status	Expected Outcome	Outcome Progress Update	Evidence of Outcome Achieved	Measuring Success Date	Outcome Evidence
		15.3a Create a register of Trust-wide Investigating Officers to ensure all have been trained and competency assessed by undertaking a minimum requirement of one investigation per annum. 15.3b Investigating Officer to receive post-panel feedback on the quality of their investigation report following Corporate Panel. 15.3c Investigation skills to be discussed within the appraisal with the line manager.	Helen Ludford, Associate Director of Quality Governance (15.3a & 15.3b)	Mandy Slaney, Lead IO AMH Eileen Morton, Lead IO AMH Georgie Townsend, Lead IO Childrens and Families and West ISD Angela O Brien, Lead IO East ISD Nic Cicutti, Lead IO LD & TQ21 (15.3a and 15.3c - responsible for their own Division)	Sara Courtney, Acting Chief Nurse (15.3a, 15.3b & 15.3c)	30.11.15	Evidence obtained: Trust-wide register of trained IO's which is maintained (15.3a) Corporate panel feedback sheet (15.3b) Appraisal paperwork (15.3c)	Trained and competent investigators will provide quality reports which will establish cause and themes for learning.	Feedback to be input into appraisals.	Quality investigations which stimulate learning to prevent reoccurrence. This will be evidenced in a reduction in the reoccurrence of themes over a 12 month period. (15.3a, 15.3b & 15.c)	31.12.16	Evidence required: Audit of serious incident investigations 12 months after IO's have been in post to ascertained that learning has taken place and themes have reduced (15.3a, 15.3b & 15.c)
		15.4a Develop a Divisional Lead Investigating Officers supervision session for case study learning from Panels and updates to National guidance.	Helen Ludford, Associate Director of Quality Governance (15.4a)	Mandy Slaney, Lead IO AMH Eileen Morton, Lead IO AMH Georgie Townsend, Lead IO Childrens and Families and West ISD Angela O Brien, Lead IO East ISD Nic Cicutti, Lead IO LD & TQ21 (15.4a - responsible for their own Division)	Sara Courtney, Acting Chief Nurse (15.4a)	30.03.16	Evidence obtained: Schedule of IO supervision meetings (15.4a)	That lead investigators will be supported through clinical supervision sessions and changes to National guidance will cascade through the Trust this will ensure that a high level of quality is maintained and the Trust is recognised as a learning organisation.	Supervision meetings held every 2 weeks.	Continued increased quality of the investigation reports which adhere to national standards proven by audit. (15.4a)	31.12.16	Evidence required: Audit of serious incident investigations 12 months after IO's have been in post to ascertained that learning has taken place and themes have reduced (15.4a)
		15.5a Create a system of Divisional and Corporate Review Panels which assess each investigation report for quality and compliance to the Nationally set criteria. These panels will apply scrutiny and challenging to the findings of the investigation. 15.5b The Divisional Panel will be Chaired by a Senior Clinician. 15.5c The Corporate Panel will be chaired by an Executive Director. 15.5dThere will be fixed Terms of Reference in place for both levels of panel. These actions will facilitate a process of quality assurance which is separated from the investigating officer undertaking the investigation. The panels will be comprised of members who are not involved in the investigation. The panels will use the closure checklist extracted from the national framework document to judge quality compliance.	Helen Ludford, Associate Director of Quality Governance (15.5a, 15.5c & 15.5d)	Mary Kloer, Clinical Services Director AMH Mayura Deshpande, Clinical Services Director, Specialised Services Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Peter Hockey, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Jennifer Dolman, Clinical Services Director (LD & TQ21) Liz Taylor, Associate Director of Nursing (Childrens and Families) (15.5b - responsible for their own Division)	Julie Dawes, Acting Chief Executive Officer (15.5a, 15.5c & 15.5d) Mark Morgan, Director of Operations AMH, LD & TQ21 Gethin Hughes, (15.5b) Director of ISDs, OMPH and Childrens and Families (15.5b)	31.12.15	Evidence obtained: Serious Incident Management Policies and Procedures rewritten (15.5a) Death reporting Procedure (15.5a) Approved Chair list for all panels (15.5b) Corporate panel schedule with allocated Chairs (15.5c) Terms of Reference (15.5d)	That there is a consistent process independent to the investigation to review and sign off of quality reports which in turn facilitates learning and improvement by investigation reports having robust resulting actions. The complete process has executive oversight to assure that it is maintained.	Updated policies and procedures published. Panel schedules and Chair lists obtained.	Continued increased quality of the investigation reports which adhere to national standards proven by audit. (15.5a, 15.5b, 15.5c & 15.5d) Please note dates for measuring success are: 31.03.16 production of monthly dashboard monitoring tool 31.12.16 for 12 month audit	31.03.16 31.12.16	Evidence required: Dashboard of the percentage of reports approved by corporate panel on the first occasion, monthly collection of data. Audit of serious incident investigations 12 months after IO's have been in post to ascertain that quality has increased. (15.5a, 15.5b, 15.5c & 15.5d)
		15.6a All serious incident investigation reports to be subject to CCG lead closure panel scrutiny and challenge. This is an independent panel comprising of Quality Managers external to the Trust and representative of the commissioners. This is a framework stipulated independent quality assurance action. All Lead IO's to be present at the panel to assist with presenting cases.	Kay Wilkinson, SI and incident Manager (15.6a)	Mandy Slaney, Lead IO AMH Eileen Morton, Lead IO AMH Georgie Townsend, Lead IO Childrens and Families and West ISD Angela O Brien, Lead IO East ISD Nic Cicutti, Lead IO LD & TQ21 (15.6a - responsible for their own Division)	Chris Gordon, COO and Director of Patient Safety (15.6a)	30.03.16	Evidence obtained: Minutes of CCG closure panels x 3 (15.6a)	That there is a consistent process independent to the investigation and SHFT to review and sign off of quality reports which in turn facilitates learning and improvement by investigation reports having robust resulting actions.	Closure panels scheduled for every two weeks. 21.07.16 Dashboard supporting the external closure panel not yet finalised. Further discussion with the CCG Quality Managers have taken place. 04.08.16 Outcome evidence overdue - have been unable to produce dashboard percentages of external closure due to the panels concentrating of the backlog clearance as of 1st August this data can be collected.	Continued increased quality of the investigation reports which adhere to national standards proven by audit. (15.6a) Please note timescale for measuring success is: 30.06.16 production of monthly dashboard monitoring tool 31.12.16 for 12 month audit	30.06.16 31.12.16	Evidence required: Dashboard of the percentage of reports approved by external closure panel on the first occasion, monthly collection of data. Audit of serious incident investigations 12 months after IO's have been in post to ascertain that quality has increased.(15.6a)
Timeliness of Investigations	16. Reporting to StEIS should be undertaken within the 2 working days of notification as required by the national guidance.	16.1a Serious Incidents will be recorded on StEIS within 2 working days of the occurrence being reported on the Safeguard Ulysses system as specified by the National Framework by the SI and Incident Team. 16.1b The 48 hr panels at Divisional Level will decided on the level of investigation required to support the prompt reporting and this will be documented on the Safeguard Ulysses system.	Kay Wilkinson, SI and Incident Manager Mandy Rogers, SI Officer Sam Clark, SI Officer (16.1a - joint responsibility)	Mary Kloer, Clinical Services Director AMH Mayura Deshpande, Clinical Services Director, Specialised Services Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Peter Hockey, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Jennifer Dolman, Clinical Services Director (LD & TQ21) Liz Taylor, Associate Director of Nursing, Childrens and Families (16.1b - responsible for their Division)	Sara Courtney, Acting Chief Nurse (16.1a) Mark Morgan, Director of Operations AMH, LD & TQ21 Gethin Hughes, (16.1b) Director of ISDs OMPH In Patients and Childrens and Families (16.1b)	30.06.16	Evidence obtained: Serious Incident Management Policies and Procedures rewritten (16.1a) Dashboard monitoring reporting to StEIS within 48 hrs (16.1a) 48 hour panel process (16.1b)	Prompt notification of SI's will aid the prompt commencement of an investigation . This will lead to timely information being gathered regarding causes and an opportunity for earlier patient safety recognition by discussing the immediate patient safety actions which require attention.	31.05.16 48% compliance to 48 hr reporting onto StEIS 21.07.16 47% compliance to 48 hr reporting onto StEIS (16.1a) 69% compliance to 48 hr panels being held within 48 hrs (16.1b) 04.08.16 31% (5/16) compliance to 48 hr reporting onto StEIS (16.1a) 04.08.16 84% compliant to the mortality panels being held in 48 hours, should by 95%	Timescale calculation - percentage of SI's reported on to StEIS within 48 hrs of reporting to be presented as a Key Performance Indicator on the dashboard. Please note that the timescale for measuring success is: (16.1a) 31.03.16 (16.1b) 30.06.16	31.03.16 30.06.16	Evidence required: 95% compliance to reporting to StEIS within 48 hrs - dashboard (16.1a) Compliance to 48 hr panels being held within 48 hrs (16.1b)
Timeliness of Investigations	17. There should be more explicit action to commence investigations promptly even when a coroner conclusion is not immediately available unless there is a specific reason to delay; any delay should have senior sign off.	17.1a The SHFT Procedure for Reporting and Investigating Deaths will stipulate that there is no delay in commencing an investigation whilst waiting for a Coroner decision on cause of death. Each death will reviewed as an individual case and the decision to investigate and at what level of investigation will be made on the clinical presentation. Each 48 hour panel Chair will be made aware of this requirement.	Kay Wilkinson, SI and Incident Manager (17.1a)	Mary Kloer, Clinical Services Director AMH Mayura Deshpande, Clinical Services Director, Specialised Services Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Peter Hockey, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Jennifer Dolman, Clinical Services Director (LD & TQ21) Liz Taylor, Associate Director of Nursing, Childrens and Families (17.1a - responsible for their own Division)	Sara Courtney, Acting Chief Nurse (17.1a)	31.01.16	Evidence obtained: Serious Incident Management Policies and Procedures rewritten (17.1a)	That the judgement of the 48 hr panel to investigate at death will not be dependent on the Coroners findings which may delay an investigation causing a potential loss of an opportunity for learning and improvement due to time delays.	21.07.16 Dashboard in place monitoring of monthly percentage of achievement against the 48 hour target. (17.1a)	6 monthly audit of reasons for delays in reporting to StEIS should show a reduction in cases where an investigation has only commenced after a Coroners ruling. (17.1a) Please note that the timescale for measuring success is: 30.03.16 for dashboard monitoring 31.08.16 for initial audit results	30.03.16 31.08.16	Evidence required: Dashboard monitoring of monthly percentage of achievement against the 48 hour target. (17.1a) Audit of delays in reporting to StEIS will show that no serious incident investigation has waited for a Coroners ruling, the decision has been made earlier. (17.1a)
Involvement of Families	18. The involvement of families in investigations requires improvement. In particular, improvements are needed in: a. developing clear guidelines for staff, including expected timescales and core standards, which recognise the need for iterative engagement when the family is ready (18.1a, 18.2a, 18.5a) b. ensuring that the investigation process is clearly defined and separate from the support and assistance offered by local treatment teams (18.3a, 18.4a, 18.5a) c. the Trust should ensure that investigators talk to families as early as possible in the process to identify any concerns and take these into account in the ensuing investigation (18.1a, 18.3a, 18.3b) d. provide reports to coroners in time for inquests (18.2a and also links to 17.1a) e. explicitly demonstrating why families are not involved (18.6a) f. identifying next of kin details for all service users as part of a core assessment including where consent to share has not been provided to enable investigators to find relatives more easily. (18.9a) g. working with primary care to identify family members (18.9b) h. where the Trust delays the commencement of an investigation due to inquests or other investigations this should be made explicit to families and the reasons explained. (18.2a) i. the performance of divisions in involving families and securing feedback (18.6a)	18.1a Process to be developed (and included in first revision of new Death reporting procedure) which formally invites any concerns from families to be raised following a death that meets the criteria set out in the new procedure and advises families as to whether an investigation will take place. (this will be over and above the actions already required by Trust policy when it is clear from the outset that the death constitutes a SIRI and Duty of Candour is engaged as well as the requirement to invite families to participate in the investigation) The Duty of Candour policy includes a flowchart for the involvement of families and points of communication. This is over and above the legal requirements of Duty of Candour and meets the requirements of the CQC regulation 20 dealing with the important factor of the involvement of families and lived ones. The Death Reporting procedure includes a guidance section specific to the involvement of families and the communication which should take place and differing points. 18.1b the Serious Incident policy and procedure specifies timescales for investigations and the sharing of reports with Coroners. There should no longer be any reason why an investigation should be delayed until an inquest is heard. It is now the approach of the trust that when required an investigation will run in tandem with police investigation unless otherwise instructed by the police and this will be explained to the family by the Investigating Officer / FLO.	Ryan Taylor, Head of Incident Management and Patient Safety (18.1a)	Mary Kloer, Clinical Services Director AMH Mayura Deshpande, Clinical Services Director, Specialised Services Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Peter Hockey, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Jennifer Dolman, Clinical Services Director (LD & TQ21) (18.1a - responsible for their own Division)	Sara Courtney, Acting Chief Nurse (18.1a)	31.07.16	Evidence required: Rewritten Duty of Candour policy inclusive of flowcharts (18.1a) Death reporting Procedure (18.1a)	There is an enhanced and clear process that involves families and takes into account any concerns that families may have and they will be more engaged in the investigation process. and this will be further supported by Family Liasion Officer post. Investigations will be conducted in an open and transparent way which leads to honesty as to any act or omission in treatment. Families will be encouraged to be a participant in service improvement to prevent recurrence of what act or omission in care their loved one may have experienced which will in turn proivde the Trust with a greater understanding of what went wrong.	External review commissioned. SHFT has commissioned an external appreciative enquiry into the experience of families in the investigation process over the last 2 years as this has been deemed as extremely important for guiding improvement activities. 03/11/2016: 18.1a Carolan Review received by the Trust. Internal review of serious incidents was not sufficient to evidence the outcome as complete due to the figure of 69% (78 records) families were involved in the investigations. Outcome to remain Red 17/11/16 The results of the external review have proven that the process for the complete involvement of families is not yet embedded. Further review to be completed internally by the FLO focusing on March 2016 onwards and reporting quarterly.	The external review into the quality of the experience of Duty of Candour and the involvement of families in SIRI investigations will provide information which will be reviewed by the Trust. There is an expectation that the Trust has improved in this area however the report will be analysed and improvement actions applied as required. (18.1a) To be completed and reported by 30.09.16 Quarterly report on family involvement to be provided by the FLO to aid focus improvement activities (18.1a) deadline for quarterly reporting to be established 31.03.17	30.09.16 31.03.16	Evidence required: Report from externally commissioned thematic review - Carolan Review (18.1a) Internal thematic review of Serious Incidents will prove that families have been included in 100% of investigations where appropriate and they wish to be involved (18.1a) 3 x example of serious incident investigation reports where families have been involved in the investigation and received the report (18.1a, 18.2a) SIOAC minutes where case studies have been presented to show the involvement of families and the provide a richness of information to the investigation (18.1a, 18.1b) Quarterly report to be provide by the FLO on family involvement (18.1a)
		18.2a Duty of Candour policy to be reviewed and rewritten to be specific about the involvement of families in investigations in an open and transparent manner. Non-family members will also be considered within this policy as will the involvement of other important others such as care staff.	Ryan Taylor, Head of Incident Management and Patient Safety (18.2a)	N/A	Sara Courtney, Acting Chief Nurse (18.2a)	31.07.16	Evidence required: Rewritten Duty of Candour policy inclusive of flowcharts (18.2a) Death reporting Procedure (18.2a)	There will be guidance and procedures in place to enable staff to be clear on the process. Staff will be appreciate the importance of involving families and be confident about the participation of families within the investigation process.	Policy refreshed and published 3 June 2016 External review commissioned. Monthly validation audit. 11.16 The results of the external review have proven that the process for the complete involvement of families is not yet embedded. Further review to be completed internally by the FLO focusing on March 2016 onwards and reporting quarterly.	The external review into the quality of the experience of Duty of Candour and the involvement of families in SIRI investigations will provide information which will be reviewed by the Trust. There is an expectation that the Trust has improved in this area however the report will be analysed and improvement actions applied as required. (18.2a) To be completed and reported by 30.09.16 The monthly DoC audit will supply information as to the quality of the recording of DoC related activities on the Ulysses system. (18.2a) Quarterly report on family involvement to be provided by the FLO to aid focus improvement activities (18.2a) deadline for quarterly reporting to be established 31.03.17	30.09.16 31.03.17	Evidence required: Report from externally commissioned thematic review.(18.2a) Monthly report from the validation of the DoC information. (18.2a) Internal thematic review of Serious Incidents will prove that families have been included in 100% of investigations where appropriate and they wish to be involved (18.2a) Quarterly report to be provide by the FLO on family involvement (18.2b)

Theme	Mazars Recommendations	SHFT Actions	Responsible Lead	Divisional Responsible Lead	Executive Accountability	Process Completion Date	Process Status	Expected Outcome	Outcome Progress Update	Evidence of Outcome Achieved	Measuring Success Date	Outcome Evidence
	families and securing feedback (18.08)	18.3a Role description for the Lead Investigator (centralised team) to include the specific role of oversight of communication and involvement of families. Investigation officers training involves a continuous golden thread through out the two day course about involving families: how to involve them, how to communication with them, how to record the communication and how to feedback to report to them. 18.3b There is a responsibility of the Divisional 48 hour panel to discuss Duty of Candour and involvement of families to ensure that there is a contact plan defined. 18.3c Scope the role, create a job description and recruit a Family Liaison Officer to directly liaise with families regarding their involvement in investigations, the questions which they would like addressing and to support the process through an agreed and structured communications plan. This role will predominantly support the families but will also support the 48 hour panels and the investigating officers. (action added 04.08.16 therefore input achievement timescale extended until 31.10.16)	Helen Ludford, Associate Director of Quality Governance (18.3a and 18.3b)	Mandy Slaney, Lead IO AMH Eileen Morton, Lead IO AMH Georgie Townsend, Lead IO Childrens and Families and West ISD Angela O Brien, Lead IO East ISD Nic Cicutti, Lead IO LD & TQ21 (18.3a and 18.3b)	Sara Courtney, Acting Chief Nurse (18.3a and 18.3b)	31.10.16	Evidence obtained: Lead Investigator Role Description (18.3a and 18.3b) Recruitment of FLO (18.3c)	The role of the Lead Investigator will be strengthened to ensure that communication between the Lead Investigator and families is effective. The engagement between families and the Trust will further be strengthened by the Family Liaison Officer post. This will ensure that the investigation process is open and transparent.	External review commissioned. Monitoring through Corporate panel that the DoC requirements have been completed and families where appropriate have been involved in the investigations. 11.16 The results of the external review have proven that the process for the complete involvement of families is not yet embedded. Further review to be completed internally by the FLO focusing on March 2016 onwards and reporting quarterly.	The external review into the quality of the experience of Duty of Candour and the involvement of families in SIRI investigations will provide information which will be reviewed by the Trust. There is an expectation that the Trust has improved in this area however the report will be analysed and improvement actions applied as required. To be completed and reported by 30.09.16. (18.3b) The corporate panel process ensures that the DoC has been achieved where possible for each individual case and this is recorded on the panel checklist. (18.3b) Quarterly report on family involvement to be provided by the FLO to aid focus improvement activities (18.3b) deadline for quarterly reporting to be established 31.03.17	30.09.16 31.03.17	Evidence required: Report from externally commissioned thematic review.(18.3b) Corporate panel checklist, random selection of 10 records (18.3b) Internal thematic review of Serious Incidents will prove that families have been included in 100% of investigations where appropriate and they wish to be involved (18.3c) Quarterly report to be provide by the FLO on family involvement (18.3b)
		18.4a Leaflet to be created which explains the Duty of Candour requirements and how families are welcomed to be involved in investigations to service users / patients / staff / next of kin.	Ryan Taylor, Head of Incident Management and Patient Safety (18.4a)	N/A	Sara Courtney, Acting Chief Nurse (18.4a and 18.4b)	31.03.16	Evidence obtained: Duty of Candour Leaflet (18.4a)	The families will be better informed on the investigation process and involving them where appropriate.	External review commissioned. Leaflet approved through committee for imminent launch in the Trust (at printers). 04.08.16 Leaflet now available to all services 11.16 The results of the external review have proven that the process for the complete involvement of families is not yet embedded. Further review to be completed internally by the FLO focusing on March 2016 onwards and reporting quarterly.	The external review into the quality of the experience of Duty of Candour and the involvement of families in SIRI investigations will provide information which will be reviewed by the Trust. There is an expectation that the Trust has improved in this area however the report will be analysis and improvement actions applied as required. To be completed and reported by 30.09.16 (18.4a) The monthly DoC audit will supply information as to the quality of the recording of DoC related activities on the Ulysses system. (18.4a) Internal thematic review of Serious Incidents will prove that families have been included in 100% of investigations where appropriate and they wish to be involved (18.4a) Quarterly report on family involvement to be provided by the FLO to aid focus improvement activities (18.4a) deadline for quarterly reporting to be established 31.03.17	30.09.16 31.03.17	Evidence required: Report from externally commissioned thematic review.(18.4a) Monthly report from the validation of the DoC information. (18.4a) Internal thematic review of Serious Incidents will prove that families have been included in 100% of investigations where appropriate and they wish to be involved (18.4a) Quarterly report to be provide by the FLO on family involvement (18.4a)
		18.5a The Trust will seek to engage lay people, families and service users to oversee the development of documents in relation to Duty of Candour and the investigation processes. This will ensure that the documents - policies, procedures and leaflets are written to easily understood by all parties and process followed.	Emma McKinney, Associate Director of Communications Chris Woodfine, Head of Patient Engagement and Experience (18.5a - joint responsibility)	N/A	Lesley Stevens, Medical Director (18.5a)	31.03.16	Evidence obtained: Role descriptions for lay persons (18.5a)	There will be true lay person involvement to inform the development process of the policies and procedures. Policies and procedures will be written in an easy read version. There will be true partnership working in the engagement of the Trust's serious incidents and mortality procedure.	Role description advertised for the MWG. 21.07.16 Lay person recruited to join the MWG. Healthwatch have agreed to have input into the SIOAC. Outcome will remain overdue until the evidence of this engagement is documented in the minutes. 04.08.16 - Evidence outcome remains red as lay person is yet to attend 3 x MWG but will join the meeting on 02.09.16 following DBS and reference checks 30.08.16 Recovery plan for action 18.5a submitted to SIOAC and action timescale approved for change - reset at 31.11.16 to allow for 3 sets of minutes following the meetings	Evidence of lay involvement in the ratification of policy and procedures through clear documentation of the ratification groups. To be overseen by the patient engagement and experience workstream. (18.5a)	30.11.16	Evidence required: Minutes of SIOAC x 3 (18.5a) Minutes of MWG x 3 (18.5a)
		18.6a Ulysses Safeguard screens to be further developed to map the Duty of Candour and family involvement and to record full compliance with each stage. This information will include why families are not involved. Audit of data capture will be used as an evidence base for assuring family involvement or reviewing cases where it has not been appropriate to facilitate involvement. This will be reported back to the different divisions as a performance check.	Thomas Williams, Ulysses Systems Developer (18.6a)	N/A	Sara Courtney, Acting Chief Nurse (18.6a)	30.06.16	Evidence obtained: Screenshot of DoC capture screens on Ulysses (18.6a) Guide to use (18.6a)	Full assurance that there are processes in place to capture the level of family involvement in the Trust's Duty of Candour processes.	Monthly validation audit in place but requires review to add additional questions.	Monthly audit to ascertain that the Duty of Candour is being undertaken and there is documentation to support this. (18.6a) The Corporate Panel checklist will ensure that the correct level of engagement where appropriate has taken place and that this is documented on a case by case basis for serious incidents. There is an expectation that the Trust will achieve 100% compliance undertaking DoC requirements as per Regulation 20 CQC and that this is clearly documented. Internal thematic review of Serious Incidents will prove that families have been included in 100% of investigations where appropriate and they wish to be involved (18.6a)	30.09.16	Evidence required: Monthly report from the validation of the DoC information. (18.6a) Corporate panel checklist, random selection of 10 records (18.6a) Internal thematic review of Serious Incidents will prove that families have been included in 100% of investigations where appropriate and they wish to be involved (18.6a)
		18.7a Data from Ulysses Safeguard to be used to report the Duty of Candour and regulation 20 (CQC) compliance to Commissioners via CQRM process. This will include the involvement of families in investigations which is over and above what is required by the regulations.	Ryan Taylor, Head of Incident Management and Patient Safety (18.7a)	N/A	Sara Courtney, Acting Chief Nurse (18.7a)	31.03.16	Evidence obtained: Monthly report from the validation of the DoC information. (18.7a)	The commissioners (CCGs) will have complete assurance that SHFT is fulfilling the Duty of Candour (CQC Regulation 20) requirement correctly. The Trust will domeonstrate that is has been open and honest and said sorry for the acts or omissions in its care which has led to patient harm.	Monthly validation audit in place but requires review to add additional questions.	Monthly audit to ascertain that the Duty of Candour is being undertaken and there is documentation to support this. The Corporate Panel checklist will ensure that the correct level of engagement where appropriate has taken place and that this is documented on a case by case basis for serious incidents. There is an expectation that the Trust will achieve 100% compliance undertaking DoC requirements as per Regulation 20 CQC and that this is clearly documented and reported externally to commissioners. (18.7a)	30.09.16	Evidence required: Achievement of 100% on the monthly report from the validation of the DoC information. (18.7a)
		18.8a Commission an external review of the current quality of the experience of the involvement of families in SIRI investigations over a 2 year period. The Review will use a mixture of Appreciative Inquiry and Experience Based Design methodology to understand the experience for staff, families, carers, patients and service users involved in SIRI investigations in the mental health and learning disability directorate. The review will provide recommendations to improve the experience of investigations for families and staff and to achieve an excellence standard of engagement.	Lesley Stevens, Medical Director (18.8a - commissioner) Helen Ludford, Associate Director of Quality Governance (18.8a - data contact)	N/A	Lesley Stevens, Medical Director (18.8a)	31.05.16	Evidence obtained: Commissioning agreement / scoping document. (18.8a)	The external review will feed into the development of improved and robust SIRI processes across the Trust and a strengthened framework for engagement with families when conducting the investigations	External review commissioned and underway 11.16 The results of the external review have proven that the process for the complete involvement of families is not yet embedded. Further review to be completed internally by the FLO focusing on March 2016 onwards and reporting quarterly.	The external review into the quality of the experience of Duty of Candour and the involvement of families in SIRI investigations will provide information which will be reviewed by the Trust. There is an expectation that the Trust has improved in this area however the report will be analysed and improvement actions applied as required. To be completed and reported by 31.10.16 (18.8a) Quarterly report on family involvement to be provided by the FLO to aid focus improvement activities (18.8a) deadline for quarterly reporting to be established 31.03.17	30.09.16 31.03.17	Evidence required: Report from externally commissioned thematic review.(18.8a) Quarterly report to be provide by the FLO on family involvement (18.8a)
		18.9a The electronic patient records where possible and at the consent of the patient or service user will contain up to date next of kin contact details and there is an information sharing agreement in place. These should be checked at each appointment. This facilitates the correct contact in the case of an emergency. 18.9b In instances where there is no recorded next of kin detail the investigation should approach other agencies to assist such as the Coroners officer or GP however they have no obligation to share. Please note - in death, there is a legal challenge that patient / service user confidentiality no longer applies in the absence of a sharing agreement however the nature of the death and the information within the investigations should be reviewed for appropriate sharing and the approach should be discussed with the Coroner. Families my still participate in the investigation and be supported to pose their specific questions. New action as of 04.08.16	Paula Hull, Deputy Director of Nursing (18.9a) Simon Beaumont, Head of Informatics (18.9a - compliance monitoring)	Sara Courtney, Associate Director of Nursing East ISD Paula Hull, Deputy Director of Nursing ISD's John Stagg, Associate Director of Nursing, LD & TQ21 Carol Adcock, Associate Director of Nursing, AMH Nicky Bennet, Associate Director of Nursing, Specialised Services Liz Taylor, Associate Director of Nursing, Childrens and Families	Sara Courtney, Acting Chief Nurse (18.2a)	31.10.16	Evidence required: Record keeping procedure stipulating the responsibility (18.9a) Serious Incident procedure (18.9b)	Early contact with families will be in place due to the correct contact details being recorded.	04.08.16 New action to address the lack of next of kin details for some patient / service users.	An informatics report will provide a base of line of recorded next of kin details which can be improved through a targeted unit based communications and monitoring supported by the record keeping group.	31.10.16	Evidence required: Informatics report showing that 80% of patient records have a next of kin listed (18.9a) Serious incident investigation report where next of kin details have been obtained through an alternative means (18.9b)
		18.10 Following the receipt of the external appreciative enquiry into the current quality of the experience of the involvement of families in SIRI investigations over a 2 year period the Trust will: 18.10a Create a task and finish group to review the report in detail and focusing on continuing improvement create an action plan to address the recommendations this will include representative from the cohort of families involved 18.10b Re-review the engagement and duty of candour policies and procedures updating where necessary 18.10c Review the Trust-wide training of family engagement and duty of candour, how this is delivered and to whom in the workforce New action added 28.08.16	Paula Hall, Deputy Director of Nursing Mayura Deshpande, Associate Medical Director - Patient Safety Chris Woodfine, Head of Patient Engagement and Experience Bobby Moth, Associate Director of LEaD Family Liaison Officer	N/A	Lesley Stevens, Medical Director (18.10a & 18.10b)	30.11.16	Evidence required: Minutes of the task and finish group (18.10a) Minutes of CARING group (18.10a) Review of the Trust-wide training re family engagement and duty of candour (18.10c) Reviewed and updated family engagement and duty of candour policy / procedures (18.10b)	That the family members and next of kin are involved in the care of their loved ones and are facilitated to be involved in investigations which arise. Families/next of kin feel communicated with in an honest and transparent manner and information is given in a timely and appropriate manner. Staff are trained on how to involve families in investigations and ensure that their concerns/issues are addressed.	28.09.16 New action added to address the recommendations of the appreciative enquiry 11.16 The results of the external review have proven that the process for the complete involvement of families is not yet embedded. Further review to be completed internally by the FLO focusing on March 2016 onwards and reporting quarterly.	The quantative research undertaken within the first appreciative enquiry will be repeated to evidence improvement. (18.10) The involvement of families and next of kin will continue to be checked and challenged at divisional and corporate panels. (18.10) That staff are able to follow policy and procedures fully understanding the content and application in practice (18.10b and 18.10c) Quarterly report on family involvement to be provided by the FLO to aid focus improvement activities (18.10) deadline for quarterly reporting to be established 31.03.17	30.09.17 31.03.17	Evidence required: Internal thematic review report on serous incident investigation reports to be undertaken at 6 monthly intervals will review family involvement (18.10a) Appreciative enquiry to be repeated for cohort April2016 to April 2018 in two years time (18.10a, 18.10b and 18.10c) Quarterly report to be provide by the FLO on family involvement (18.10)

Theme	Mazars Recommendations	SHFT Actions	Responsible Lead	Divisional Responsible Lead	Executive Accountability	Process Completion Date	Process Status	Expected Outcome	Outcome Progress Update	Evidence of Outcome Achieved	Measuring Success Date	Outcome Evidence
Multi-agency working	19. The Trust Board should seek co-operation with other providers and commissioners to agree a framework for investigations in preparation for future incidents regarding escalation. Divisions should then apply this framework where the incident report suggests another organisation should review or investigate the circumstances of a death.	19.1a As part of a wider stakeholder group comprising of CCGs, Acute Trust and the Local Authority create a process framework for undertaking multi-agency Serious Incident investigations. The issue regarding differences between the health and social care investigation frameworks should also be clearly defined. This group is being lead by the CCG. When this process is defined it will be adopted into the SHFT Serious Incident management policies. Whilst the process is being clearly defined by the CCG there is in place an interim process of communication with the CCG when another provider fails to engage with SHFT in a joint investigation.	Helen Ludford, Associate Director of Quality Governance (19.1a)	N/A	Sara Courtney, Acting Chief Nurse (19.1a)	30.06.16	Evidence obtained: Agenda and minutes related CCG lead meetings to define the process for multi-agency investigations (19.1a)	That the deaths of those individuals who cross services will be investigated only once by a multi provider team thus providing a comprehensive report for families and other parties such as the Coroner.	Engagement with WHCCG who are leading on the development of a protocol. Temporary agreement in place where SHFT can request assistance from the CCG if it is believed that a multi provider investigation is necessary but other parties will not engage. 04.08.16 (19.1a) Audit has not yet been completed and is featuring as part of the thematic review to be published 30.09.16 although the evidence outcome is red the thematic review is underway and will provide a more detail review than a pure audit. (19.1a) Example of a multi-agency investigation has been sourced. 30.08.16 Recovery plan for action 19.1a submitted to SIOAC and action timescale approved for change - reset at 30.09.16 as the audit will complete at this time	Quarterly report which stipulates which Serious Incident investigation have had multi provider which is shared with the CCGs. It is anticipated that SHFT will always respond to a request to be involved in a multi provider investigation and will be able to document this through audit. (19.1a)	31.09.16	Evidence required: Audit of Q1 SI's stipulating which have been multi-agency focused (19.1a) Example of a multi-agency investigation in which SHFT have participated or led (19.1a)
Deaths in detention and inpatient deaths	20. The Trust should retain a contemporaneous list of all inpatient deaths mapped to Mental Health Act status to enable Trust-wide oversight of all inpatient deaths and deaths in detention.	20.1a A Ulysses Safeguard / Tableau extraction report to be written to provide a quarterly report of all deaths in detention under the Mental Health Act. Report to be validated by the Senior Clinical Chairs of the 48 hr mortality review panels to ensure that the system information capture is correct and all deaths of this type have been reported as Serious Incidents. 20.1b SHFT will follow the Coroners documented and published guidance into investigating 'deaths in custody'.	Simon Beaumont, Head of Informatics Thomas Williams, Ulysses Systems Developer (20.1 a - joint responsibility) Kay Wilkinson, SI and Incident Manager (20.1b)	Mary Kloer, Clinical Services Director AMH Mayura Deshpande, Clinical Services Director, Specialised Services Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) (20.1a and 20.1b - each responsible for their own Divisions)	Mark Morgan, Director of Operations AMH, LD & TQ21 Gethin Hughes, Director of ISDs, OMPH In Patients, ISD's and Childrens and Families (20.1a and 20.1b - each accountable for their own Divisions)	30.06.16	Evidence obtained: Serious Incident Management Policies and Procedures rewritten (20.1a and 20.1b)	That all deaths of those under detention will be investigated for learning and compliance to the National Framework.	Flag' for in detention present within the Ulysses Safeguard system. Tableau extraction report to be created.	Quarterly report which provides audit information stipulating that each death in detention has been reported as an Serious Incident and investigated. (20.1a and 20.1b)	31.08.16	Evidence required: Ulysses extraction report proving that all inpatient deaths of those under a section have been investigated as a Serious Incident. (20.1a and 20.1b)
Deaths in detention and inpatient deaths	21. All deaths of service users in detention should be investigated, whether expected or not. These investigations should occur regardless of inquest conclusions. This will give assurance that the 24/7 nature of the care required has been of the highest standard. Specific issues addressed in the Terms of Reference for these investigations should include: a. to ensure that physical health care symptoms are not dismissed where challenging behaviour presents; b. that delays in seeking physical health care are not apparent; c. that service users are fully aware of decisions regarding whether to treat or investigate chronic or acute symptoms and that these are made in an informed manner; d. that access to full care and treatment is not restricted in any way; e. that staff are adequately supported to provide physical health care and trained to do so.	21.1a The death of a service user under detention must be investigated as per the Serious Incident Framework 2015. A 'flag' will be apparent on the Ulysses Safeguard risk management system which will trigger a decision to investigate at the 48 hr panel by the panel Chair. This process will be supported by SHFT Death reporting process where it is specific that all deaths of detained patients are reported and investigated as a Serious Incident. Terms of Reference for the investigation will be constructed on a case by case basis but will include a review of both of the mental health and physical health care which has been provided to a service user or patients. In situations where SHFT may not be the main provider of physical health care the opinions of that provider will be sought, if engagement in the investigation cannot be gained this will be reported to the CCG commissioners. This may be the case is a patient is transferred from SHFT inpatient services to an acute trust for physical health care needs but remains under a section of the mental health act. Terms of reference will also be constructed to address the specifics of the recommendation listed in a, b, c, d and e.	Helen Ludford, Associate Director of Quality Governance Kay Wilkinson, SI and Incident Manager (21.1a)	Mary Kloer, Clinical Services Director AMH Mayura Deshpande, Clinical Services Director, Specialised Services Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) (21.1a - each responsible for their own Divisions)	Mark Morgan, Director of Operations AMH, LD & TQ21 Gethin Hughes, Director of ISDs, OMPH In Patients, ISD's and Childrens and Families (21.1a - each accountable for their own Divisions)	30.03.16	Evidence obtained: Serious Incident Management Policies and Procedures rewritten (21.1a)	That all deaths of those under detention will be investigated for learning and compliance to the National Framework.	Flag' for in detention present within the Ulysses Safeguard system. Tableau extraction report to be created.	Quarterly report which provides audit information stipulating that each death in detention has been reported as an Serious Incident and investigated. (21.1a)	31.08.16	Evidence required: Ulysses extraction report proving that all inpatient deaths of those under a section have been investigated as a Serious Incident. (21.1a)
		21.2a Review the content of the five day physical health course which LEaD provide and ensure that there is the correct percentages of staff attending from each service. Course content and learning outcomes which will be reviewed. 21.2b Attendance data recorded per service.	Bobby Moth, Associate Director of LEaD Steve Coopey, Head of Clinical Development (21.1a and 21.1b)	Carol Adcock, Associate Director of Nursing AMH (21.1a and 21.1b) Mary Kloer, Clinical Services Director AMH (21.1a and 21.1b) Kate Brooker, Associate Director AMH (21.1a and 21.1b) Kathy Jackson, Head of Nursing Inpatient (OPMH)	Mark Morgan, Director of Operations AMH, LD & TQ21 Sara Courtney, Acting Chief Nurse Julie Dawes, Acting Chief Executive (21.1a and 21.b - joint accountability)	31.07.16	Evidence required: Review of course content and learning outcomes (21.2a) Attendance records by service by team (21.2b)	All AMH services will have staff who are competent in managing physical health care needs of the individual service users. Reduction in the rate of physical health management featuring as a contributory factor in SI investigation reports.	21.2a Course content currently being reviewed by the ADoNs from AMH and a LEaD representative. Additional options being scoped alongside the 5 day course. Alternatives are physical health specialist subject sessions and e learning. Subject matter inclusive of diabetes and respiratory. 21.2b Training records being obtained by Louise Hartland LEaD. 04.08.16 Input evidence request made for information - meeting was held with ADoNs to discuss e learning and shorter course options	Divisional and service level training records to that staff have been trained. (21.2b) Achieve of 90% compliance to clinical audit of physical health needs. (21.2a) Physical health audit to be undertaken in Q3. Audit of SI contributory factors to be undertaken in Q2. (21.2a) Please note the timescales for measuring success are: 31.12.16 for Q3 audit and training records 30.09.16 for SI Q2 audit	31.12.16 30.09.16	Evidence required: Results of Q3 physical health audit (21.2a) Attendance records by service by team (21.2b) SI contributory factors audit for Q2 (21.2a) additional evidence above 5-day course to show broader range of training conducted (21.2a)
		21.3a As part of service redesign, ensure that integrated teams contain physical expertise as part of the staffing component.	Liz Skeats, HR Business Partner (MH) Kerry Salmon, HR Business Partner (ISD's) Jane Pound, Head of HR	Carol Adcock, Associate Director of Nursing AMH Mary Kloer, Clinical Services Director AMH Kate Brooker, Associate Director AMH Sarah Constantine (OPMH), Clinical Services Director Kathy Jackson, Head of Nursing Inpatients (OPMH) (21.3a - responsible for own Divisions)	Mark Morgan, Director of Operations AMH, LD & TQ21 Sara Courtney, Acting Chief Nurse (21.3a - joint accountability)	31.07.16	Evidence required: Service redesign plans to include physical health nursing staff in a mental health setting (21.3a)	All AMH services will have staff who are competent in managing physical health care needs of the individual service users. As a result of this action there will be a reduction in the rate of physical health management featuring as a contributory factor in SI investigation reports.	HR are involved in the recruitment of general registered nurses for all of the MH inpatient units. This activity is being supported by the ADoNs. 04.08.16 Input evidence request made - verbal update provided that all MH units are advertising RN positions as part of their staffing review.	Divisional and service level training records to that staff have been trained. Achieve of 90% compliance to clinical audit of physical health needs. Physical health audit to be undertaken in Q3. Audit of SI contributory factors to be undertaken in Q2. (21.3a) Please note the timescales for measuring success are: 31.12.16 for Q3 audit and training records 30.09.16 for SI Q2 audit	31.12.16 30.09.16	Evidence required: Results of Q3 physical health audit (21.3a) Attendance records by service by team (21.3a) SI contributory factors audit for Q2 (21.3a)
		21.4a A clinical audit to be undertaken within Q3 of 2016/17 to evidence that physical health needs of mental health and learning disability patients are being met.	Mayura Deshpande, Associate Medical Director, Patient Safety and all Clinical Service Directors Helen Algar, Clinical Audit Facilitator (21.4a - joint responsibility)	Carol Adcock, Associate Director of Nursing AMH Mary Kloer, Clinical Services Director AMH Kate Brooker, Associate Director AMH Jennifer Dolman, Clinical Services Director LD John Stagg, Associate Director of Nursing LD (21.4a - responsible for own Divisions)	Mark Morgan, Director of Operations AMH, LD & TQ21 Sara Courtney, Acting Chief Nurse (21.4a - joint accountability)	31.11.16	Evidence required: Physical audit proforma (21.4a)	This action will create a focus on physical health care which will lead to better standards being delivered.	Audit scheduled for Q3	90% to be achieved through clinical audit of physical health needs to provide assurance that the Trust is providing the correct level of physical health care by skilled doctors and nurses. (21.4a)	31.12.16	Evidence required: Results of Q3 physical health audit (21.4a)
Information management	22. The Trust should develop an agreed RiO extract and Ulysses reporting protocol to capture all deaths of Adult Mental Health, Older People Mental Health and Learning Disability service users including community and inpatient locations to form the basis of future mortality review.	22.1a Tableau based reports to be devised by informatics team which extract data from the Ulysses system. The content of this reports will be incident / mortality data extracted from Ulysses triangulated with the mortality data which is extracted from the National Spine. This will ensure that the Mortality Meetings have knowledge of all service users and patients who are on an active caseload and have died.	Simon Beaumont, Head of Informatics Thomas Williams, Ulysses Systems Developer (22.1a - joint responsibility)	N/A	Sara Courtney, Acting Chief Nurse Paula Anderson, Chief Finance Officer (22.1a - joint accountability)	30.03.16	Evidence obtained: Tableau based mortality reports (22.1a)	The complete dataset of mortality information and incidents is easily accessible through the Tableau system for use within the Mortality Meetings.	Tableau reports available	High quality correct data which informs the Mortality Meeting evidenced through the minutes on SharePoint. This is to ensure that all deaths are know to the Trust and that the procedure is applied with the outcome being that all deaths which need to be investigated are investigated. This will be evidenced through the Mortality Meeting minutes. (22.1a)	30.09.16	Evidence required: Minutes of the mortality meetings x 3 ALL DIVISIONS (22.1a) Observed attendance at the mortality meetings (22.1a)
Information management	23. The spreadsheet arrangement currently in place in TQ21 is insufficient to monitor deaths at corporate level as part of the whole Learning Disability service provision. TQ21 service users should be incorporated into Trust administration systems in a way which ensures their deaths are captured for reporting and investigation purposes.	23.1a Devise and replace the current process in TQ21 with a more robust and complete process agreed by all parties. Report solution to the Mortality Forum. TQ21 is a social care provider does not have a 'patient administration system' which can be triangulated against the National Spine data. Case load NHS numbers should be investigated as a solution.	Simon Beaumont, Head of Informatics (23.1a)	Carol Cleary, Head of Service TQ21 Jennifer Dolman, Clinical Service Director (LD & TQ21) Debbie Robinson, Associate Director TQ21 (23.1a - joint responsibility)	Mark Morgan, Director of Operations AMH, LD & TQ21 Paula Anderson, Chief Finance Officer (23.1a - joint accountability)	30.06.16	Evidence required: Process for TQ21 to be inserted into the Death reporting Procedure at the next review (23.1a)	The complete dataset of mortality information and incidents is easily accessible through the Tableau system and compared to the TQ21 caseload by matching against NHS numbers.	In discussion re process 21.07.16 Raised at the Quality Oversight Committee for discussion. Questions posed as to how mortality monitoring especially around the 12 months post discharge information is managed by other social care providers. 04.08.16 Discussed at MWG process now in place	High quality correct data which informs the Mortality Meeting evidenced through the minutes on SharePoint. This is to ensure that all deaths are know to the Trust and that the procedure is applied with the outcome being that all deaths which need to be investigated are investigated. This will be evidenced through the Mortality Meeting minutes. (23.1a)	30.09.16	Evidence required: Minutes of the mortality meetings x 3 TQ21 (23.1a) Observed attendance at the mortality meeting (23.1a)

Improvement Plan for: CQC Inspection Jan2016 -

Southern Health NHS
NHS Foundation Trust

Version No: Final V1.0
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Date: *27/05/2016*

MONITORED VIA CQC DELIVERY GROUP WEEKLY

Approved by: *Chris Gordon - CQC*

Produced by: *Louisa Felice - Head of Executive Affairs and Projects*
Tracey McKenzie - Head of Compliance

CQC progress dashboard – all actions including sub-actions - position as at 16/11/16

2016	May	June	July	August	September	October	November	December
Red	**0**	**0**	**1**	**4**	**1**	**1**	**0**	0
Amber	**0**	**0**	**0**	**0**	**0**	**0**	**1**	0
Green	**0**	**0**	**0**	**0**	**0**	**0**	**0**	5
Blue Completed	**26**	**36**	**17**	**3**	**5**	**2**	**0**	0
Expected number of completed actions each month	***27***	***36***	***18***	***7***	***6***	***3***	***1***	***5***
Validation Process								
Blue - **unvalidated - documents checked - still to be reviewed in practice**	**0**	**0**	**1**	**2**	**2**	**2**	**1**	
Blue - **reviewed during Exec site visit but further work required**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	
Blue - **Exec validated during site visit**	**27**	**36**	**16**	**1**	**3**	**0**	**0**	

* Reverted back to Red

Blue - Exec validated
Blue - unvalidated
Green
Amber
Red
not begun

Requirement Notice?	Action/s to be taken	How will completion of the action be evidenced (Evidence and method of review)	Who is responsible for completing the action Name & Job Title	Date action must be completed	Month	Action Progress Blue=Complete Green= Begun/On Track Amber= Risk of slippage Red=Overdue	Recovery plan - date action will be back on Track	Progress - to include position statement, risks, obstacles, action taken etc.	*Evidence saved in folder*	*Evidence checked and approved (TRACEY TO DO)*	*Exec assurance received*	How will you evidence that the completion of the actions has led to the intended outcome	Intended Outcome Achieved Blue=Complete Green= Begun/On Track Amber= Risk of slippage Red=Overdue
Enforcement Action	1.1 Central Quality Governance team to be restructured to deliver a Business Partner model (replicated from HR and Finance model) to strengthen the links and accountability lines between the central governance team and divisional quality structures.	New business partner model will be in place and posts will be appointed into (submission of documents)	Helen Ludford Associate Director of Quality Governance	31/08/2016	August	Red	31/01/2017	19/10/16: The appointment of 3 x Quality Governance Business Partners was due by the end of September. Due to recruitment delays it was agreed that the short-term requirement would be met by recruiting interim candidates. Two of the three Quality Governance Business Partner roles have been recruited to; one will start in November and the other in December / January following due HR processes. The third post currently has been filled by an interim candidate whilst substantive recruitment continues; further interim arrangements to be in place by 31/10/16, whilst substantive positions to be filled.	***IN FOLDER:*** *1.1 - Governance team Structure as of 1 August 2016 showing vacancies*			Tracking examples of risks being identified and escalated Review of Board and sub-committee agendas at year end against top organisational risks	
	1.4 Establishment of and appointment to new role - Deputy Director of Nursing and Quality,Mental Health and Learning Disabilities Division - to provide senior professional and governance leadership. Interim appointment to be made whilst the substantive appointment is recruited to	Interim and then substantive appointments made and individuals in post	Mark Morgan Divisional Director Mental Health and Learning Disabilities	Interim appointment 31/05/2016 Substantive appointment 30/11/2016	November	Amber		May: Post agreed at Trust Executive Group. Interim appointment made (Debra Moore) to provide professional leadership pending recruitment of a substantive individual					
	1.6 Risk Management Policy to be reviewed (including Risk Appetite Statement)	Revised Policy will be published (submission of documents)	Helen Ludford Associate Director of Quality Governance	31/08/2016	August	Blue - unvalidated	31/10/2016	19/10/2016: Risk management strategy has been approved. Risk appetite framework was submitted to the Trust Board at the end of September and will be submitted to the AARC in October. 14/11/2016: The Trust Board approved the Risk Appetite Statement, Risk Management Policy and Strategy subject to minor amendments.To be presented at next Trust Board.	*IN FOLDER:* *Risk Management Strategy and Policy (DRAFT out for consultation)* *To receive copy of finalised Trust Board minutes and mark action as complete - validated*	*YES - MA*			
Enforcement Action	2.3 Develop a strategic 3 year capital programme to ensure appropriate short/medium/long term planning	Longer term strategic plans for Capital planning will be in place	Paul Johnson Head of Estate Services	31/03/2017	Mar-17	Green						Site visits consistently show evidence of staff aware of ligature risks associated with their units and of measures in place to mitigate risk.	
	2.11 Improve the robustness of the Site-specific security management reviews. All new reviews will go back over recommendations from previous years' reports to identify what actions, if any, have not been addressed and what management controls are in place to manage any identified risks	All security risks will be clearly identified, assessed and mitigated	Paul Johnson Head of Estates Services	30/08/2016	August	Blue - unvalidated		July 2016: The organisation has put in place a cyclical process over a 24 month period to audit sites with regards to security and this forms part of the Health Safety and Security Assessment process.	***In folder:*** *2.11.1. HSSA dates 2016 - 2023 xls spreadsheet* *2.11.2. HSSA Guidance document* *2.11.3. Antelope hse - ECT HSSA 2016 document* *2.11.4. Antelope Hse Saxon - HSSA 2016 document* *2.11.5. Saxon Ward Antelope Hse - role risk assessments document* *2.11.6. ECT Antelope Hse role risk assessments document*	*YES - TM*			
Trust wide Must Do	See actions in 2 above												
	3.2 The Quality, Improvement and Development Forum (QID) will receive assurance reports regarding the mitigation of risks associated with the environment. This will allow for exception reporting to the Quality & Safety Committee.	QID papers and minutes (submission of documents)	Deputy Directors of Nursing: Sara Courtney Paula Hull Debra Moore	31/07/2016	July	Blue - unvalidated	30/09/2016	July 2016: New reporting structures have been drafted and first meetings will take place in August to finalise TORs and membership. Environmental risks will be reported to the SAFE group by exception on a monthly basis 09/08/16 - Sara Courtney to develop framework by 16/08/16 23/09/16 - Agreed at CQC delivery meeting that estates would populate frameworks by end of September and will then liaise with clinical teams around addressing gaps identified 30/09/16 - all in place on SharePoint	***In folder:*** *3.21 - Screenshot of risk summaries on SharePoint* *3.22 - Example1 - Antelope* *3.23 - Example2 - Elmleigh*	*YES - TM*		Clearly auditable evidence of identification and mitigation of risk and of appropriate escalation	
	3.3 Existing team dashboards will be further enhanced to align them to the Trust's approach to team-level objective setting via the navigational maps.	All teams will have team performance dashboards in place and Trust Board will have visibility of every teams performance (submission of documents)	Simon Beaumont Head of Information Sara Courtney Deputy Director of Nursing and Quality	31/03/2017	Mar-17	Green		May: Information team presenting team level performance to Trust Executive Group on a weekly basis from April 2016. Programme in place to roll out the planned improvements over the financial year.					
	3.4 A systematic approach to providing 'intensive support' to frontline teams highlighted as having a reduced level/quality of delivery performance will be developed and rolled out across the Trust throughout 2016 . This will include a review of Practice Development roles and capacity	Trust wide team performance will be supported with a systematic approach to 'intensive support' programmes (submission of documents)	Sara Courtney Deputy Director of Nursing and Quality	31/12/2016	December	Green		May: Organisational Development leads presented current programmes of support and a proposed 'intensive support' package to Trust Executive group in April 2016					
	3.5 Team Quality Improvement plans will be in place for every team across the Organisation by the end 2016 These will encompass all elements of the Navigation Maps, will include core measures as well as tailored measures to the specific team objectives	Every team will have its own team level Improvement plan linked to its team Navigation Map, incorporating all improvement actions (submission of documents)	Sara Courtney Deputy Director of Nursing and Quality	31/12/2016	December	Green		May: Many teams within Learning Disabilities, Mental Health, Childrens and the ISDs have already initiated the creation of a single Improvement plan as a result of their Nav Map exercise. These are not standardised at present			*YES - 21/07/16 - Ridgeway Centre - DM* *21/07/16 - Bluebird - DM*		
Enforcement Action	The Trust will deliver the Mortality and SIRI action plan in full and to time.	Monitored through separate SIRI and Mortality Action Plan										Internal audit of invetigation process to be added to audit schedule for Q4	
	4.7 The Organisational learning strategy will be reviewed and updated	New strategy (submission of documents)	Helen Ludford Associate Director of Quality Governance	31/08/2016	August	Red	31/10/2016	October 2016: The Organisational Learning Strategy has been drafted and is currently out for review and consultation. To be Approved in November 2016	**In folder** *4.7 - copy of draft strategy*				
	4.9 All SIRI investigation reports to include as standard a Terms of Reference which requires the investigator to determine whether any similar incidents have taken place within the team/unit in the preceeding 12 months and what action was taken as a result of these. This will allow for improved identification of themes and lead to improved actions to address the root causes. · 48hr panel chairs to be advised of new requirement · Commissioning manager training will include reference to this requirement	Investigation reports (submission of documents)	Helen Ludford Associate Director of Quality Governance	30/08/2016	August	Blue - unvalidated		June 2016: This work is in progress as part of the on-going improvements to the SI reporting process August 2016: Processes in place but do not have sufficient evidence from each area to validate at present					
	4.10 The Trust will upskill frontline staff in quality improvement methodologies using the existing Team Viral programme to support this	Course content and Attendance logs (submission of documents)	John Monahan Organisational Development	31/03/2017	Mar-17	Green		June 2016: Plan in place to develop training day for Quality Ambassadors who will be appointed to teams as part of the implementation of the Quality Improvement Strategy in Q3 2016/17.					
Trust wide Must Do	5.3 Undertake a review of the Trust's staff engagement strategy	Review report (submission of documents)	Amanda Smith Deputy Director of Workforce Emma McKinney Associate Director of communications	30/09/2016	September	Red	31/10/2016	October 2016: The Staff Engagement Plan was been modified and an update is given regularly at the CQC Delivery Group. The PMO have not received a new revised Staff Engagement Strategy to underpin this plan. New post in place in HR to look at developing strategy - which is planned to be in place by January 2017.	**In folder** *5.3 - copy of staff engagement plan*				
	5.4 A review of staff feedback mechanisms will be undertaken to determine whether there are sufficient processes in place for staff to escalate matters beyond their line manager when these fall below the threshold that would require whistleblowing procedures to be followed. This will include a review of the methods through which feedback is collated and used when this is received at events such as staff briefings, staff survey etc. Promotion of exisiting/new mechanisms to be communicated to staff	Review report and communications (submission of documents)	Amanda Smith Deputy Director of Workforce Emma McKinney Associate Director of communications	31/10/2016	October	Blue - unvalidated			***In folder:*** *5.41. Your Voice -Team brief and poster* *5.42. Comms actions to promote - Your Voice* *5.43. weekly bulletin with example of improvement in estates comms*	*YES - TM*			

Trust wide Must Do	See action in 5 above												
	6.1 Ensure frontline staff are fully engaged in the Trust's Training Needs Analysis process by reviewing current practice and identifying ways in which this can be improved. Consideration will be given to the hosting of open days by the LEaD department and a communications drive during the months when the TNA process is undertaken.	Staff engagement activities around TNA (submission of documents)	Bobby Moth Associate Director of Leadership, Education and Development	31/10/2016	October	Blue - unvalidated			***In folder:*** *6.11 - LEaD filenote re actions taken* *6.12 - Comms regarding events*				
Requirement Notice	7.2 Task & Finish Group to: - review the functionality of the existing RiO risk assessment tool and determine the improvements required - determine how the new 'My Safety Plan' (collaborative safety care plan) and crisis plans reflect the risk information and are incorporated onto RiO - carry out a gap analysis of the risk assessment and risk care planning training currently available and determine the improvements required - establish trajectory of compliance for My Safety Plans being in place and new risk management training being undertaken	Report from Task and Finish group (Submission of document)	Liz Durrant, Area Manager – Southampton AMH	30/09/2016	September	Blue - unvalidated		<u>June 2016</u>: Task and finish group in place and work has commenced <u>September 2016:</u>	***In folder:*** ***7.2** 1. AMH Divisional Risk Task and Finish Group Minutes 18 May 2016* *7.22. AMH risk task and finish group Minutes 13 July 2016* *7.23 Clinical risk management template* *7.24 Draft My safety plan guidelines* *7.25Physical health assessment screen shot* *7.26 Risk screen proposal document* *7.27 - request for change documents*	*YES - TM*		Increased numbers of patients have a 'My Safety Plan' in place (trajectory to be determined by t&f group and evidenced by RiO report or manual audit) Increased compliance with new training programme (trajectory to be determined by t&f group and evidenced by LEaD reports) Thematic reviews of AMH incidents will be carried out on a 6 monthly basis and will expect to see a reduction in the number of incidents where failings in risk management were a causative or contributory factor.	
	7.3 Make the necessary changes to the risk module on RiO in association with Servelec to reflect the recommendations of the task and finish group	Updated risk assessment module on RiO (Submission of document)	Tony Goodwin, Senior Systems Manager	TBC at end Sept 16 (dependant on extent of changes recommended by T&F group)	TBC	Green		<u>June 2016:</u> Dependant on outcome of above action					
	7.4 Devise a risk management training package and establish a programme to roll this out in 2017 that reflects the recommendations of the task and finish group	New training materials and schedule for roll out (Submission of documents)	Louise Hartland, Governance, Quality and Compliance Manager LEaD	31/12/2016	December	Green		<u>June 2016</u>: Dependant on outcome of above action					
Requirement Notice	8.4 Complete the review of the current Clinical Disengagement Policy and make any necessary improvements to it. The review process will include a Soton Learning network event which will discuss learning from previous incidents associated with clinical disengagement.	Revised (Version 6) SH CP 97 "Clinical Disengagement / Patients who DNA" policy available on Trust website- (Submission of documents)	Area Heads of Nursing: Carol Adcock Nicky Duffin Liz James	30/09/2016	September	Blue - unvalidated		<u>June 2016:</u> Review in progress <u>September 2016:</u> Policy has been reviewed, updated and approved via the AMH governance processes	*8.41 Clinical Disengagement policy (Word & PDF version)* *8.42 Minutes of meeting where policy was approved*	*YES - TM*		Corporate panels will monitor on an ongoing basis whether DNA management continues to be a contributory or causative factor in incidents Biannual audit of DNA management until practice is embedded	
	8.5 Launch revised Clinical Disengagement policy including headlining it at AMH Learning Network event	Communications to staff and agenda of learning network event (Submission of documents)	Area Heads of Nursing: Carol Adcock Nicky Duffin Liz James	31/10/2016	October	Blue - unvalidated		October 2016: Policy has been approved, updated via the governance processes.	*8.51 Email cascade & poster advertising launch event*				
Requirement Notice	9.3 Use results of audit to feed into Trust-wide review of junior medical on-call rota	Trust-wide review report (Submission of documents)	Dr Mayura Deshpande, Clinical Service Director	31/08/2016	August	Red	TBC - recovery plan not yet received	<u>23/08/16</u> - audit results reviewed and non-compliance identified. Shows wider issue related to junior medical on-call which will not be addressed by end of August. <u>04/10/16</u> - interim arrangements in Specialised services still not achieving full compliance. Further work required - recovery plan requested. <u>18/10/16</u> - Dr Lesley Stevens asked for review to be undertaken to put in place a long-term measure for the on-call rota. A short-term mitigation is in place to ensure all episodes of seclusion have an initial medical review within the first hour. Consultant cover is arranged where junior medical staff are unable to undertake this. An administrative post is also being recruited currently to ensure that there is a central point for logging all on-call rotas.				Periodic audit of seclusion medical review until practice is embedded	
Requirement Notice	See Action 2 (warning notice tab) for Trust-wide actions which will include AMH services											Staff understanding of ligature management process evident on peer reviews/site visits and	
Requirement Notice	See action 2 (warning notice tab) in relation to Trust-wide improvements in ligature/estates management and action 2.12 specifically in relation to the Melbury roof												
Requirement Notice	13.3 External contractor to carry out building works of new seclusion room	Building works completed on new seclusion room (site visit)	Paul Johnson, Head of Estate Services	31/10/2016	October	Red		<u>November 3rd:</u> Works are largely complete; awaiting completion of snag list. Due for completion Nov 4th.	*IN FOLDER:* *13.31 - project meeting notes*			n/a - evidence of individual actions will provide the necessary assurance	
Requirement Notice	See action 2 (warning notice tab) regarding Trust-wide improvements in ligature/estates management which will apply to Evenlode												
Requirement Notice	See action 2 (warning notice tab) in relation to Trust-wide improvements in ligature/estates management which will apply to The Ridgeway Centre											Peer reviews and site visits Regular review of incidents linked to the	
Requirement Notice	See action 3 (warning notice tab) re plans for team-based improvement plans that will apply across the organisation and action 4 (warning notice tab) re sharing learning across the Trust.												
Requirement Notice	See action 5 (warning notice tab) for Trust-wide actions in relation to the supervision process.												
SHOULD	See action 6 (warning notice tab) re Trust-wide plans relating to the supervision process												
SHOULD	26.3 Additional staff to be trained in graphic facilitation so as to roll it out to all CPA meetings to help improve patients' understanding and involvement in treatment planning	Training records for graphic facilitation and CPA minutes (submission of documents)	Dr Mayura Deshpande, Clinical Service Director, Bluebird House Karen Dixon, Modern	31/12/2016	December	Green		<u>October 2016:</u> Graphic Facilitation training is provided as part of the Bluebird House induction programme. Key elements of the induction programme will be co-ordinated on the LEaD system to ensure accurate records of attendance are maintained. This will be in place for the October 2016 planned induction.				Consistent evidence at site visits, peer review and through patient feedback of involvement in care planning.	
SHOULD	28.2 Review the restrictive interventions policy, in line with the position statement and address any identified gaps	Revised restrictive interventions policy (submission of documents)	Dr Mayura Deshpande, Clinical Service Director, Bluebird House & Chair of Safer Forum Debra Moore, Deputy Director of Nursing - MH/LD	31/07/2016	July	Red	31/10/2016	<u>19/08/16</u> Consultation on draft restrictive practice policy complete - comments being incorporated into document. Restrictive intervention suite of underpinning procedures reviewed <u>11/10/16</u> - further comments received on updated policy are being incorporated into the final version. <u>18/10/16</u> - This action will remain Red until the policy has been approved and communicated to staff. Additional actions related to training provision will be added to the action plan to align with actions on the Trust Risk Register.	*awaiting copy of completed policy*			Monitoring of restraint by Safer Forum will show restraint techniques being used in accordance with Trust position statement and policy. Duration of restraint will be closely monitored with outlying trends investigated	
	28.3 Review the training programme, in line with the new restrictive interventions policy, and produce a paper with recommendations for future training	Recommendations paper presented to TEG Minutes of TEG discussion (submission of documents)			July	Blue - unvalidated		July 2016: Review completed and paper being presented to TEG on 17th August	*awaiting copy of paper*		*YES - TEG Sept16*		
	28.4 Implement the changes to the training programme and roll-out to relevant staff groups	Revised training materials and roll-out schedule (submission of documents)	Simon Johnson, Head of Essential Training Delivery	TBC following outcome of recommendations paper	TBC	Green							
SHOULD	30.3 Carry out a scoping exercise to look at the possibility of moving seclusion paperwork to RiO	Feasibility paper (submission of documents)	Dr Mayura Deshpande, Clinical Service Director	31/12/2016	December	Green						Seclusion paperwork consistently found to be compliant with MHA Code of practice on audit or	
SHOULD	See action 28 above.												

Date	Visit ref.	Service	Site	Domain	Issue	THEME	CoP Ref:	Action we will take	How we will know it is achieved	Date when action will be completed	Name of responsible manager	Internal Comments from PAS	Progress update	Evidence of Completion	Action Progress Blue=Complete Green= Begun/On Track Amber= Risk of slippage Red=Overdue
25/02/2015	33803	Specialised	Oak Ward, Southfield	2: Purpose, Respect, Participation, Least Restriction	Patient feedback about the quality of the IMHA service was not entirely positive. There was no evidence that the quality of IMHA provision was monitored or patient feedback gathered in this regard. The IMHA service was reactive rather than proactive on the ward, in that advocates came by appointment only.		20.12	• Clinical ward manager and modern matron to liaise with the service user rep and gather any feedback on the IMHA service and feedback directly to the IMHA service if any concerns have been raised. • IMHA posters to be displayed on ward areas • Primary nurses to discuss the IMHA service in 1 to 1's • MDT to discuss in progress reviews and CPA's • Staff meetings to discuss IMHA service and capture issues relating to the quality of the service for feedback to the IMHA service • Clinical ward manager to identify any training needs for staff re: IMHA services • Clinical ward manager and modern matron to speak directly with IMHA service to enquire if a committed day could be given to Southfield. • The Division to work with HCC to ascertain how quality review and standards for the service can be measured	• Clinical ward manager and modern matron to have spoken to service user rep and gathered feedback about IMHA services • Posters will be displayed on ward areas • RIO will confirm IMHA has been discussed in 1 to 1;s with primary nurses • RIO will confirm IMHA has been discussed in CPA's and progress reviews • Clinical ward manager to have training sessions booked covering IMHA topic • Clinical manager and modern matron will have spoken to IMHA services and provide written feedback to the Division • The Division will have notes of a meeting with the IMHA service and HCC to discuss quality standards	30/06/2015	Nicky Bennett	none			
14/01/2016	35471	Specialised	Beech Ward, Southfield	2: Admission to the ward	There was no AMHP report, either full or outline, on file for patient B.		14.93	1. Supervision will be provided to the MHA Administration team to address the importance of obtaining AMHP outline reports as per the Code of Practice. 2. A named person at the relevant local authority will be identified to support a joint process between the Trust and the authority to ensure that such reports are obtained. 3. An MHA audit will take place in three months' time to monitor whether the reports are being provided.	1. Supervision will be held with relevant MHA administration team. 2. The local authority will be contacted and a process set up to for obtaining missing AMHP reports. 3. An MHA audit of AMHP reports will be completed.	1. 12/02/2016 2. 29/02/2016 3. 31/05/2016	Siven Rungien, MHA Manager	none	Partially complete	Supervision provided to team, email discussion with Southampton AMHP lead. Audit to be undertaken. 09/08/16 - audit report received	COMPLETED
09/02/2016	35472	Specialised	Cedar Ward, Southfield	2: Leave of absence	That it was not clear whether or not patients had been given a copy of their section 17 leave form. Some patients told us they were sometimes given a copy.		MHAS: 17 CoP: Chapter 27	1) The MHA Manager will meet with the ward manager to discuss the requirements of the section 17 leave policy and forms.	1) Meeting between MHA Manager and Cedar ward manager; 2) Audit in three months' time to verify compliance with policy as outlined below.	1. 08/04/2016 2. 31/07/2016	Siven Rungien, MHA Manager	Our Section 17 policy requires that copies of the forms are given to patients. To support this, the forms are produced in triplicate: the yellow copies are specifically for patients. Staff are required to tick on the master form that a patients has been given a copy.	Partially Complete	Discussion with ward manager has taken place. Audit to be undertaken 09/08/16 - audit report received	COMPLETED

How we will know it is achieved	Date when action will be completed	Name of responsible manager	Internal Comments from PAS	Progress update	Evidence of Completion	Action Progress Blue=Complete Green= Begun/On Track Amber= Risk of slippage Red=Overdue
• Clinical ward manager and modern matron to have spoken to service user rep and gathered feedback about IMHA services • Posters will be displayed on ward areas • RIO will confirm IMHA has been discussed in 1 to 1;s with primary nurses • RIO will confirm IMHA has been discussed in CPA's and progress reviews • Clinical ward manager to have training sessions booked covering IMHA topic • Clinical manager and modern matron will have spoken to IMHA services and provide written feedback to the Division • The Division will have notes of a meeting with the IMHA service and HCC to discuss quality standards	30/06/15	Nicky Bennett	none			
1. Supervision will be held with relevant MHA administration team. 2. The local authority will be contacted and a process set up to for obtaining missing AMHP reports. 3. An MHA audit of AMHP reports will be completed.	1. 12/02/2016 2. 29/02/2016 3. 31/05/2016	Siven Rungien, MHA Manager	none	Partially complete	Supervision provided to team, email discussion with Southampton AMHP lead. Audit to be undertaken. 09/08/16 - audit report received	COMPLETED
1) Meeting between MHA Manager and Cedar ward manager; 2) Audit in three months' time to verify compliance with policy as outlined below.	1. 08/04/2016 2. 31/07/2016	Siven Rungien, MHA Manager	Our Section 17 policy requires that copies of the forms are given to patients. To support this, the forms are produced in triplicate: the yellow copies are specifically for patients. Staff are required to tick on the master form that a patients has been given a copy.	Partially Complete	Discussion with ward manager has taken place. Audit to be undertaken 09/08/16 - audit report received	COMPLETED

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Portsmouth Safeguarding Adults Board Annual Report 2015 - 2016

www.portsmouthsab.uk

Portsmouth Safeguarding Adults Board

Funded by:

Portsmouth City Council

Hampshire Constabulary

NHS Portsmouth Clinical Commissioning Group

Working in partnership with:

Solent NHS Trust

Hampshire Fire and Rescue Service

Portsmouth Hospitals NHS Trust

Care Quality Commission

healthwatch Portsmouth

South Central Ambulance Service NHS Foundation Trust

NHS England

Hampshire Care Association
You're in caring hands

Department for Work & Pensions

National Probation Service

Contents

Statement from the Chair

Thank you for your interest in safeguarding adults in Portsmouth. As independent Chair of the Portsmouth Safeguarding Adults board, I am pleased to be introducing this Annual Report covering the first year of operation under The Care Act 2014. It is also my first year as Chair and I am very grateful to all partners for their help and ongoing support. The report shows what the Board aimed to achieve on behalf of the residents of Portsmouth during 2015 - 2016. We have reviewed how the Board worked and established a new structure to ensure that we can meet the challenges and new duties under the Care Act 2014.The partnership has developed and strengthened over this year and although there is still much to do, this Annual Report reflects what we have been able to achieve.

Our overarching focus for next year is to ensure adults are safeguarded in a way that supports them in making choices and having control about how they want to live. In consultation with its wider partners, service users, carers and Healthwatch we have agreed the following priority areas:

- Knowing our Population - to know what information and data is currently collected by all partner agencies and understand what it is telling us and act on it
- Safeguarding Adult Reviews (SARs) - ensure that learning from SARs and other processes are tangibly embedded in local practice
- Workforce - develop an Adult Safeguarding Learning and Development Strategy and ensure a range of training and development is available across agencies
- Governance - ensure we have robust processes that allow for partnership working including adults with care and support needs and their carers.

Keeping adults safe in Portsmouth involves us all working together in very challenging times. This year has seen unprecedented pressure on partners in terms of resources and capacity and I would like to thank all partners and those who have been involved in the work of the Board, for their time and effort, which has made such a big difference. I look forward to continuing to chair the partnership next year.

Robert Templeton, PSAB Independent Chair

What is safeguarding adults?

"Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action." Care Act (2014)

Who are we?

The Portsmouth Safeguarding Adults Board (PSAB) is a partnership of key organisations in Portsmouth who work together to keep adults safe from abuse and neglect. These include:

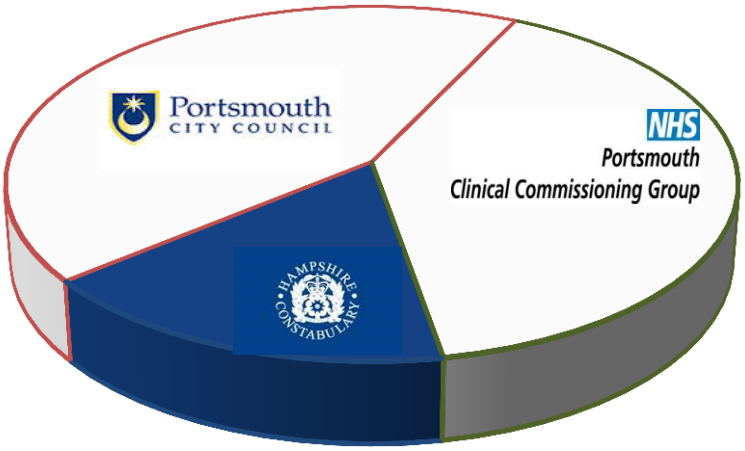
- Adult social care
- Health
- Emergency services
- Prison and probation services
- Housing
- Community organisations.

The board has an independent chair that can provide some independence from the local authority and other partners. This is especially important in terms of:

- offering constructive challenge
- holding member agencies to account
- acting as a spokesperson for the PSAB.

How are we funded?

2015-2016

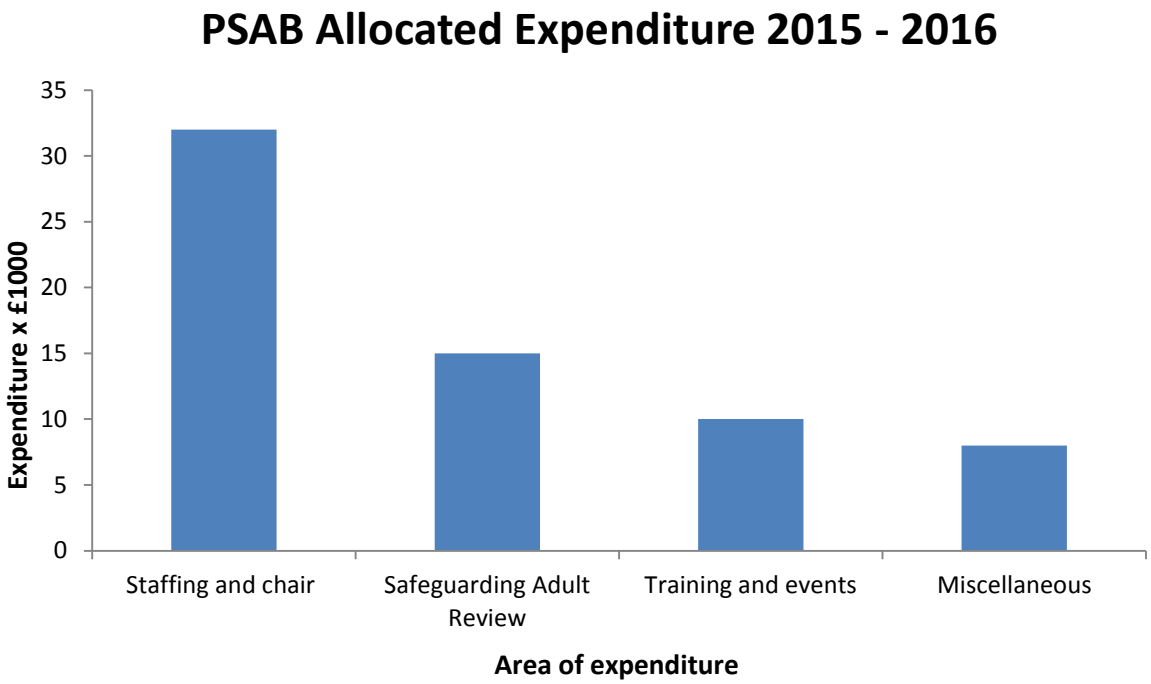


Portsmouth Clinical Commissioning Group £26k

Hampshire Constabulary £11k

Portsmouth City Council £28k

Total: £65,000



Our Vision

Our Vision is…

Portsmouth is a city where adults at risk of harm are safe and empowered to make their own decisions and where safeguarding is everyone's business

The Care Act 2014 sets out a clear legal framework for how local authorities and other organisations should protect adults at risk of abuse or neglect. Safeguarding Adults Boards are a legal requirement and work to the Department of Health six principles of safeguarding:

Empowerment

- Presumption of person led decisions and informed consent.

Protection

- Support and representation for those in greatest need.

Prevention

- It is better to take action before harm occurs.

Proportionality

- Proportionate and least intrusive response appropriate to the risk presented.

Partnership

- Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.

Accountability

- Accountability and transparency in delivering safeguarding.

All of the work of the PSAB contributes to making the vision a reality.

What is Abuse and Neglect?

The Department of Health gives the following as examples of abuse and neglect. However, as abuse and neglect can take many forms, local authorities should not be constrained in their view of what constitutes abuse or neglect, and should always consider the circumstances of the individual case.

Physical

- including hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions;

Sexual

- including rape and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting;

Psychological

- including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or unreasonable and unjustified withdrawal of services or supportive networks;

Exploitation

- either opportunistically or premeditated, unfairly manipulating someone for profit or personal gain;

Financial or material

- including theft, fraud, exploitation, coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property , inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits;

Neglect and Acts of Omission

- including ignoring medical or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating;

Discriminatory

- including discrimination on grounds of race, gender and gender identity , disability, sexual orientation, religion, and other forms of harassment, slurs or similar treatment; and

Institutional (or organisational)

- including neglect and poor care practice within an institution or specific care setting like a hospital or care home, for example. This may range from isolated incidents to continuing ill-treatment.

Abuse or neglect may be deliberate, or the result of negligence or ignorance.

Developments in 2015-2016

How have we responded?

Under Section 42 of the Care Act, a local authority has a duty to make enquiries or cause others to make enquiries in cases where it has reasonable cause to suspect

- that an adult has needs for care and support (whether or not the local authority is meeting any of those needs) and
- is experiencing, or at risk of, abuse or neglect and
- as a result of those care and support needs, is unable to protect themselves from either the risk of, or experience of, abuse or neglect.

This year saw the transition from Adult Social Care safeguarding to a Multi- Agency Safeguarding Hub (MASH). Hampshire Constabulary and Portsmouth City Council have created the Adult MASH with a team of social workers and police officers working together who have direct links with colleagues in areas such as health, trading standards, community safety and children's safeguarding. The Adult MASH is responsible for overseeing all the safeguarding referrals made within Portsmouth and works with local partner agencies to safeguard adults at risk across the city.

Safeguarding Activity in Portsmouth

A **concern** is a 'worry' regarding a person's safety and an **enquiry** is what needs to be looked at to confirm a person is safe.

Safeguarding can take many different forms depending on the nature of the concern. Below are examples of how the MASH team responded to two different enquiries during this year (NB. names and some details have been changed to protect anonymity):

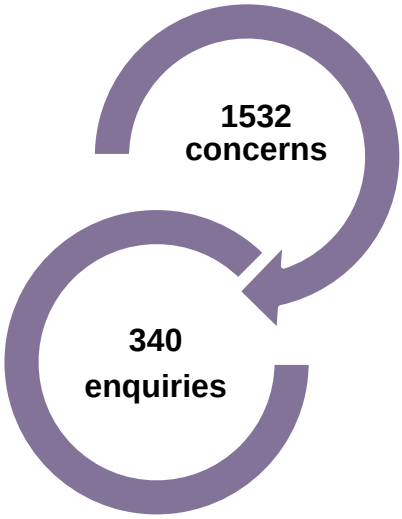
Example 1: Financial Abuse

Peter was a man who had a brain injury, was dependent on alcohol and was street homeless. A safeguarding concern was raised as he was regularly having his money stolen. He was found unconscious in the street. After receiving appropriate medical attention, the social worker arranged for an appointeeship which meant his money was looked after by the council and he could collect smaller amounts on a more regular basis. The safeguarding process initiated the process of support for his issues with alcohol and Peter is now living in supported accommodation.

Example 2: Institutional Harm

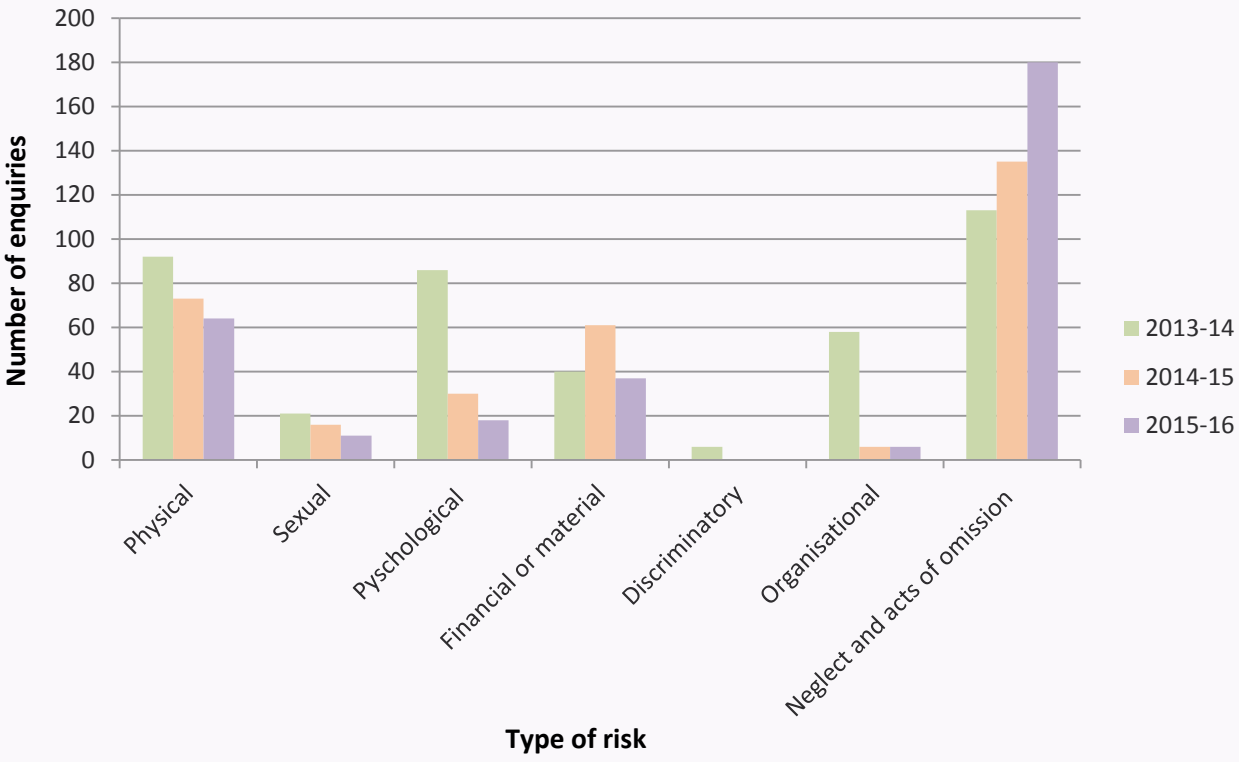
A residential care home did not comply with fire safety standards, allowing smoking in bedrooms without appropriate safeguards in place. The call bell system did not work and a resident with mobility issues was placed at the top of the home without any means of calling for assistance. The home also had staffing issues with the manager being absent often. The safeguarding team worked in partnership with Hampshire Fire and Rescue Service, Care Quality Commission and the home to produce an action plan, prioritising the highest areas of risk. The safeguarding team social worker initially made visits twice a week to ensure progress was being made. The home made the required improvements and the safeguarding enquiry was closed.

Safeguarding Activity in Portsmouth

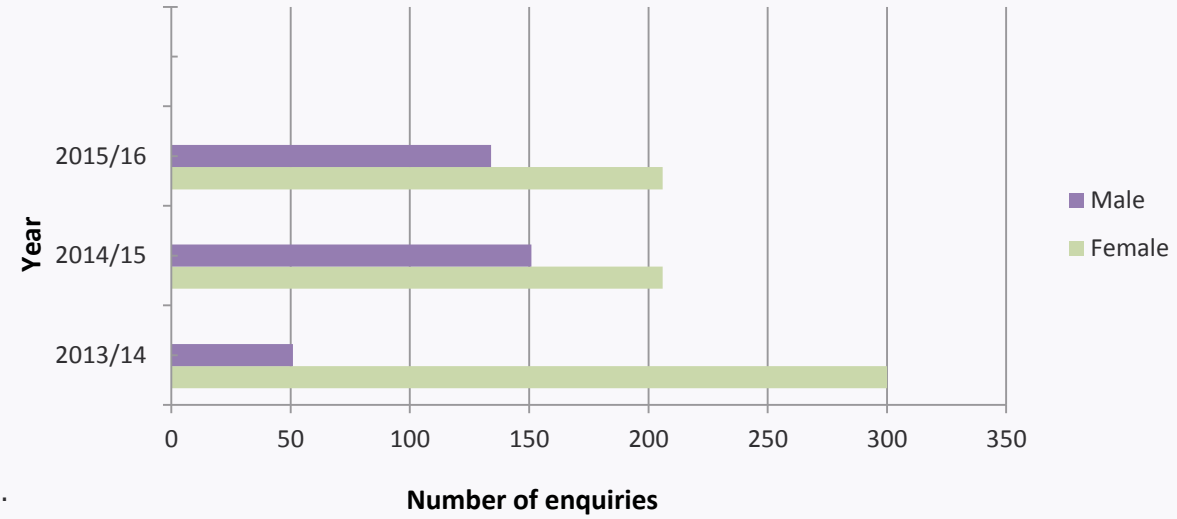


There were safeguarding concerns received for 1532 individuals during 2015-2016. Of these 340 were deemed to require further input and were taken forward as enquiries. This represented a decrease of 17 enquiries from the previous year.

The Graph below shows counts of enquiries by type and source of risk:



The Graph below shows counts of enquiries by gender:



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How does this compare to the national picture?

The breakdown by gender for 2015 - 2016 in Portsmouth strongly reflects the national picture from the Safeguarding Adults Collection data collection which showed the breakdown as 60% women, 40% male.

The distribution of enquiries by type of risk is identical to that of the national picture with neglect and omission being the largest category and discriminatory being the smallest.

Deprivation of Liberty Safeguards (DoLS)

Sometimes, when an individual needs care, the care they receive may involve restricitng their independence and freedom. If they are receiving care in a care home or a hospital they may not be able to leave as they choose, may have their routine decided for them or may not be able to choose the type of care or treatment they receive. This can only be done in the best interest of the individual. For example, a person with severe dementia may not be free to leave the care setting unaccompanied or in the middle of the night.

The Mental Capacity Act 2005 provides the legal framework applying restrictions to a person's liberty when it is considered to be in the best interest of that individual. The Deprivation of Liberty Safeguards are an amendment to the Act and sets out how the restrictions need to be assessed and authorised. The safeguards apply if a person is unable to make decisions for themself (is deemed to lack mental capacity) and are a set of checks to ensure the deprivation of their liberty is in their best interest and is carried out in the least restrictive way. The checks are carried out by

expereienced staff who have had specialist training and are separate from the staff providing the care.

A Supreme Court Judgement in 2014 resulted in an amendment to the definition of Deprivation of Liberty. A person was now considered to be deprived of their liberty, if they were subject to continuous supervision and control, and not free to leave, regardless of whether they were objecting or not, which had previously been the case. This resulted in a huge increase in DoLS referrals. In 2013/14 there were 102 referrals but in 2015/16, 1460 DoLS assessments were carried out and of these 482 were urgent (i.e. needed to occur within seven days). Portsmouth City Council responded to this by training more specialists (Best Interest Assessors) to carry out DoLS assessments and currently have 24 in total.

What difference does it make?

The following are two examples of when the use of DoLS have safeguarded and improved the wellbeing of the individual.

1. AA was a woman aged 47 with a brain injury following a suicide attempt. The DoLS assessment was carried out in a residential home and facilitated conditions being applied which required the provider to improve her living environment. The assessment also identified that AA would benefit from equipment to aid her communication. This input led directly to an improvement in the assessment of her capacity and enabled her to demonstrate capacity, and ultimately to communicate in a way that allowed her to articulate her wishes and feelings.

2. BB was a man in a nursing home. His assessment confirmed lack of capacity and discovered that BB was unable to leave his room due to mobility issues. Family members had been promised BB would move to a ground floor room but this had never happened. DoLS were put in in place with conditions to facilitate the move. BB is now in a ground floor room with access to communal areas of the home. This has improved the quality of his life by increasing his independence and reducing his social isolation.

Key Achievements during 2015-2016

PSAB Activity

The PSAB met quarterly during the period and there was excellent multi-agency representation.

In partnership with the Portmouth Safeguarding Childrens Board the PSAB held a safeguarding week in June 2015 with a series of events to raise awareness of safeguarding within the city.

PSAB worked with the other Local Safeguarding Adults Boards (Hampshire, Southampton and the Isle of Wight) to produce a multi-agency Risk Management Framework designed to guide staff on how to manage cases relating to adults where there is a high level of risk, in order to prevent an escalation of crisis.

Key achievements from PSAB Partners

South Central Ambulance Service (SCAS) has improved their safeguarding referral form and now, in most cases, an electronic form is sent by 4G from the crew securely from the scene of the incident. SCAS also now have a safeguarding manager in post with the responsibility of the day to day running of the safeguarding team.

Hampshire Fire and Rescue Service (HFRS) has continued its commitment in developing, promoting and delivering health and wellbeing interventions for individuals with needs of care and support across our local communities. HFRS's work with vulnerable groups encourages improving confidence, reducing the risk of harm, and increasing engagement in community activities. As a part of HFRS's Prevention and Early Intervention activities during this year the service prepared for the launch of the Safe and Well initiative in April 2016. This updated home fire safety visit not only aims to reduce fire risk in the home by fitting and checking smoke alarms, but also takes into account the occupier or occupier's behaviours and the social and physical environment in which they live.

Hampshire Constabulary has engaged with a range of partner agencies and local communities to bring the 'PREVENT' plan to life designed to protect local communities against radicalisation. The police are currently engaging with minority communities and the voluntary and community sector around female genital

mutilation (FGM) and have worked with partner organisations to develop a joint plan to manage this area of harm.
Hampshire Constabulary has been working towards an improved Domestic Abuse risk assessment which has enabled a more focused and effective management of the most serious domestic abuse cases.

Portsmouth Hospitals NHS Trust held its third Annual Adult Safeguarding Awareness Week in June 2015 to coincide with the PSAB / Portsmouth Safeguarding Children's Board event. Activities included teaching / education sessions; 'Trolley Dashes' taking key safeguarding messages to the clinical areas; distribution of resources; Safeguarding, Mental Capacity Act and Deprivation of Liberty Safeguards quizzes; nursing competency sign-off.
In 2015/16 there has been a 4% reduction in the proportion of concerns that relate to Trust provided care and less than a third of safeguarding allegations relating to hospital provided care were partly or wholly substantiated.
The Trust arranged and hosted an event to allow local multi-agency partners to meet and contribute to the Law Society proposals on reforming the Deprivation of Liberty legislation.

Portsmouth Clinical Commissioning Group created and recruited to the post of 'The Head of Safeguarding and Patient Safety incorporating the Designated Nurse (Adult and Children) which commenced in February 2016. An Associate Designated Nurse Safeguarding Adults has been recruited from February 2016. Safeguarding Policy has been reviewed and updated. Portsmouth CCG Safeguarding Week took place in June 2015.

Workforce development

During 2015-2016 the PSAB had a sub-group which worked in partnership with the Safeguarding Adults Boards of neighbouring Local Authorities to ensure staff working with adults with support and care needs were appropriately trained to prevent, recognise and respond to safeguarding issues.

Some examples of how PSAB partners have contributed to having a workforce appropriately trained in safeguarding:

Online safeguarding refresher training for GPs

Solent NHS Trust has embedded training around Domestic Abuse and now has a dedicated Lead for Domestic Abuse policy and guidance.

All Hampshire Fire and Rescue Service frontline staff undertook an annual programme of safeguarding training to ensure they maintain an awareness of the key indicators of abuse and a clear understanding of how to report such concerns.

All staff from the Hampshire and Isle of Wight Community Rehabilitation Company received training on the Safeguarding Adult Multi-Agency Policy, Guidance and Toolkit which was launched in May 2015.

Portsmouth NHS Hospitals Trust has increased staff awareness and understanding of safeguards designed to protect adults who lack capacity to make decisions about where they are accommodated, resulting in three-fold increase in the number of applications for Deprivation of Liberty Safeguards Authorisations.

Safeguarding Level 1 e-learning is now mandatory across NHS England for all staff

Portsmouth Clinical Commissioning Group have provided Mental Capacity Act training to their staff and staff in care homes

South Central Ambulance Service staff had face to face safeguarding adults training including the Mental Capacity Act.

Portsmouth City Council have trained 6 Best Interest Assessors for the Deprivation of Liberty Safeguarding Team

Making Safeguarding Personal

Making Safeguarding Personal is about developing a working environment that focuses on the personalised outcomes wanted by people with care and support needs who may have been subjected to abuse or neglect.

Safeguarding enquiries can be conducted by either the Local Authority or by a delegated third party organisation.

During 2015/16, less than half of people involved in safeguarding enquiries were asked about their desired outcomes. As a Board, we recognise that this is an area which could be improved upon. However, of those that were asked, the vast majority of desired outcomes were achieved.

Opportunities going forward:

- A new form has been introduced during 2016 to ensure that individuals involved in safeguarding have an opportunity to provide feedback on the experience and contribute to the cycle of improvement.
- The PSAB will explore opportunities for co-production and involvement from people with care and support needs and their carers throughout its work.

How have PSAB partners captured the voice of people with care and support needs and their carers?

Healthwatch Portsmouth, part of Learning Links, has a statutory function to obtain the views of local people regarding their needs for, and experiences of, local care services and importantly to make these views known.

Hampshire and the Isle of Wight Community Rehabilitation Company / National Probation Service Portsmouth VOICE is a Service User Consultation Group run by a senior Probation Officer. This group is attended by any Service Users who are interested in giving their views to assist in the development and improvement of services from the CRC.

Feedback from Portsmouth VOICE resulted in the development of a peer mentor support group called Open Door. This peer mentor support group meets weekly and provides mutual aid and support to all members.

Safer Portsmouth Partnership A representative from the group contributed to the process and met with the relative of an individual who was murdered.

South Central Ambulance Service All services users' comments influence the development of safeguarding policy and procedures. SCAS has focused on consent through training and policy development in the last year. The voice of service users is fed into the safeguarding department via the Patient Experience team

Portsmouth Hospitals NHS Trust has introduced an internal system to monitor patient awareness / consent to safeguarding referral. This will be embedded and monitored further in 2016/17.

NHS England captures the voice of patients / families through a triangulation process with Complaints and Patient Safety.

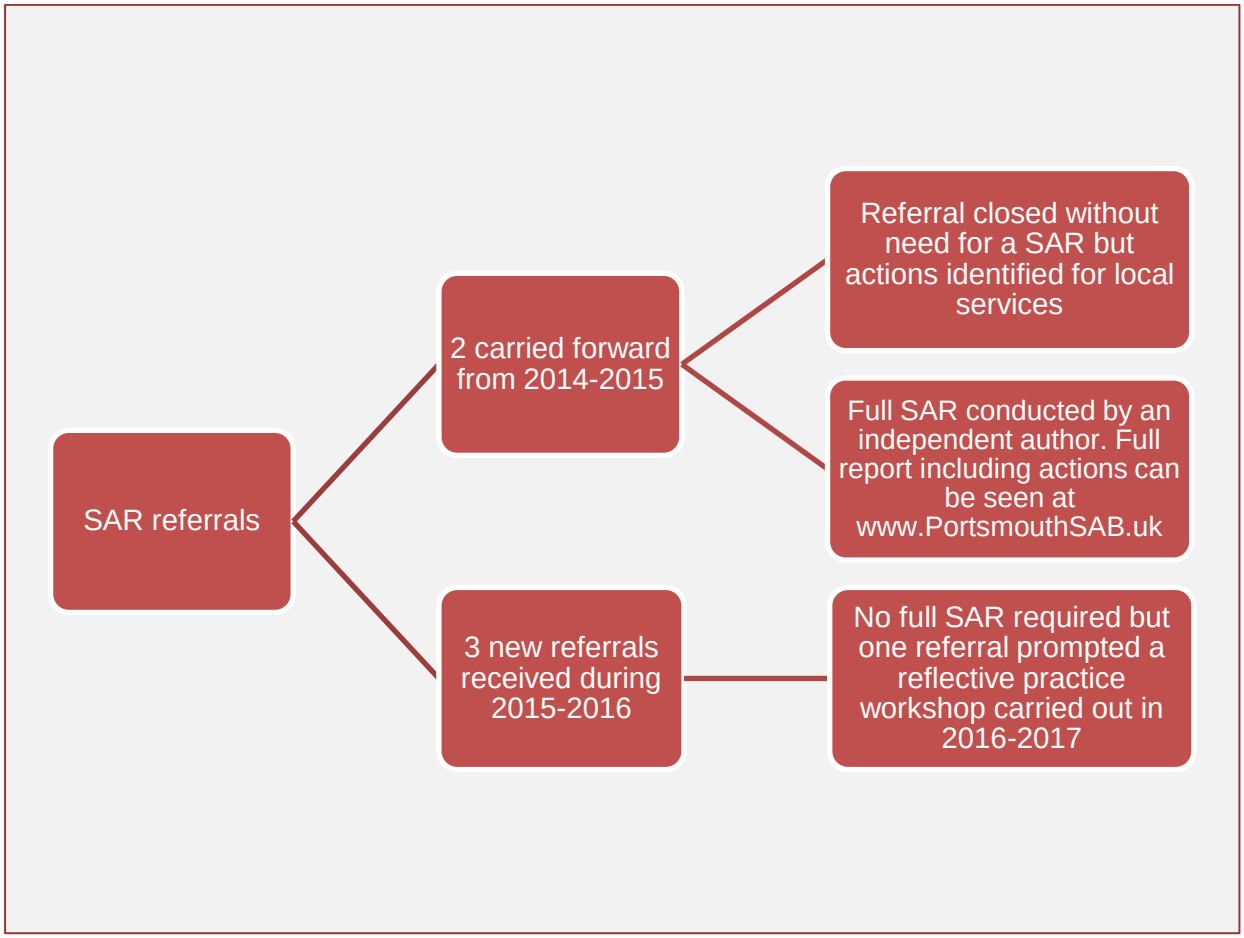
Safeguarding Adult Reviews (SARs)

The Care Act 2014 states that a safegaurding adult review (SAR) must take place when:

"There is reasonable cause for concern about how the Safeguarding Adult Board, members of it or others worked together to safeguard the adult, and death or serious harm arose from actual or suspected abuse"

The PSAB has a SAR subgroup which met regularly throughout 2015-2016. The group is a multi-agency group with members who have a specialist role or experience in safeguarding adults.

Summary of SAR activity during 2015-2016:



How have the findings of the SAR made a difference?

Some of the key learning points:

- All agencies, including all health services, will take individual responsibility for raising appropriate safeguarding adults alerts, even if this leads to multiple referrals for the same incident.

- If an individual is moving to a new supported living or residential service, there is a plan for them to prepare for the new environment. A contingency plan is also agreed, so if the person decides it is not suitable for them within a period of time from the beginning of the placement, an alternative can be arranged.

- Any individual who is deemed to pose a risk to themselves or others will have a formal multi-agency risk assessment and risk management plan in place, which is shared with the adult or their appropriate representative, if they lack capacity. This will be reviewed on a regular basis by the agencies involved with the adult or their appropriate representative.

- Where placements in a residential or supported living setting are at risk of breaking down as the individual's needs or risks appear to be unable to be met by the placement, an urgent multi-agency review is called to agree a plan, which is appropriate and proportionate to the assessed risks.

The SAR sub-group ensures that the learning points are implemented to improve practice.

If you would like a copy of the PSAB Strategic Plan for 2016 - 2017 or

If you are an adult with care and support needs or a carer and would like to hear about or be involved in the future work of the Portsmouth Safeguarding Adults Board please email

psab@portsmouthcc.gov.uk

or write to Portsmouth Safeguarding Adults Board Manager, Portsmouth City Council, Core 5 Floor 5 Civic Offices, Guildhall Square, Portsmouth, PO1 2AL

If you are concerned about an adult at risk:

Phone the Adult Safeguarding Team on 023 9268 0810 or email PortsmouthAdultMASH@portsmouthcc.gov.uk

CQC update and CQC strategy 2016 to 2021

Anne Davis
CQC Inspection Manager
December 2016

Our purpose

The Care Quality Commission is the independent regulator of health and adult social care in England.

We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our current model of regulation

Register

We **register** those who apply to CQC to provide health and adult social care services

Monitor, inspect and rate

We **monitor** services, carry out expert **inspections**, and judge each service, usually to give an overall **rating**, and conduct **thematic reviews**

Enforce

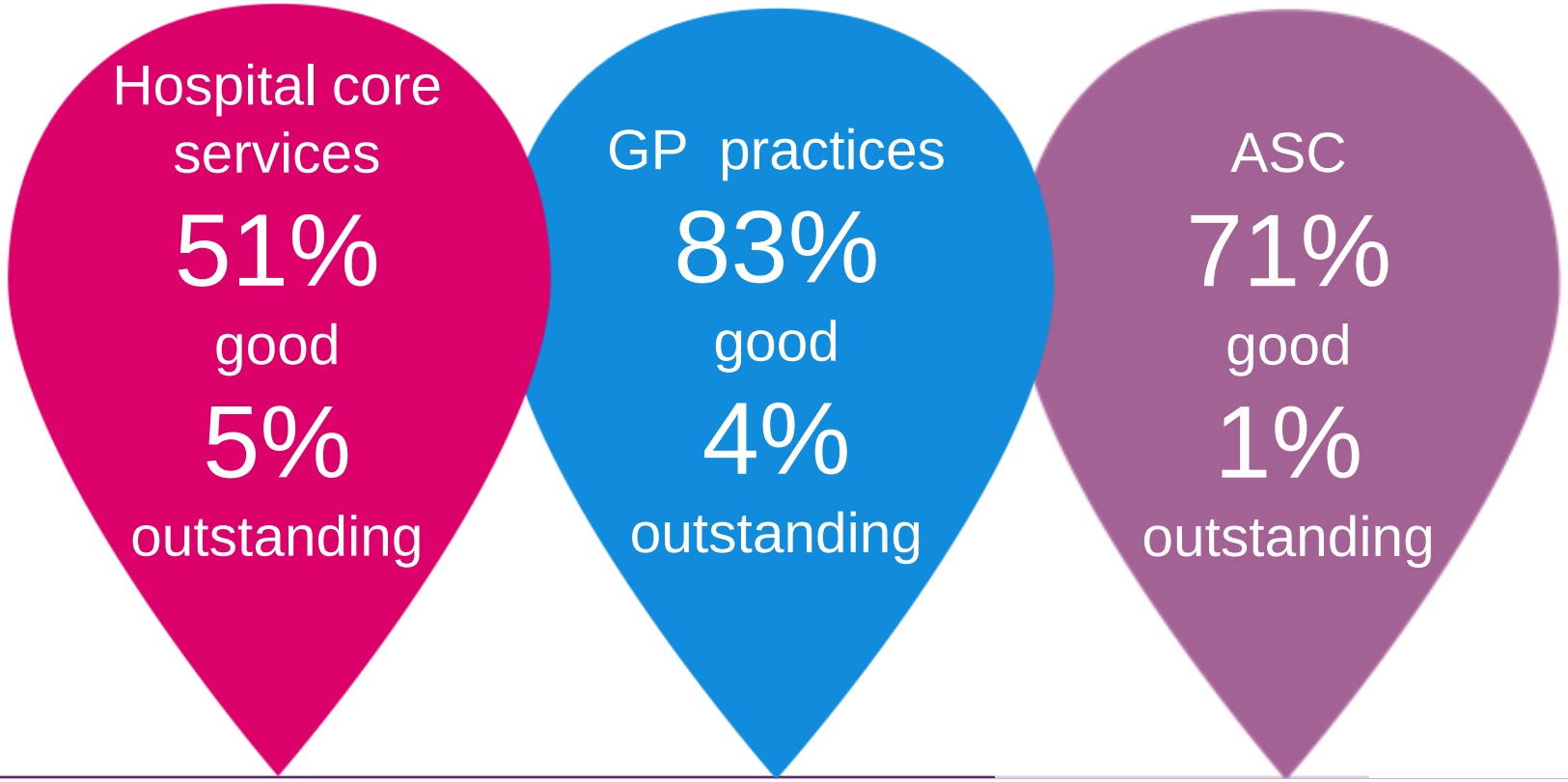
Where we find poor care, we ask providers to improve and can **enforce** this if necessary

Independent voice

We provide an **independent voice** on the state of health and adult social care in England on issues that matter to the public, providers and stakeholders

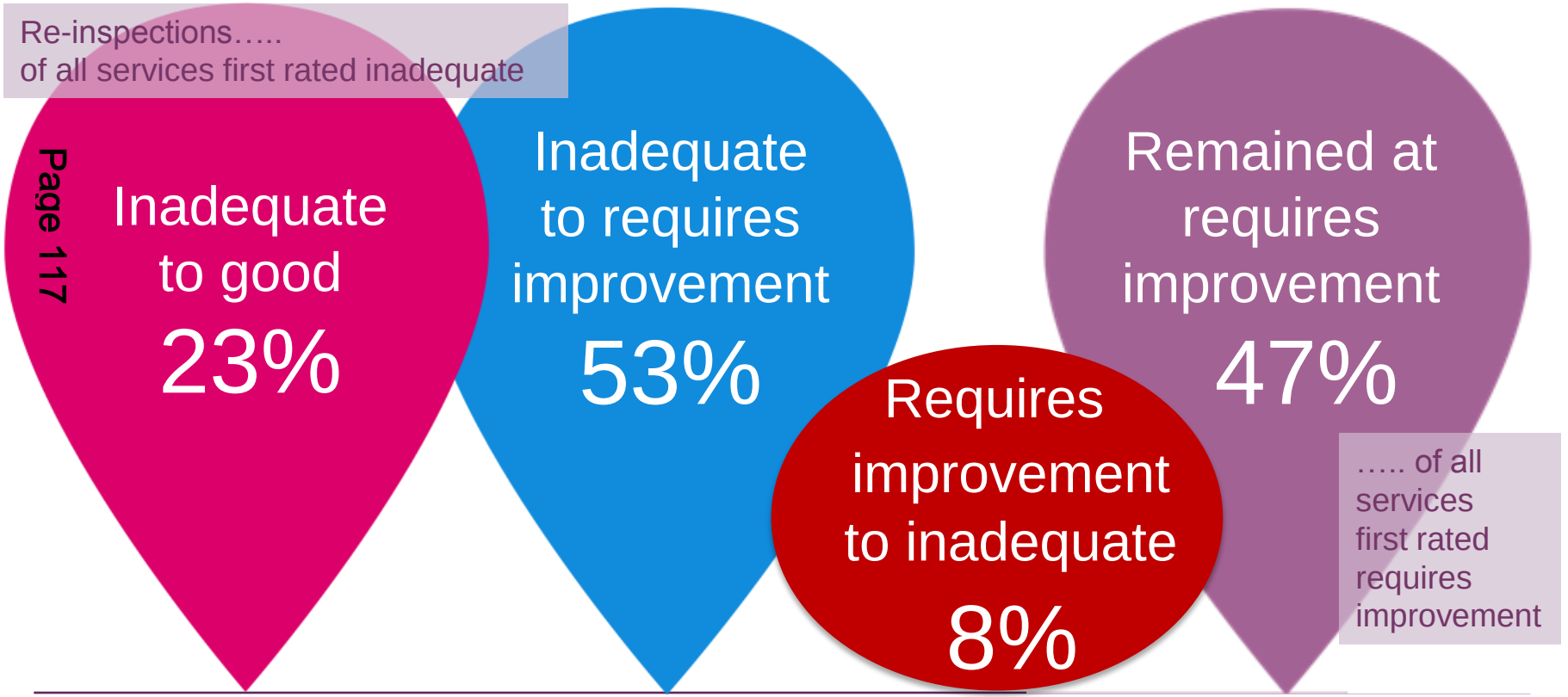
Good and outstanding care

- Despite challenging circumstances, most people are still getting high quality care
- Many services improving and collaborating



But some very poor care

- Wide quality variation continues with evidence of deterioration
- But some services are struggling to improve despite clear information on what is needed



Why a new CQC strategy?

A changing environment

Use and delivery of regulated services is changing

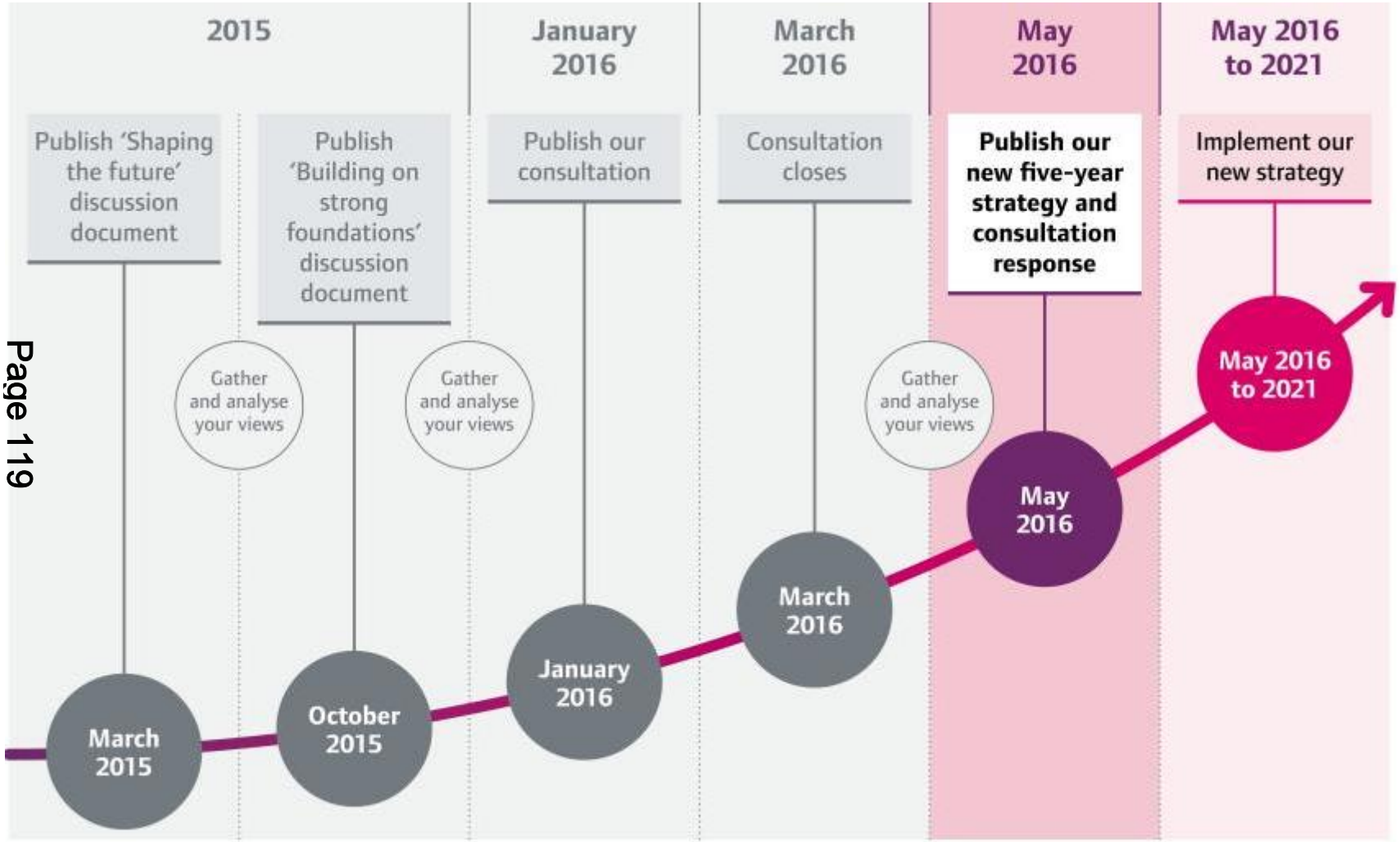
CQC must deliver its purpose with fewer resources

Adapt and improve

We want to become more efficient and effective to stay relevant and sustainable for the future

The public, and organisations that deliver care, have told us we have improved but we know there is more to do

Strategy timeline



Ambition

Our ambition for the next five years:

A more targeted, responsive and collaborative approach to regulation, so more people get high-quality care

Four priorities to achieve our strategic ambition

1. Encourage improvement, innovation and sustainability in care

2. Deliver an intelligence-driven approach to regulation

3. Promote a single shared view of quality

4. Improve our efficiency and effectiveness

What will stay the same?

- Our **purpose, role and operating model** - inspections will continue to be central to our assessments of quality

- Our **work with the public** to understand and focus on what matters to people

- Our role in **protecting and promoting equality and human rights -** including for people being cared for under the Mental Health Act or the Mental Capacity Act Deprivation of Liberty Safeguards

What we will do differently

- Support innovation by working with providers delivering care in new ways
- Focus more on the quality of care for population groups and how well care is coordinated across organisations
- Rate how well NHS Trusts are using their resources

- Focus resources towards higher-risk applications at registration
- Build and use our insight to target our inspections where risk is greatest or quality improving

What we will do differently

- Expect providers to describe their own quality against our five key questions
- Share data sets with partners, other regulators and commissioners on care quality

- Improve the experience of providers and the public by moving as many interactions as possible online
- Invest in our internal systems and improve our processes to make sure that we can work efficiently and effectively

What will our strategy mean for hospitals?

- Focus on core services that require improvement
- Update ratings based on smaller, more focused inspection; use more unannounced inspections
- Expect providers to describe their own quality against our five key questions
- Work with NHS Improvement to give new ratings on efficient use of resources
- Produce shorter reports, more quickly that make clear how we have come to our conclusion

Hold an annual review of each provider to determine where to focus our inspection activity for the year ahead

What will our strategy mean for primary care?

- Reduce duplication for providers, agree actions jointly where there are risks of poor care
- Extend inspection intervals for good or outstanding practices
- Focus on understanding innovative models of care and areas where potential risks may emerge

Federations and other new care models: focus on well-led question, consider inspection of sample locations alongside, understanding potential risks using local data

For urgent and emergency care, including OoH and NHS 111: inspect related services at the same time

What will our strategy mean for adult social care?

- Improve and use local information to better inform inspections
- Expect providers to describe themselves using the 5 key questions
- Move to greater intervals between inspections for services rated good or outstanding as information improves

- Respond to risk and improvements for those requiring improvement as information improves
- Clarify where services are good with outstanding features and where services that require improvement are not meeting fundamental standards

For corporate providers: Understanding impact on quality through culture, policies and head office leadership, improving local activity

Thank you

www.cqc.org.uk/ourstrategy

@CareQualityComm

enquiries@cqc.org.uk

Your name
Your job title