Portsmouth CITY COUNCIL

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NOTICE OF MEETING

HEALTH OVERVIEW & SCRUTINY PANEL

THURSDAY, 29 JUNE 2017 AT 9.30 AM

CONFERENCE ROOM A, SECOND FLOOR, CIVIC OFFICES

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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 Leo Madden (Chair)
Councillor Steve Wemyss (Vice-Chair)
Councillor Yahiya Chowdhury
Councillor Alicia Denny
Councillor Gemma New
Councillor Lynne Stagg
Councillor Michael Ford JP
Councillor Gwen Blackett
Councillor Gary Hughes
Councillor Mike Read
Councillor Elaine Tickell
Councillor Philip Raffaelli

Standing Deputies

Councillor Dave Ashmore
Councillor Ben Dowling
Councillor Steve Hastings
Councillor Lee Hunt
Councillor Ian Lyon
Councillor Tina Ellis

(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 - 8)

RECOMMENDED that the minutes of the previous meeting on 2 May 2017 be agreed as a correct record.

4 **Sustainability and Transformation Plan** (Pages 9 - 12)

Mark Smith (Hampshire and IoW STP Programme Director) will answer questions on the report that will follow.

5 **South Central Ambulance Service Update** (Pages 13 - 20)

Tracy Redman (Head of Operations South East) will answer questions on the attached report.

6 **Crisis Resolution Home Treatment Team update** (Pages 21 - 36)

Charlotte Hope and Mark Nichols from Southern Health and James Dawson, Clinical Manager and Home Treatment Team from Solent NHS Trust will answer questions on the attached report.

7 **Portsmouth Healthwatch Update** (Pages 37 - 42)

Siobhain McCurrach, Project Manager will answer questions on the attached report.

8 **Adult Social Care Update** (Pages 43 - 48)

Angela Dryer Deputy Director Adult Services will answer questions on the attached report.

9 **Learning Disability Transformation Programme update** (Pages 49 - 60)

Mark Stables Service Manager - Integrated Learning Disability Service and John Attrill Learning Disabilities Champion will present this item and answer questions on the attached reports.

10 **Portsmouth Clinical Commissioning Group update** (Pages 61 - 66)

Dr Elizabeth Fellows will answer questions on the attached report.

11 **Southern Health Foundation Trust - Update** (Pages 67 - 104)

Mark Morgan (Director of Operations for the Mental Health, Learning Disability and Social Care Division, and Sara Courtney (Acting Director of Nursing and Allied Health Professionals) will answer questions on the attached report.

Please note that appendix D - Mental Health and Learning Disability Services: Statement of Strategic Direction can be read here http://www.southernhealth.nhs.uk/news/publication-of-clinical-services-strategy/

12 Dates of Future Meetings

Members are asked to note the dates of future meetings for 2017/18:

Thursday 14 September
Thursday 23 November
Thursday 1 February
Thursday 22 March

All meetings will start at 1:30pm.

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, 2 May 2017 at 9.30am in the Guildhall.

Present

Councillor Jennie Brent (Chair)
David Tompkins
Alicia Denny
Leo Madden
Lynne Stagg
Gwen Blackett, Havant Borough Council
Mike Read, Winchester City Council
Elaine Tickell, East Hampshire District Council

1. Welcome and Apologies for Absence (AI 1)

Councillors David Keast and Philip Raffaelli sent their apologies.

2. Declarations of Members' Interests (AI 2)

Councillor Stagg declared a non-prejudicial interest in item 6: she is involved in the Milton Neighbourhood Planning Forum.

3. Minutes of the Previous Meeting (AI 3)

RESOLVED that the minutes of the previous meeting are a correct record.

4. Hampshire & Isle of Wight Sustainability Transformation Plan (AI 4)

The Chair informed the panel that this item had been withdrawn and would come to the next meeting.

5. Portsmouth Hospitals' NHS Trust - update. (AI 5)

Peter Mellor, Director of Corporate Affairs apologised for not having attended the previous meeting and in response to questions, clarified the following points:

<u>Onsite traffic congestion.</u>

One of the causes is the large number of outpatient clinics each day. The timing of clinics has been reviewed and they have been spread more evenly throughout the week.

The parking facilities have also been reviewed. The Trust is keen to encourage visitors to park in the ‘behind barrier’ car parks at either the North Entrance or in the multi-storey car park at the South of the site. The current ‘pay and display’ spaces will be changed to staff usage. The introduction of a one-way system is also being considered.

The bus companies are concerned about the time it takes to get through the site and the impact on keeping to their timetables. The Trust will work closely with the bus services to see what can be done to improve the situation..

Vascular services

Major vascular surgery is now carried out in Southampton but Portsmouth Hospitals NHS Trust still provides the majority of the 'day to day' vascular services at Queen Alexandra Hospital

A multi storey car park is being built at Southampton General Hospital and is expected to be completed in 2-3 months' time. This should alleviate their severe traffic congestion.

Staff survey results

The increase in physical violence from other staff, patients, relatives and the public that was reflected in the survey is a worrying trend.

With the help of the unions, a discreet anonymous helpline system was set up some months ago. Although there have been very few formal approaches to the helpline, the problem still needs to be resolved. This is only possible if staff tell us what is happening.

He was not aware that staff on staff physical violence was a problem.

It is a shame that the staff were not asked if they would recommend QA as a place to work or receive treatment in separate questions. These questions were part of a national survey.

PHT has a zero tolerance of abuse of its staff. Security is on hand to deal with incidents and offenders will be prosecuted or expelled as appropriate. It is dependent on staff complaining. Unfortunately, some staff almost consider verbal abuse and assault as part of t of their job.

A system has been introduced asking staff to report every incident that is outside the norm so that trends can be detected and areas of learning developed. In more serious cases, staff will be retrained or removed and safety mechanisms introduced e.g. new equipment.
The new system encourages staff to report It is must be noted that the more staff are encouraged to report all incidents, the higher the rate.

There are also quite comprehensive whistleblowing and reporting processes where staff can speak to HR or to a Governor.

The wellbeing service encourages healthy food to be on sale in the canteen, staff to make use of the gym and pool. It also discourages smoking and heavy drinking.

Staff are discouraged from coming in to work if they are ill as this would spread germs and put staff and patients at risk.

Just under 75% of staff took up the offer of the flu jab.

There are a number of incidents with patients assaulting staff involve alcohol or drugs.

Staffing levels
Overall staffing levels are good on the whole. Extra staff often need to be brought in to help deal with the large number of extra beds that are open at the moment. These staff tend to be temporary or agency staff who cost more. The Department of Health is trying to address the excessive cost of agency staff byplacing restrictions on how much hospitals are allowed to pay agencies and by tightening up the rules on self-employed staff.

There is a minimum level of English required for foreign staff.

Portsmouth Hospitals NHS Trust is currently recruiting nurses from the Philippines.

We are seeing more and more patients who are suffering from mental health disorders.

Alcohol and drug misuse.
There is no plan to charge people for attendance at A&E caused by their alcohol or drug abuse.

Abuse of NHS services.
Overseas patients who are not entitled to free NHS treatment are charged.

Discharges.
There are currently 250 patients who have been declared medically fit and ready for discharge but who are still waiting for an appropriate support package of care to be in place before they can leave the hospital. All partners within the local healthcare system have committed to significantly reduce the number by the end of July.

RESOLVED that the update be noted.

6. Solent NHS Trust and NHS Property Services' update on Phase 2 of St James' Hospital. (AI 6)

Geoff Lewis, Estates Programme Manager and Christopher Box, Associate Director of Estates & Facilities Solent NHS Trust and Nicola Booth, Senior Transaction Manager, NHS Property Services clarified the following points in response to questions:

The construction phase is expected to take 12 months and service relocation a further month. The completion date should be August 2018.

Proposals for additional parking at Portsmouth Football Club are being considered. These would not be available on match days. As these are generally in the evenings or on Saturdays, there would be no impact on work activity. These are for staff only and the parking at St Mary's predominantly for patients.

This is a long term measure to address parking issues.

Bournemouth hospital and Portsmouth City Council have expressed an interest in the catering service that will be based at St Mary's. It would be complicated to offer this service to QA because of the PFI in place.

The planning application for the development of St James' site includes the creation of more parking spaces adjacent to the Limes. These spaces would be controlled.

The panel expressed disappointment that they had not been informed that the additional parking at Fratton Park was for staff only.

RESOLVED that the update be noted.

The meeting ended at10:20am.

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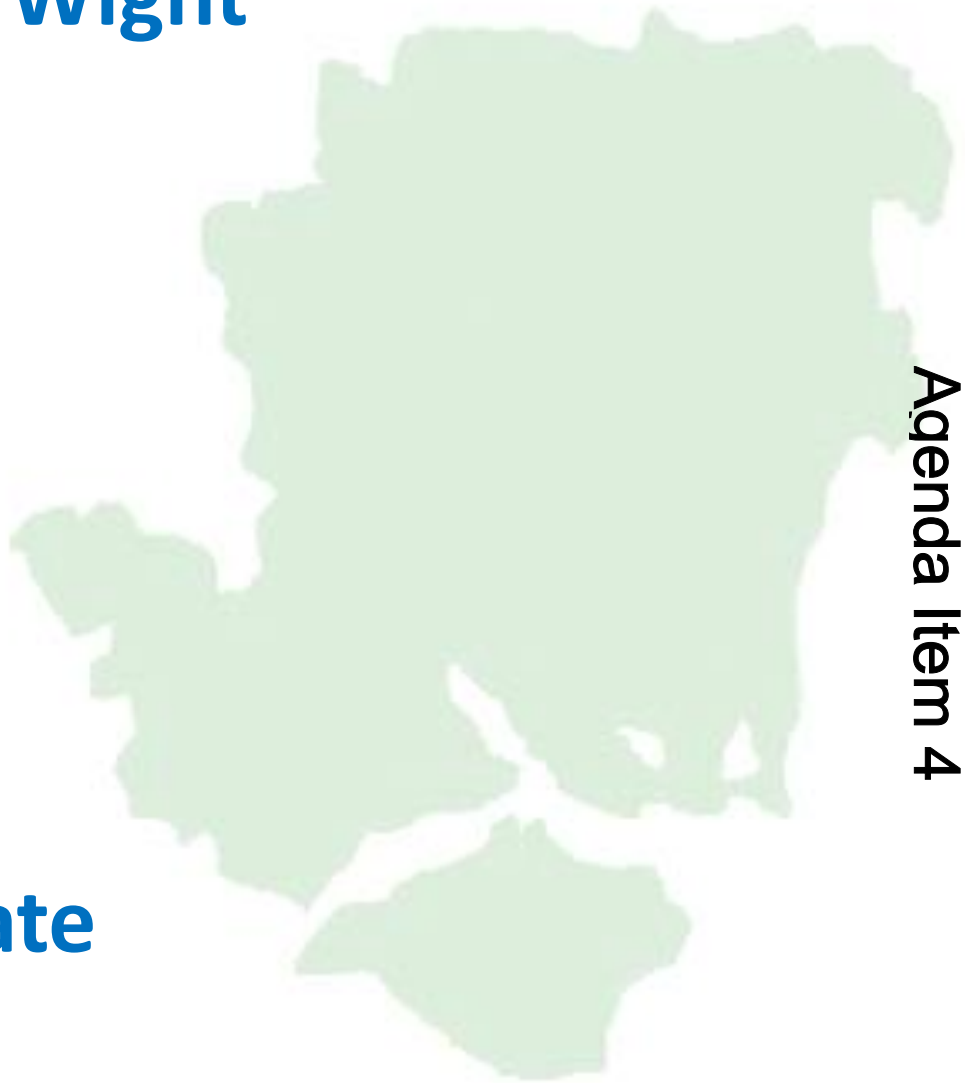
Councillor Jennie Brent
Chair

Hampshire and Isle of Wight Sustainability and Transformation Partnership



Agenda Item 4

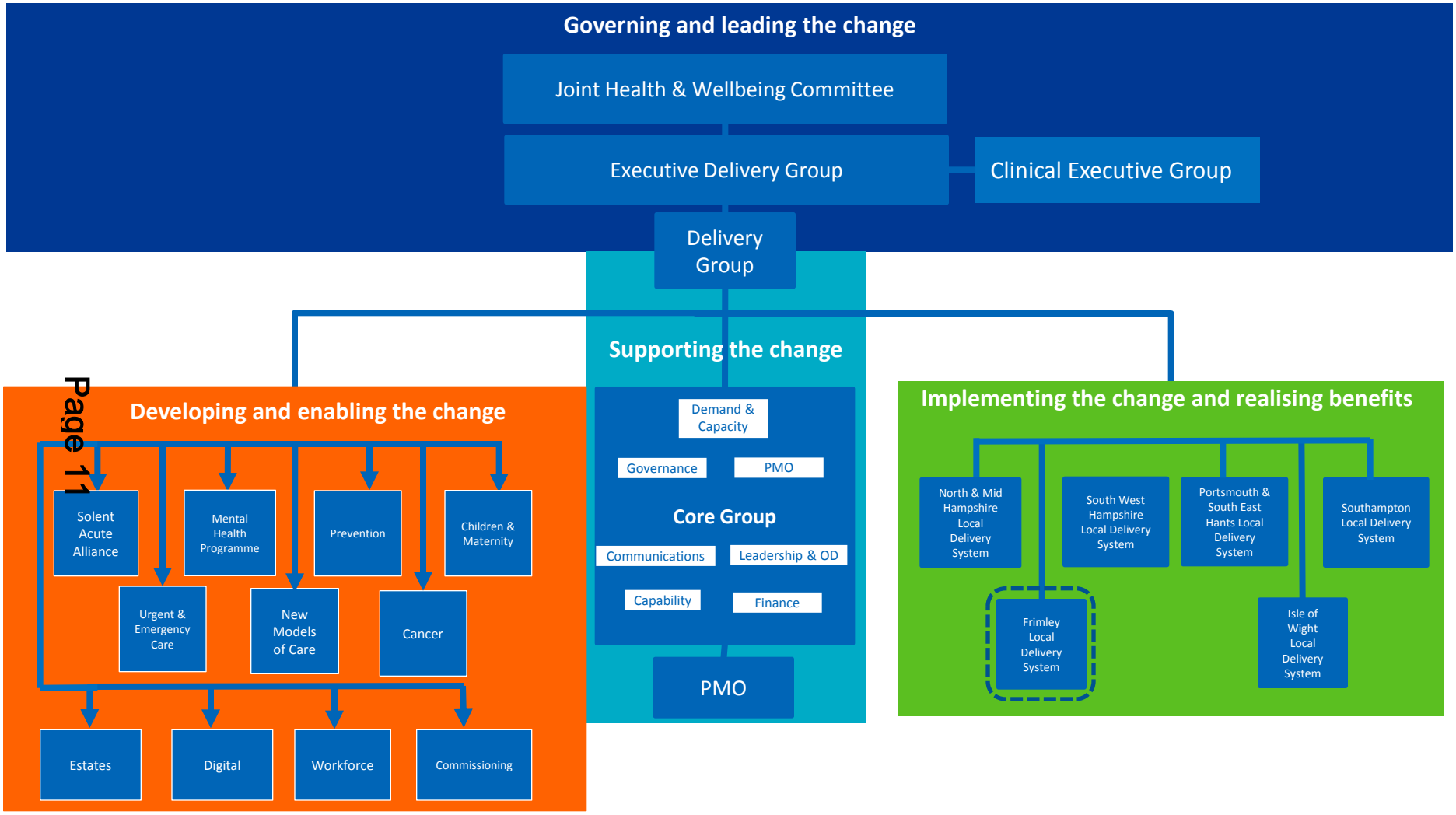
Core programme update
June 2017

Our core delivery programmes

This document provides an update on our seven core delivery programmes. Following the publication of NHS England's Five Year Forward View Next Steps the core programmes have been amended to reflect both national and local priorities. There are now seven core programmes focused on transforming the way both physical and mental health and care are delivered.

Core Programme	Summary
1. Prevention at scale	To improve healthy life expectancy and reduce dependency on health and care services through a radical upgrade in prevention, early intervention and self care: a sustained focus on delivering prevention at scale in HIOW.
2. New Care Models	To improve the health, wellbeing and independence of HIOW population through the accelerated introduction of New Models of Care and ensure the sustainability of General Practice within a model of wider integrated health and care. This will be delivered through the Vanguard programmes and local health system New Care Models delivery arrangements.
3. Urgent and Emergency Care	To create a sustainable, high quality and affordable configuration of urgent and emergency services for the population of HIOW and the out-of-hospital services to support that configuration, ensuring that no patient stays longer in an acute or community bed based care than their clinical condition and care programme demands. Focus will include reducing the rate of delayed transfers of care by improving discharge planning and patient flow, and by investing in capacity to care for patients in more appropriate and cost effective settings
4. Solent Acute Alliance	To deliver the highest quality, safe and sustainable acute services to southern Hampshire and the Isle of Wight. To improve outcomes, reduce clinical variation and cost through collaboration between UHS, Portsmouth Hospitals, Isle of Wight Trust and Lymington Hospital. Provide equity of access, highest quality, safe services for the population.
5. Cancer	To improve the prevention and early detection of cancer , ensuring that patient treatment and their experience of that treatment is as good as it can be. We will also work to ensure that people are supported to live with and beyond their cancer diagnosis.
6. Mental Health Programme	To improve quality, capacity and access to MH services in HIOW. Achieved by the four HIOW Trusts providing mental health services (Southern Health, Solent NHST, Sussex Partnership FT and Isle of Wight NHST), commissioners, local authorities, third sector and people who use services, working together in an Alliance to deliver a shared model of care with standardised pathways
7. Children and maternity	To ensure the children and young people of Hampshire and the Isle of Wight have the best start in life, having the access they need to high quality physical and mental health care.

STP governance structure



Our core delivery programme activity

Core Programme	Progress to date	Objectives for the next six months
1. Prevention at scale	• Diabetes Prevention Programme now active with additional national funding obtained – 119 people referred in first month in West and North Hants, Fareham and Gosport • 'Stop before the op' now actively promoted in all acute trusts	• Diabetes Prevention programme to roll out in Southampton and Portsmouth
2. New Care Models	• Each local area has completed a new care models self assessment to enable a HIOW plan to be developed	• Analysis of self-assessments to identify key priorities and resource requirements
3. Urgent and Emergency Care	• Investing circa £3m capital to support GP streaming in three emergency departments: £855k at Portsmouth Hospitals, £1m at UHS, £969k at Hampshire Hospitals • Agreement of a delivery plan including eight key priority areas	• Transforming care services in north and mid-Hampshire , options appraisal and preparation for public consultation • Development of an enhanced NHS 111 service model including assessment by a clinician and direct booking for out of hours appointments
4. Solent Acute Alliance	• Contributed to the Acute Services Review, identifying options to provide safe and sustainable services on the Isle of Wight • Moved HIOW vascular services to UHS from April 2017	• Designing a Wessex Renal service using a 'Hub and Spoke' model • Designing spinal surgical services across Alliance partners, supported by commissioners • Prioritising further opportunities to achieve benefits in quality, cost and sustainability
5. Cancer	• Invested **£**148k additional funding into non-recurrent MRI scan capacity to improve cancer 62 day wait performance	• Continued focus on improving achievement of the 62 waiting time standard • Improving rehabilitation and recovery services
6. Mental Health Programme	• Secured £456k non-recurrent revenue for University Hospitals Southampton to provide 24hr psychiatric liaison services • Provided immediate resilience and improvement support for Isle of Wight mental health services • Commenced process of establishing a specialised mental health and learning disability service for Hampshire and Southampton	• Working with 'Building Health Partnerships' to develop plans to work with community and voluntary sector to embed coproduction into HIOW mental health crisis service design
7. Children and maternity	• Scope of programme agreed including identification of key priorities : improving care for children with ADHD/ Autism, paediatric urgent and emergency care, Tier3/4 CAMHS, paediatric acute bed review	• Stakeholder engagement to help shape plans for key priority areas

South Central Ambulance Service NHS
NHS Foundation Trust

SOUTH CENTRAL AMBULANCE SERVICE NHS FOUNDATION TRUST

Portsmouth Health Overview and Scrutiny Panel

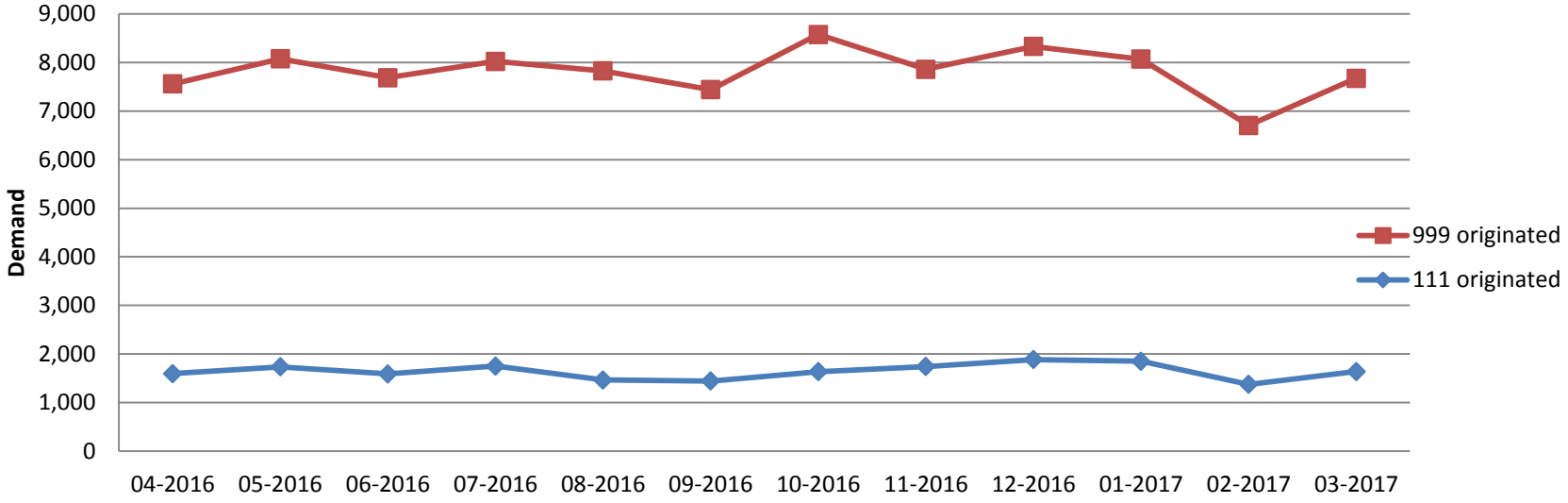
June 2017

Proud to be caring for you!

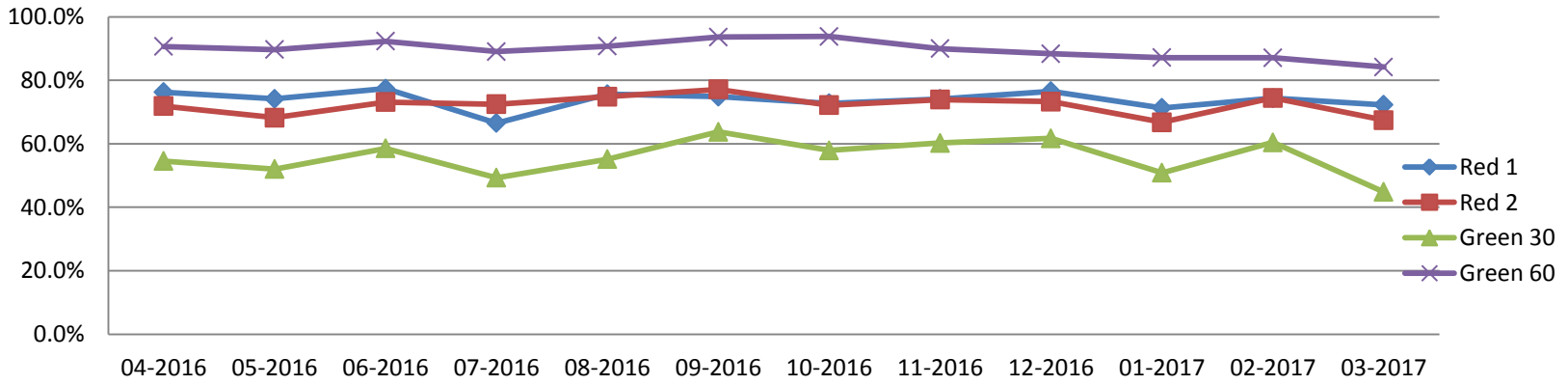
Operational Context - 2016/17

- South East Hampshire Activity & Demand
- Portsmouth CCG Activity & Demand
- PHT Handover Delays
- Challenges
- Developments

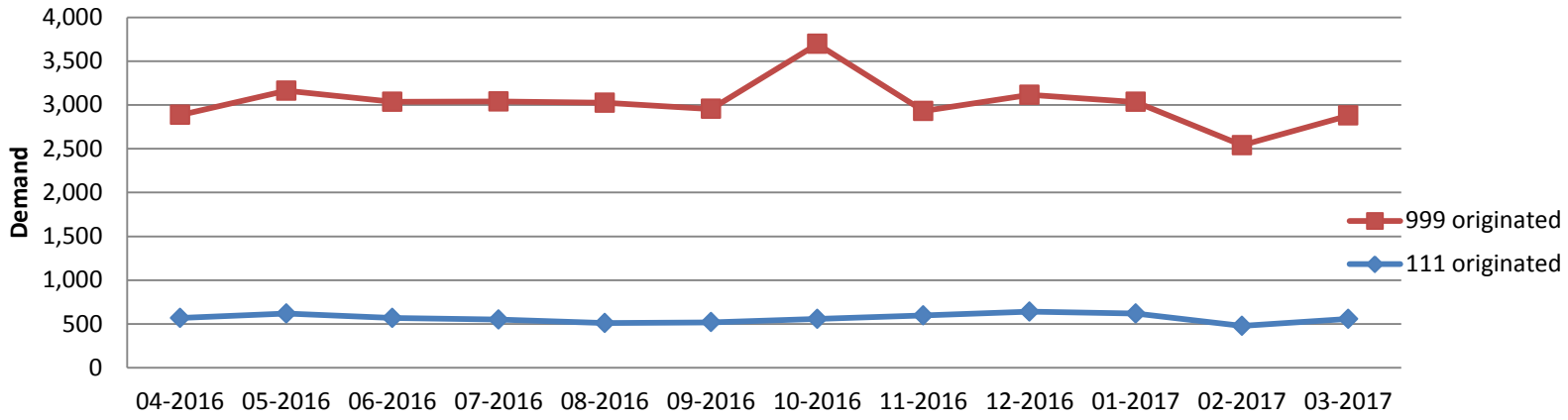
SE Hampshire Activity – 2016/17



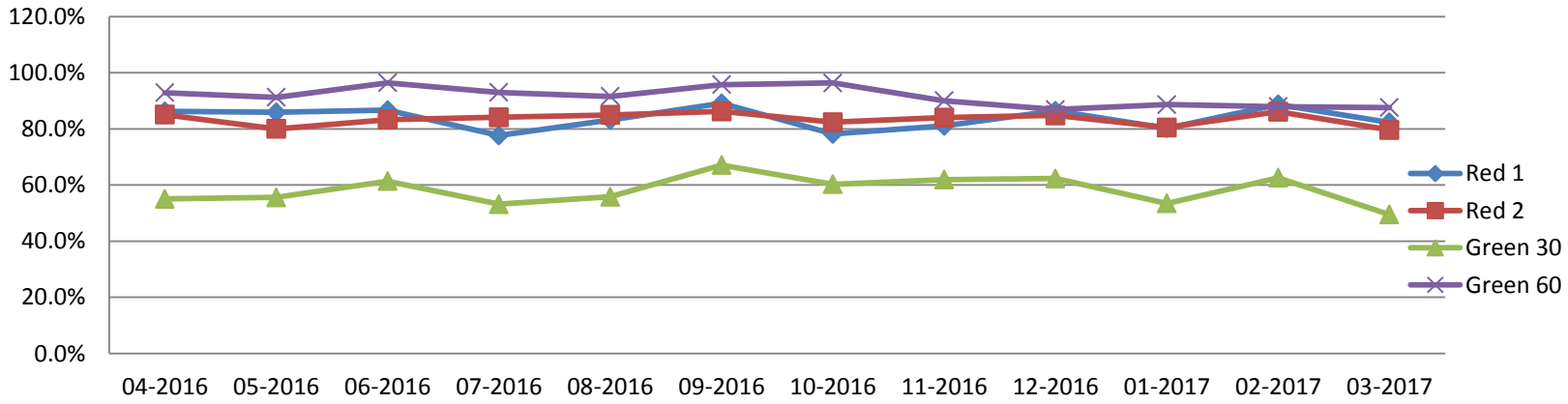
SE Hampshire Performance – 2016/17



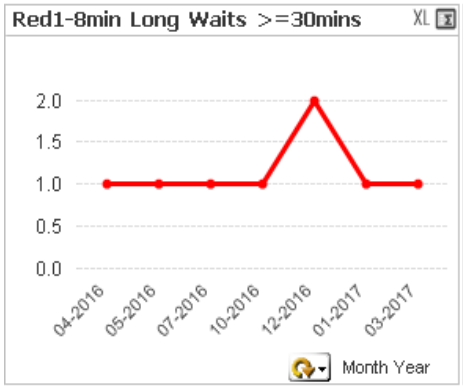
Portsmouth CCG Activity – 2016/17

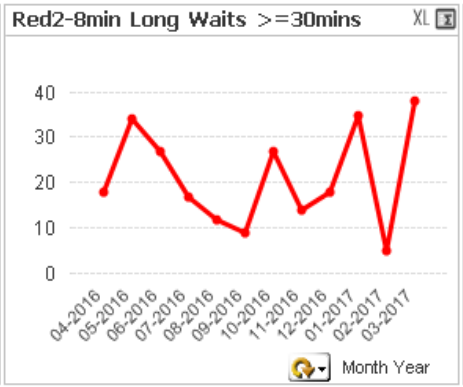


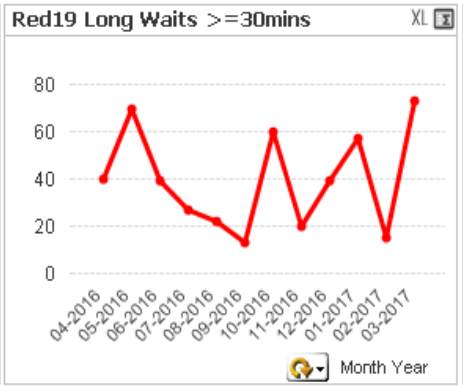
Portsmouth CCG Performance – 2016/17

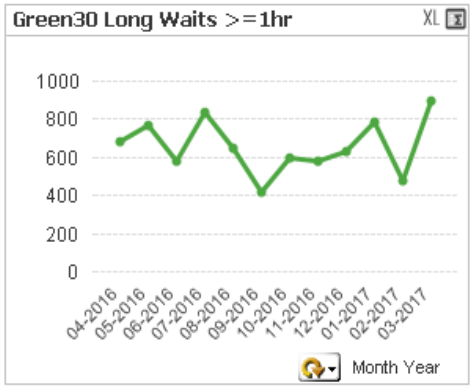


SE Hampshire Long Waits

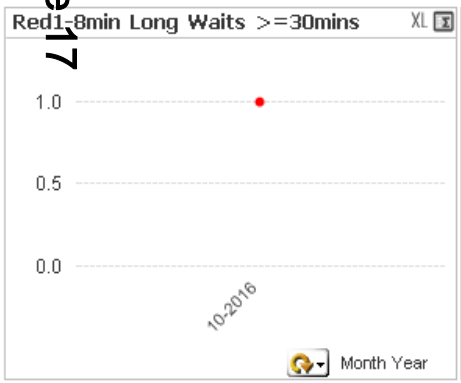


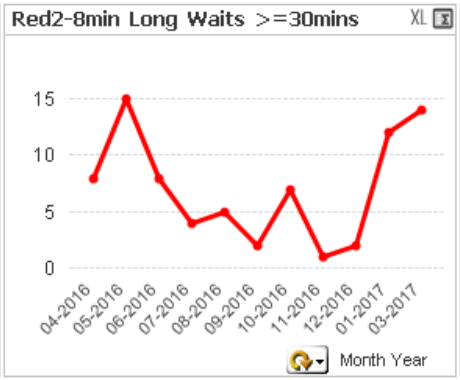


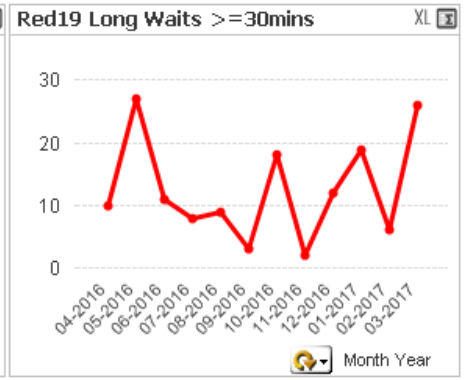


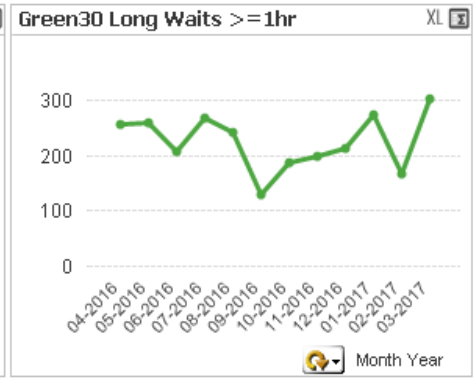


Portsmouth CCG Long Waits

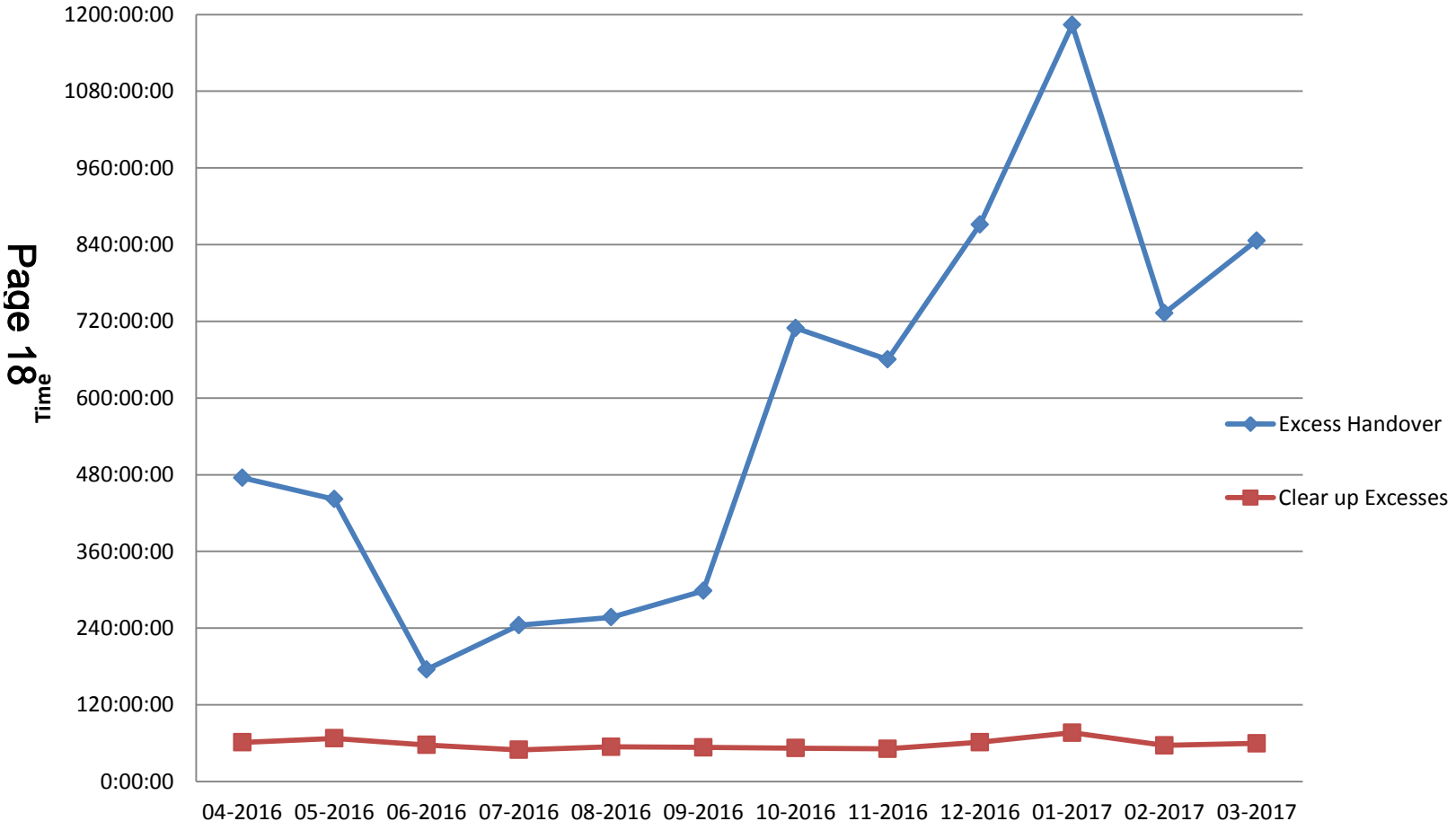








PHT Handover & Clear Up Excess – 2016/17



Challenges

- Retention of experienced staff
- Recruitment of qualified staff
- Availability of alternative care pathways
- Long Waits
- Hospital/System resilience and capacity - impact on Hospital Handover delays

Developments

- Staff rotations into the wider system - Toolkit
- Band 6 Paramedic
- High intensity users project
- Implementation of new Rosta
- Electronic Patient Records
- Alternative Pathways / DOS
- NARP
- Continued engagement with the A&E Delivery Board
- Engagement with the development of the ACS / LDS

Agenda Item 6

AMHT – EAST

MARK NICHOLS AND CHARLOTTE HOPE

SERVICE HOURS

- 24/7 , 365 days a year
- Limited night cover – one band 6
- Mixture of short and long days offered to staff
- Care navigators work 7 days a week (Mon-Fri, 8-8pm, Sat-Sun 8-4pm)

SKILL MIX

- 13 band 6 nurses
- 2 band 6 nurse prescribers
- 1 band 6 transfer facilitator
- 1 band 5 social worker
- *Total: 16.76 full time*
- 11 band 3 support works
- *Total: 10.4 full time*
- 5 band 4 care navigators
- *Total: 5 full time*
- 2 band 3 team admin support *(2 full time – does not come out of AMHT budget)*
- 2 band 7 team leaders
- *Total: 2 full time*
- 1 band 8 (split across AMHT and MHLT)

AREA/REFERRALS AND CASE LOAD

- Referrals from GP, Community mental health team, Mental health liaison team, Other allied professionals
- Population of around 450000
- We cover, Fareham, Gosport, Havant, Waterlooville, Border, Petersfield and some GP's in Titchfield, Locks Heath, Wickham and Bishops Waltham.
- Average case load 45-60 patients

Team Referral and Activity - Referral Analysis

Southern Health NHS
NHS Foundation Trust

Select a Division
Adults Mental Health

Area
East

Service Line
AMH - Hospital at home

Team Name
All

Referring CCG
All

Referring GP Practice
All

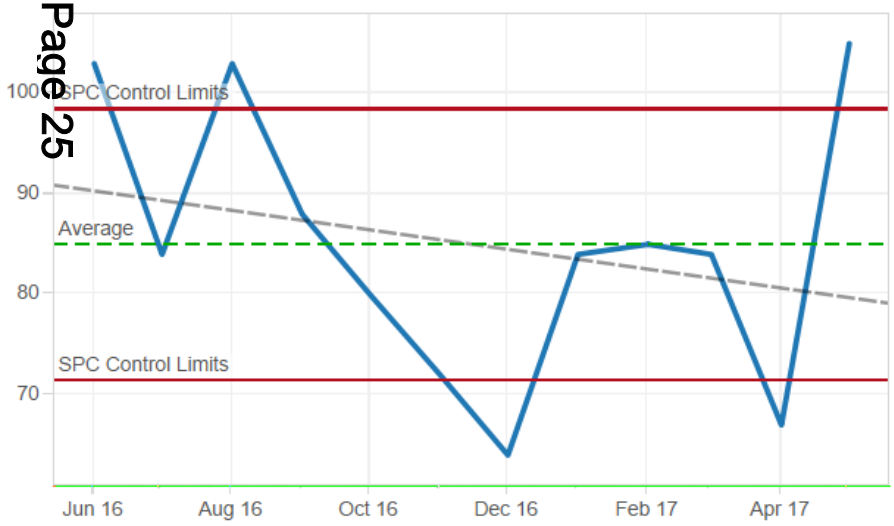
Referrals received

	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17
Referrals received	103	84	103	88	80	72	64	84	85	84	67	105	53

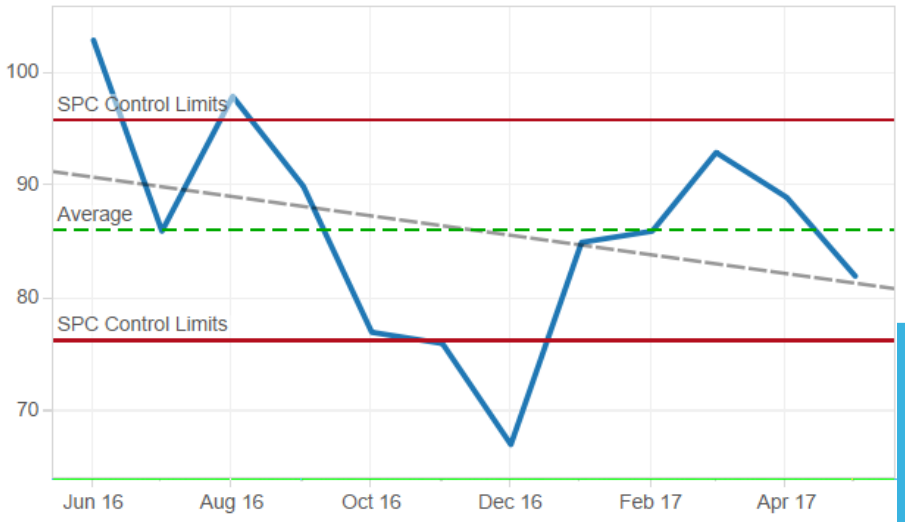
Referrals discharged

Avg. Referral length (weeks)	4.0	4.0	3.7	3.6	3.2	3.1	2.9	2.9	2.8	2.6	2.0	2.0	1.9
Avg. Total appointments	12.2	13.0	18.1	15.6	15.5	15.5	15.5	12.9	11.7	12.5	10.0	10.8	11.6
Number of discharges	67	85	90	76	86	77	103	93	86	98	50	89	82

Referrals received over the last 12 months (excluding current month)



Referrals discharged over the last 12 months (excluding current month)



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Version control (number, last amended date, author) : 1.0, 01/05/2016, Jackie Bell-Tye

CORE FUNCTION

- To support patients in crisis at home
- Crisis plans
- Support patients to manage risk
- Brief psychological interventions
- The use of a crisis bed as an alternative to admission – with support of Havant housing
- Medical reviews
- Support early discharge from inpatient unit

DEVELOPMENTS/IMPROVEMENTS

- AMHT completed a pilot study as part of a CQUIN for a day therapy programme. Pilot November 2016 - March 2017
- Very keen to reintroduce this service
- Carers support
- Increase staffing on nights to allow more availability for assessments.
- Meet 4 hour crisis assessment time standards
- Meet 24 hour response assessment time standards
- Trust looking at CRHT fidelity

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Solent NHS Trust
Report to HOSP Portsmouth City Council
Portsmouth Crisis Resolution and Home Treatment Team

Introduction

The Portsmouth Crisis Resolution and Home Treatment Team (CRHTT) Solent NHS Trust is a 24 hours crisis assessment and treatment team.

The team work with patients aged 16-65 who have a registered Portsmouth GP. By definition the catchment area includes the Portsmouth Peninsula, GP surgeries in the Cosham/Drayton area terminating at the Crookhorn Surgery, Waterlooville.

The CRHT are tasked to provide the following service interventions:

- Alternatives to inpatient admission.
- Psychiatric Crisis Assessment 24/7.
- Intensive treatment at home.
- Early discharge from inpatient beds.
- 3 day follow up assessments following inpatient discharge.
- Reception phone hub for 1983 Mental Health Act assessment Requests.

Currently the Single Point of Access (SPA) for all referrals into mental healthcare services sits with the CRHTT who triage routine faxed referrals from GPs predominately routing to A2i. Crisis referrals are accepted by telephone alone.

The CRHTT came into its current format in 2006 combining a dual function of psychiatric crisis assessment with the provision of home treatment based care as an alternative to hospital admission. Key policy drivers at the time included *The Mental Health Policy Implementation guide* (2003) Department of Health and *Crisis Resolution Home treatment: Guidance Statement on Fidelity and Good Practice* (2006) Department of Health.

Despite subsequent changes in government and a move away from structures focussed service models to outcomes based principles, CRHTTs remain a central component of healthcare policy as they are effective alternatives to hospital admission. Adequate resourcing to deliver on this role is identified in very recent guidance *Old Problems, New Solutions: Improving acute psychiatric care for adults in England* (2016) Royal College of Psychiatrists, Independent Commission on Acute Psychiatric Care for Adults in England.

The threshold for crisis referrals is those patients presenting with psychiatric crisis of a severity and risk that requires intensive home treatment to avoid admission and/or significant risk of a serious and untoward event within 24-48 hours. The CRHTT aim to engage with patients within 2-4 hours of receiving a referral, this can mean completion of assessment or arrangement of the same later that day. The team have the ability to assess round the clock and this can include the patient's home at night time. The service is always staffed and has never deployed an on call cover at night.

The CRHT are the sole clinical decision making agency responsible for determining the most appropriate environment to treat patients in crisis, balancing the wishes of patients and carers with assessed risk and clinical need. The decision to admit to hospital or treat at home is therefore driven by both a shared understanding of the person's risk and the best available evidence for effective mental health care.

A central ethos is the provision of care that seeks to reduce risk and aid recovery but is located in the patient's own home representing a least restrictive environment approach. Positive risk taking is utilised to achieve this and is a key component in the patient's recovery journey.

Service Hours 24/7		**Staffing**
Early Shift	08.00-17.45	3 Qualified RMNs (B6) and 2 HCSW (B3)
Late Shift	12.15-22.00	2 Qualified RMNs (B6) and 2 HCSW (B3)
Night Shift	21.45-08.00	1 Qualified RMN (B6) and 1 HCSW (B3)

NB Weekends run at 2 Qualified and 2 HCSWs on E/L shifts

Staff work 9.22 hour shifts and have three off days per week based on 37.5 hours F/T. This supports a good work life balance and allows the CRHTT to benefit from a considerable crossover period when both early and late shift staff are on duty. On average the team receive between approximately 6 referrals a day including 1983 MHA Ax requests.

Skills Mix and Banding

The service employs:

Mental Health Practitioners (Band 6)
These are experienced RMNs with several years' experience prior to their move to CRHTT. Core duties include shift co-ordination, resource management, provision of comprehensive biopsychosocial mental health assessments, risk assessment and medicines management.

Discharge Liaison Nurse (Band 6)
The service has a dedicated Band 6 discharge liaison practitioner whose role is to drive and ensure all planned discharges are safe, well planned and appropriate. This role is one key marker of a high quality crisis service as identified by the Royal College of Psychiatrists (2015).

Support Time Recovery Workers/ Health Care Support Workers (Band 3)
The CRHTT benefits from particularly skilled and experienced band 3 staff who conduct psycho social interventions, goal setting and distress tolerance work among many other interventions. Band 3 staff play a key role in staffing the crisis phone line and conducting phone calls.

The CRHTT has **1 Clinical Psychologist** and **1 Cognitive Behavioural Therapist** embedded within the team as part of the acute care pathway and patients have access to crisis psychological assessment/formulation and therapeutic interventions.

Referrals Routes/Rights

GPs

The CRHTT receive referrals by phone from Portsmouth GPs primarily in hours but also out of hours via the OOHs GP service. The GP is no longer required to have seen the patient that day but some contact with the patient needs to have occurred that week. The patient must consent to referral and have capacity to do so. This can be a point of friction where concerns are held by others but not the patient.

Community Mental Health Services

Recovery Teams North and South, the A2i Team and Early Interventions in Psychosis (EIP) can all refer to the CRHTT by phone. This occurs in hours.

Community Midwives and Health Visitors

Qualified midwives and health visitors can refer to the CRHTT by phone.

Recovery Hub Services

Professionally registered practitioners either nurses or social workers within drug and alcohol services can refer to CRHTT.

Hampshire Liaison and Diversion Scheme

Qualified RMNs and social workers within this specialist police custody and court diversion scheme can refer direct into the CRHTT.

Hampshire Constabulary

Police doctors (FME) can refer to the CRHTT either for 1983 MHA requests or for crisis assessments, the latter less so since the advent of HLDS.

Mental Health Liaison Team (QA Hospital Southern Health Foundation NHS Trust)

The MHLT service based at QA hospital can refer patients seen at QA with a Portsmouth GP who require either admission to hospital or home treatment from CRHTT. The CRHTT itself covers this function at QA between the hours of midnight and 08.00 hrs.

Known secondary care mental health patients

24/7 direct self-referral is available for patients suffering with severe and enduring mental illness and **currently** open to secondary care mental health services at St Mary's mental health campus. Referral is made by phone and constitutes a significant part of OOHs contact during night shifts and weekends. The CRHTT have sought to improve referral access by also accepting referrals from concerned family members and friends although the patient is still required to consent to referral.

Exclusion criteria

Portsmouth CRHTT currently do not accept direct self referrals by members of the public who are not currently open to secondary care mental health services. Advice given in these scenarios is to seek urgent GP appointment.

Portsmouth CRHTT are not currently commission or resourced to offer emergency crisis assessments for patients self presenting at the St James Hospital site.

Core Functions:

- Rapid psychiatric crisis assessments within 2-4 hour time frame.
- 24/7 clinical decision making to route to inpatient informal admission or home treatment.
- Home based home treatment interventions to reduce distress, reduce risk, enhance coping and promote recovery – psycho social interventions, distress tolerance work, goal setting, problem solving work, motivational enhancement work.
- Rapid access to medical and non-medical prescribing (nurse) in order to ensure swift access to medicines and effective treatment. Order, supply and administration of medications as required and directed by prescribers.
- Early discharges from inpatient wards back to home address under home treatment or via 3 day follow up. Construction and feasibility testing of discharge plans for patients by dedicated CRHTT Discharge Liaison Nurse.
- Phone hub and receiving agency for 1983 Mental Health Act assessment requests from all stake holders and partner agencies e.g. police, GPs, mental health community services, QA Hospital.
- Out Of Hours crisis cover for the following services: CAMHS, Older Personal Mental Health, Learning Disabilities, Mental Health Liaison Team and Hampshire Liaison and Diversion service.

Key Stake Holders/Partner Agencies:

- Hampshire Constabulary
- South Central Ambulance Service
- Portsmouth Probation Services
- Portsmouth Social Services (Adult and Children)
- Portsmouth Hospitals NHS Trust
- Housing Providers – Richmond Fellowship
- 3rd Sector and Voluntary Sector – Solent Mind
- Drug and Alcohol Recovery Services

Crisis Concordat Adherence

Following the national announcement of *The Mental Health Crisis Concordat – Improving outcomes for people experiencing mental health crisis* (2014) HM Government and the learning identified in the CQC report *Right Here Right Now* (2015) the Portsmouth CRHTT transitioned to taking direct crisis referrals from emergency services offering rapid psychiatric crisis assessments for all Portsmouth patients (whether they are open to secondary care mental health services or not) - if they have the capacity to consent and the referral has come from our partner agencies in the police and ambulance service.

The protocol is resource dependent and competing community assessments or home treatment visit can impinge on the CRHTT's ability to respond but many Portsmouth patients have received rapid assessments within this arrangement when emergency services have encountered them in psychiatric crisis.

Brief Overview of CRHT Activity

May 2017

Referrals	197
CRHT Face 2 Face Assessments	141
Home Treatment Episodes	52
3 Day Follow Up – Early Discharge Work	18
CRHT Admissions to Inpatient Unit	37 (73%)
Total Admissions to Orchards	51

2016-2016 Monthly Average

Referrals	180
CRHT Face 2 Face Assessments	117
Home Treatment Episodes	44
3 Day Follow Up – Early Discharge Work	12
CRHT Admissions to Inpatient Unit	20
Total Admissions to Orchards	33

Key Challenges, Threats to functionality and Development Needs

All Age Service

Solent NHS Trust is working with commissioners to undertake a transformation project which will deliver an integrated crisis service for people over the age of 18. This is connected to a national agenda to achieve this although the number of trusts who have successfully transitioned is small.

From a CRHT perspective this will mean building a new team which incorporates the functions of the current Intermediate Care Team (ICT) Older Persons Mental Health Team. This will be a complex and demanding challenge but one which we think will eventually provide a tangible, higher quality service for our patients.
We are aware that one of the key areas of this transformation programme is around the skills, competencies and capacity within the current teams which is going to require levels of training and support to equip staff with the skills to provide care for a wider patient group.

CQC Inspection

During last year's Solent NHS acute crisis care inspection the CQC overall considered the standard of care with the CRHTT was good but they highlighted two areas of concern that needed further development to ensure high quality patient centred care. The service has responded to these points and has been improving over the last 12 months.

1. Care Plans. The CRHTT were not consistently using agreed care plans with service users capturing their wishes and needs within crisis resolution. This has been addressed through the introduction of a protocol to ensure all patient have a My Crisis Plan (Crisis and Contingency Plan) which clearly identifies what wellness looks like, how to spot when the person is going in to crisis and what steps need to be implemented to reduce risk and promote recovery from crisis. Building resilience to crisis is a requirement of both the Crisis Concordat and the CQC report Right Here Right Now and the CRHTT will need to demonstrate continued adherence to this in our care planning.

The service now conducts regular 2 weekly audits of all case notes to ensure we are actively talking to patients and constructing client centred crisis plans that build resilience and reduce risk.

2. Inspectors noted that not all staff were in date with various statutory and mandatory training courses. The team were aware of this and there were reasons that this had occurred – including IT issues relating to the system. Significant improvement on training compliance has now occurred through work rounds and alternate training methods but this will need to be maintained.

National shortage of Consultant Psychiatrists

Due to national shortage of consultant psychiatrists, the CRHTT receive consultant oversight from the inpatient consultants as part of their role covering the acute care pathway. These arrangements are satisfactory, however if personnel were available, the service would be enhanced further through more dedicated psychiatrist time. The directorate are well aware of this issue and actively looking to address it.

The provision of Advanced Nurse Practitioner (ANP) posts on the inpatient wards is a helpful step towards meeting the prescribing needs of patients but no such Band 7 post exists within the CRHTT although line management are considering the feasibility of this within the context of known resources/fiscal restraints.

Sustainability and Transformation Plans (STP)

The Portsmouth CRHT has been relatively successful in providing an alternative to hospital admission since its inception and locally inpatient bed availability is unusually good when judged against the national picture. This is a function of staff competencies and systems that support positive risk taking and recovery orientated approaches. Whether the team retains its structure and operational clarity is less certain in the forthcoming STP.

Values

Although the Portsmouth CRHTT has been successful in its gate keeping role it has received occasional criticism in the past for a lack of warmth and empathy when working with patients, families and carers. There are many excellent and caring staff within the CRHTT but hearing this concern is important. Since coming into post as its clinical manager I have focused on ensuring staff make manifest the core conditions patients experiencing crisis have stated they value. These include to be treated with respect, listened to, treated with warmth and compassion, not judged, offered the right care and in a timely manner. All these needs were identified in the CQC Report Right Here Right Now (2015)

References

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Department of Health and Concordat Signatories (2014) *Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis.* London: HMSO.

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healthwatch Portsmouth

What is Healthwatch Portsmouth?

- Healthwatch is the **local**, **public led**, **independent** group that makes sure people's voices are heard in decisions about health and social care services.

- We act as a local **champion** to help people speak up about the services they receive.

- We put local people at the heart of all services and make sure their voices are always heard.

2016 – 2017 highlights - engagement

- Walk-through report with recommendations looking at the QA Hospital's urgent care pathway + second walk through visit
- Mystery shopping activity looking at access to GP surgeries
- 'Why people choose go where for medical care/advice'

Our Impact

- Our care pathway recommendations are taken seriously by senior management and acted on e.g. knock-on effect of changes on patients
- GP Surgery recommendations made (e.g space for private conversations, protocols for electronic reminders, online appointments, engagement with all sections of the community

Outcomes

- Improvements to hospital discharge processes, to be surveyed July 2017
- Healthwatch to visit practices this year to discover the improvements made

What is our focus for this year?

- 8 statutory functions, internal, advocacy, small scale and larger projects
- Public and patient stakeholder feedback on our priorities - 'top ten choice'
- Resulting top 4:

  Hospital Discharge

  Mental Health services

  Experience of people in care homes

  Differing methods of accessing GP services

Community Engagement work

- Sustainability and Transformation Plan (STP) engagement work in ‘phase 2’ surveys
- Pharmacy Needs Assessment – patient survey and resulting ‘PNA’ consultation
- Enter and View with trained volunteers with learning disabilities to visit 2 care homes
- Hospital Discharge survey QA Hosp patients
- Mental Health services for young people
- Supporting ‘advance care planning’ programme for people living in care homes
- Differing methods of accessing GP services timings /range of health professionals

Thank you for listening

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Report to: **Health Overview and Scrutiny Panel**

Date: **29 June 2017**

Report by: **Angela Dryer, Deputy Director of Adult Services**

Subject: **Adult Social Care update on key areas**

1. Purpose of the Report

To update the Health Overview and Scrutiny Panel on some of the key issues for Adult Social Care up to June 2017.

2. Recommendations

The Health Overview and Scrutiny Panel note the content of this report.

3. Update on Key Areas

3.1 Overview:

Portsmouth City Council Adult Social Care, (ASC) provides support and advice to adults aged 18 years and over who require assistance to live independently. This may be the result of a disability, long term health condition or frailty associated with growing older. Our aim is to help people have as much choice and control as possible over how their needs for care and support are met. For some, when independent living is no longer possible, we will help people find the longer term care arrangements that best suit them.

Following the systems thinking intervention work ASC's purpose is defined as:

Help me when I need it to live the live I want to live

This overall purpose provides an overarching purpose for the service. For specialist areas within the service the wording may change slightly to reflect the work undertaken but is able to be linked back to the overall purpose of the service.

ASC provides a service to approximately 6,000 people throughout the year with a staff compliment of 800 (600 full time equivalent posts) undertaking a wide variety of roles, both in commissioning and direct delivery of services.

4.0 Summary of 2016/2017

During 2016/17 ASC were faced with a number of challenges, not all of which were predictable. These included:

- **Demand for services:**
- ASC has seen an increase in the demand for older people with complex needs requiring larger packages of care. Supporting people to remain at home is what the majority of people tell us they want. This has led to increase in the average weekly cost of people with needs being supported to remain at home.
    - The number of older people receiving domiciliary care from ASC per week as of March 2016 was 951 (via either a Direct Payment (DP) or direct provision) at a total weekly cost of £118,897.16 (£125.10 pw per person). By March 2017 this figure had changed to 957 people at a total weekly cost of £138,843.72 (£145.08 pw per person).
- Whilst the figure above shows an average increase per week in costs, what it does not reflect is the fact that in March 2016 57.51% of people receiving domiciliary care had packages costing less than £100. This reduced to 46.80% by March 2017. Conversely 17.39% of people's packages cost over £200 in March 2016, a figure which increased to 21.95% by March 2017.
- This increase in cost for domiciliary care was due not only because of increased complexity, but also because ASC successfully supports people to remain at home longer, which is reflected in the statistics relating to:
    - Residential care - seeing a reduction in numbers from 258 (March 2016) to 242 (March 2017)
    - Nursing care - seeing a reduction from 147 (March 2016) to 140 (March 2017).
- **New legislation and Court Judgements**
  Of all of the precedents handed down by the Courts that affect ASC, by far the majority concern Deprivation of Liberty. There have been 23 significant judgements that impact on practice in the last 2 years.
  Which has seen the number of applications since The "Cheshire West" judgement alone increase from 786 in 2014/15 to 1473 in 2016/17.
  The Supreme Court Judgement in 2016 and subsequent legislation is likely to extend the duty relating to Deprivation of Liberty to people within their own homes. At this stage it is impossible to estimate the impact that this will have on demand and capacity.
- **Acute Hospital Pressures**
  Pressure on Portsmouth ASC to discharge patients more quickly from the acute hospital setting has increased significantly. With the Discharge to Assess model and a general expectation that that as soon as a referral is received the team assesses and discharges the patient, care costs and demand on the limited capacity of the provider market

to respond, as well as challenges in recruiting and retaining staff within the hospital team saw an increase in delayed transfers of care attributable to ASC, with awaiting allocation being a significant issue.. Following some analysis undertaken at the hospital team it was identified that in excess of 40% of referrals for Social Work input from Hospital wards were found to be inappropriate. The introduction and imbedding of the Integrated Discharge Bureau at QA has had the inevitable teething issues which have impacted on the work of the Social Work team. The team now aim to see people and triage them on the day the referral is received, which has reduced the inappropriate referral significantly.

- **Funding and budget pressures**
  The 16/17 gross annual expenditure for adult social care (ASC) activities was £64.5m. This is funded from a variety of sources. The majority is from the ASC council cash limit budget of £43.4m. ASC funding also relies heavily on income (client assessed charge for care) which was anticipated to be £9.4m in 16/17.

  ASC is also funded by monies from the NHS. This is central Government policy that part of the NHS allocation is transferred to Local Authorities in order to support social care activities. In 2016/17 this NHS funding will come via the Better Care Fund (BCF) which is £7.1m.

  In addition to the increase in population of older people is the rise in the number of people with challenging behaviour resulting from a learning disability. Within Portsmouth 90 people account for £7.7m of our expenditure.
- **Market sustainability**
  Significant challenges exist in respect of the local market for social care, including cost and sustainability of some services, in particular where there are low rates of pay to staff; local authority rates being challenged as insufficient to provide quality services; and the ability to retain a suitably qualified workforce in competition with surrounding local authorities.
- Whilst ASC has reduced the number of people who are placed in residential care and increased the number of people in receipt of care and support in their own homes, there continues to be a need for nursing home care placements. ASC contracts with Care UK to provide 62 beds in Portsmouth, (in Harry Sotnick House) and the home have had a voluntary suspension in place in 2016/17 which has recently been lifted. This self-imposed suspension has impacted on ASC as it has required placements, which would have been made within Harry Sotnick House to be found elsewhere.
- The environment of the domiciliary care market both nationally and locally is a complex one, a mixture of large national and smaller

regional or local companies employing carers often from a limited pool of people, with a growing demand for services. Providers pay staff varied rates, though many use the National Living Wage, (previously National Minimum Wage). A recent court judgement has also legislated for staff who cover 'sleep-in' shifts to be paid at least the NLW for the entire shift, again increasing cost for providers and PCC

- The national state of the market as reported through the media and regulatory bodies has highlighted concern over the state of domiciliary care; providers 'handing back' Local Authority funded contracts and here; a lack of domiciliary care capacity; the increased cost of domiciliary care; and the overall fragility of the market. In addition, National commentators focus on market funding and linking standards directly to funding.
- During 2016/17 2 domiciliary care providers ceased providing care within Portsmouth. The transfer of packages from these two providers amounted to 820 hours of care per week and affected 75 ASC funded clients as well as a number of privately funded individuals.
- The situation in relation to domiciliary care remains challenging with approximately 900 hours per week affecting 95 individuals being handed back and alternative provision sourced.

- **Better Care Fund**
- The aim of the BCF is to bring about greater integration of Health and Social Care through the pooling of resources. Although creating a pooled fund it is not new money, rather that which is already in the Health and Social Care system now being brought together to enable organisations to integrate services, share risk, and agree priorities.
- Since its announcement in 2013 we have been working closely with local NHS partners to see how we will put in place the principles behind the BCF and how we will make the diminishing resources we have work to best effect.
- The BCF currently funds fieldwork resources, (Social Work and Occupational Therapy) for Older People and people with Physical disabilities and funds the community connector scheme, engaging with people to help manage social isolation and prevent development of need for social care in the future.
- At the spring budget of 2017 the government announced additional monies for adult social care for the next three years, known as the Improved Better Care Fund. For Portsmouth the amount equates to approximately £7m over the three years. ASC and the finance support services are currently drafting a financial strategy which will set out the criteria for access to these funds to ensure bids for the money demonstrate sustainable transformation.

5.0 Budget & Savings

- The outturn position for ASC showed a £700k overspend position for 2016/17.
- The saving target for 2017/18 is £1.3m. Progress against savings are reviewed monthly within the service and discussed with the portfolio member. Budget position reported in line with council procedures.

6.0 Priorities for 2017/18

It is proposed that updates against these priorities are reported through the quarterly letters

- To ensure all registered services are adhering to the Care Quality Commission (CQC) regulations & outcomes laid out under the CQC 5 Key Lines of Enquires.
- To ensure a fit for purpose training programme for care staff is in place to meet the requirements of the Care Certificate.
- Standardise policies, processes and procedures across the residential services to provide a robust and consistent approach to care for our most vulnerable service users.
- Provide a detailed and structured activities programme across the dementia services.
- To work with external partners and third sector to bring new experience to people with dementia & work with social enterprise arenas'.
- Complete Roll-in of systems thinking across OPPD services and redesign ASC's initial point of contact.
- Configure OPPD service model focussed on re-ablement and prevention of unnecessary hospital admission.
- Appoint a Principal Social Worker - **Completed**
- Appoint a lead interventionist and complete systems thinking interventions across all areas of ASC - **Completed**
- Achieve savings targets.
- Agree integrated working methods with community health provider.
- Agree a service offer for people with autism.
- Replace client record system for ASC.
- Re-tender domiciliary care contract.
- Tender for bed based care home resources for people with challenging behaviour.
- Tender/renew Community Equipment Store contract.

Angela Dryer

Deputy Director Adult Services

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APPRENTICESHIPS

John Attrill

www.portsmouth.gov.uk

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Agenda Item 9

Apprenticeships for people with learning disabilities

- Apprenticeships are important as they are a way of getting people of learning disabilities in to real work.
- When apprenticeships are within Portsmouth City Council the council can get the funding back from the governments Apprenticeships levy.
- We want to expand the engagement in Horticulture and Landscaping works.
- We want to demonstrate to all areas of the City Council how they can bring forward apprenticeships for people with learning disabilities.

Apprenticeships for people with learning disabilities

- We want to work with partners for example colleges and social enterprises.
- We will also work with skill training providers who can access funding to support our people through out the apprenticeship.

All this will work together in accordance with an agreed action plan in consultation cultural services of Portsmouth City Council.

Apprenticeships for people with learning disabilities

- We are developing a range of social enterprises to engage with people with learning disabilities in Horticulture.
- Each person will be a assessed so we are clear about their aspirations and potential.
- For some opportunities in Horticulture will be therapeutic. Some will be volunteers and others will have potential for apprenticeships
- There will be clear plan to support people with learning disabilities to reach their goal.

Apprenticeships for people with learning disabilities

- The Learning Disability Champion will welcome comments or questions at any time about apprenticeships for people with learning disabilities.
- The Learning Disability Champion can be contacted as follows.

Honorary Alderman John Attrill Learning Disability Champion of Portsmouth City Council Kestrel Centre St James Hospital Locksway Road Southsea P048LD telephone number 023 9268 4600 email john.attrill@portsmouthcc.gov.uk

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What are we doing in Portsmouth? - Transformation Programme

The purpose of the Learning Disability service is to support people with a learning disability to achieve meaningful outcomes related to work, health, keeping safe, empowerment, independence and social inclusion, in the most cost effective way. The transformation programme is designed to deliver those outcomes.

The transformation programme is based on three key principles:

- People with a learning disability have a right to work towards the same outcomes as anyone else
- We work best when we work **with** people, understanding their needs, aspirations and assets and those of their carers
- Delivery of improved outcomes can support cost effectiveness

Budget Context.

The Local Government Association states that the number of people using Learning Disability Services increases on average by 2-3% per annum. The budget pressure is greater however because of the increased complexity of need - young people living on into adulthood and a significant increase in the numbers of older people. This produces a 7% per annum budget pressure. Alongside this Local Authorities experience reductions in budget allocations from Central Government which means that Transformation must not only deliver improved outcomes but significant cost reduction. 2017-18 the LD service in Portsmouth has a £1.3m funding shortfall. The Learning Disability Service in Portsmouth has achieved significant savings through contract negotiations, moves to Supported Living from Residential Care and the development of lower cost services. However the law of diminishing returns applies and we can only save money and protect delivery if we do things differently. The LGA working with a large number of LAs concluded that the only sustainable savings plan involves supporting people to be part of their Community and supporting people to be independent which reflects our Statement of Purpose. In the short term we have a clear set of actions to deliver savings

There are 7 key elements of the Transformation programme. They support each other and together offer a coherent and comprehensive approach to deliver cost effectiveness and better outcomes for people.

Day Services

We have de- commissioned 66% of the in-house service and much of the independent sector provision and have 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 Services try and do everything to a 'high street' model where you receive support for a particular purpose from a service designed to deliver a particular outcome. The DST has resulted in a flourishing market place with Health and Independence Services, Social Enterprises, a work finding and training service and specialist services for those 'at risk' under the Transforming Care Agenda. The residual in house service focusses on supporting people with complex physical needs and is becoming a Centre of Excellence. Feedback from service users, family carers and other agencies is universally positive

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 Demonstration site for the South East 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

Working with Education we are

- Designing information and decision making tools to support people to take control of their planning
- Developing formats for planning in both Children and Adults services that support the focus of the 4 outcomes
- Designing services (eg Day Services as above) to deliver outcomes related to the 4 PfA outcomes
- Developing the 'Local Offer' to provide the information that people need about what is available and how they access it. Also to help them think through what is right for them
- Working with 'In Control', Colleges, young people and their families as part of a Partners in Policy making project to improve post 16 transitions and ensure that all are working together to deliver in relation to the 4 outcomes

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 Housing strategy is underpinned by Aims and Principles.

We aim to:

- Increase the range/choice of options
- Maximise independence, sense of ownership and personal responsibility
- Promote development and maintenance of personal relationships
- Reduce stigma/promote inclusion - Community Relationships
- Be cost effective
- Develop a local market
- Support Transition into adulthood
- Reduce financial vulnerabilities around limited provision for 'specialist' services
- Support choice and decision making
- Increase quality in both accommodation and support
- Be collaborative

We will:

- Increase Floating Support ie move away from 24 hr support arrangements where possible. We will need to develop on call arrangements and alternative ways of support eg drop in service rather than staff visiting homes where more suitable. We want to do this because it promotes independence and reduces cost
- Develop a KeyRing Model
- Develop Home Ownership
- Move away from people with complex needs in small Units. Where there are 3-4 people with complex needs and 24 hr support in a Shared House there are often issues of compatibility and we often have to staff intensively so that people can go out as individuals or part of a smaller group. This is too costly
- Develop more schemes with flats and communal areas with 8 maximum as a guide. This is primarily for 24 hr supported settings
- Actively de-commission anywhere we would be reluctant to place. This will cause disruption but the alternative may mean placing reluctantly/ not placing which risks placement by another Authority with cost transfer to us/ payment for voids/increased charges from providers operating on a smaller scale/unplanned closures
- Reduce Sleep In On Call and replace with less intrusive and costly means of getting help if needed
- Replace poor quality accommodation with better.
- Develop a culture of doing nothing for people that they can do themselves or do themselves with training
- Develop capacity for difficult to place and growing need - complex needs/older people.
- Disaggregate where people live from their Day Service
- Reduce overprovision by offering group support based on compatibility of need. So we will not offer a place in a house with SIOC to someone who doesn't need that facility. Where significant adaptions are made - hoists etc we will place people who need that facility. We will establish clear categories of Housing and Support options within a range and match to people's needs This creates a significant tension with for example people choosing on the basis of friendship
- Support informed and collaborative decision making
- Develop mechanisms for collaboratively agreeing quality and quality measurement methods

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. The capacity to develop a range of services is limited by the fact that our funding is tied up in a residential respite service (Russets) that is part of a PFI arrangement. However we have converted 2 houses to support emergency placements and provide for people who need a smaller quieter environment. We have also put into place Gig Buddies an innovative befriending service

Integration

The integrated team is made up of Nurses, Social Workers, Psychology, Occupational Therapists, Speech and Language Therapy, Psychiatry. CQC have rated the Service 'Outstanding' and we are one of very few LD Teams in the UK to be judged as such. We have introduced single line management, single assessment and a Named Worker system. This means that all service users have an allocated worker. It could be any one of the range of professionals which has meant changing roles of, for example, Nurses. The introduction of Named Worker reflects an asset based approach and has moved the focus away from getting involved when something isnt working to planning proactively in relation to aspirations and outcomes. It has made market development possible as workers are identifying the outcomes that people are wanting to work towards and what needs to happen for those outcomes to be achieved. Workers have an ongoing relationship with people on their caseload and their families which makes aggregation of need possible and means that when opportunities occur because of the relationship and knowledge the Named Worker has referrals are readily forthcoming. We have developed a link worker system so services have a Named Worker. This enables us to understand, challenge and support services effectively. Specifically in relation to the health element of the Team - We have an excellent Liaison Team at Q A hospital. We also provide the liaison service on behalf of Hants. Every G P surgery in Portsmouth has a Link Nurse, Health facilitation training is available to all providers and we support people to have Health Action Plans

Collaboration

In terms of carers 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 in measuring the quality of that service and support carers and service users to have their say. All Day Services have or are developing 'governance groups'. As part of implementing the Housing Strategy we have recently trained service users and carers to 'Enter and View'. Feedback from parents and carers has led to significant changes at Russets in terms of environment. 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 obtain regular feedback from service users and carers regarding their experience of the service provided by the Integrated Team

We are currently working with People First to establish a service user led advocacy service in Portsmouth and have successfully applied for a Partners in Policymaking course from In Control who will begin working with service users and carers in September

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

This all comes together in the Partnership Board which has a wide range of stakeholders and which monitors the transformation programme as well as being the conduit for stakeholder views. The Partnership Board has a number of subgroups including Housing and Transition both of which have service user and carer representation

Transforming Care

The Transforming Care Agenda is focussed on reducing the number of people currently in hospital settings and minimising the number of admissions by acting proactively locally

- We have 7 people in hospital (specialist hospitals) Based on demographic size/population Portsmouth estimated inpatient (those in secure hospital settings) number should be 12/13
- By March 2017 we expect to have only 2 people in hospital
- We have an intensive support element of the integrated team to support and keep people in the community through one to one work and support to providers
- We know who is a risk of admission and we support them more closely
- We are developing locally based services for people who have behaviour that challenges including a new purpose built Supported Living Service for 12 people

Conclusion

Taking forward the Transformation Agenda is clearly a challenge but we are at a point where significant progress has been made and we have strong collaborative arrangements and relationships with stakeholders. For information regarding how specifically we are taking different areas forward we are happy to provide detail in the form of Strategies and Action Plans

Mark Stables 11.6.17

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NHS
Portsmouth
Clinical Commissioning Group

CCG Headquarters
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Portsmouth PO1 2GJ

Tel: 023 9289 9500

21 June 2017

Cllr Leo Madden
HOSP Chair
Portsmouth City Council
3rd Floor, Civic Offices
Guildhall Square
Portsmouth PO1 2AL

Dear Cllr Madden,

Update for Portsmouth Health Overview and Scrutiny Panel

This letter is intended to update you and the members of the Portsmouth Health Overview and Scrutiny Panel on some of work the Clinical Commissioning Group has been involved with over the past few months.

This formal update is in addition to the regular informal meetings with you and your panel colleagues, and which, I hope, continue to be useful for all concerned.

Our website – www.portsmouthccg.nhs.uk – may provide some further details about what we do if members are interested, but of course we are always happy to facilitate direct discussions if there are particular issues which are of interest to the panel.

1 Changes to our clinical leadership

Since our last update in February, Dr Linda Collie, a GP with the East Shore Partnership in the city, has been confirmed as the CCG's new chief clinical officer. She joined the CCG in 2013 and succeeds Dr Jim Hogan, the current CCG chief clinical officer, who retired in May having held that role since the CCG was formed.

Dr Dapo Alalade has also stepped down from his clinical executive role with the CCG. To fill the vacancies created by the departures of Dr Hogan and Dr Alalade, Portsmouth GPs Dr Annie Eggins and Dr Nick Moore have been elected to the executive team.

2 Engagement Your Big Health Conversation

We mentioned in our last update in February that we were embarking on the first phase of a programme of engagement called 'Your Big Health Conversation.'

Ultimately this engagement activity will support the development of new systems of NHS care both within Portsmouth, and across the wider local health economy. Our intention behind the initial phase was to do two, specific things. Firstly, to begin a 'plain English' conversation with local people about the challenges facing the NHS in this area and the likely consequences of those challenges, and secondly to start the process of gathering feedback about potential changes to services in the future.
This is very much the start of what we plan to be an ongoing, phased programme of engagement process, that can be built up over a period of time, rather than be a 'means to an end' for one specific proposal.

This first phase was conducted as a survey although we may use a range of different techniques to engage people in future. The survey was prominent on the websites of all three local CCGs and promoted via social media, and news media, and also through a network of contacts in the city – partner organisations, stakeholders, GP surgeries and Patient Participation Groups, and other patient and public representative groups.

The survey asked people their views on the greatest strengths, but also frustrations, of the NHS in this area, what could be done differently to improve patient care, and also sought responses to enquiries about access to GPs, mental health care , bed blocking and priorities for a seven day NHS.

We are still undertaking the detailed analysis of the 1950 responses we received (311 specifically from the Portsmouth PO1-PO6 area) but preliminary findings have been interesting and were reported to our Governing Board in May – the paper is available here: Big Conversation preliminary report

Some points of interest to date are:

- 52.3% of Portsmouth respondents (64.7% overall) said that the NHS needed to change and that GPs and community care services should be the priority for this - only one in ten regarded hospital-based services as a priority;
- Most respondents (41.9%) believe that one way of improving access to primary care is for patients with minor problems to see another NHS professional rather than a GP; a further third thought that people should be encouraged to take more responsibility for minor health problems themselves;
- Two thirds felt that people could benefit more from larger specialist centres for some treatments even if they are further from home, with only one in five advocating a approach of 'all services at all hospitals';
- Nearly half of those who responded opted for improved care closer to home as the best means of tackling bed blocking, even if that resulted in fewer hospital beds overall;
- Seven day access to NHS services generated more of a mixed response with no clear, standout preferred answer – the three main preferences for the priority for

seven days services were: urgent care should be the priority for weekend services (36.6%); all NHS services should be available, every day – Saturdays and Sundays should be like any other day (29.7%) while 22.4% believed that there were already enough NHS services available at the weekend.

We need to stress that these are just a sample of preliminary findings to date and have come from us analysing the quantifiable data. Several of the questions also offered people the chance to share their views in free text form and this is what we are reviewing now. This will give us a richer supply of information and we can share the main findings of this with you in a future update if that would be helpful.

We anticipate being able to start Phase 2 of our engagement programme over the summer and the focus for this is likely to be exploring potential new models of primary care with people in Portsmouth.

3 CCG annual report/engagement report

We have recently published our annual report for 2016/17 on our website. The report effectively serves three purposes. It provides a detailed look at our financial accounts, provides assurance on our governance policies and processes but it also gives us the opportunity to review our year and look ahead to how things are likely to develop over the next few years, too.

You may also be interested in our annual engagement report which sits alongside our main annual report and summarises the patient experience, engagement and consultation work we have undertaken during the year, all of which helps us in commissioning and improving services.

4 New approach to contracting arrangements with Portsmouth Hospitals NHS Trust

Our NHS contract with Portsmouth Hospitals NHS Trust is reviewed annually and the current contract has been agreed for two years from April 2017 – March 2019. The financial terms of the Standard NHS Contract are based on national tariff prices in accordance with 'Payment by Results' (PbR). Essentially this is the payment system in England under which commissioners pay healthcare providers for each patient seen or treated, taking into account the complexity of the patient's healthcare needs

Payment by Results has been in place for many years and was introduced at a time when the NHS needed to create additional capacity to radically reduce waiting times in elective care. The needs of the NHS have changed since this time, and locally it has been agreed that the PbR arrangements do not fit well with the current challenges facing us, including unscheduled care demands, and the need to radically transform services and improve efficiency.

So, with the Trust, we have been exploring effective alternative payment mechanisms that would give the Trust some certainty of income whilst aligning financial incentives to enable them to undertake the clinical service transformation required and to focus on opportunities for efficiencies and cost reduction.

This has resulted in what is known as an 'Aligned Incentive Contract', which has been introduced elsewhere in the NHS but is a new approach for this area.
The new arrangements place the focus on working together in partnership to address the challenges we face, taking a holistic view of how best we utilise our resources to achieve the best outcomes for our patients. Rather than focusing on transactional tariff based financial payments, we will instead focus on value – cost, efficiency, effectiveness and quality.

This should provide much more support and freedom for clinicians to do the right thing for patients. This change only affects the financial arrangements, the other terms and conditions of the NHS Standard Contract remain. The new arrangement came into effect from 1 April 2017.

5 Surgery moves and changes

Queens Road Surgery closure

On December 30th 2016, the CCG was advised by the two GP partners at the Queens Road surgery that they wished to give notice on their GP contract with effect from June 30th 2017.

The CCG's responsibility is to secure the ongoing provision of GP services for patients who were registered with the practice. We investigated a range of options including potential merger with another practice, identification of another provider to take over the practice, and automatic transfer to one or more practices.

Unfortunately none of these options were possible, and so we looked at the capacity of other existing practices in the city to provide GP services for these patients and took the decision to a write to all patients, and issue a media release, explaining that the practice was closing and asking them to register with an alternative practice of their choice.

We have been continuing to work with staff at Queens Road practice to ensure that the more vulnerable patients on their list are supported to register with another practice. We are monitoring the rate of re-registrations and has issued a further press release and Queens Road practice have sent text messages to patients reminding them of the need to re-register.

Any patient who has not re-registered by 1st July will be automatically transferred to one of the two closest practices in the city.

Changes to the opening hours at Guildhall Walk Healthcare Centre

Following the review of Guildhall Walk Healthcare Centre, the CCG put a contract in place for the provision of GP services for registered patients from July last year. There are currently 7228 patients registered with the surgery who benefit from longer opening hours than most other practices, in that the practice is open until 8pm on two days week and from 08.00 to 12.00 Saturdays and Sundays.

We have reviewed the activity and utilisation of the service at weekends with the practice and activity on a Sunday is particularly low. The practice is not able to offer the same multidisciplinary mix of staff as provided during the rest of the week. The Sunday service is also not very "resilient" as it is dependent on availability of GP locums.

The CCG and the practice have therefore agreed that the Sunday service, which is only available for patients registered at Guildhall Walk, will stop with effect from July 31st. We are currently working with the practice to communicate this change to patients and other stakeholders. The patients registered at Guildhall Walk Healthcare Centre will continue to benefit from a full service on Saturday morning and two late evenings a week for both pre-bookable and walk- in appointments.

As noted above, as part of the current national commitment to deliver improved GP access on weekdays and at weekend to all patients in the city, the CCG has a well-developed plan to gradually extend access for all of the patients in Portsmouth, by GPs collaborating and working at scale across the whole city.

I will, of course, be happy to provide clarification on any of the above updates either before, or at, your June meeting.

'Winter pressures' scheme to be extended

In December we launched a GP 'Winter Pressures' Scheme to help relieve pressure on urgent care services whilst allowing us to test new collaborative methods of delivering city-wide primary medical care services, in preparation for the challenge of meeting the government's plans for us to deliver seven day primary care services by 2019/20.

The scheme is being delivered by the Portsmouth Primary Care Alliance (an alliance of GP practices working across the city) on behalf of the CCG. The scheme went live a fortnight before Christmas and was initially due to run until April to cover the winter period.

More than 400 patients were contacted by the service in its first six weeks of operation, which resulted in more than 180 patients seeing a GP at the weekend.

Under the scheme, people in Portsmouth who call NHS 111 on during the day on a Saturday, and are deemed to need urgent primary medical care, receive a telephone call from a local GP who will then either manage their condition on the phone or book them in to a Portsmouth GP practice that day to be seen face-to-face. This service supplements the existing Out of Hours GP provision and means that those who need urgent primary care advice can access a local GP when they call on a Saturday.

Although initially set up just to cover the winter months, the service has been retained and will continue to operate, and there is a plan to extend this further over the next two years to meet the government commitment of extending access to GP services.

Yours sincerely,

Dr Elizabeth Fellows
Chair of the Governing Board

Southern Health NHS
NHS Foundation Trust

Portsmouth City Council
Health Overview and Scrutiny Panel
June 2017

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 services in Hampshire and Learning Disability services in Oxfordshire.

Fareham and Gosport, North Hampshire, South East Hampshire and West Hampshire Clinical Commissioning Groups all commission mental health and learning disability services from Southern Health. West Hampshire leads on behalf of the other Clinical Commissioning Groups for this contract.

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.

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 2016.

During September 2016 the CQC undertook a follow up inspection, and as a result lifted the warning notice.

In March 2017 the CQC carried out a week long follow up inspection of both our mental health and learning disability services and our community services. The draft report is currently being finalised.

Mazars report: actions and progress (Appendix A)

Serious Incident Requiring Investigation (SIRI) process

- A new oversight process for serious incidents requiring investigation was established soon after the publication of the Mazars report. This new process has greater

oversight from the Trust's 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 weekly.

As a result, SIRI completion rates within the 60 day timeframe have improved, with 100% success for the last 12 months. It should be noted, however, that bereaved families are not always able to participate in investigations. 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%, which has been met or exceeded three times in the last six months. Continuous monitoring of these statistics is carried out, so that any risks or issues are mitigated and addressed. 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.

In order to ensure the effectiveness of the new measures put in place, methods of audit and assessment are currently taking place. An interim external assessment into the quality of investigation reports has been carried out by Niche Grant Thornton, and has identified improvements in the narrative and context given in investigations but also highlights some areas where improvements could still be made. These reviews will be continuing with a final assessment report due to be delivered to the Trust Board in the Autumn.

Terms of reference have also been agreed for a project to evaluate the effectiveness of the SIRI investigation team, with initial feedback due to be reported by the end of June 2017.

Patient and Family Engagement

- An Experience, Involvement and Partnership Strategy has been developed (as part of the wider Quality Improvement Strategy) and will soon be launched, to provide a greater focus and drive further improvements in how we engage patients, families and carers across the Trust.
- A Family Liaison Officer has been recruited and uses a referral process to support families throughout the serious incident investigation process. Members of the public have been recruited to attend the Mortality Working Group, and some of the Trust Mortality meetings, and further 'patient partners' are being sought.
- 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 developed an action plan to address the recommendations made in the report, which is attached as Appendix C.
- The Trust has reviewed the training materials, role descriptions and policies for serious incident handling and investigation. Some families have also been involved in this work.

- A network of families has been contacted and consulted about their experiences, and this feedback has been used as part of the action plan (mentioned above).
- A series of survey questions have been agreed with the CQC to ask of families after the incident investigation process has been concluded. The first of these surveys has been completed, which has showed improvements as well as other areas for consideration.
- A forum for families has been established, made up of those who want to support the Trust in making continued improvements in involvement and engagement. To date the group has reviewed Trust policies around incident investigation and duty of candour, and co-designed an information leaflet for patients and their families and carers which explains the investigation process. They have also co-designed the materials for a workshop on confidentiality and information sharing, intended to examine current processes and develop them where possible.
- Julie Dawes, Interim CEO, has met with families who feel very strongly about the Trust in order to listen to their individual concerns and understand their stories and backgrounds.
- The Trust is also supporting 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.

Throughout the process of improving how we engage patients and their families and carers we have developed a network of people to contact for feedback, and are committed to continue growing this network over time.

CQC report: actions and progress (Appendix B)

During September 2016 the CQC undertook a follow up inspection across many of our sites, which resulted in the warning notice being lifted. A further week long inspection took place in March 2017 and we are currently reviewing the draft report for factual accuracy.

A weekly Quality and Improvement Planning Delivery Group has been established to ensure that the action plans from the Mazars report and CQC inspections are closely monitored and updated. This works alongside the new project management approach to monitoring and reporting progress against the delivery plans, enabling the Trust to track progress much more efficiently.

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.

Estates improvements

The Ligature Manager, who was appointed early in 2016, developed site specific environmental work plans for all inpatient and community Learning Disability and Mental Health teams. This year she is working to review each one of these plans to ensure they are progressed and updated as necessary. A dedicated site has been created to provide a central location for all ligature risk assessment paperwork and advice, accessible for every

member of staff in the Trust. Additional ligature training has been carried out, and a review of the mandatory training package is also underway.

All estates actions on the CQC action plans from the January 2016 and September 2016 inspections will have been completed by the end of this month. A Trust Environment Plan has been written, that includes a quality programme called 'Back to the tools'. Launched in November 2016, this involves estates staff doing site visits, assessments and checks on a continuing basis, to identify maintenance issues and remedial work for completion. Over 200 actions have been created as a result, which is more than would have been identified using previous processes, and has improved working environments and patient areas. This has also improved staff relations for the estates teams.

Kingsley Ward in Melbury Lodge, Winchester, was closed in November 2016 to allow for planned modernisation of the environment, including redecoration of the ward, the removal of key walls to improve lighting and lines of sight, and some gardening work. Patients were moved for their comfort and safety, and the ward was reopened in March 2017. At Elmleigh in Fareham, more building work has taken place including ensuite bathrooms all refurbished and anti-climb guttering installed.

Quality Improvement Strategy

- Southern Health NHS Foundation Trust is currently reviewing and updating the Quality Improvement Strategy that was launched in 2016.
- The Divisional Quality Performance Reporting framework is continuing, 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 quality meeting structure and agenda framework and a senior nurse weekly 'Back to the floor' programme.
- Every clinical team has its own quality improvement plan as part of the wider strategy, these were seen and noted by the CQC during the March 2017 inspection.
- The Quality Improvement priorities have been agreed for 2017/18, with input from some of our patients and service users, and these are aligned with the five key CQC areas.
- The Central Quality Governance Team now has individual staff aligned to each of the divisions, to strengthen the links and accountability lines between the central team and divisional quality structures.
- A new project will soon begin to appoint Quality Ambassadors across the Trust. The vision is to have one member of staff taking on this role within each team in the Trust, at Health Care Support Worker level, to ensure quality improvement is a focus at team meetings and during other discussions. These ambassadors will receive additional training in quality improvement methodology to allow them to identify actions and embed changes locally.

Staff engagement

We have continued to develop and implement a number of initiatives in place to support staff 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.
- A series of 'Your Voice' staff engagement events, aimed at promoting and evaluating the methods currently used for engagement, and exploring how effective these are in different areas of the Trust.
- The Trust website and intranet site are being separated and the intranet is being redesigned to make it more user friendly and increase accessibility. This project has been carried out using feedback from staff through surveys and workshops.
- The Team Brief monthly email newsletter that is circulated across the Trust has been updated and is now supported with a live briefing session led by Interim CEO Julie Dawes, open for all staff to attend or dial into as a conference call.
- 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.
- Our Interim CEO Julie Dawes sends a weekly email to the whole Trust, and has put in place a series of dedicated 'Listening Events' across the Trust aimed at discussing staff's views and concerns and answering questions.
- Using feedback from staff, the Trust values have been refreshed and the annual appraisal paperwork has been updated in line with these, to help staff feel more aligned to the aims of the organisation.

Leadership

We are continuing through a period of change within the leadership at Southern Health, in order to create a strong team to lead the Trust as it moves ahead with developments within the health service locally.

On 25 May Lynne Hunt was appointed as Chair of Southern Health. Lynne has a track record of almost 40 years public service, working in the NHS within mental health services. She began her career as a nurse in Dorset, before moving to London and has held a number of clinical and Board level roles. Most recently she has been Non-Executive Director and Vice Chair of Dorset Healthcare NHS Foundation Trust. Lynne will begin as Chair on Monday July 3.

The process to appoint the new Chair was extensive and involved service users, staff and local partner organisations. A key focus for Lynne in her new role will be to drive forward developments within the Trust that will shape the future of services, as part of the Clinical Services Strategy, and more widely as part of the Hampshire and Isle of Wight Sustainability and Transformation Plan.

The current leadership team at Southern Health:

- The Non-Executive Directors resigned their positions in April 2017, and recruitment will now begin for their replacements.
- The advert for a substantive Chief Executive Officer has been published and it is anticipated that interviews for this role will be held during the Summer.

- Sara Courtney continues to act up as Director of Nursing and AHPs whilst Julie Dawes fills the Chief Executive role.
- Chris Ash will be leaving the Trust in August to join a healthcare trust in New Zealand.
- Gethin Hughes is going on a secondment and joining colleagues at Western Sussex Hospitals NHS Foundation Trust to support them as Director of Integrated care. Whilst Gethin is away, Paula Hull (Director of Nursing for the ISD) will be taking on elements of his role and helping support the business units.
- Dr Lesley Stevens is joining the Hampshire and Isle of Wight Sustainability and Transformation Plan as Chief Officer for Mental Health. Dr Sarah Constantine, Clinical Chair of the ISD (Integrated Service Division) will be stepping up into the role of Medical Director on an interim basis.

The future

Southern Health NHS Foundation Trust has now launched its Clinical Services Strategy; a plan for its mental health and learning disability services as well as an assessment of developments in the provision of community physical health services. A four month review was undertaken in support of this strategy, to understand how our services should be configured to best meet the needs of local communities in the future.

To help us do this work, we partnered with experts from 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. We also listened to the views of a variety of people, including health workers and experts, families and the people who use our services, as they are experts in the experience they have had.

The resulting strategy document (attached as Appendix D) contains seven priorities which are now the focus of our work. These include fundamentally improving access to care through a single point of contact, better 24/7 crisis support, greater inclusion of service users in the design and delivery of services, and ensuring people receive a more consistent level of service across Hampshire. They identify developments for those services as well as the organisation, and the overall direction provides for a dynamic and positive future.

In particular, the Board has identified the benefits of much greater inclusion of service users and carers in the organisation as well as in the delivery of services, a systematic quality improvement methodology, the greater integration with primary care, and much greater involvement of clinical staff in the management and organisation of the Trust's services. These plans mark a turning point in the Trust's life and the opportunity to move forward in a different way from the past.

Version Control

Southern Health NHS
NHS Foundation Trust

Version No	3.5
Date	31/05/2017
Leads	Sara Courtney, Chief Nurse Tracey McKenzie, Head of Compliance and Assurance Mehreen Arshad, Programme Lead (Quality and Improvement Planning) Briony Cooper, Programme Lead (Quality and Improvement Planning)

Change record

Date	Author	Version	Page	Reason for Change
19.4.17	L Connor	V3.0	All	Set up change record and version number system
27.04.17	B Cooper	V3.1	IP	Updated actions 7.4 and 28.4 from QIPDG meeting on 25.4.17. Added date for completion.
11/05/2017	L. Connor	V3.2	IP	updated 7.4 clinical risk management training from overdue to completed-unvalidated.
24.5.17	B Cooper	v3.3	IP	additions to unvalidated actions.
31.5.17	B Cooper/ LC	v3.5	IP	added info to 28.6 - still on track. 4.10 - added info re validation and need for recovery plan.. Validation of 2.11 and 3.4.

CQC January 2016 Improvement Action Plan

Completion 97%

Action Plan Position Status

RAG status	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Red Overdue	11	6	7	6	6	3	5	1	1	0
Amber At Risk of Slippage	1	0	0	0	0	0	0	0	0	0
Green On track	24	21	15	11	10	12	7	1	1	2
Blue Complete	68	74	78	83	82	82	82	104	104	106
Blue Unvalidated	5	8	9	9	11	12	15	3	3	1
TOTAL	109	109	109	109	109	109	109	109	109	109

Assurance and Validation Process

RAG Status	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Unvalidated - pending Executive validation	2	2	2	1	0	1	3	12	0
Executive validated	1	3	0	0	0	0	0	22	0

UIN	Trust Action	Responsible Lead	Completion Date	Action Status	Recovery Date	Progress Update	Evidence	Evidence Validation	Executive Validation
WN004 4.10	4.10 The Trust will upskill frontline staff in quality improvement methodologies using the existing Team Viral programme to support this	John Monahan Organisational Development	31/03/2017	**on track**	recovery date tbc	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. March 2017: This is an ongoing action as it is part of the Team Viral programme which will continue into 2017/18. John Monahan and his team have delivered Team Viral to 98 teams across the Trust during 2016/17 and there is an activity during the day where different quality improvement techniques are introduced to the team. The teams will then apply a selection to their action plans to give them a methodology to take their actions forward. This has delivered to the teams that have participated in the programme to date and will continue to deliver going forward. Since this action has been complete, they have evaluated that there is further in depth quality improvement training which will be undertaken by Helen Ludford and a pilot for training has been set for Q1 2017/18. The viral course (improving clinical practice through learning) has a live date due in the first quarter of 2017/18/ Training for the Quality Ambassadors will also be delivered in April 2017. NHS England are running patient safety training - which is a new QI methodology. LEaD also have online modules and further work will need to be done to roll this across the Trust for QI. Action is complete however further work is underway to embed the quality improvement to the core of the organisation. Followed up with John Monahan re update of progress/achievements to Committee or Board - needed for Executive validation. May 2017: SC has reviewed programme in place and is checking figures for number of staff who have completed the programme. 25.5.17 Fiona Byrne Interim People Development Lead updated that 1st 'Improving Clinical Practice through Learning ' training due 15.6.17. Earlier date 3.4.17 postponed due to numbers signed up. 26.5.17 SC not validate as completed. Met with Fiona Byrne to quantify number of teams and content of internal quality improvement training. 10 teams have completed year long NHSE Patient Safety Forum service improvement training/project; some teams have accessed Wessex Collaborative training; Viral Quality completed by a number of teams. The Clinical Services Strategy will bring in service transformation teams. The trust will have organisational SI with dedicated SI and quality leads and a Director for Transformation.. Quality ambassadors will also have 1/2 day	IN FOLDER: 4.10 Viral Essentials PowerPoint presentation - Improving Learning Through Clinical Practice 4.10 Module 16 session plan 4.10 Module 16 prospectus 4.10 Email from John Monahan re outline of work undertaken in 2016/17 4.10 Email from Fiona Byrne 25.5.17 re Improving Learning Through Clinical Practice training	YES - MA	SC to action
RN007 7.4	7.4 Devise a clinical risk management training package and establish a programme to roll this out in 2017 that reflects the recommendations of the task and finish group	Louise Hartland, Governance, Quality and Compliance Manager LEaD	31/12/2016	**unvalidated**	30/05/2017	A task and finish group was set up to develop the e-learning RiO Risk/Crisis/Safety Plan training module. Communication was sent out to AMH RiO users in January prior to the release of the new RiO modules. As summary recovery plan was submitted to the PMO as an extension was requested on the completion date. This is because the e-learning could not be developed until the team had information on what forms will be in use on RiO. The new completion date is planned for 31 March 2017. March 2017: The content for the e-learning training package is currently being piloted in AMH through face to face team sessions. The last session was scheduled for the 27th March 2017. Project team is meeting on the 29th March 2017 to finalise the content based on the pilot feedback. The anticipated 'build' time for the e-learning is a minimum of 4-6 weeks. New completion date is planned for 15th May 2017. All AMH RIO users were provided with a guidance document when the new RIO Risk Summary was implemented. The e-learning package is supplementary to this guidance. The guidance document is attached. David Kingdon has done a number of sessions for the Trusts consultants and CMHTs. 25April2017 e-learning package in development and being tested end April. **11/5/17.** The Open RIO Risk Summary Assessment Form e-learning training for AMH Staff was launched today. All AMH RIO users have been emailed to advise them that the training is available and to complete the training at their earliest opportunity. Louise Hartland.	IN FOLDER: 7.4 Recovery plan 7.4 Chaser email 7.4 Update from Louise Hartland (29/3/17 and 11/5/17) 7.4 Important New RIO RISK Summary Assessment Form (AMH Only) E-learning Training launched (Email from Simon Johnson 12may17)	YES - BC	DK to action

UIN	Ref No	Requirement Notice?	CQC Domain	Core Service	Location	Theme	CQC Action	Cause of Regulation Breach	Trust Action	Evidence of Action Completed	Outcome Measure	Evidence of Intended Outcome Achieved
WN001 1.1	1	**Enforcement Action**	**WELL-LED**	Provider / Trust	Board	Risk Management	Key risks and actions to mitigate risks were not driving the senior management team or the board agenda	Key risks and actions to mitigate risks were not driving the senior management team or the board agenda	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)	Board clearly sighted on and assured about the management of key risks and the delivery of the quality improvement agenda with clear sight of the mortality improvement plan and CQC improvement plans	Tracking examples of risks being identified and escalated Review of Board and sub-committee agendas at year end against top organisational risks
WN001 1.2									1.2 Review of Ward to Board reporting on quality performance (Board and its sub-committees)	2016/17 reporting schedule will be agreed at Trust Board (submission of documents)	Clear Ward to Board visibility of reporting and accountability	
WN001 1.3									1.3 Executive Quality Portfolios to be revised and strengthened with the three Clinical Executives forming a 'Quality Team'	Executive portfolio changes will be published and communicated both internally and externally (submission of documents)	Clear accountability demarkation for the quality agenda between Executive portfolios and shared responsibility for delivery between three clinical Executives to ensure accountability for delivery of quality improvement plan.	
WN001 1.4									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.	Deputy Director of Nursing and Quality, Mental Health and Learning Disabilities Division post is appointed to	Strengthening of Professional leadership and Quality Governance focus within the Mental Health and Learning Disability Division	
WN001 1.5									1.5 New Divisional Quality Performance Reporting framework to be launched and embedded across the organisation to ensure Ward to Board quality performance reporting and escalation of concerns, including 'hotspot' reporting	Ward to Board audit trail of quality performance reporting (submisison of documents)	Clear Ward to Board visibility of quality performance	
WN001 1.6									1.6 Risk Management Policy to be reviewed (including Risk Appetite Statement)	Revised Policy will be published (submission of documents)	Improved risk management across the organisation	
WN002 2.1	2	**Enforcement Action**	**SAFE**	Provider / Trust	Trust wide	Environment	The trust must make significant improvement to the safety and quality of healthcare provided by ensuring governance arrangements are effective in identifying and prioritising risks to patient safety arising from the physical environment including ligature risks, falls from height and risks from patients absconding	The trust did not have effective governance arrangements that identified, prioritised and mitigated risks to patient safety, for example, ligature risks, fall from heights and risks from patients absconding	2.1 The Trust will review and redesign the Trust Infrastructure Group (TIG) decision making framework to ensure Quality Impact Assessment and Risk mitigation is a core element of prioritisation of capital bids. Capital bid applications will need to include a Quality Impact Assessment and Risk Score and all new bids will require a quality impact assessment in year.	Quality impact and risk mitigation will be in place at local unit level for all works (submission of documents)	Capital planning process appropriately prioritising bids on the basis of clinical risk	Site visits consistently show evidence of staff aware of ligature risks associated with their units and of measures in place to mitigate risk.
WN002 2.2									2.2 New process to be designed and fully implemented to ensure delays to any estates work linked to patient safety are escalated to both TIG and Trust Executive Group. This will include a monthly 'capital status report' to the Trust Executive group	Monthly exception reporting to TEG will be in place (submission of documents)	Exception reporting to Trust Executive Group on a monthly basis to allow for early escalation of delays in environmental improvement programme	
WN002 2.3									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	Strategic Capital plans will be in place improving the prioritisation, risk assessment and risk management of environmental risks at the frontline	

WN002 2.4								2.4 Each MH/LD/OPMH inpatient unit will have its own site-specific environmental and estate work plan. This will be held on a central sharepoint location in order that frontline staff can view the plan at any time. Capital prioritisation decisions will be formally shared in a set reporting framework with frontline clinical teams following every TIG meeting.	Environmental improvement plans will be in place. These will include estate works timescales (as appropriate). (review of sharepoint files)	Improved interface between estates and clinical services
WN002 2.5								2.5 Estates team to produce and install standardised displays of capital plans for each site	Clear plans will be displayed (site visits)	Clear, visible plans will be in place on each unit
WN002 2.6								2.6 The previous Task and Finish ligature group terms of reference and purpose will be reviewed and a new Trust Ligature Management Group will be formed. Membership will be reviewed and strengthened with increased clinical membership, including the appointment of a senior clinical co-chair with estates. The ToR will include the following elements:- - Act as an expert decision making group in relation to ligature decisions - Prioritise capital expenditure for ligatures against the capital control total agreed by the Trust executive - Ensure that there are processes in place to deliver the ligature management programme to include risk assessment and identification, operational mitigation and financial allocation - Develop a new risk assessment tool which will help the clinical teams to assess comprehensively - Ensure that the Trust is fully compliant with accepted standards & guidance from external agencies (eg.NICE) - Monitor and audit identified ligature works across the Trust - Monitor the uptake of E-Learning Training and Assessment on Ligature Risk Care - Monitor the quality and completion of Ligature Risk Assessments across the Trust - Ensure that appropriate management information is	Minutes of Ligature Management Group Reports to Quality Improvement and Development Forum (QID) (submission of documents)	More robust risk identification and risk mitigation will be in place
WN002 2.7								2.7 The Trust ligature risk assessment tool will be redesigned away from using 'the Manchester Tool', to using industry agreed risk assessment methodology (5x5)	New risk assessment tool (submission of documents)	improved understanding of risk assessment and more consistent risk scoring at the frontline and more robust risk mitigation plans will be in place
WN002 2.8								2.8 An annual ligature risk assessment programme will be rolled out to include the newly appointed Project lead, estates lead and clinical lead for the area undertaking a joint risk assessment to ensure continuity, quality and a collective agreement as to the risks, mitigations and controls in place. This will report into the Trust ligature management group	All MH/LD/OPMH inpatient units will have a ligature risk assessment completed on the new paperwork that is accurate and of a high quality (submission of documents)	Triangulation of risk assessment will ensure all risks, mitigations and controls are in place
WN002 2.9								2.9 The Ligature Management Policy will be updated to ensure the new risk assessment process is clearly documented	New Ligature management policy (submission of documents)	Clear policy change and consistent implementation
WN002 2.10								2.10 Appoint a dedicated full time Trust clinical ligature project manager	New manager in post	Named lead will coordinate all elements of Ligature Risk assessment and mitigation

WN002 2.11									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	All security risks will be clear to frontline teams and all will have management and mitigation plans in place	
WN002 2.12									2.12 Install anti-climb guttering at Melbury Lodge to reduce the risk of service users accessing the roof and garden fencing. During the undertaking of the works, security will be enhanced in the garden area, staffing levels will be increased, risk assessments and admission criteria will be reviewed.	Guttering will be in place. Number of service users successfully accessing the roof will reduce (site visits)	Guttering will minimise the risk of patients accessing the roof	
	3	**Trust wide Must Do**	**SAFE**	Provider / Trust	Trust wide	Environment	The trust must make significant improvement to the safety and quality of healthcare provided by ensuring governance arrangements: are effective in recording and implementing interim and long-term control measures to mitigate risks to patient safety arising from the physical environment including ligature risks, falls from height and risks from patients absconding.	n/a	See actions in 2 above			Clearly auditable evidence of identification and mitigation of risk and of appropriate escalation
MD003 3.1									3.1 The Trust approach to thematic review will be more systematic and robust. This will allow for more meaningful opportunities for staff to idenitfy trends and take appropriate action to implement control measures. Peer review schedule for 2016/17 will include thematic peer reviews over several sites.	Annual Thematic Review schedule will be in place and delivered (submission of documents)	Identification of themes and trends will be more robust	
MD003 3.2									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)	QID will receive assurance of team-level mitigation of risks associated with the environment.	
MD003 3.3									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)	Teams will have greater ability to review their own performance and understand how this is linked to their objectives including those around patient safety.	
MD003 3.4									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)	Early intervention to provide support to struggling teams will mitigate the risk of significant deterioration in performance including that linked to the management of environmental risks	
MD003 3.5									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)	Having a single, team level Improvement plan will enable teams to more accurately monitor and deliver required improvement actions including those linked to environmental risks	
	4	**Enforcement Action**	**SAFE**	Provider / Trust	Trust wide	Investigations & learning	The trust must make significant improvement to the safety and quality of healthcare provided by ensuring governance arrangements: are effective at delivering robust incident investigation to ensure opportunities for future risk reduction are identified and acted upon.	The trust did not have effective governance arrangements to deliver robust incident investigation	The Trust will deliver the Mortality and SIRI action plan in full and to time. **Monitored through separate SIRI and Mortality Action Plan**	Robust governance of the mortality and serious incident process following assurance to external auditors	New death reporting processes will be embedded across the organisation	Internal audit of investigation process to be added to audit schedule for Q4
WN004 4.1									4.1 Amend Mortality reporting process to ensure all Learning Disability and Adult Mental Health inpatient deaths are reported as SIRIs and undergo full Root Cause Analyisis investigation	Updated policies and procedures Ulysses data (submission of documents)	Inpatient deaths in AMH/LD will be investigated in a consistent fashion	
WN004 4.2									4.2 All Root Cause Analysis Investigations that are not SIRIs (excluding pressure ulcers) will go through the same processes as SIRIs, (this may include a thematic review where appropriate), including corporate panel sign off	Updated policies and procedures Ulysses data (submission of documents)	Ensure high quality of investigation and all opportunities for Organisational Learning are identified and actioned regardless of whether a SIRI or not	
WN004 4.3									4.3 IMA audit tool will be amended to ensure it includes adequate checks against RiO	IMA audits undertaken and feedback provided to staff (submission of documents)	Mitigate risks inherent in IMA stage of process	

WN004 4.4									4.4 The Trust will commission an external review of the experiences of family members in the investigation process to provide recommendations on how this can be improved. Action will be taken based on review findings and recommendations	Review will be completed and clear improvement recommendations will be identified and implemented (submission of documents)	Improved experience for family members/carers involved in investigations into deaths	
WN004 4.5									4.5 The Trust will appoint a Trust Patient Experience Lead	Postholder will be in place with clear job description and clear objectives	A dedicated lead for Patient Experience will ensure maximum focus, coordination and improvement will be delivered across all services	
WN004 4.6									4.6 CAS system to be used to disseminate learning from SIRIs where corporate panel has grade these as level 4 or 5	Alert system will be in use and same day dissemination of learning from corporate panels will be evidenced (submission of documents)	Improve the culture of organisational learning from serious incidents	
WN004 4.7									4.7 The Organisational learning strategy will be reviewed and updated	New strategy (submission of documents)		
WN004 4.8									4.8 Where corporate panels grade incidents as 4 or 5, a follow-up panel structure will be put in place to gain assurance re completion of action plans.	Panel minutes (submission of documents)		
WN004 4.9									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)		
WN004 4.10									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)		
MD005 5.1	**5**	**Trust wide Must Do**	**RESPONSIVE**	Provider / Trust	Trust wide	Supporting staff	The trust must make significant improvement to the safety and quality of healthcare provided by ensuring governance arrangements: identify, record and effectively action concerns about patient safety raised by staff.	n/a	5.1 Medical Director will review Associate Medical Director appointments and Roles and clarify the role of the Clinical Director with Divisional Directors to ensure consistency	Standardised Role desciptors and job plans will be in place (submission of documents)	Improved medical leadership throughout the Organisation with standardised Role Descriptors and clear accountabilities and objectives	
MD005 5.2									5.2 A structured leadership visibility programme will be introduced to include executive safety walkabouts, 'Back to the Floor' programme etc.	Programme to be in place and frontline teams to report increased visibility of senior leaders (submission of documents)	Improved senior leadership visibility at the frontline (including Executives and NEDs) and increased focus on Patient Safety	
MD005 5.3									5.3 Undertake a review of the Trust's staff engagement strategy	Review report (submission of documents)	A more engaged workforce who feel supported to raise concerns and are confident they will be dealt with appropriately	
MD005 5.4									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)	Staff clear as to the escalation processes that are in place to raise concerns about patient safety	
	6	**Trust wide Must Do**	**SAFE**	Provider / Trust	Trust wide	Supporting staff	The trust must make	n/a	See action in 5 above			

MD006 6.1							significant improvement to the safety and quality of healthcare provided by ensuring governance arrangements: identify, record and effectively action concerns raised by staff about their competence to carry out their roles.		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)	Improve staff engagement in the annual Training Needs Analysis process	
MD006 6.2									6.2 Conduct a staff survey to include a question that evaluates whether staff feel that their appraisal and/or revalidation process has adequately addressed their training needs	Survey results (submission of documents)	Appraisal and revalidation process will be used to assess any skills and competency gaps and staff will be supported to address these.	
MD006 6.3									6.3 A review of the current supervision policy and procedures to be undertaken to ensure they are fit for purpose and updated as necessary. This will include scoping the possibility of an electronic solution linked to the LEaD system to optimise supervision record keeping	Staff supervision records will be in place and staff will report supervision has taken place and has been effective	Standardised approach to supervision to support staff and provide a structured 'space' for concerns around competencies to be raised	
RN007 7.1	**7**	**Requirement Notice**	**SAFE**	Community-based mental health services for adults of working age.	Southampton AMH community teams	Risk assessments & care planning (including capacity & consent)	The trust must ensure that staff undertake risk assessments for all patients that use the service and that patients' care plans include the risks that have been identified and the actions required to manage these.	There was not consistent use of risk assessment processes. Crisis plans were not used consistently.	7.1 Interim action: Update AMHT/CMHT SOP to limit the places on RiO where risk information is entered. (Risk Assessment module and the latest consultant letter only)	Revised SOP Communications to staff about revised SOP/minutes of team meeting discussions (Submission of documents)	100% of risk assessments will be completed. Decreased numbers of patient safety incidents where failures in risk management were a contributory or causative factor.	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.
RN007 7.2									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)		
RN007 7.3									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)		
RN007 7.4									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	New training materials and schedule for roll out (Submission of documents)		
RN008 8.1	**8**	**Requirement Notice**	**SAFE**	Community-based mental health services for adults of working age.	Southampton AMH community teams	Risk assessments & care planning (including capacity & consent)	The trust must ensure that staff follow a consistent procedure for following up on patients who do not attend their appointments, especially those identified as posing a high risk of harm to themselves and/or to others.	There was no clear process for following up on patients who did not attend their appointments, even when a person was identified as high risk of harm to themselves and/or others.	8.1 Interim action: All multi-disciplinary team meetings to include discussion of patients who DNA as a standard agenda item.	Communications to staff/minutes of team meeting discussion MDT agendas (Submission of documents)	A robust system and consistent procedure is in place applied 100% of the time. Decreased numbers of patient safety incidents where poor management of DNA episodes was a contributory or causative factor.	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
RN008 8.2									8.2 Administration of MDT meetings to be changed in order that discussions about patients who DNA and the plans that are agreed as a result are entered onto the individual patient's RiO record rather than in the MDT minutes	Audit of individual patient records who DNA as identified through Tableau report (Submission of documents)		
RN008 8.3									8.3 Revise the CMHT and AMHT Standard Operating Procedure to reflect the requirement for teams to discuss people who DNA at the MDT meetings	Revised SOP within AMHT and CMHT Communication of SOP amendments to team/discussion of SOP amendments at team meetings (Submission of documents)		
RN008 8.4									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)		

RN008 8.5									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)		
RN009 9.1	9	**Requirement Notice**	**SAFE**	Child and adolescent mental health wards.	Bluebird House	Restrictive practice	The trust must ensure that it follows the Mental Health Act Code of Practice (chapter 26, paragraph 26.128). This requires that the responsible clinician or duty doctor (or equivalent) undertakes the first medical review of a young person in seclusion within one hour of the commencement of seclusion, if the seclusion was authorised by an approved clinician who is not a doctor or the professional in charge of the ward.	In Bluebird House medical staff were not able to attend young people's medical reviews, within one hour of the commencement of seclusion, as they had other commitments.	9.1 Interim action: Put plans in place to ensure Consultant Psychiatrist on-call or senior registrar on-call undertake the initial medical review for new episodes of seclusion out of hours if on-call trainee doctor is unavailable and that any breaches are reported on Ulysses as an incident.	Communications to staff Minutes of Trust SAFER group meetings Review of Ulysses incidents (Submission of documents)	Trust will have a model of on-call cover that is able to meet the requirements of the MHA Code of Practice whilst being cost-effective and sustainable.	Periodic audit of seclusion medical review until practice is embedded
RN009 9.2									9.2 Carry out a review of all episodes of seclusion in AMH, specialised services and LD from Dec 2015 - April 2016 to determine how many episodes of seclusion were not reviewed within the first hour by the on-call doctors out of hours and thereby establish scale of the problem.	Review report (Submission of documents)		
RN009 9.3									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)		
	10	**Requirement Notice**	**SAFE**	Acute wards for adults of working age and psychiatric intensive care units	All wards	Environmental & equipment	The trust must ensure that premises and equipment are safe. The provider must identify and prioritise action required to address environmental risks on the wards, such as management of ligature points.	There has been insufficient action taken to identify and prioritise action required to address environmental ligatures on the wards.	See Action 2 (warning notice tab) for Trust-wide actions which will include AMH services		A clear understanding by frontline staff of the ligature, environmental and equipment related risks on each inpatient unit and robust systems and processes for prioritising and managing these.	Staff understanding of ligature management process evident on peer reviews/site visits and up to date unit-based environmental work plans in place Ongoing monitoring of incidents linked to ligature points or environment
RN010 10.1									10.1 Develop a clear process for identifying and prioritising environmental risks across AMH services that includes the process for escalation and governance responsibilities.	Environmental Process document for AMH Minutes of AMH Environmental Meetings (Submission of documents)		
	11	**Requirement Notice**	**SAFE**	Acute wards for adults of working age and psychiatric intensive care units	Kingsley Ward, Melbury Lodge	Environmental & equipment	The trust must ensure it takes sufficient action to manage the safety of patients at Kingsley ward, Melbury Lodge, including ensuring staff can clearly observe patients to mitigate environmental risks	Insufficient action had been taken and to manage the safety of patients at Kingsley ward. Staff could not clearly observe patients and patients could access the roof and climb out of the wards garden. The trust had not ensured security arrangements were in place to keep patients safe whilst receiving care, including, restrictive protection required in relation to the Mental Health Act 1983. Patients detained under the Mental Health Act 1983 have absconded from Kingsley ward via the fence and the roof. The most recent abscond was 21 February 2016.	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		No incidents linked to AWOLS/falls from Melbury Lodge. Reduction in the number of incidents linked to observations on the unit	
RN011 11.1									11.1 Domed mirrors to be installed on Kingsley Ward, Melbury Lodge to improve the sight lines	Domed mirrors in situ (site visit)		Peer reviews and site visits Regular review of incidents linked to the environment at Melbury Lodge to identify any emerging or unresolved issues. Evidence of action taken in response to patient safety incidents related to the environment

RN012 12.1	**12**	**Requirement Notice**	**SAFE**	Acute wards for adults of working age and psychiatric intensive care units	Kingsley Ward, Melbury Lodge	Environmental & equipment	The trust must ensure that it protects patients' privacy and dignity in a safe way on Kingsley ward.	The trust had not ensured that patients' privacy and dignity is protected in a safe way on Kingsley ward.	12.1 Vistamatic windows to be installed on all 25 bedroom doors, Resource Room and Family Room	New doors installed (site visit)	Improved privacy and dignity for patients on Kingsley Ward whilst still allowing safe observations	Review of patient feedback from Melbury ward to ensure continued patient satisfaction around privacy and dignity
RN013 13.1	**13**	**Requirement Notice**	**SAFE**	Acute wards for adults of working age and psychiatric intensive care units	Hamtun PICU, Antelope House	Environmental & equipment	The trust must ensure that the works on the seclusion room on Hamtun psychiatric intensive care unit are completed so that the room is fit for purpose.	The seclusion room on Hamtun psychiatric intensive care unit is not fit for purpose.	13.1 Amend Hamtun seclusion room plans taking into account MHA Code of Practice and additional suggestions made by CQC	Revised seclusion room plans/drawings (submission of documents)	Fit for purpose seclusion room on Hampton ward that complies with MHA Code of Practice Standards	n/a - evidence of individual actions will provide the necessary assurance
RN013 13.2									13.2 PFI partners to provide costings for new design and issue tender	Costings and tender paperwork (submission of documents)		
RN013 13.3									13.3 External contractor to carry out building works of new seclusion room	Building works completed on new seclusion room (site visit)		
RN013 13.4									13.4 Interim action: Screen to be used as an interim measure, when the seclusion room is in use, to protect privacy and dignity of patients	ward manager spot checks		
RN014 14.1	**14**	**Requirement Notice**	**SAFE**	Acute wards for adults of working age and psychiatric intensive care units	Elmleigh & Melbury Lodge	Environmental & equipment	The trust must ensure that staff at Elmleigh and Kingsley ward at Melbury Lodge check and record medicine fridge temperatures to ensure medicines are stored at the correct temperature.	Staff did not always check and record medicine fridge temperatures at Elmleigh and on Kingsley ward at Melbury Lodge to ensure medicines were stored at the correct temperature.	14.1 Medicines Management team to re-issue advice re action to be taken if outside of safe range.	communications from Meds management team (submission of documents)	Appropriate management of medication fridges	Site visits and peer reviews consistently find evidence of fridge temperatures being managed appropriately Failed validation beacuse random sampling demonstrated lack of consistent application. Identified areas issued with improvement plan and to be folowed-up.
RN014 14.2									14.2 Fridge temperature monitoring template to be reviewed and re-issued so as to assure standardisation across the trust	New template (submission of documents)		
RN014 14.3									*14.3 Survey of the maximum temperatures reached in all inpatient dispensing rooms where medicines are stored to be carried out and solutions to be sought to ensure temperatures remain within the recommended limits (e.g. air conditioning installation)* **THIS ACTION HAS BEEN SUPERSEDED.** It was not felt to be sufficiently robust as described originally. Carrying out a survey of rooms using room temperature data collected over the last 6 months is unlikely to give an accurate picture of maximum room temperatures. Instead, the new Interim Chief Pharmacist has suggested the development of a risk assessment tool that will highlight any temperature issues on an ongoing basis rather than as a one off exercise. The new action is as follows: **Develop a risk assessment tool for assessing the impact of temperature excursions over the established limit and circulate guidance for its use**	Completed survey results and plans for remedial works (submission of documents)		
	15	**Requirement Notice**	**SAFE**	Wards for people with learning disabilities and autism	Evenlode	Environmental & equipment	The trust must ensure that environmental risks are addressed at Evenlode and that appropriate measures are implemented to effectively mitigate the risks to patients using the service.	The environmental risks at Evenlode must be addressed. Until the necessary changes are made to make the environment as safe as possible, appropriate measures must be implemented immediately	See action 2 (warning notice tab) regarding Trust-wide improvements in ligature/estates management which will apply to Evenlode		A safe environment will be provided for patients at Evenlode with remedial estates works completed as appropriate and residual risks managed through clinical risk management processes.	
RN015 15.1									15.1 Introduce immediate safeguards to ensure patient safety - shortening of cables - review of ligature risk assessments - review and update patient risk plans - increase night time observations	(Site visits) Evidence was also reviewed by CQC at repeat visit in February 2016.		Peer reviews and site visits Regular review of incidents linked to the environment at Evenlode to identify any emerging or unresolved issues.

RN015 15.2								to mitigate effectively the risks to people using the service.	15.2 Engage and consult effectively with the patient group around further changes being made to reduce the risk from ligature points.	Minutes from patient engagement meetings,1-1 discussions documented in care notes (submission of documents)			Evidence of action taken in response to patient safety incidents related to the environment
RN015 15.3									15.3 Schedule of bedroom works to be completed by external contractors	Bedroom works completed (site visits)			
RN015 15.4									15.4 Once structural bedroom works are completed, install new ligature-free beds and wardrobes.	New furniture in place (site visits)			
	16	**Requirement Notice**	**SAFE**	Wards for people with learning disabilities and autism	The Ridgeway Centre	Environmental & equipment	The trust must take action to address the remaining environmental risks at the Ridgeway Centre.	Known environmental risks at the Ridgeway Centre had not been addressed.	See action 2 (warning notice tab) in relation to Trust-wide improvements in ligature/estates management which will apply to The Ridgeway Centre		A safe environment will be provided for patients at The Ridgeway Centre with remedial estates works completed as appropriate and residual risks managed through clinical risk management processes.	Peer reviews and site visits Regular review of incidents linked to the environment at Evenlode to identify any emerging or unresolved issues. Evidence of action taken in response to patient safety incidents related to the environment
RN016 16.1									16.1 Address outstanding ligature points in garden as highlighted by CQC	remedial works carried out (site visit)			
RN017 17.1	**17**	**Requirement Notice**	**SAFE**	Wards for people with learning disabilities and autism	Evenlode	Environmental & equipment	The trust must ensure that that the clinic room at Evenlode is fit for purpose and contains all appropriate essential equipment for	The clinic room at Evenlode must be made fit for purpose and contain all appropriate essential equipment for resuscitation.	17.1 Identify gaps in essential resuscitation equipment and purchase any necessary additional equipment	equipment in place (site visit)	Safe fit for purpose clinic room facility	Site visits and peer reviews consistently find clinic room fit for purpose. Failed validation because site visits evidenced inconsistent approach. Improvement plans in place. Further site visits to be carried out.
RN017 17.2									17.2 Remove staff lockers currently within clinic room	no unnecessary items in clinic room (site visit)		
RN017 17.3									17.3 Purchase clinic room treatment chair	equipment in place (site visit)		
RN018 18.1	**18**	**Requirement Notice**	**SAFE**	Wards for people with learning disabilities and autism	Evenlode	Supporting staff	The trust must ensure that staff at Evenlode receive appropriate and up to date specialist training to be able to carry out their jobs as safely and effectively as possible.	The training, learning and development needs of staff had not been identified and actions taken to meet any gaps.	18.1 Review all staff training records to ensure compliance with statutory and mandatory training and seek staff views as to additional training they feel is required.	Training Records and 1:1/appraisal paperwork (site visit)	Staff feel properly trained to carry out their roles and supported in accessing this.	Report that provides assurance that staff have accessed all the training that they and their line manager agreed was required following individual training needs analysis
RN018 18.2									18.2 Liaise with LEaD to establish how best to meet identified training needs on an ongoing basis and ensure all staff are booked onto required courses.			
MD019 19.1	**19**	**MUST**	**SAFE**	Wards for people with learning disabilities and autism	Trust wide	Supporting staff	The trust must ensure that its 'Protocol for the Safe Bathing and showering of People with Epilepsy' is embedded as swiftly as possible and that staff receive appropriate training to ensure understanding and consistency of practice.	n/a	19.1 The protocol will be re-visited with all appropriate staff through discussion in team meetings. Reference to the protocol will be included in local induction checklists.	Staff to sign to evidence reading and understanding of bathing protocol Updated local induction checklists (submission of documents)	100% compliance with 'Protocol for the Safe Bathing and showering of People with Epilepsy' for inpatients with epilepsy.	Bathing care plan audits Staff awareness demonstrated at peer review/site visits
MD019 19.2									19.2 Posters to be created and placed in each room with a bath	Posters visible in each bathroom (site visits)		
	20	**Requirement Notice**	**SAFE**	Wards for people with learning disabilities and autism	Evenlode & The Ridgeway Centre	Investigations & learning	The trust must ensure that learning takes place following serious incidents.	The trust had not analysed and responded to information gathered from internal reviews to take action to address issues where they were raised, or used information to make improvements and demonstrated they have been made. The trust had not monitored progress	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.		Learning is shared. Actions and recommendations have been considered and, where appropriate, applied not only within the team but across the service, the division or the entire Trust.	
RN020 20.1									20.1 Add standing agenda item regarding learning from incidents to local quality and governance meetings.	Agendas and minutes of local quality and governance meetings (submission of documents)		Site visits and peer reviews consistently find that staff are able to describe learning from incidents across the Trust
	21	**Requirement Notice**	**EFFECTIVE**	Wards for people with learning disabilities and autism	Evenlode & The Ridgeway Centre	Supporting staff	The trust must ensure that staff at the Ridgeway Centre and Evenlode receive consistent and regular supervision and senior management oversight.	Staff did not receive appropriate on-going supervision in their role.	See action 5 (warning notice tab) for Trust-wide actions in relation to the supervision process.		100% of available staff have received supervision in the last 6 weeks.	
RN021 21.1									21.1 Roll out a programme of regular supervision in Evenlode and the Ridgeway Centre ensuring that by end June 2016, all clinical staff have had a clinical supervision session and there is a clear schedule for future supervision in place.	Supervision records (submission of documents)		Site visits and peer reviews consistently find that supervision records on staff files show 4-6 weekly supervision sessions

RN022 22.1 RN022 22.2	**22**	**Requirement Notice**	**RESPONSIVE**	Wards for people with learning disabilities and autism	Evenlode & The Ridgeway Centre	Environmental & equipment	The trust must make the necessary improvements to the environment at both services in order to protect people's dignity and privacy at all times.	The provider must make the necessary improvements to the environment at both services in order to protect people's dignity and privacy at all times.	22.1 Install curtains in patient bedroom (RWC) 22.2 Seek options (from various specialist resources / national standards) for door observation panels that do not compromise privacy and dignity (Evenlode)	Environmental modifications in place (Site visits)	Privacy and dignity will be maintained.	Site visits, peer reviews and patient feedback consistently report privacy and dignity being managed appropriately at the two sites
SD023 23.1 SD023 23.2	**23**	**SHOULD**	**RESPONSIVE**	Provider / Trust	Trust wide	Investigations & learning	The trust should review its policies relating to complaints to ensure they reflect current legislation, best practice, role and responsibilities and the management of local concerns. It should continue to	n/a	23.1 Undertake a thematic peer review of the complete complaints management process involving staff and complainants to review the process in practice and make recommendations for improvements 23.2 Review complaint policy and procedure to ensure that they are aligned with national best practice guidance and incorporate recommendations from the thematic peer review	Thematic peer review report with recommendations and SMART action plan which will be presented to QID (submission of documents) Revised policy and procedure available for staff on website & communicated via weekly bulletin and incorporated into relevant training (submission of documents)	Up to date policy and procedure which reflect best practice and National Guidance and lead to an improved complaints process reflected by feedback from complainants and staff.	Improved feedback from all staff involved in complaints process/response sign off and feedback from complainants
SD024 24.1	**24**	**SHOULD**	**RESPONSIVE**	Provider / Trust	Trust wide	Investigations & learning	The trust should continue to develop its complaints reports to the board to contain more detailed analysis and explanation so the board is provided with more robust information for assurance.	n/a	24.1 Enhance the reports submitted to Quality & Safety Committee and the Exec Board Report to include: - evidence of specific learning and service improvement as a result of complaints - case trend analysis related to areas, services and staff groups - evaluation of quality of complaint response letters (6 monthly)	Revised reports to QSC & Board (submission of documents)	More informative Board sub-committee reports to present themes and assure Board that learning from complaints is being implemented	Positive feedback from Board members that they are assured through reports they receive that service improvements are taking place as a result of complaints
SD025 25.1 SD025 25.2 SD025 25.3	**25**	**SHOULD**	**EFFECTIVE**	Community-based mental health services for adults of working age.	Southampton AMH community teams	Supporting staff	The trust should ensure that staff in all teams receive regular supervision and that this is used to support implementation of the improvement plan. Supervision should include a review of caseloads and monitoring of care records.	n/a	See action 6 (warning notice tab) re Trust-wide plans relating to the supervision process 25.1 Supervision templates developed by LD and Specialised services to be reviewed and the most appropriate one circulated for interim use within AMH 25.2 AMH specific clinical supervision template to be designed 25.3 All Soton community staff to have had first supervision session and planned schedule of supervision sessions in place	 Communication of template to staff/minutes of team meeting discussions (submission of documents) Standardised template in use across all AMH teams (site visits) Monthly supervision date reports reviewed by area managers monthly and submitted quarterly to AMH Performance and Assurance Board, evidenced in minutes (submission of documents)	100% of available staff have received supervision in the last 6 weeks.	 Site visits and peer reviews consistently find that staff feel supported and have clinical supervision in place
SD026 26.1 SD026 26.2 SD026 26.3	**26**	**SHOULD**	**EFFECTIVE**	Child and adolescent mental health wards.	Bluebird House	Involving patients	The trust should ensure that there are suitable arrangements in place to ensure that all young people are involved in all aspects of planning their care and treatment in Bluebird House	n/a	26.1 Consultant psychiatrists and ward managers to ensure that all patients have advanced statements 26.2 Template of CPA meeting to be changed to ensure wishes of young people are formally captured 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	Audits of patient records (submission of documents) New template (submission of documents) Training records for graphic facilitation and CPA minutes (submission of documents)	Increased young persons' engagement in their care planning	Consistent evidence at site visits, peer review and through patient feedback of involvement in care planning.
SD027 27.1 SD027 27.2	**27**	**SHOULD**	**SAFE**	Child and adolescent mental health wards.	Bluebird House	Restrictive practice	The trust should ensure that where rapid tranquilisation is used by intramuscular injection, young people in Bluebird House have their physical health	n/a	27.1 Remind all clinical staff of the risks associated with using Rapid Tranquilisation intramuscular medication and the benefits of the Track and Trigger 27.2 Ensure reference to Track and Trigger Tool is included on local induction checklist for agency staff.	Communications to staff (submission of documents) Amended local induction checklist (submission of documents)	Improved aftercare for patients receiving intramuscular rapid tranquilisation medication.	Consistent evidence at site visits, peer review and through audit of track and trigger tool being used post administration of rapid tranquilisation IM.

SD027 27.3							observations monitored on the format within their care files.		27.3 Carry out an audit of compliance with the Track and Trigger tool from March-May 2016 to determine scale of compliance issues and allow better targeted future interventions aimed at increasing compliance with its use.	Audit report (submission of documents)		
SD028 28.1	**28**	**SHOULD**	**SAFE**	Child and adolescent mental health wards.	Bluebird House	Restrictive practice	The trust should ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. The provider should ensure that they address the high levels of prone restraint and provide staff at Bluebird House with appropriate restraint training as agreed.	n/a	28.1 Develop a Trust position statement that sets out the principles staff should work to with regards to restrictive practice. This will sit above a suite of policy documents and protocols that address restraint,	Position statement (submission of documents)	A clear restraint reduction strategy will be in place and there will be robust Trust systems for monitoring the numbers, positions and durations of restraints with the wishes of patients will be taken into account.	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
SD028 28.2									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)		
SD028 28.3									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)		
SD028 28.4									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)		
SD028 28.5									28.5 Ulysses to be updated and staff to record the duration of each type of restraint as part of the incident reporting processes. Statistics from these incidents will be reviewed as part of the services governance arrangements and issues will be escalated via the SAFER forum.	Through regular reports to the Trust Quality Improvement and Development Forum. Monthly review via local governance and Monthly review at Safer forum (submission of documents)		
SD029 29.1	**29**	**SHOULD**	**EFFECTIVE**	Child and adolescent mental health wards.	Bluebird House	Risk assessments & care planning (including capacity & consent)	The trust should ensure that suitable arrangements are in place to obtain the consent of patients in relation to the care and treatment provided in Moss and	n/a	29.1 Staff to be trained in assessing and recording of capacity and consent as part of their local induction (open to all staff).	Training records held by the Modern Matron Audit of records (submission of documents)	All clinicians who undertake therapeutic activities with patients will record the patients' consent in their electronic patient record.	Consistent evidence at site visits and peer reviews and through documentation audit of capacity to consent to treatment being recorded appropriately.
SD030 30.1	**30**	**SHOULD**	**SAFE**	Child and adolescent mental health wards.	Bluebird House	Restrictive practice	The trust should ensure that staff in Bluebird House always record the length of seclusion and the time when seclusion has ended.	n/a	30.1 Design seclusion flow chart	New flow-chart (submission of documents)	All episodes of seclusion will be carried out in accordance with the Mental Health Act 1983 Code of Practice and Trust policy	Seclusion paperwork consistently found to be compliant with MHA Code of practice on audit or peer review/site visit spot checks
SD030 30.2									30.2 Review Trust seclusion documentation to ensure it is as simple as it can be for staff to complete.	Revised seclusion documentation (submission of documents)		
SD030 30.3									30.3 Carry out a scoping exercise to look at the possibility of moving seclusion paperwork to RiO	Feasibility paper (submission of documents)		
	31	**SHOULD**	**SAFE**	Child and adolescent mental health wards.	Bluebird House	Restrictive practice	The trust should ensure that staff in Bluebird House continue to monitor the use of prone restraint and there is senior oversight of this.	n/a	See action 28 above.		All episodes of restraint recorded as per Trust policy	
SD032 32.1	**32**	**SHOULD**	**SAFE**	Child and adolescent mental health wards.	Bluebird House	Environmental & equipment	The trust should ensure that a medical emergency bag is available on all wards at Bluebird House. We noted the wards were spread out and it would take staff in the region of five minutes to go to Hill ward where the bag was kept, potentially putting young people at risk.	n/a	32.1 New emergency bags to be ordered and placed on each ward.	Emergency bags in situ on each ward (site visit)	Medical emergency bags are available for use on each ward	n/a - evidence of individual actions will provide the necessary assurance

SD033 33.1	**33**	**SHOULD**	**EFFECTIVE**	Acute wards for adults of working age and psychiatric intensive care units	All wards	Risk assessments & care planning (including capacity & consent)	The trust should ensure that it clearly documents the decision-making behind judgements of a patient's capacity to make a decision.	n/a	33.1 The Ward round proforma which is copied to each patient's RiO record will be amended and standardised for all inpatient units to include the following: - Does the person have the capacity to consent to treatment? Y/N, Why? - Are there any other decisions that require capacity testing? Y/N/ Who will test/ When? This is to be discussed and documented in all MDT meetings and the additional prompts around the capacity to consent will be contained within the MDT pro forma.	Compliance to be monitored as part of recordkeeping audits (submission of documents)	The inpatient's mental capacity to consent will have been recorded and staff will be able to see and monitor any changes.	Consistent evidence at site visits and peer reviews and through documentation audit of capacity to consent to treatment being recorded appropriately. Failed validation because site visits evidenced inconsistent approach. Improvement plans in place. Further site visits to be carried out.
SD034 34.1	**34**	**SHOULD**	**CARING**	Acute wards for adults of working age and psychiatric intensive care units	All wards	Involving patients	The trust should ensure it clearly documents when patients have been involved in the development of their care plan.	n/a	34.1 Supervision template to be amended to include requirement for care plans to be reviewed. This will allow documentation around patient involvement to be picked up and discussed on an individual basis with staff.	Documentation audits Patient experience surveys (submission of documents)	The care plans will be completed in a person centred way with person's view recorded	Documentation audits and spot checks at peer review and site visits consistently show evidence of patient involvement in developing care plans.
SD035 35.1	**35**	**SHOULD**	**SAFE**	Wards for people with learning disabilities and autism	Evenlode & The Ridgeway Centre	Supporting staff	The trust should make every effort to ensure there are enough qualified nursing staff recruited to fully staff both services.	n/a	35.1 Ensure staff establishment is met with Trust recruitment processes being followed.	Budget and staffing in post reflect WTE. Recruitment drive in place to deliver any shortfall. (submission of documents)	Full nursing establishment in place in order to provide safe services	Ongoing monitoring of staffing levels and review of patient safety incidents to ensure there are no themes or trends that emerge relating to staffing levels.
SD036 36.1	**36**	**SHOULD**	**CARING**	Wards for people with learning disabilities and autism	Evenlode & The Ridgeway Centre	Involving patients	The trust should ensure it engages and consults effectively with patients whenever significant changes are to be made that will affect	n/a	36.1 Establish programme of patient meetings that include planned changes within service.	Patient Community Meeting Agenda (submission of documents)	Patients are informed and consulted when any changes within the service are planned	Patient satisfaction with level of information being provided about service change as evidenced at patient meetings and through monitoring of complaints and other feedback.
SD036 36.2									36.2 Extra-ordinary Meetings to be held if changes need to be made rapidly.	Minutes of Meetings with Patients (submission of documents)		
SD036 36.3									36.3 Meetings minuted and copies of minutes available for patients to access.	Minutes of Meetings with Patients (submission of documents)		
SD037 37.1	**37**	**SHOULD**	**CARING**	Wards for people with learning disabilities and autism	Evenlode & The Ridgeway Centre	Involving patients	The trust should consult with patients and review the activities provided for them at both services, to make sure that the activities provided meet people's needs	n/a	37.1 OT to consult with Patient group to discuss and understand their needs and preferences	Revised activity programme and evidence of patient engagement (submission of documents)	Patients have range of activities that meets their needs and wishes.	Patient satisfaction with activities on offer as evidenced through site visits/peer review and from monitoring of complaints and other feedback.
SD037 37.2									37.2 OT to develop activity programme that meets people's needs and wishes and is linked to their goal setting to promote discharge			
SD038 38.1	**38**	**SHOULD**	**WELL-LED**	Wards for people with learning disabilities and autism	Evenlode	Supporting staff	The trust should consult openly with the staff at Evenlode about the long-term future of the service. The trust should take steps to improve staff morale, to ensure all staff at the service feel fully supported and are able to share in the trust's vision and values.	n/a	38.1 Ensure regular communications to the team either by letter, email or face to face to keep them up to date with future plans regarding the Evenlode service.	Evidence of regular communication / meetings with the Team	Staff kept informed of the future of Evenlode.	Staff satisfaction with level of information being provided to them as evidenced through site visits/peer review and from monitoring of complaints and other feedback from staff.

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Serious Incidents and Mortality Improvement Action Plan

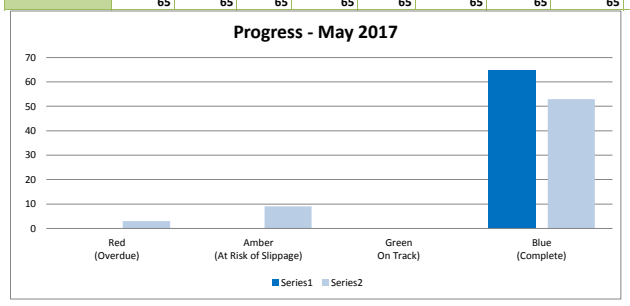
Version No 16.95

Date 31/05/2017

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

Completion 90%

RAG status	December		January		February		March		April		May		June	
	Process Input	Outcome Achieved	Process Input	Outcome Achieved	Process Input	Outcome Achieved	Process Input	Outcome Achieved	Process Input	Outcome Achieved	Process Input	Outcome Achieved	Process Input	Outcome Achieved
Red (Overdue)	3	4	3	1	0	1	0	4	0	4	0	3		
Amber (At Risk of Slippage)	0	0	0	0	0	0	0	9	0	9	0	9		
Green On Track)	7	28	7	32	8	32	0	0	0	0	0	0		
Blue (Complete)	55	33	55	32	57	32	65	52	65	52	65	53		
TOTAL	65	65	65	65	65	65	65	65	65	65	65	65		



NHS Southern Health NHS Foundation Trust

Change record

Date	Author	Version	Page	Reason for Change
27.04.17	B Cooper	v16.91	All	Set up change record and version number system
27.04.2017	B Cooper	v16.92	master pl	exception of spec services; 16.1 48 hour reporting onto StEIS target not met (36% in March); 18.7 Duty of
9.5.17	L. Connor	v16.93	All	5/5/17 Chased for updates, 9/5/17 . 11b physical health percentages added, 16 Childrens compliant,
25.5.17	Lconnor	V16.94	MP	Updated evidence on 9, 10, 11, 12, 16, 18.7, 18.9 for 26th May Evidence review panel
31.5.17	B Cooper	v16.95	All	18.7 changed from overdue to completed following evidence review panel

Theme	Mazars Recommendations	Process Completion Date	Process Status	Process Progress Evidence	Evidence of Outcome Achieved	Measuring Success Date	Recovery Date	Outcome Status	Progress Update	Outcome Measure	Expected Outcome
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.	31.07.16	**Complete**	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)	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	26.05.17 revised recovery date tbc	**Overdue**	11.1a Course content reviewed by the ADoNs from AMH and LEaD. 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 & c Training records being obtained by L Hartland LEaD. 04.08.16 Input evidence request made for information - meeting was held with ADoNs to discuss e learning and shorter course options October 2016: 5 day physical health course reviewed. The duration of the course does not make it a feasible option for inpatient staff. AMH, Specialised Services & LD Plan - Agreed all qualified nurses and HCSW's working in inpatient services will need to demonstrate competency in the following; - Physical Observations, - Track and Trigger Tool and SBAR(d), - Blood Glucose Monitoring . LEaD practice educators will assess the competency of senior nurses. Nurses achieving level 4 competency will then cascade assessments. LEaD will be introducing 3 skill buttons for the competencies on the training accounts of all staff in the target group on 25/10/16. Staff will be required to e-verify via the LEaD system when they have achieved each competency. All verifications will require manager authorisation. Target is for 80% of staff to be deemed competent in Track and Trigger and SBAR(d) by end of December 2016. Training/education is available via face to face or electronic delivery to support staff to acquire the knowledge and skills in physical health assessment and monitoring. LH meeting Kathy Jackson, Head of Nursing Inpatients (OPMH) 25/10/16. KJ is aware of this action. LH will present plan (as per action 11 above) to the ward managers at the meeting and arrange roll out of assessments for senior nurses. 11/10/16 A summary recovery plan was submitted by Steve Coopey for all actions: - 11.1a Discussions held with divisional leads to agree actions and attendance at physical health steering group commenced. Carole Adcock completed the review of 5 day physical health course. Divisional leads to agree actions following review, share work drafted on education pathway for registered staff and to confirm use of core physical health training workbook which supports competency assessment in practice. - 11.1b To agree which staff require core + additional training and confirm % targets trained in physical observations for mental health inpatients by 31.12.16 - 11.1c Louise to provide on-going attendance data on request or in line with agreed targets 17.10.16 11.a The risk related to physical health training in the MH inpatient units has been added to the divisional risk register (for MH) following discussion at AMH MOM in October 2016. Risk no.1100 - AMH - management of physical health care of service users. Risk states that currently the 5 day course is not attended and is being replaced with other training options. 20.10.16 11.1a Specialised Services have devised a project called improving access to physical health for the forensic patient; course developed - trainee advanced nurse practitioner masters pathway. 03.11.16 Further update re OPMH physical health course (CUSP) rolled out. 05.01.17 Update on 11.1d - Physical health assessment and monitoring policy now updated and circulated to the Resuscitation Committee for comments due back by 06.01.17. Task and finish group to be formed once the policy is agreed. A physical health strategy for AMH has also been drafted to ensure staff recognise and respond to patients' physical health needs, and work with service users in the community and look to reduce the incidence of premature mortality. Further update to be received from physical health task and finish group which will convene on 06.01.17	Evidence required: Course attendance records - site / service percentage (11.1b & 11.1c) - Saved 20feb17 data - T&T 87%, Phys obs 84%, Blood Gluc 81% March 2017 agreed that target training figure should be 90% trained. Results of the physical health audit of AMH sites (11.1a) 11.1a. physical health clinical audit report - MH (nov16). 11.1a nov16 audit results 93% - Helen Alger - full physical health review completed within 7 days of admission Audit of SI reports proving a reduction in physical health contributory factors (11.1a) Review of the published Physical Assessment and Monitoring Policy and Procedure for Mental Health and Learning Disability Services which includes a reference to diabetic monitoring (11.1d) AMH Physical Health Strategy (11.1d) Nov16 draft already saved.	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.
Timeliness of Investigations	16. Reporting to StEIS should be undertaken within the 2 working days of notification as required by the national guidance.	30.06.16	**Complete**	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)	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	30.06.17	**Overdue**	March 2017 : 16.1a Compliance to 48 hour reporting onto StEIS: 36% (Jul-16), 19% (Aug), 42% (Sep), 59% (Oct), 75% (Nov), 44% (Dec), 65% (Jan-17) 71% (Feb) 16.1b Compliance to 48 hour panels being held within 48 hours: 55% (Jul-16), 36% (Aug), 46% (Sep), 64% (Oct), 77% (INov) 67% (Dec) 78% (Jan) 71% (Feb-17) Levels of compliance with the mortality panels being held within 48 hours is monitored through Tableau on a daily basis and this is actively discussed at the MF. The compliance to the requirement to report onto StEIS withi 48 hours is monitored on a monthly basis and whilst improvement has been seen in the pressure ulcers, compliance to other serious incidents has deteriorated. It is recommended that this action remains red until indicators have reached the required trajectory. Further discussed at QIP Delivery Group the need for divisions to telephone the central SI team at end of 48 hour panel so can put any SI onto STEIS within deadline. Need to continue to monitor. A recovery date for this action has been set for June 2017. 27.04.17 16.1a Compliance to 48 hour reporting onto StEIS: 36% (Jul-16), 19% (Aug), 42% (Sep), 59% (Oct), 75% (Nov), 44% (Dec), 65% (Jan-17) 71% (Feb) 36% (Mar) 16.1b Compliance to 48 hour panels being held within 48 hours: 55% (Jul-16), 36% (Aug), 46% (Sep), 64% (Oct), 77% (INov) 67% (Dec) 78% (Jan) 71% (Feb-17) 82% (Mar) 48 hour panel guidance for ISD been amended to highlight that panel needs to call central SI team if decided that incident is SI. Performance discussed at QIPDG on 25.04.17 with ISD flowcharts/guidance shared for MH division to use if helpful. 5.5.17 Chased for status - Kay and Divisional leads / Requested summary recovery plan - Liz Taylor 8/5/17. We have not breached this in children and Families and are within compliance for reporting - updated divisional leads AMH was Mary Kloer - now David Kingdon, ISD Was Peter Hockey now Rachel Anderson. 25/5/17 evidence review panel - target not met. A change in process has ocurred with SI team attending/linking into 48 hour divisional panels to get immediate update re decision making re whether incident is SI.	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)	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.
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)	31.10.16	**Complete**	Evidence required: Record keeping procedure stipulating the responsibility (18.9a) Serious Incident procedure (18.9b)	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	30/09/2017	**Overdue**	04.08.16 New action to address the lack of next of kin details for some patient / service users. 06.09.16 Specialised Services - maintained on Rio- Next of Kin, on details where available (18.9a) 09.10.16 (18.9a and 18.9b due 31 October) showing 80% of patient records have a next of kin listed and SI investigations where next of kin details have been obtained through an alternative means Recommendation – Action to remain red until required trajectory is achieved. Currently discussions are progressing whether the Next of Kin field in Rio could be changed to a mandatory field. 05.01.17 100% (24/24) involvement of families/next of kin in serious incidents. 100% trajectory achieved since October 2016: - Oct 100% (15/15) - Nov 100% (10/10) - Dec 100% 24/24) Outcome status changed from overdue (red) to on track (green). Continue monitoring status of the action until 31 March 2017 and ensure that the process has been embedded. 15.03.17 record keeping guidance in place. Next of kin not always being recorded - new tableau report showing % with N of K recorded - 80% not met therefore changed to red. There is evidence that Nof K information is sought from other sources e.g. coroner (18.9b). 27.04.17 100% compliance with families or next of kin being involved in SI where possible: -Jan 100% 24/24 - Feb 100% 16/16 -Mar 100% 30/30 Tableau report as at 27.04.17 shows that 80% target of next of kin or other relationship being recorded not yet met. AMH 64.9% LD 87.6% ISD physical health 59.5% ISD OP therapy 38.5% OPMH Community 76.7% **5.5.17** Requested summary recovery plan from Divisional owners (Not LD)	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)	Early contact with families will be in place due to the correct contact details being recorded.

CQC Improvement Action Plan - Inspection Septembe

Version No	3.6
Date	02/06/2017
Leads	Sara Courtney, Chief Nurse Tracey McKenzie, Head of Compliance and Assurance Mehreen Arshad, Programme Lead (PMO - Quality and Improveme Briony Cooper. Programme Manager (PMO- Quality and Improvem

CQC September 2016 Action Plan Dashboard

Completion	62%

Action Plan Position Status

RAG status	Dec	Jan	Feb	Mar	Apr
Overdue	0	2	0	2	2
At risk of Slippage	0	0	0	0	1
On track	17	15	16	9	5
Complete	0	0	0	5	5
Unvalidated	20	20	21	21	24
TOTAL	37	37	37	37	37

Assurance and Validation Process

	Sep	Oct	Nov	Dec	Jan
Unvalidated	7	5	3	3	0
Validated	0	0	0	0	0

	Apr	May	Jun	Jul	Aug
Unvalidated	5				
Validated	2				

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May	June
1	
0	
4	
23	
9	
37	0

Version Control

Change record

Date	Author	Version	Page
19.4.17	L Connor	V3.1	All
27.04.17	B Cooper	v3.1	IP
5.5.17	Lconnor	V3.2	all
12.05.17	B Cooper	v3.3	IP
18.5/17	l Connor	V3.4	All
02.06.17	B Cooper	v3.5	All

Feb	Mar
1	1
0	4

Sep	Oct

Reason for Change
Set up change record and version number system
41.8 bathrooms Parklands - changed to at risk of slippage. 42.6 and 42.7 anti roll guttering Elmleigh at risk of not meeting recovery date 30/05/17.
Chased for update on over due, at risk and unvalidated actions.
guttering completed - changed from overdue to complete-unvalidated; 41.8 Parklands bathrooms should be completed by May 18th and so changed to on track from risk of slippage; 43.3 updated
42.6 building work complete-unvalidated. Added evidence to 41.4, 44.1, 45.2.
41.8 building works completed - change to complete-unvalidated; 42.3 changed form on track to overdue with recovery date 16/06/17.

UIN	Trust Action	Completion Date	Action Status	Recovery date	Progress Update	Evidence	Executive Validation
RN043 43.1	Fully deliver and embed all the actions from the January 2016 CQC inspection and the Mortality & Serious Incident Action plan. In addition to include:	30/09/2017	On Track	n/a			
RN043 43.2	INTERNAL REVIEW: Embedment of the new committee structure for quality governance	30/06/2017	On Track	n/a			
RN043 43.3	EXTERNAL REVIEW: Well-led review carried out by NHSI in Q4 2016/17 or Q1 2017/18 (tbc by NHSI)	30/06/2017	On Track	n/a	09/5/17: Discussed at QIPDG, SC stated External well-led review was not carried out by NHSI and it was thought that CQC inspection would be a focused Well Led inspection. However, although CQC inspection in March 17 had some well-led elements, it was not a Well Led focused inspection. Expect it will form part of the comprehensive CQC review in Q4 2017-18.		
RN043 43.4	EXTERNAL REVIEW: Niche / Grant Thornton Phase 2 review and testing of Mortality & Serious Incident Action plan	31/08/2017	On Track	n/a	07 April 2017: Niche gave initial feedback on phase 2 testing and overall felt good progress being made and could see significant improvements in Board visibility and culture. Had yet to look at all evidence and will ask for additional evidence as original request did not include everything required for assurance.		

actioned

UIN	Ref No	Requirement Notice?	CQC Domain	Core Service	Location	Theme	CQC Action	Regulation Breached	Cause of Regulation Breach	Trust Action	Executive Accountability
RN043 43.1	43	REQUIREMENT NOTICE	WELL-LED	n/a	Trust-wide	Governance processes	The trust must continue to review and embed more effective governance systems to ensure effective monitoring of quality and safety	Regulation 17 HSCA (RA) Regulations 2014 Good governance	Whilst a number of new processes had been introduced and strengthened, the trust had not embedded systems and processes to ensure quality and safety of services.	Fully deliver and embed all the actions from the January 2016 CQC inspection and the Mortality & Serious Incident Action plan. In addition to include:	Sara Courtney - Interim Chief Nurse
RN043 43.2										INTERNAL REVIEW: Embedment of the new committee structure for quality governance	
RN043 43.3										EXTERNAL REVIEW: Well-led review carried out by NHSI in Q4 2016/17 or Q1 2017/18 (tbc by NHSI)	Paul Streat, Director of Corporate Governance
RN043 43.4										EXTERNAL REVIEW: Niche / Grant Thornton Phase 2 review and testing of Mortality & Serious Incident Action plan	Sara Courtney - Interim Chief Nurse

UIN	Ref No	Requirement Notice?	CQC Domain	Core Service	Location	Theme	CQC Action	Regulation Breached	Cause of Regulation Breach	Trust Action	Executive Accountability	Month	Evidence of Action Completed	Outcome Measure
RN039 39.1	**39**	**REQUIREMENT NOTICE**	**SAFE**	n/a	All inspected	Documentation & Record Keeping	The trust must ensure better consistency in relation to the quality and detail of risk assessments across the wards	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Reg 12(1)(2)(a)12(2)(d)12(2)(c)	There was inconsistency in the quality and detail of risk assessments across the wards	All patients, where environmental risks have been identified, will have an environmental safety plan recorded within RiO. This will record the mitigations for the risks identified with their risk assessment.	Mark Morgan - Operational Director	Jan-17	AMH Environmental meeting minutes Acute Care Forum minutes Review of safety plans within RiO	Risk assessments that are up to date and evidence that that are reviewed following incidents.
RN039 39.2					Elmleigh					The use of MDT care plans will be standardised across all AMH units and wards through the work carried out by the task and Finish Group, established via the Acute Care Forum.		Apr-17	Discussion will be evidenced in the minutes of the ACP Forum	
RN039 39.3										Elmleigh Ward Managers will review each individual's risk assessment on RiO to ensure that, where appropriate, the mitigations for environmental risks are clearly recorded within the patient's record.		Jan-17	Environmental risks mitigations are recorded within RiO- evidence provided via AMH CQC minutes	
RN040 40.1	**40**	**REQUIREMENT NOTICE**	**SAFE**	Forensic inpatient / secure	Ravenswood House	Documentation & Record Keeping	The trust must ensure that staff at Ravenswood House review risk assessments regularly and following incidents.	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Reg 12(1)(2)(a)12(2)(d)12(2)(c)	The risk assessments at Ravenswood House were not reviewed and updated following incidents.	Carry out a review of all HCR20s and rectify any breaches	Mark Morgan - Operational Director	Nov-16	Up to date HCR20s	Risk assessments that are up to date and evidence that that are reviewed following incidents.
RN040 40.2										NHSE to carry out external review of HCR20s		Nov-16	Up to date HCR20s	
RN040 40.3										Conduct audit by reviewing all risk assessments, RiO summaries and progress notes		Sep-16	Audit results showing full compliance	
RN040 40.3										Communicate to all staff the importance of updating risk assessments in light of risk incidents		Sep-16	copy of staff briefing minutes of team meetings	
RN041 41.1	**41**	**REQUIREMENT NOTICE**	**SAFE**	Forensic inpatient / secure	Ravenswood House	Environmental	The trust must complete plans to improve and make safe the range of environments across the mental health and learning disabilities services in line with its estates improvement plan.	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Reg 12(1)(2)(a)12(2)(d)12(2)(c)	The premises at several locations, identified in this report, were subject to plans to improve and make them safe. This work had not yet been completed	The service to be placed in derogation by the commissioners due to Medium Secure Standards in relation to the perimeter fence not being met.	Mark Morgan - Operational Director	Sep-16	Copy of Derogation Notice from the commissioners	Safe environment
RN041 41.2										The Estates Department to produce options and costings for fencing for the service to consider		Dec-16	Fencing option paperwork	
RN041 41.3										Due to the perimeter fence all leave in the grounds will now be classed as community leave via section 17 and will be approved by the MOJ where required.		Sep-16	Section 17 leave records	
RN041 41.3--->41.4										Review daily perimeter check log back to May 2016 to identify gaps. All relevant staff will be reminded of their requirement to complete the log on a daily basis. Additionally, individual staff who were present on the days of the missed sign off will also be spoken to.		Oct-16	Team meeting minutes Audit data	
RN041 41.3-->41.5				Adult mental health rehab	Forest Lodge					Carry out remedial paintwork on ceilings to address immediate concerns prior to full works being completed		Apr-17	Completed works, signed off by service	
RN041 41.4-->41.6										Full refurbishment of the communal bathrooms to be undertaken as part of wider refurbishment work at Forest Lodge. A 12week refurbishment programme of work is starting on 3 January 2017 and due to be completed in April 2017. The bathroom refurbishment will include the ceiling repair as well as addressing the current mechanical ventilation issues, which are causing condensation.		Apr-17	Completed works, signed off by service	
RN041 41.5-->41.7				Acute mental health inpatients	Parklands					The maintenance issues in the en-suite bathroom to be addressed immediately. This includes replacing the cistern, some pipework and the damaged wall panelling, as well as full deep clean. The bathroom will be reopened by 14th October 2016.		Oct-16	Completed works, signed off by service	
RN041 41.5-->41.8										Bathrooms will be fully refurbished as part of a wider refurbishment programme in Parklands Hospital. The works are due to start in January, and they have been programmed to focus on bathrooms first, with completion anticipated by the end of March, however this may run into April. The rest of the works should be completed by the end of May.		May-17	Completed works, signed off by service	
RN042 42.1	**42**	**REQUIREMENT NOTICE**	**SAFE**	Acute wards for adults of working age and psychiatric intensive care units	Elmleigh	Environmental	The trust must review the risks identified at Elmleigh in relation to lack of action following incidents, poor lines of sight, multiple ligature risks, safe management of mixed gender areas, risks from patients absconding and ineffective staffing arrangements.	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Reg 12(1)(2)(a)12(2)(d)12(2)(c)	The premises at several locations, identified in this report, were subject to plans to improve and make them safe. This work had not yet been completed	POOR LINES OF SIGHT: Parabolic Mirrors and CCTV to be installed to increase visability Any remaining gaps in visibility will be mitigated via nursing risk assessment or other methods, as appropriate	Mark Morgan - Operational Director	Feb-17	Mirrors and CCTV in place to increase visibility	Safe environment
RN042 42.2										POOR LINES OF SIGHT: The risks are being mitigated by risk assessment of the individual patients. This is reviewed every time there is a change in patient's need/ presentation and reflected within the patient's RiO record. Observation levels may be increased in order for staff to monitor more frequently their mental state and risk to self and others. Additionally, staff may be allocated to the central observation area (at the top of the T) so that they have patient's bedrooms and main ward corridor in their line of sight.		Sep-16	Up to date risk assessments on RiO	
RN042 42.3										LIGATURE RISKS: Replacement programme of Elmleigh Green Bay windows has been identified as phase 1 priority to reduce the ligature points. The windows in the other bedrooms are being replaced in phase 2. The works will be undertaken March to May 2017		May-17	New windows installed	

UIN	Ref No	Requirement Notice?	CQC Domain	Core Service	Location	Theme	CQC Action	Regulation Breached	Cause of Regulation Breach	Trust Action	Executive Accountability	Month	Evidence of Action Completed	Outcome Measure
RN042 42.4										LIGATURE RISKS: Suspended ceilings at Elmleigh to be reviewed for replacement. Quotes are being obtained at present and the use of Single Tender Waiver is being considered. The programme of work is then to be agreed as part of the capital bid for the unit.		tbc	Ceilings do not pose a risk to the patients	
RN042 42.5										Elmleigh Ward Managers review the each individual's risk assessment on RiO to ensure that, where appropriate, the mitigations for environmental risks are clearly recorded within the patient's record		Oct-16	Environmental risks mitigations are recorded within RiO	
RN042 42.6										ABSOND RISK: Obtain the quote and fit anti roll guttering to the remaining two courtyards and anti roll guttering on all roof at rear of building which is patient accessible. The programme of work is yet to be confirmed		Feb-17	Anti roll guttering fitted to the roof	
RN042 42.7										ABSOND RISK: Obtain the quote and fit anti roll guttering to the top of the fence in the blue bay. The programme of work is yet to be confirmed.		Feb-17	Anti roll guttering fitted to the fence	
RN042 42.8										ABSOND RISK: Remove the tree in the courtyard		Nov-16	Tree removed	
RN042 42.9										STAFFING LEVELS: When staffing numbers are low the following actions are completed by the ward to mitigate the risks: 1. Safer staffing is completed every morning which reviews the staffing levels, skills mix, acuity of the patients, availability of the PRISS team, this informs ward of staff deployment requirements, identifies the need to request urgent NHSP shifts etc. 2. Every day the ward reviews the staffing and acuity for next 48 hours and plans accordingly as above. 3. Staff training is cancelled if required to ensure safe staffing levels on the ward 4. Staff are moved from one bay to another to ensure adequate cover through the unit 5. If Registered Nurse staffing levels are low, HCSWS are over recruited to provide additional support to the Registered Nurse 6. Ward managers are supernumerary on the rota, when staffing levels are low, they become ward based and carry out clinical duties for the shift. 7. Band 6s who have management days are requested to complete clinical duties for the shift.		Sep-16	Safer staffing figures unit rota	
RN042 42.10										ACUITY & DEPENDENCY: audit is carried out every 6 months on all of our units to ensure the staffing levels are appropriate for the acuity and dependency of the patient group, in line with the safer staffing requirements		Sep-16	Acuity and Dependency audit results	
RN043 43.1	**43**	**REQUIREMENT NOTICE**	**WELL-LED**	n/a	Trust-wide	Governance processes	The trust must continue to review and embed more effective governance systems to ensure effective monitoring of quality and safety	Regulation 17 HSCA (RA) Regulations 2014 Good governance	Whilst a number of new processes had been introduced and strengthened, the trust had not embedded systems and processes to ensure quality and safety of services.	Fully deliver and embed all the actions from the January 2016 CQC inspection and the Mortality & Serious Incident Action plan. In addition to include:	Sara Courtney - Interim Chief Nurse	n/a	Delivery of the outcomes as detailed within the two action plans	Robust governance processes are in place and evidence of embedding is being monitored
RN043 43.2										INTERNAL REVIEW: Embedment of the new committee structure for quality governance		Jun-17	Minutes of Safe, Effective & Caring group meetings Minutes of Quality & Safety Committee Board minutes	
RN043 43.3										EXTERNAL REVIEW: Well-led review carried out by NHSI in Q4 2016/17 or Q1 2017/18 (tbc by NHSI)	Paul Streat, Director of Corporate Governance	Jun-17	NHSI Well-led Review report	
RN043 43.4										EXTERNAL REVIEW: Niche / Grant Thornton Phase 2 review and testing of Mortality & Serious Incident Action plan	Sara Courtney - Interim Chief Nurse	Aug-17	Phase 2 report	
SD044 44.1	**44**	**Should**	**SAFE**	Child and Adolescent mental Health Wards	Bluebird House	Incident reporting	The trust should ensure the arrangements for agency staff to access the incident reporting system at the Bluebird Unit are embedded	n/a	n/a	Long standing agency workers in post at Bluebird House who have been working on the unit for over 6 months have access to the reporting systems. Additionally, there is a generic agency log-in account set up which enables staff to log on to the system and then they can create their own Ulysses account. Substantive staff should be made aware of this and this should be communicated to agency staff as part of their induction on to the ward	Mark Morgan Operational Director	Oct-16	Increased reporting from agency staff	All incidents are reported in a timely manner
SD045 45.1	**45**	**Should**	**SAFE**	n/a	Bluebird House	Staff engagement	The trust should engage staff to understand the actual extent and impact of staffing levels and mix across the older person`s mental health wards and Bluebird House.	n/a	n/a	Local QIP is in place to manage staffing and the vacancy rate has reduced. There have been new starters in September and another Band 6 started in the first week of October 2016. There are daily reviews of staffing by ward managers and band 6 staff to ensure that staffing is allocated to facilitate leave and escorts .All instances of leave cancellation are reported. There are no reports of observations not being completed as required.	Mark Morgan Operational Director	Oct-16	Daily staffing reviews and QIP minutes	Safe staffing levels

UIN	Ref No	Requirement Notice?	CQC Domain	Core Service	Location	Theme	CQC Action	Regulation Breached	Cause of Regulation Breach	Trust Action	Executive Accountability	Month	Evidence of Action Completed	Outcome Measure
SD045 45.2					OPMH wards					Recruitment plan has been drawn up with input from Head of Nursing & AHP, HR & Recruitment. New models of working have been worked up and costed. Letter from HoN sent to all OPMH staff September 2016 explaining what senior staff were doing about vacancies. Further comms sent to GWM staff December 2016 to futher improve engagement. There have been qualified new starters. An agreed plan to over recrut to HCSW in each OPMH ward has had some success in the organic wards. Further recruitment initiatives planned for hard to recruit to areas. Daily review of staffing with ward managers escalating challenges to Matrons & HoN where required. Recriutment/vacancies will be on QUIP plans where appropriate. Visits planned in Jan & Feb 2017 of Matrons & HoN to ward team meetings to engage staff further. Skill mix review taken place in GWM - engagement improved with staff.All incidents concerning staffing levels reported via Ulysses - escaltion will also have ocurred to mitigate risk. Qualified nursing vacancies on risk register.	Gethin Hughes Operational Director	Dec-16	Daily staffing reviews and QIP minutes. Team meeting minutes. Comms sent to staff. Risk register. Recruitment plan.	
SD046 46.1	**46**	**Should**	**WELL-LED**	n/a	Trust-wide	Staff engagement	The trust should continue to actively engage and meet with staff during this time of uncertainty change of leadership	n/a	n/a	Fully deliver and embed all the actions from the January 2016 CQC inspection relating to staff engagement. In addition:	Paul Streat, Director of Corporate Governance	n/a	Staff survey results Your Voice Feedback external visits by stakeholders	A workforce who feel valued, listened to and safe to raise concerns as well as empowered and able to generate new ideas and make decisions to implement positive changes
SD046 46.2										Recruit staff engagement expert to carry out review and gap analysis		Dec-16	Expert in post	
SD046 46.3										Launch staff engagement programme		Dec-16	Presentation of staff engagement phased approach	
SD047 47.1	**47**	**Should**	**SAFE**	n/a	AMH rehab	Patient acuity & dependency	The trust should ensure it monitors the changing requirements of patients that may be admitted to the rehabilitation and older person`s wards, to ensure that patient and staff safety is maintained within the environment.	n/a	n/a	An admission protocol will be written for service users who are temporarily transferred from the Acute Mental Health wards to AMH Rehabilitation units	Mark Morgan - Operational Director	Feb-17	Admission protocol will be in place	Safe environment for both patients and staff
SD047 47.2					OPMH					The Admission, Transfer & Discharge Protocol to be followed. Escalation Protocol to be written for patients who require transferring to other mental health units and for patients whose discharge required expediting.	Gethin Hughes - Operational Director	Feb-17	Escalation Protocol will be written, shared & available.	

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ACTION PLAN FOR REVIEW OF FAMILY INVOLVEMENT IN IN

Version No	4.3	Discussed at Caring Group on 13/04/2017 with S
Date	02/06/2017	
Produced by	Dr Mayura Deshpande, Associate Medical Director (Quality, Governance Paula Hull Deputy Director of Nursing & Allied Health Professionals Mehreen Arshad, Programme Lead (Quality Governance) Chris Woodfine, Interim Head of Patient Experience and Engagement and Finish Group Family Involvement	

ACTION PLAN FOR REVIEW OF FAMILY INVOLVEMENT IN INVESTIGA

Completion 0%

RAG status	April		May		June	
	Process Input	Outcome Achieved	Process Input	Outcome Achieved	Process Input	Outcome Achieved
Red (Overdue)	0	0	0	0	0	0
Amber (At Risk of Slippage)	0	0	0	0	0	0
Green On Track)	11	3	17	3	0	0
Blue (Complete)	0	0	0	0	0	0
Complete-unvalidated	5	0	6	2	0	0
Total*	41	41	41	41	41	41

* there are 41 actions in total, however 2 actions are duplicated with action 1.1e covered by 2.5 an

Sara Courtney confirming approval of plan

Change re

& Patient Safety)

Task

Date
16.5.17
02.06.17

ATIONS

July	
Process Input	Outcome Achieved
0	0
0	0
0	0
0	0
0	0
41	41

d action 4.1 covered by actions 2.3 and 3.4.

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Author	Version	Page	Reason for Change
B Cooper	V4.2	All	First version re monitoring of plan. Deadline dates for actions reviewed.
B Cooper	v4.3	All	Updated progress

UIN	Carolan Theme	Recommendation	Trust Actions	Process Input (measures)	Responsible Lead	Essential Partners	Executive Accountability	Process Completion Date	Process Status	Progress Update	Expected Outcome	Measuring Success Date (Outcome Completion)	Outcome Status	Outcome Measure	Evidence in folders (Process)	Evidence in folders (Outcome)
1.1a	Recognising that family involvement begins with the very first patient contact, and that it is critical to delivering effective healthcare services	1.1 Working with service users, patients, families and staff to identify, develop and implement best practice on engaging with families who have relatives who are accessing services provided by the Trust	1.1a The Trust will work with patients, service users and families to develop and implement best practice on engagement	1.1a Establishment of a Task and Finish Group for the Family Involvement Action Plan and the family first involvement group 1.1a Contacting and engaging with service users, families and staff to establish a network of stakeholders interested in working with the Trust 1.1 Identifying best practice of involvement and engagement of families	Chris Woodfine, Head of Patient Engagement and Experience	Carla Roadnight, Area Head of Nursing and AHPs Pam Sorensen, Engagement Advisor	Sara Courtney, Chief Nurse	30/04/2017	Completed-unvalidated	A Family first involvement group was formed in January and continues to meet on a monthly basis. There was a learning network in AMH Southampton to engage staff and hear their ideas. The Triangle of Care has been identified as a collection of best practice that will address issues expressed by families. April 2017 Experience, Involvement and Partnership Strategy developed with patient involvement - with comms dept for final version to be formatted. Implementation plan for strategy in place. Best practice guidance developed and circulated to staff. Task and finish group amended terms of reference so they can continue involvement with this plan. Family First Group continues to meet. Complaints working group had final meeting in April with a planned feedback in 6 m to show improvements made. May 2017 bi-monthly Task and finish group monitors plan.	Divisional champions and accountable leads will work with service users, patients and families to agree a set of principles to support a culture that truly values user involvement in physical and mental health teams.	30/04/2017	Completed-unvalidated	A plan that will be developed to ensure that there is a focus on culture which truly recognises the importance of family involvement from the outset.	1.1 Task and Finish Group ToR 1.2 Task and Finish Group Minutes/agendas 1.3 Family First Involvement Group ToR 1.4 Family First Minutes/agendas 10.02.17;06.03.17;31.03.17 1.5 Learning network event AMH 1.6 Best Practice for involvement and engagement of families. 1.7 Task and Finish Group amended ToR 1.8 Story Telling Toolkit (for staff) 1.9 Best practice guidance 2.0 Complaints Working Group T of R 2.1 Complaints working group minutes 06.12.16;07.02.17;14.03.17	1.1 Experience, Involvement and Partnership Strategy draft v7.1 2017/18 1.2 Strategy Implementation Plan 2017/18 1.3 Family Experience in Engagement agenda/minutes 25052017
1.1b	Recognising that family involvement begins with the very first patient contact, and that it is critical to delivering effective healthcare services	1.1 Working with service users, patients, families and staff to identify, develop and implement best practice on engaging with families who have relatives who are accessing services provided by the Trust	1.1b To put in place the enabling strategies to support the successful implementation of the Triangle of Care standards	To launch enabling strategies: 1.1b Carer involvement in developing and co-producing plans and actions as described in actions 1.1 1.1b Creating a communications plan 1.1b Refine/adapt HR processes to support alignment of family involvement to clinical practice e.g. job descriptions, objectives, appraisals, clinical supervision and pre and post qualification training	Chris Woodfine, Head of Patient Experience and Engagement Emma McKinney, Head of Communications Graeme Armitage, Interim Head of HR	Sarah Cole, Family Therapist Specialised Services	Sara Courtney, Chief Nurse	30/09/2017	On Track	April 2017 Experience, Involvement and Partnership self assessment for clinical services to complete presented at April PT Exp workstream meeting. May 2017 Quality Account priorities include objectives on care planning - use same evidence. CW meeting JR in comms on 7.6.17 to develop communication plan. CW meeting with F & G CCG to explore carers event with PHT and CCG. 'Sharing information' workshop on 24.5.17 with service users/carers/families/staff - reviewed leaflet for sharing information and made recommendations for changes. Relationship with 3rd sector organisations eg 'Carers together', 'Carers in Southampton'. Divisions have some mechanisms in place to talk with carers.	In the identification of best practice methodologies, there are a set of enabling strategies that need to be delivered.	30/04/2018		Co-produced plans which are coherent	1.1 Experience, Involvement and Partnership self assessment April 2017 1.2 examples of above 1.3 Sharing Information workshop agenda and materials 24.5.17 1.3 Sharing Information workshop facilitator notes 24.5.17	
1.1c	Recognising that family involvement begins with the very first patient contact, and that it is critical to delivering effective healthcare services	1.1 Working with service users, patients, families and staff to identify, develop and implement best practice on engaging with families who have relatives who are accessing services provided by the Trust	1.1c Phase 1: Ensure carers are identified at the first contact or as soon as possible thereafter	1.1c Co-produce a caret's charter/statement of principle that aligns with HCC development of a carers strategy 1.1c Develop guidance and training for staff to enable high levels of care planning skill within staff groups, including the importance of involvement of families and service users	Pam Sorensen, Engagement Advisor(now left) Records Keeping and Care Planning work stream (Paula Hull)	Chris Woodfine, Head of Patient Experience and Engagement External carer groups Hampshire County Council MH/LD/SS	Sara Courtney, Chief Nurse	30/06/2017	On Track	Guiding principled being drafted (March 2017) following joint work with 'Carers Together'. Draft to be shared more broadly for comment etc. On track to meet June 2017 date. April 2017 Carers Charter in draft format attached. May 2017 Training programme for staff in care planning reviewed with revised programme in development; guidance for staff on expected record keeping standards in development. Clinical audits for holistic assessment and care planning will be repeated this year. Clinical reference cards with top tips on record keeping being printed for clinical staff. Patient Exp workstream to draft principles for patients/engagement in general to complement the guiding principles for carers. Aim to have core principles for any involvement whether patient/carer etc. SJ, Head of Essential Training, reviewing the training portfolio to see how family involvement currently reflected in training and then to look at how to weave principles of family involvement in all relevant training.	Staff understand what is expected of them with regards to family involvement; Equally, families understand what to expect from our services	30/04/2018		Staff understand what is expected of them with regards to family involvement; Equally, families understand what to expect from our services	1.1c Carers Charter draft v3 1.2 Families First minutes 31.03.17 1.3 Record keeping and care planning minutes 1.4 QIPDG minutes section 6.6 23052017	1.1 Experience, Involvement and Partnership self assessment April 2017 1.2 examples of above
1.1d	Recognising that family involvement begins with the very first patient contact, and that it is critical to delivering effective healthcare services	1.1 Working with service users, patients, families and staff to identify, develop and implement best practice on engaging with families who have relatives who are accessing services provided by the Trust	1.1d Phase2: Ensure staff are carer aware and trained in carer engagement strategies	1.1d Run staff and carer events and forums to encourage development of practice	Heads of Nursing and AHPs		Sara Courtney, Chief Nurse	30/04/2018		May 2017 Quality Conference Oct 2017 will have family/carer involvement.	Divisional champions and accountable leads will work with service users, patients and families to encourage development of practice	30/04/2018		Divisional champions and accountable leads will work with service users, patients and families to encourage development of practice		
1.1e	Recognising that family involvement begins with the very first patient contact, and that it is critical to delivering effective healthcare services	1.1 Working with service users, patients, families and staff to identify, develop and implement best practice on engaging with families who have relatives who are accessing services provided by the Trust	1.1e Phase 3: Ensure that the Trust strategy on engagement is linked to the staff engagement strategy	1.1e Develop policy and practice protocols on confidentiality and information sharing (covered under action 2.5)												
1.1f	Recognising that family involvement begins with the very first patient contact, and that it is critical to delivering effective healthcare services	1.1 Working with service users, patients, families and staff to identify, develop and implement best practice on engaging with families who have relatives who are accessing services provided by the Trust	1.1f Phase 4:Ensure families/carers have an introduction to the service and staff, with a relevant range of information across the care pathway	1.1f Co-produce an information leaflet for family with service and care co-ordinator contact information	Carla Roadnight, Area Head of Nursing and AHP	Carer groups	Sara Courtney, Chief Nurse	30/08/2017		May 2017 CW to speak to MF who has developed leaflet for her team and discuss whether can be replicated across AMH.	Families know who to contact if they have any questions	28/02/2018		Families know who to contact if they have any questions		
1.1g	Recognising that family involvement begins with the very first patient contact, and that it is critical to delivering effective healthcare services	1.1 Working with service users, patients, families and staff to identify, develop and implement best practice on engaging with families who have relatives who are accessing services provided by the Trust	1.1g Phase 5: Develop a range of carer support services or covering all the key points on the care pathway	1.1g Map out the key points of the care pathway 1.1g measures to be developed in later phase	tbc	tbc	tbc	tbc		tbc	Carers needs are assessed and support provided	tbc		Increased levels satisfaction on patient experience survey question and AMH carer survey		
1.1h	Recognising that family involvement begins with the very first patient contact, and that it is critical to delivering effective healthcare services	1.1 Working with service users, patients, families and staff to identify, develop and implement best practice on engaging with families who have relatives who are accessing services provided by the Trust	1.1h Phase 6: Develop defined posts responsible for carers	1.1g Map out the key points of the care pathway 1.1g measures to be developed in later phase	tbc	tbc	tbc	tbc		tbc	Within services there is a local lead/champion	tbc		Within services there is a local lead/champion		
2.1a	Improving the way the Trust communicates and engages with families	2.1 Ensuring that policy, guidance and procedure related to investigations recognises and supports the iterative process of family engagement	The Trust will improve the way communication and engagement is undertaken with families ensuring that there is a recognition of the process of family engagement within the policies and guidance in relation to investigations by: 2.1a Conducting a review of the policies and procedures related to SIRI and complaint investigations to ensure that they are informed by the same principles of engagement with families	2.1a Undertake a review of all policies and procedures relating to SIRI and complaint investigations with input from front-line clinical staff 2.1a Update policies and procedures pertaining to SIRI and complaint investigations which include the elements of engagement with families as principles	Helen Ludford, Associate Director of Quality Governance Paula Hull, Divisional Director of Nursing & AHP (ISD)	Complaints Working Group Family First Involvement Group Mortality Forum	Sara Courtney, Chief Nurse	31/07/2017	On Track	January 2017 The SIRI policy and procedure has been reviewed with input from the Family First Involvement Group. Version control tables in policy/procedures show their input. March 2017 Complaints working group reviewed the complaints policy. The policy is to be reviewed by July 2017. May 2017 The SI policy will be reviewed again once national guidance issued. Complaints policy review underway.	All Trust policies and procedures relating to investigations are aligned to ensure that communication with families is meaningful.	30/09/2017	On Track	Involvement of families' in the review of the SIRI policy and procedure and complaints policy, as identified by the reviewers/contributors within the policies.	1.1 Family First Involvement meeting minutes (Jan 2017). 1.2 Complaints working group minutes (Feb 2017).	1.1 Policy for Managing Incidents and Serious Incidents 1.2 Procedure for the Reporting and Management of Serious Incidents 1.3 revised complaints policy
2.1b	Improving the way the Trust communicates and engages with families	2.1 Ensuring that policy, guidance and procedure related to investigations recognises and supports the iterative process of family engagement	The Trust will improve the way communication and engagement is undertaken with families ensuring that there is a recognition of the process of family engagement within the policies and guidance in relation to investigations by: 2.1b Incorporating the principles of engagement with families to the admissions and discharge policy (including inclusion in crisis contingency care plan).	2.1b Update admissions and discharge policy to include the principles of family engagement (care planning, family communication and liaison)	John Stagg, Associate Director of Nursing & AHP (Learning Disabilities)		Sara Courtney, Chief Nurse	30/09/2017			All Trust policies and procedures relating to investigations are aligned to ensure that communication with families is meaningful.	30/09/2017		Involvement of families' in the review of Admissions discharge and transfer policy as identified by the reviewers/contributors within the policy.		
2.2a	Improving the way the Trust communicates and engages with families	2.2 Recognising that Duty of Candour is not the same as family engagement and ensuring that policy, guidance and procedure reflects this	2.2a Development of a Trust strategy for involving patients, families and the public with specific reference to families	2.2a Develop a Trust strategy on Experience, Involvement and Partnership	Chris Woodfine, Head of Patient Engagement and Experience	Pam Sorensen, Engagement Advisor	Sara Courtney, Chief Nurse	30/04/2017	Completed-unvalidated	March 2017 The Caring group received the final draft of the strategy and is due to be submitted to the QSC at the end of March for final sign-off. April 2017 slight amendment made to strategy and ready for launch. Implementation plan in place. May 2017 Strategy with comms team for final design prior to circulation.	There will be increased levels of involvement of patients and families in their own care and in the way the Trust develops and improves services.	30/04/2018		Compliance with the standards outlined in the overarching Trust strategy.	1.1 Experience, Involvement and Partnership Strategy draft v7.1 2017/18 1.2 Strategy Implementation Plan 2017/18	
2.2b	Improving the way the Trust communicates and engages with families	2.2 Recognising that Duty of Candour is not the same as family engagement and ensuring that policy, guidance and procedure reflects this	2.2b Trust to set the expectation that staff and services will engage with families as a matter of course from the point of first contact with the patient	2.2b All "My assessment of the patient" should include staff making contact with patient/service user's family)	Paula Hull, Divisional Director of Nursing & AHPs (ISD)	Record Keeping and Care Planning Workstreams	Sara Courtney, Chief Nurse	tbc		April 2017 An example of this is within the Children and families business unit who have developed a new template called 'My Plan' which will require a collaborative approach to care planning with parents. May 2017 CW meeting with PH in early July to discuss family involvement in care planning.	Better clinical outcomes and patient experience as well as reduced spend	tbc		Staff are directly involving families in care-planning.		
2.2c	Improving the way the Trust communicates and engages with families	2.2 Recognising that Duty of Candour is not the same as family engagement and ensuring that policy, guidance and procedure reflects this	2.2c Trust to ensure that staff and services are aware that Duty of Candour is about being honest when things have gone wrong (training of the duty of candour through providing an e-learning training package)	2.2c Develop an e-learning package (short session of 45 minutes) on "Being Open and Duty of Candour to ensure staff and services are aware of being honest when things have gone wrong 2.2c Duty of Candour module in the Investigating Officer training workshop 2.2c Masterclass on sharing findings of investigations	Helen Ludford, Associate Director of Quality Governance Elaine Ridley, Family Liaison Officer	Vicki Tinkler, Project Manager (LeAD) Tom Williams, Ulysses System Developer Nick Fennemore, Head of Chaplaincy, Spiritual & Pastoral Care	Sara Courtney, Chief Nurse	30/06/2017	Completed-unvalidated	10/04/17 Bulletin article launching e learning module for duty of candour. April 2017 duty of candour session in the Investigating Officer training has been up dated and is now given by the Family Liaison Officer. May 2017 Masterclass 'sharing investigation reports' developed by FLO and chaplain with two provisional dates set for training - 3.7.17 and 17.7.17.	Staff are aware of the difference between Duty of Candour and family engagement and there is a culture that fosters staff being open with families which also supports a "No Blame" culture	31/03/2018		Compliance with Duty of Candour as monitored through the SI and mortality KPI dashboard and audit of records	1.1 Bulletin article 1.2 E-learning programme 1.3 IO programme	1.1 SI KPI dashboard

2.2d	Improving the way the Trust communicates and engages with families	2.2 Recognising that Duty of Candour is not the same as family engagement and ensuring that policy, guidance and procedure reflects this	2.2d Review policy for Duty of Candour and ensure that it sits under the overarching position statement and ensure that this is interlinked to the complaints policy and the serious incident policy and procedure	2.2d Review the Being Open policy incorporating the legal Duty of Candour 2.2d Review the SI policy and procedure 2.2d Review the complaints policy 2.2d Review the safeguarding policy 2.2d Ensure all the above policies align.	Sarah Pearson, Head of Legal and Insurance Services, Chris Woodfine, Head of Patient Engagement and Experience Caz Maclean, Associate Director of Safeguarding	Complaints Working Group Patient Safety Group Family First Involvement Group	Sara Courtney, Chief Nurse	30/09/2017	On track	January 2017 The SI policy and procedure has been reviewed with input from the Family First Involvement Group . February 2017 The complaints working group reviewed the policy. March 2017 DoC Policy agreed through policy ratification group on17/03/17, uploaded to intranet 21/03/17, for sign of via Caring Group on 13/04/17. The documents that have been uploaded state that they are to go to Caring group in April but it was agreed that as changes largely minor it could be uploaded in the meantime. May 2017 Complaints policy under review. Safeguarding adult policy reviewed Feb 2017 and Safeguarding children policy reviewed March 2017. ? Family First group reviews these.	Staff are aware of the difference between Duty of Candour and family engagement and there is a culture that fosters staff being open with families which also supports a "No Blame" culture	31/12/2017		Staff are competent in applying the Duty of Candour readily and where appropriate; and there is a clear understanding amongst staff in the difference between family engagement/involvement and duty of candour	1.1 Family First Involvement meeting minutes (Jan 2017). 1.2 Complaints working group minutes (Feb 2017).	add policies
2.3a	Improving the way the Trust communicates and engages with families	2.3 Ensuring that steps taken to engaging families in investigations, and the results of those steps are recorded in the investigation report	2.3a The SIRI procedure should state that steps are to be taken to engage families and this should be documented	2.3a Review the SIRI procedure and add statement regarding the engagement of families'	Helen Ludford, Associate Director of Quality Governance	Family First Involvement Group	Sara Courtney, Chief Nurse	31/05/2017	Completed-unvalidated	Jan 2017 The SI policy and procedure have been reviewed - section 4.5 in procedure details the involvement of patients/ families/loved ones. Policy is to be reviewed again July 2017 following publication of new national SI Framework.	Staff are consistently documenting the involvement of families during/following an investigation	30/11/2017		Investigation and reports demonstrate involvement of families where families wish to be involved.	1.1 Policy for Managing Incidents and Serious Incidents 1.2 Procedure for the Reporting and Management of Serious Incidents	
2.3b	Improving the way the Trust communicates and engages with families	2.3 Ensuring that steps taken to engaging families in investigations, and the results of those steps are recorded in the investigation report	2.3b Consistent use of the CCG Quality checklist at the 48 Hour Panel and Corporate Panel as a reference guide	2.3b Add the use of the CCG Quality checklist as a reference guide at the 48 Hour Panel and the Corporate Panel in the SIRI reporting procedure	Helen Ludford, Associate Director of Quality Governance	SI Team Lead Investigating Officers Chair of the 48 Hour Panels	Sara Courtney, Chief Nurse	31/07/2017	On track	Jan 2017 SI policy and procedures reviewed. Appendix 11 contains the commissioner checklist. Use of this is at corporate panel is in section 9.2 of procedure. SI policy /procedure to be reviewed July 2017 following publication of new national SI Framework.	Staff are consistently documenting the involvement of families during/following an investigation	30/11/2017		All checklists demonstrate that families have been invited to contribute to the terms of reference		
2.3c	Improving the way the Trust communicates and engages with families	2.3 Ensuring that steps taken to engaging families in investigations, and the results of those steps are recorded in the investigation report	2.3c Review and modify the structure of the Ulysses to include specific headings to record any notes/detail on the steps taken to engage with families	2.3c Add consistent headings within Ulysses SIRI reports in family engagement	Helen Ludford, Associate Director of Quality Governance	Tom Williams, Ulysses System Developer	Sara Courtney, Chief Nurse	30/06/2017	On track	May 2017 BC discussed possible changes to headings with TW.	Staff are prompted to document the involvement of families during an investigation	31/08/2017		The Ulysses systems contains a section to document on the steps taken to engage with families		
2.3d	Improving the way the Trust communicates and engages with families	2.3 Ensuring that steps taken to engaging families in investigations, and the results of those steps are recorded in the investigation report	2.3d Add family engagement and its recording to SIRI training workshop	2.3d Add family engagement and its recording to SIRI training workshop	Helen Ludford, Associate Director of Quality Governance	n/a	Sara Courtney, Chief Nurse	31/05/2017	Completed-unvalidated	April 2017 Investigating Officer training has information and video on involvement of families, loved ones and patients. Training also has specific session on Duty of Candour. Feedback forms form training very positive with staff feeling better and knowledgeable about carrying out investigations.	Investigating Officers are trained on steps taken to engage families and how to record onto Ulysses	31/12/2017		Investigating Officers feel confident on engaging families in investigations	1.1 Investigating Officers 2 day training presentation. 1.2 Investigating Officers training - Duty of Candour presentation.	1.1 Feedback forms Oct 2016 1.2 Feedback forms April 2017 1.3 Feedback forms May 2017
2.4a	Improving the way the Trust communicates and engages with families	2.4 Co-producing with families a leaflet that can be sent to all families following a death that explains how investigations are conducted, how the families can get involved, and signposts families to appropriate support and advice	Families have said that written information is important, but that it should not be sent to families, but should be handed to them, following a discussion with the IO. 2.4a The Family Liaison officer will develop with families a leaflet that will be given by the IO as an aide memoire to their conversation with the family detailing the investigation process and signposting and support; this will form part of the suite of documents that sits within the SIRI procedure - with inclusion from the Family Reference Group.	2.4a Co-produce leaflet for families on the investigation process and support.	Elaine Ridley, Family Liaison Officer Helen Ludford, Associate Director of Quality Governance	Family First Involvement Group Chris Woodfine, Head of Engagement and Experience Investigating Officers	Sara Courtney, Chief Nurse	31/03/2017	Completed-unvalidated	March 2017 Leaflets have been developed with input from family workshops and the Family First Involvement Group and planned for publication by 31 March 2017. April 2017 leaflets printed - given to IOs on Investigating Officer training days.	Families feel involved in the investigation as they wish to be.	31/03/2017	Completed-unvalidated	Families understand how investigations will be conducted, how they can get involved and be signposted to appropriate support and advice	1.1 Leaflet for families on serious incident investigations.	1.1 Family Liaison Officer report
2.4b	Improving the way the Trust communicates and engages with families	2.4 Co-producing with families a leaflet that can be sent to all families following a death that explains how investigations are conducted, how the families can get involved, and signposts families to appropriate support and advice	2.4b Seek regular feedback from families regarding their experience of the investigation process	2.4b Undertake a quarterly survey of families' experience of the investigation process	Elaine Ridley, Family Liaison Officer Helen Ludford, Associate Director of Quality Governance	Family First Involvement Group Chris Woodfine, Head of Engagement and Experience Investigating Officers	Sara Courtney, Chief Nurse	31/12/2017	On Track	March 2017 The Family Liaison Officer sent 15 questionnaires to families involved in investigations of deaths of loved ones. % questionnaires returned by date of report to Caring Group in March. Feedback positive re contact with IO and support given, however families say reports not easy to understand and unclear on what actions being taken by Trust. To repeat survey on quarterly basis. May 2017 ER completing quarterly surveys with families.	Families feel involved in the investigation as they wish to be.	30/04/2018	On track	Families report positive feedback in their involvement and support offered	1.1 Questionnaire appendix 1 Family Engagement FLO report 07/03/17 Caring Group. 1.2 Questionnaire appendix 1 Family Engagement FLO report June Caring Group.	1.1 Family Engagement FLO report 07/03/17 Caring Group 1.2 Family Engagement FLO report June Caring Group
2.5a	Improving the way the Trust communicates and engages with families	2.5 Improving the recording of next of kin data, including where consent to share has not been provided	2.5a Ensure that the Next of Kin section on Rio is made a mandatory field and the Change Control Board oversee a range of training and guidance to ensure that Next of Kin data is completed in all care records	2.5a Amend the Next of Kin section on Rio to ensure that this field is made mandatory 2.5a Embed review of training and guidance for Next of Kin data within the Change Control Board Terms of Reference 2.5a Devise a Trust procedure on what staff should do if there is no Next of Kin data included	Paula Hull, Divisional Director of Nursing & AHP (ISD)	Change Control Board Technology Transformation Team	Paula Anderson, Director of Finance Sara Courtney, Chief Nurse	31/10/2017	On track	May 2017 Performance on meeting next of kin recording has been added to Tableau and is monitored closely by divisions. Inconsistent performance with some teams very high % of next of kin details recorded while other teams have low %. Section 8.3 of openRio Standard Operating Procedure and section 8.2 of SyStmOne Standard Operating Procedure has instructions to staff on recording next of kin data. These are to be updated with clarification regarding recording information where there is no known next of kin or the patient declines to give next of kin details.	A strengthened process for Next of Kin recording is standardised across the Trust with staff understanding that this is a crucial aspect of clinical record-keeping and care planning.	31/10/2017		Next of kin recording is in place consistently across the Trust	1.1 OpenRio/SystmOne Standard Operating procedures re Next of kin	
2.5	Improving the way the Trust communicates and engages with families	2.5 Improving the recording of next of kin data, including where consent to share has not been provided	2.5b Ensure that the monitoring of next of kin recording is carried out	2.5b Data extraction from Tableau for reporting and remediation	Simon Beaumont, Head of Informatics	Divisional Records User Group	Paula Anderson, Director of Finance	31/10/2017	On track	May 2017 Performance on meeting next of kin recording has been added to Tableau and is monitored closely by divisions. Inconsistent performance with some teams very high % of next of kin details recorded while other teams have low %. Not yet meeting 80% target set by Trust across all divisions.	A strengthened process for Next of Kin monitoring is in place across the Trust	31/10/2017	Complete	A metric is developed on Tableau for monitoring next of kin data	1.1 screenshots of tableau	1.1. screenshots of tableau
2.5	Improving the way the Trust communicates and engages with families	2.5 Improving the recording of next of kin data, including where consent to share has not been provided	2.5c Co-produce guidance across the Trust for information sharing based on the consensus statement	2.5c Deliver a families workshop to understand their perspective on barriers to engage 2.5c Understanding the staff perspective on blocks to information sharing 2.5c Workshops involving family, service users and staff to develop guidance	Chris Woodfine, Head of Engagement and Experience	Lesley Barrington, Head of Information Governance MH division Sarah Cole, Family Therapist Specialised Services		31/10/2017	On track	A family workshop was delivered in January and February 2017 which were highlighted that information sharing was a primary issue The IG training resources now include the consensus statement on information sharing and suicide prevention. May 2017 'Confidentiality' workshop for staff in development. 24.5.17 Sharing Information workshop. Information governance team to rewrite information sharing leaflet based on feedback and reflecting what used by other trusts.	Staff are competent in managing confidentiality and information sharing with families	31/03/2018		RIO records show the judgements staff have made on information sharing when working with families and service users	1.1 Sharing Information workshop agenda/materials 24.5.17	
2.6a	Improving the way the Trust communicates and engages with families	2.6a Keeping families fully informed of the progress of the investigation and making this an explicit part of the Investigating Officer's role	2.6a Provide better training for Commissioning Managers as practice	2.6a Scoping of improved training for Commissioning Managers on the SIRI procedure which should be standardised across the Trust 2.6a Ensure roll out of improved training for Commissioning Managers 2.6a Undertake an audit of the findings om implementing improved training of Commissioning Mangers	Elaine Ridley, Family Liaison Officer Helen Ludford, Associate Director of Quality Governance		Sara Courtney, Chief Nurse	31/12/2017	On track	Jan 2017 Role of the IO and CM included within the revised SIRI procedure. Investigating officer and commissioning manager role descriptions reviewed and updated version added to the SIRI policy. May 2017 SI policy/procedures to be reviewed in July 2017 following new national SI Framework. More CM training planned.	There is clarity on the roles for the Investigating Officer, Commissioning Manager and Family Liaison Officer and that these roles have an appreciation of the importance of keeping families involved on the progress of the investigation	31/12/2017		Robust and clear descriptors and expectations of Trust staff roles who are involved in the investigation process	1.1 Policy for Managing Incidents and Serious Incidents 1.2 Procedure for the Reporting and Management of Serious Incidents	
2.6b	Improving the way the Trust communicates and engages with families	2.6b Keeping families fully informed of the progress of the investigation and making this an explicit part of the Investigating Officer's role	2.6b Ensure that the Investigating Officer and Commissioning Manager training gives clarity of their roles and responsibilities as well as the roles and responsibilities of the Family Liaison Officer role	2.6a Ensure the SIRI policy and procedure clearly outlines the roles of the Investigating Officer, Commissioning Manager and the Family Liaison Officer Remaining actions covered by 3.4	Helen Ludford, Associate Director of Quality Governance	Elaine Ridley, Family Liaison Officer	Sara Courtney, Chief Nurse	31/07/2017	On track	Jan 2017 Investigating officer and commissioning manager role descriptions reviewed and updated versions added to the SIRI policy. Need to add role description of Family Liaison Officer to revised policy. May 2017 Serious Incident Policy will be reviewed once national Serious Incident framework is published- to include job description of FLO.	There is clarity on the roles for the Investigating Officer, Commissioning Manager and Family Liaison Officer and that these roles have an appreciation of the importance of keeping families involved on the progress of the investigation	31/12/2017		Robust and clear descriptors and expectations of Trust staff roles who are involved in the investigation process		

2.7	Improving the way the Trust communicates and engages with families	2.7 Providing counselling (as appropriate) or signposting families to suitable organisations that can provide bereavement or post-traumatic stress counselling	The Trust accepts responsibility for the need to signpost to families relevant support and to be proactive in seeking support where it is not immediately available. 2.7a Increase awareness of the FLO role amongst staff and families.	2.7a FLO to attend governance and business meetings across divisions to raise awareness of her role and follow up after 6 months 2.7a Investigating Officer makes contact with the FLO via the IMA panel	Elaine Ridley, Family Liaison Officer	Investigating Officers	Sara Courtney, Chief Nurse	31/12/2017	On track	May 2017 FLO is regularly attending the Caring Group and makes contact with Investigating Officers and attends panels. FLO has attended some governance meetings in services and will continue to go out to teams.FLO is receiving referrals from IO.	FLO post is embedded within the Trust	30/06/2017	On track	FLO receives referrals from Investigating Officers in a timely manner	Caring group minutes	FLO reports
2.7	Improving the way the Trust communicates and engages with families	2.7 Providing counselling (as appropriate) or signposting families to suitable organisations that can provide bereavement or post-traumatic stress counselling	The Trust accepts responsibility for the need to signpost to families relevant support and to be proactive in seeking support where it is not immediately available. 2.7b FLO to identify the key resources that families may need access to	2.7b Family Liaison Officer to identify the key resources that families may need access to 2.7b FLO to develop a resource bank of community resources	Elaine Ridley, Family Liaison Officer	Third sector networks (external)	Sara Courtney, Chief Nurse	31/12/2017			Families receive information for support according to their needs	30/06/2018		The Trust has robust processes in place to ensure that families are provided with comprehensive information and resources regarding how an investigation is undertaken and signposts to appropriate support and advice		
2.8	Improving the way the Trust communicates and engages with families	2.8 Providing a central telephone number and email address for families so that they can contact the investigating team and not be reliant upon Investigating Officers who may have changed role or changed organisation	The Trust accepts the principle that families need to contact someone who is informed. 2.8a Commissioning Managers to create a communications plans with families at the outset and ensure that there is a proactive mechanism for advising families upon change of IO	2.8a Communication plans to be created including contact details of CM and IO Also covered under action 2.4a and 4.6a	Commissioning Managers	Investigating Officers	Sara Courtney, Chief Nurse	31/10/2017			Staff provide the right contact details to the families and that there are clear processes of handover when a staff member changes their role	31/12/2017		All investigations to have in place a communication plan with families		
3.1	Increasing the competency of staff to engage with families	3.1 Co-producing with families training for staff on engaging with families	3.1a Conduct a review of training for staff on the importance of engaging with families in investigations with input from the Family First Involvement Group.	3.1a Conduct a review of training for staff on the importance of engaging with families in investigations with input from the Family First Involvement Group. 3.1a Conduct a training needs analysis with IOs and CMs 3.1a Review of the training programme	Helen Ludford, Associate Director of Quality Governance	Chris Woodfine, Head of Engagement and Experience	Sara Courtney, Chief Nurse	31/10/2017	On track	May 2017 SJ, Head of Essential Training, reviewing the training portfolio to see how family involvement currently reflected in training and then to look at how to weave principles of family involvement in all relevant training.	Training for Investigating Officers and CMs are co-produced with families	31/12/2017		Training for Investigating Officers and CMs are co-produced with families		
3.2	Increasing the competency of staff to engage with families	3.2 Involving families in the delivery of training to staff, which can be achieved through co-delivery of the training, or through video or written case studies/testimonies.	3.2a The training content includes personal stories, videos, case studies/testimonies	3.2a Scope improved training programme including training content 3.2a The training content includes personal stories, videos, case studies/testimonies 3.2a Include and implement competency documents to assess fitness to practice and testing communication skills of staff training as well as best practice models	Elaine Ridley, Family Liaison Officer	Chris Woodfine, Head of Engagement and Experience Learning Education and Development (LEaD)	Sara Courtney, Chief Nurse	31/12/2017	On track	May 2017 CW to link with SC training lead who is undertaking a review of competencies staff require for care planning, risk assessment.	Training resources includes personal accounts of families	31/12/2017		Training resources includes personal accounts of families		
3.3	Increasing the competency of staff to engage with families	3.3 Increasing the amount of training on working with families offered to Investigating Officers as part of their core training	Training for Investigating Officers and also crucially for Commissioning Managers will align within the context of the Trust position statement on engaging with families following death of a service user 3.3a Deliver the training programme as defined by action 3.2	3.3a Training to be made available online or a folder resource 3.3a Ensure roll out of training programme through LEaD	Helen Ludford, Associate Director of Quality Governance	Learning, Education and Development (LEaD)	Sara Courtney, Chief Nurse	31/03/2018			Staff have a detailed resource on training for their roles as Commissioning Manager and Investigating Officer	30/06/2018		Undertake an audit on implementation of improved training for Commissioning Mangers and IOs		
3.4	Increasing the competency of staff to engage with families	3.4 Developing person specifications for the Investigating Officer role that includes the competencies needed for successfully engaging with families	Training for Investigating Officers and also crucially for Commissioning Managers will align within the context of the Trust position statement on engaging with families following death of a service user 3.4a Review the role description and person specification for the CM and IO role and develop specific competencies	3.4a Undertake a review job descriptions of the IO, CM and FLO 3.4a Ensure clarity of roles and responsibilities 3.4a Include competencies needed for successful engagement with families	Helen Ludford, Associate Director of Quality Governance	Associate Directors of Nursing & AHPs (all divisions)	Sara Courtney, Chief Nurse	31/07/2017	On track	May 2017 job descriptions reviewed.	IOs and CMs are clear about their roles and meet the person specification	31/07/2017		Robust and clear descriptors and expectations of Trust staff roles who are involved in the investigation process		
3.5	Increasing the competency of staff to engage with families	3.5 Providing clarity about the role of lead Investigating Officers in supporting Investigating Officers with the role	As covered in action 3.4. In addition: 3.5a To review the capacity of the central investigation team	3.5a To review the capacity of the central investigation team 3.5 Produce a business case following the review as appropriate	Helen Ludford, Associate Director of Quality Governance	SIRI team	Sara Courtney, Chief Nurse	30/06/2017	On track	May 2017 project to review investigating officer role underway - will look at capacity;training and feedback on the role.	There is clarity on the roles for the Investigating Officer, Commissioning Manager and Family Liaison Officer and that these roles have an appreciation of the importance of keeping families involved on the progress of the investigation	31/10/2017		Robust and clear descriptors and expectations of Trust staff roles who are involved in the investigation process	1.1 Investigating Officer Review terms of reference	
3.6	Increasing the competency of staff to engage with families	3.6 Providing peer support opportunities and administrative help for Investigating Officers	3.6a To assess the IOs need for supervision and support and devise a programme	3.6a Undertake an anonymised questionnaire survey and quantitative analysis of current lead Investigating Officers to ascertain their experience of role so far, and clarify what resources they may require 3.6a Commission Psychologists to review roles and conduct an analysis and feedback 3.6a Develop a peer support network of lead Investigating Officers 3.6a Scope a programme of psychological supervision for divisional investigating Officers	Helen Ludford, Associate Director of Quality Governance Hazel Nicholls, Clinical Director, Primary Care & IAPT	Lead IOs Divisional IOs	Sara Courtney, Chief Nurse	31/10/2017			Staff have a strong network of support and information sharing to enable their role competencies	31/12/2017		Staff have a strong network of support and information sharing to enable their role competencies		
4.1	Improving the quality of reports	4.1 Ensuring that investigators contact the families as soon as possible and that any concerns or questions that the family may have are incorporated into the terms of reference for the investigation	Covered under actions 2.3 and 3.4	Covered under actions 2.3 and 3.4												
4.2	Improving the quality of reports	4.2 Giving families access to findings of any investigation including interim findings.	4.2a Establish a protocol on sharing interim findings with families whilst maintaining factual accuracy and adhering to timescales	4.2a Establish a protocol on sharing interim findings with families whilst maintaining factual accuracy and adhering to timescales	Helen Ludford, Associate Director of Quality Governance	Elaine Ridley, Family Liaison Officer Families with experience of an investigation	Sara Courtney, Chief Nurse	30/09/2017			Reports are accurate and sensitive to the feelings of the families	31/12/2017		Reports are accurate and sensitive to the feelings of the families		
4.3	Improving the quality of reports	4.3 Giving families the opportunity to respond/comment on the findings and recommendations outlined in the final report and be assured that this will be considered as part of the quality assurance and closure process undertaken by the commissioners	4.3a Ensure that families are given the opportunity to comment on the findings and that this is a clear step in protocol	4.3a Ensure that families are given the opportunity to comment on the findings and that this is a clear step in protocol	Helen Ludford, Associate Director of Quality Governance	Investigating Officers	Sara Courtney, Chief Nurse	31/12/2017			Reports are accurate and sensitive to the feelings of the families	31/03/2018		Reports are accurate and sensitive to the feelings of the families		
4.4	Improving the quality of reports	4.4 Sharing updated action plans with the families six months after the report has been completed	4.4a Revise SIRI procedure to include the updated action plan to be shared with families subject to families agreement	As covered in action 2.1a and 2.3a. In addition: 4.4a Action planning with families to be monitored at the WAGs and MOMs 4.4a Revise the SIRI procedure to include that the IO should establish with families on an individual basis whether they would like to see the updated action plan	Helen Ludford, Associate Director of Quality Governance	Complaints Working Group Family First Involvement Group Mortality Forum	Sara Courtney, Chief Nurse	31/12/2017			Families are informed where they wish to be of progress made on agreed actions	31/12/2017		Families are informed where they wish to be of progress made on agreed actions		
4.5	Improving the quality of reports	4.5 Writing the report in plain English, avoiding jargon, or provide comprehensive glossary of terms and a list of abbreviations	4.5a Ensure that the reports are written in plain English, avoiding jargon, or provide comprehensive glossary of terms and a list of abbreviations	4.5a A new revised checklist to be incorporated into the Area and Trust Corporate Panels to including the criteria that all reports must be written in plain English 4.5a Each divisional SIR panels and corporate SIRI panel will have a lay member representative 4.5a Provision of a checklist for Ulysses, to ensure that the author includes a glossary 4.5a Develop training or resources for staff on report writing	Helen Ludford, Associate Director of Quality Governance	Associate Director of Nursing & AHPs (all divisions) Investigating Officers Tom Williams, Ulysses System Developer	Sara Courtney, Chief Nurse	31/12/2017		May 2017 quality of serious incident reports is being reviewed. Workshop on best practice in June 2017.	All reports are clear and easy to understand for families	30/06/2018		All reports are clear and easy to understand for families		
4.6	Improving the quality of reports	4.6 When families do not feel able to engage with the investigation immediately following the death of their loved one, ensuring that they have the opportunity to raise questions and concerns and input into the review at a time of their choosing	4.6a Ensure adherence to timescales of the 60 day limit whilst also ensuring that staff are aware that they should open the investigation at any stage/allow an opportunity for discussion with the families	As covered in action 2.8a. In addition: 4.6a Communications plan to include detail/note of family preference for timely contact 4.6a Ensuring that SIRI procedure details clear arrangement for point of contact following closure of an investigation	Investigating Officer		Sara Courtney, Chief Nurse	31/12/2017			Families are able to be involved at a time that is suitable to them	31/03/2018		Families are able to be involved at a time that is suitable to them		
4.7	Improving the quality of reports	4.7 Considering how the resulting improvements in services following changes recommended by investigations can be measured	4.7a Develop mechanisms for feedback from families to enable Trust to measure changes in involvement of families in investigations	4.7a Generate qualitative data from surveys and interviews with families to evidence families' involvement 4.7a Evidence of families attending the Improvement Panel to observe the improvements made as a result of the recommendations from the investigations 4.7a Inviting families to visit the service to illustrate the changes 4.7a Consider a review to be repeated in 2 years time to ascertain embedding of improvements	Elaine Ridley, Family Liaison Officer Helen Ludford, Associate Director of Quality Governance Associate Director of Nursing & AHPs (all divisions)	SIRI team	Sara Courtney, Chief Nurse	31/03/2018		May 2017 FLO is sending questionnaires to families for feedback. Results are included in reports to Caring Group.	Families are assured that the improvement within the services are embedding following the actions developed from the recommendations of the investigation have been completed	31/06/2018		Survey responses are positive and attendance levels of families at improvement panels	FLO reports	