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NOTICE OF MEETING

HEALTH OVERVIEW & SCRUTINY PANEL

THURSDAY, 1 FEBRUARY 2018 AT 3.00 PM

THE EXECUTIVE MEETING ROOM - THIRD FLOOR, THE GUILDHALL

Telephone enquiries to Jane Di Dino 023 9283 4060 or Lisa Gallacher 023 9283 4056
Email: jane.didino@portsmouthcc.gov.uk lisa.gallacher@portsmouthcc.gov.uk

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 (Fareham Borough Council)
Councillor Gary Hughes (Hampshire County Council)
Councillor Andrew Lenaghan (Havant Borough Council)
Councillor Mike Read (Winchester City Council)
Councillor Elaine Tickell (East Hants District Council)
Councillor Philip Raffaelli (Gosport Borough Council)

Standing Deputies

Councillor Dave Ashmore
Councillor Ben Dowling
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 3 - 10)

RECOMMENDED that the minutes of the previous meeting held on 23 November 2017 be agreed as a correct record.

4 **South Central Ambulance Service - update.** (Pages 11 - 14)

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

5 **Community Pharmacy South Central - update** (Pages 15 - 24)

Debby Crockford, Chief Officer will answer questions on the attached report.

6 **Portsmouth Clinical Commissioning Group- update.** (Pages 25 - 28)

Innes Richens, Chief of Health and Care Portsmouth will answer questions on the attached report.

7 **Southern Health NHS Trust** (Pages 29 - 90)

Mark Morgan, Director for Mental Health and Learning Disability will answer questions on the attached report.

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.

HEALTH OVERVIEW & SCRUTINY PANEL

MINUTES OF THE MEETING of the Health Overview & Scrutiny Panel held on Thursday, 23 November 2017 at 2.30 pm in Conference Room A - Civic Offices

Present

Councillor Leo Madden (Chair)
Councillor Steve Wemyss
Councillor Yahiya Chowdhury
Councillor Alicia Denny
Councillor Lynne Stagg
Councillor Michael Ford JP, Fareham Borough Council
Councillor Tina Ellis, Fareham Borough Council
Councillor Andrew Lenaghan, Havant Borough Council
Councillor Philip Raffaelli, Gosport Borough Council

1. Welcome and Apologies for Absence (AI 1)

Apologies for absence were received from councillors Gareth Hughes, Mike Read, Elaine Tickell and Gemma New.

Councillors Stagg and Chowdhury advised they would need to leave the meeting at 3:50pm as they had another council meeting to attend.

2. Declarations of Members' Interests (AI 2)

Councillor Steve Wemyss declared a non-pecuniary interest as he works for the NHS.

3. Minutes of the Previous Meeting (AI 3)

RESOLVED that the minutes of the meeting held on 14 September 2017 be agreed as a correct record.

4. Portsmouth Looked After Children and Safeguarding (AI 4)

Innes Richens, Chief of Health and Care Portsmouth, Tina Scarborough, Deputy Director of Quality and Safeguarding (CCG), Jonathan Prosser, Clinical Director for Children's Services (Solent NHS Trust), Abbie Aplin, Director of Midwifery (PHT) and Mike Taylor, Operations Director (SSJ) had been invited by the panel to talk on their action plan. Caroline Bishop, Inspection Manager (CQC) who was invited to present a later item on the agenda, also was present for this item.

Tina Scarborough gave a brief background and introduced the action plan which all providers present today had signed up to. The two actions that had been given to the CCG are progressing well. With regard to recommendation 2.1, training has been updated but they had found it has not been well

embedded. With recommendation 2.2 a draft job description for the designated doctor for LAC has been prepared and circulated to key partners for comment. Mrs Scarborough explained that the recommendations for looked after children were a particular challenge as they need to ensure that health assessments are completed. In response to a question Mrs Scarborough said that it would be a local authority decision to move looked after children back into the city but if this was done it would make a massive difference.

In response to a question all present said they had accepted the recommendations from the CQC.

In response to further questions the following matters were clarified:

- Regular updates with staff take place to ensure that the recommendations are embedded.
- A lot of the quick wins on the action plan had already taken place. Some of the actions were more of a culture change which would take longer to achieve.
- The role of the CQC is not to micro manage. The CQC have regular meetings with organisations to monitor progress.
- The action plan was submitted within the required timeframe and the CCG has not received any feedback from inspectors either way so it was assumed that they were satisfied with this. The plan is monitored regularly and the health sub group of the Portsmouth Safeguarding Children's Board (PSCB) goes more into the detail and reports progress to the newly formed PSCB and Portsmouth Safeguarding Adult Board (PSAB) Safeguarding Improvement Board. The Improvement Board is due to meet for the first time tomorrow (24 November).

Members were pleased to see a cross agency action plan although felt that it would be useful if the action plan had a RAG rating system giving details for red and amber actions of what more is needed to complete the action. Mrs Scarborough said that this was included on her version of the action plan and would ensure that this was sent to councillors following the meeting. Members felt it would be helpful to have an update report on progress against the action plan come to their March meeting and commented it would be helpful know who is responsible for each action and how the success of meeting each action is being measured.

RESOLVED that the report be noted and an update on progress against the action plan come back to the March meeting.

5. Solent NHS Trust Update (AI 5)

As Lesley Munro was unwell and therefore not able to attend to present this item, the panel requested that the update letter be moved to their next meeting on 1 February to ensure the correct people are present to answer questions.

6. PHT Quality Improvement Plan following the CQC inspection (AI 6)

The report was introduced by Peter Mellor, Director of Corporate Affairs. He explained that the plan had been developed with staff and partners to address the concerns raised by the Care Quality Commission during their recent inspections and to help with getting the Trust to a rating of 'good' and then 'outstanding'. He advised that Mark Cubbon, Chief Executive, Portsmouth Hospitals NHS Trust, intends to regularly publish progress against the plan.

Mr Mellor said he was happy to answer any questions on the plan from members.

The following matters were clarified by Mr Mellor:

- With reference to section 1.1 of the plan regarding the re-launch of the protected meal time initiative, Mr Mellor explained that an example might be that lunch is served between 12 and 1 and during that time the doctor might need to take the patient to be scanned so they would miss their lunch. This was deemed unacceptable so the Trust has now re-launched this initiative to protect the lunchtime period so that the patient does not miss a meal.
- There is a definition of a significant incident which Mr Mellor did not have to hand. He explained that members of staff are required to report any serious incident that might occur. Any learning that comes from the investigation into the incident needs to be shared throughout the organisation. The trust comply with the Duty of Candour regulations which is the concept of honesty and transparency and the trust always involve patients in how their complaint will be resolved. If a formal complaint is received there will always be an investigation. If the patient is not happy with the way this is handled they can report this to the health ombudsman.
- The MRI, CT scanners etc. are in use 12 hours a day.
- Melloney Poole is the new chair of PHT who was appointed in October. Not all of the CEO's team are in place. The Director of Communications is due to start on 4 December and three new non-executive directors will be appointed.
- With regard to the warning notices from the CQC regarding their care of vulnerable patients and, in particular, those with mental health issues, an agreement is now in place with Solent NHS Trust to have a resident psychologist in the ED and staff have been trained to better deal with matters. Significant improvements have been made and the Trust reports back to the CQC on a weekly basis and the CQC is satisfied with progress being made.
- PHT enjoy support from NHS England and NHS Improvement which they are grateful for but Mr Mellor was not aware that PHT were going to have anyone allocated to stand by them.

- With regard to the STP and the large savings required, Mr Mellor said that all providers are working well together but plans are still in their infancy. Any decisions will have to be ratified by the participant organisation's Board. Mr Mellor felt that it will be essential to monitor and maintain the quality of the services being provided whilst introducing any significant change.

- PHT are struggling with filling nursing vacancies partly due to the uncertainties of the future of European nurses. Recruitment is more challenging and PHT is having to now draw from nursing staff in other parts of the world such as the Philippines. This is the same with many other hospital trusts. The University of Portsmouth is now offering a nursing degree but it will be at least three years before these nurses are trained and can be recruited.

Councillor Wemyss advised Mr Mellor of his experience of submitting a complaint on behalf of his Mother, to then be asked by the hospital whether this was an official complaint. Mr Mellor explained that there are two systems in the hospital to report complaints (1) through the Patient Advisory Liaison Service (PALS) where an issue on a ward can be raised immediately; and (2) a formal letter of complaint which is dealt with by the Complaints Department. Once a formal letter of complaint is received a formal letter acknowledging the complaint is sent back to the patient. An investigation is then undertaken and the interested parties are all asked to contribute before the findings of the investigation are sent back to the complainant in a letter that is signed by the Chief Executive. Councillor Lenaghan reported that in his experience the PALS service worked very well.

RESOLVED that the quality improvement plan be noted.

7. PHT Update (AI 7)

The report was introduced by Peter Mellor. In response to questions the following matters were clarified:

- The number of patients who were medically fit for discharge had improved this week however PHT were aware that the numbers needed to remain at this level and be consistent. Numbers were at their worst 3-4 weeks ago at approximately 301 and the number today is now below 250 which is a significant improvement. The goal is 100-150. At the beginning of last week this reached a head and an internal incident meeting was called where system partners came into the hospital to support the trust and enable more medically fit for discharge (MFFD) patients to move to a more appropriate setting.

- The discharge lounge is in place for those patients who have been discharged but are awaiting their prescriptions and transport so this can free up beds in wards. Mr Mellor explained that previously some doctors did not write prescriptions until the end of their rounds but they have now put pharmacists into some of the wards to help speed up this process. This has proved a good resolution.

- One member asked why prescriptions for patients had to go through the hospital instead of being delivered to their home. Mr Mellor thought that there was probably a higher cost implication but recognised that any extra cost would be massively lower than the cost of a patient staying in a bed. He promised to raise the idea/question with his colleagues.

- All system partners are supportive and working to get patients to the most appropriate setting.

- The previous plan agreed by community and social care providers was to get the number of DToC to 108 by 15 September. The intention was to recruit domiciliary care workers to support patients in their own home. This was dependent on recruitment - Portsmouth City Council recruited well to fill their quota and were able to recruit more easily. Due to the geography of Portsmouth, staff are able to see 3 or 4 patients in a morning whereas for Hampshire this is more difficult as it is a much larger area to cover. Hampshire County Council have also found it more difficult to recruit staff but there has been some progress made.

- With regard to Fareham Community hospital being used to help PHT with beds, Mr Mellor said that for the short term this was not an option as they do not have in-patient beds, but this might be an option for the longer term. It is likely that the future will see an increased use of Fareham Community Hospital but this would need partnership working.

- The aim of the frailty ward is to turn around those patients who are suitable as quickly as possible but within 72 hours. With winter approaching it was decided it was best to do less elective orthopaedic work to provide this service. PHT had shared their winter plan with the CCG and this was approved.

- One of the orthopaedic wards has already been closed to establish the frailty service. Orthopaedic provision is limited and 8 beds have been moved into another area and they have been outsourcing patients to the Spire Portsmouth Hospital. The frailty unit will be permanent but not in the same place. The orthopaedic department has been tasked with planning to resume normal activity within their own bedbase by 1 March.

- There are approximately over 200 nursing vacancies overall. Some departments within PHT have more vacancies than others. PHT are keen not to use agency staff and are actively trying to recruit to these vacancies.

(Councillors Stagg and Chowdhury left the meeting at this point).

Councillor Madden reported to the panel that prior to the meeting he had received an email from Dr Elizabeth Fellows, Chair and Clinical Executive of Portsmouth CCG to advise of some proposed changes to the spinal pathway at Queen Alexandra Hospital as it was no longer sustainable in its present

form. This would impact on approximately 230 patients a year on average. He asked Peter for some more information and asked whether the panel would need to scrutinise this. Mr Mellor suggested that the panel needed to decide whether the proposed changes would be a substantial change of service. PHT had yet to decide on the final outcome. He explained that with the Sustainability and Transformation Plan (STP) the likelihood is that not every hospital in the country would be able to provide every service and instead patients would need to travel to perceived centres of excellence. It was likely though that due to the numbers of patients and the number of qualified surgeons there would not be a case to keep this service at Portsmouth and for this to move to Southampton.

Mr Mellor added that once the proposed way forward had been agreed, HOSP would be alerted and it would then be for the panel to decide whether this constituted a substantial variation in service.

RESOLVED that the update be noted. The panel noted that further correspondence from PHT on the proposal to the spinal service would be communicated to them once it had been decided. The email sent from the CCG to the chair today would be circulated to the other members of the panel for information.

8. Local Dentists Committee Update (AI 8)

The report was introduced by Keith Percival, Honorary Secretary of the Hampshire and Isle of Wight Local Dental Committee. He also gave a brief update on the University of Portsmouth Dental Academy community activities outreach programme including:

- School 'BrushUP' programme - includes supervised tooth brushing and fluoride application, involved with 15 schools and 2 nurseries involving approximately 900 children.
- Community placement activities by DHDT students include nursing homes, rehabilitation centre, centre for learning difficulties and schools for oral health education and promotion
- Adult oral health check for homeless and hard to reach population - this is a new venture this year and replaces the screening and oral health promotion we did in the past 4 years at different venues like the rehabilitation centres, sure start centres, probation and other community venues. The Dental Van will be located at four different venues across the Portsmouth city on 4 occasions.
- Adult oral health check in combination with NHS health check is a pilot with Pharmacy department and we will have the van in 5 venues. The outcomes are captured on a software Pharmaoutcomes and the council is involved with this through Pharmacy.

The UOP Dental Academy was funded by PCC for 3 years however the funding has been withdrawn and regrettably is no longer funded by PCC.

In response to questions the following matters were clarified:

- The LDC covers NHS dentists only and was established on the inception of the NHS. Private patients can access NHS care. The LDC supports the general dental practice committee.
- The freedom to speak up campaign will be universal when launched and the LDC are keen to carry this forward.
- There are currently sufficient NHS services but the concern is that dentists are independent contractors and if they do not fulfil their quota NHS England will take the money back. Mr Percival felt that in the future dentistry will no longer be sustainable for the NHS. This is not imminent but it is a concern for the LDC.
- Dentists are restricted to public sector pay constraints.

RESOLVED that the update be noted.

9. CQC Update (AI 9)

The report was introduced by Caroline Bishop, CQC inspection manager. She advised that the CQC are working more closely with stakeholders and are due to have more consultation next year. She added that a more focussed inspection of Portsmouth Hospitals Trust had taken place but she could not share the findings as the report was not yet published.

In response to questions the following matters were clarified:

- The CQC acknowledge that they need to be talking more to stakeholders before their inspectors go in to complete inspections and they rely heavily on intelligence. She advised that if members had concerns they can share these with the CQC and they would welcome a level of involvement from councillors. Members of the panel could contact her directly as the inspector responsible for the service, or through the HOSP support officers if they have concerns about a particular establishment.
- The CQC have a very close working relationship with PHT and they regularly meet with them to discuss their improvement plan. The CQC will be re-inspecting Portsmouth as part of their next phase working.
- If they have serious concerns about an organisation they will carry out an unannounced inspection.
- Members of Parliament did provide feedback to the CQC as they get to see and hear about consistent problems with organisations from their constituents.

It was agreed that when a provider has been invited to a HOSP meeting to discuss their action plan following a CQC inspection that officers will also invite the CQC to the same meeting to give their views. Ms Bishop also said that if the panel felt it useful she was happy to arrange a regular

meeting/conference call with the panel to discuss inspections they are carrying out in this area.

RESOLVED that the update report be noted and agreed that when a provide has been invited to a HOSP meeting to discuss their action plan following a CQC inspection that officers will also invite the CQC to the same meeting to give their views.

10. Dates of Future Meetings (AI 10)

Members noted the dates of future meetings as follows:

- 1 February
- 22 March
- 14 June
- 13 September
- 22 November

The formal meeting ended at 4.35 pm.

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Councillor Leo Madden
Chair

Agenda Item 4

South Central Ambulance Service NHS
NHS Foundation Trust

Title	Health Overview and Scrutiny Panel - Portsmouth
Author	Tracy Redman MSc Head of Operations SE South Central Ambulance Service NHS Foundation Trust (SCAS)
Date	January 2018

Contents

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  - Staff rotations into the wider Health System
  - Admission avoidance
  - Continued engagement with the A&E Delivery Board
  - Ongoing engagement with the development of the ACS / LDS
- Performance
- Challenges
  - Retention of experienced staff
  - Recruitment of qualified staff
  - Embedding NARP and new service delivery model
  - Hospital/System resilience and capacity - impact on Hospital Handover delays

Developments

National Ambulance Response Programme

UK Ambulance Services have seen some significant changes over recent months with the introduction of the National Ambulance Response Programme (NARP).

The Programme aims to improve patient outcomes and increase the operational efficiency of ambulance service provision.

The changes include call handlers being given more time to assess 999 calls that are not immediately life threatening, which will enable them to identify patients' needs better and send the most appropriate response.

SCAS fully implemented NARP on 31st October 2017 and is currently working thorough local demand modelling to ensure the optimum service delivery. This requires changes to the fleet and some alterations to staff rosters.

In addition the call categories have changed to allow more effective prioritisation of resources.

The new call categories are:

CATEGORY 1 - LIFE-THREATENING Time critical life-threatening event needing immediate intervention and/or resuscitation e.g. cardiac or respiratory arrest; airway obstruction; ineffective breathing; unconscious with abnormal or noisy breathing.
CATEGORY 2 - EMERGENCY Potentially serious conditions (ABCD problem) that may require rapid assessment, urgent on-scene intervention and/or urgent transport.
CATEGORY 3 – URGENT Urgent problem (not immediately life-threatening) that needs treatment to relieve suffering (e.g. pain control) and transport or assessment and management at scene with referral where needed within a clinically appropriate timeframe.
CATEGORY 4 – NON-URGENT Problems that are not urgent but need assessment (face to face or telephone) and possibly transport within a clinically appropriate timeframe.
TYPE S – SPECIALIST RESPONSE (HART) Incidents requiring specialist response i.e. hazardous materials; specialist rescue; mass casualty

Staff rotations into the wider Health System

SCAS continue to work closely with partner health care providers to ensure efficient and effective collaboration. SCAS staff have previously worked in Primary Care in the South East Hampshire area and following a successful pilot further work in this area is under development. This will support wider system working as well as providing opportunities for staff to develop.

Admission avoidance

SCAS are integral to ongoing programmes of work to support patients being treated in their own home or at the most appropriate place. This includes SCAS clinicians managing conditions at home; either via the telephone or face to face and onward referrals to other health care professionals where required. Further to this the health system are using electronic patients to transfer information across partners and develop appropriate care pathways.

Performance

Aligned with the above categories are a new set of Ambulance Quality Indicators (AQIs) which are evidence based to support patient outcomes.

SCAS performance under new AQIs (November 2017):

	National Targets		Hampshire			Portsmouth CCG		
	Mean	90th	Demand	Mean	90th	Demand	Mean	90th
Cat 1	00:07:00		1,384	00:07:17	00:12:39	218	00:06:03	00:09:51
Cat 2	00:18:00		7,900	00:15:12	00:30:07	1,158	00:12:54	00:25:44
Cat 3		02:00:00	6,901		01:51:53	962		02:12:56
Cat 4		03:00:00	938		02:51:08	99		02:40:39

Challenges

Retention of experienced staff / Recruitment of qualified staff

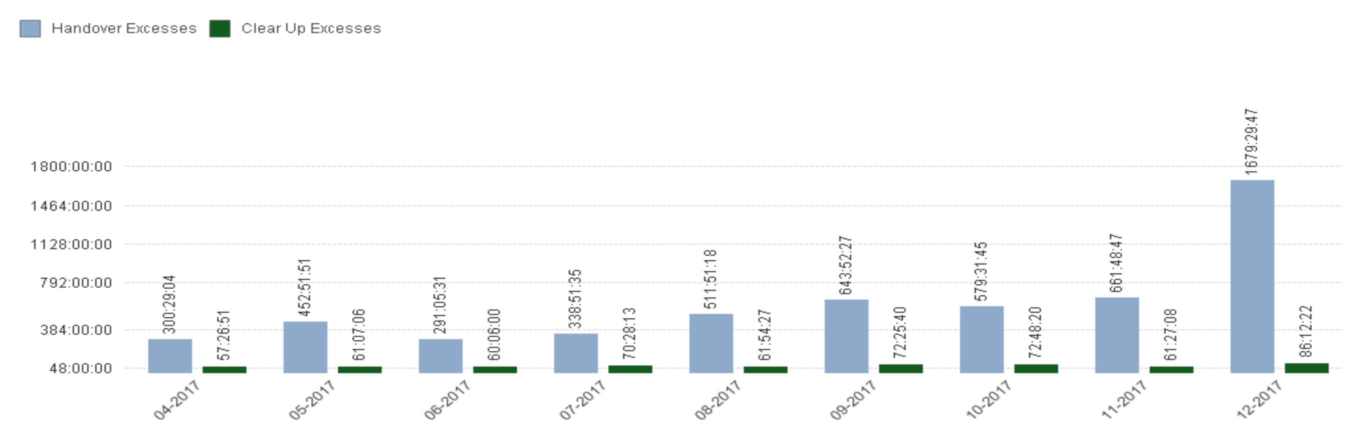
A continued area of challenge due to workforce dynamics and other opportunities for health care professionals.

Embedding NARP and new service delivery model

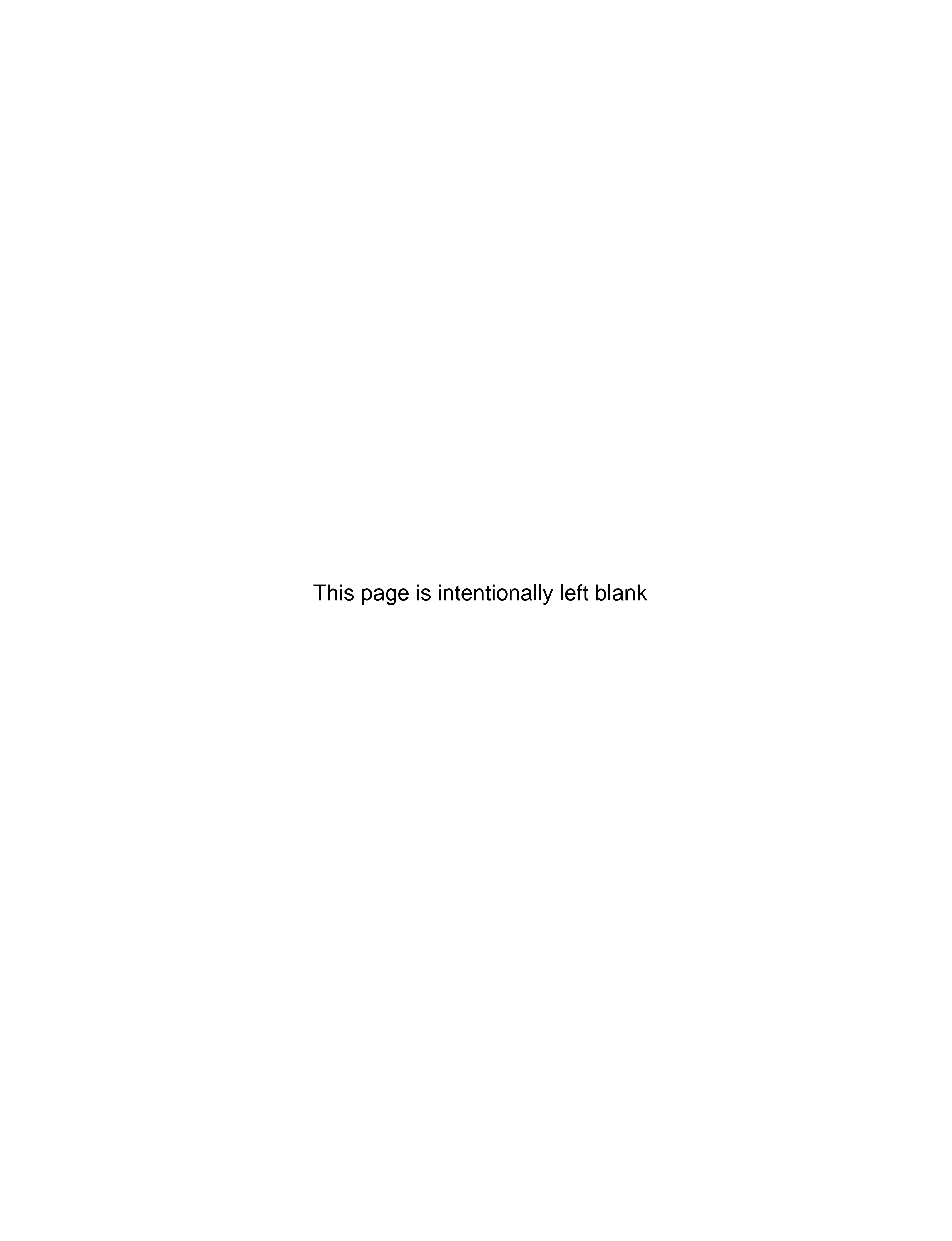
Establishing local delivery models with changes to fleet and staff rosters.

Hospital/System resilience and capacity - Impact on Hospital Handover delays

Hospital handover delays remain the most significant challenge to SCASs service delivery; the chart below shows the number of Ambulance hours lost by month from April 17 – Dec 17.



SCAS continue to work closely with Portsmouth Hospitals and other health and social care providers to mitigate the effects of these delays on patient care, and the impact on staff.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Report to the Health Overview and Scrutiny Panel (February 2018)
Deborah Crockford, Chief Officer Community Pharmacy South Central

Purpose of this Report
The purpose of this report is to highlight the key developments at both national and local level that have impacted the pharmaceutical and public health services delivered to patients and consumers through community pharmacy since the last update (in February 2016) or that are likely to shape services in the near future.
In September last year the LPC (Local Pharmaceutical Committee) introduced a new, public name accompanied by a new website containing information for both the public and professionals (www.cpsc.org.uk)

Next steps on the NHS Five Year Forward View

Key achievements, key deliverables and implementing changes
In the document, NHS England set out its main national service improvement priorities over the next two years, April 2017 – April 2019, within the constraints of what is necessary to achieve financial balance across the health service:
Urgent and emergency care; Mental health; Strengthening the NHS workforce;
Primary care; Integrating care locally; Patient safety;
Cancer; Funding and efficiency; Harnessing technology and innovation

For brevity I have chosen to examine just two of these priorities with respect to deliverables from our community pharmacies:

Urgent and emergency care: Key deliverables for 2017/18 and 2018/19
• Hospitals, primary and community care and local councils should also work together to ensure people are not stuck in hospital while waiting for delayed community health and social care (see TCAM)
• Enhance NHS 111 by increasing from 22% to 30%+ the proportion of 111 calls receiving clinical assessment by March 2018, so that only patients who genuinely need to attend A&E or use the ambulance service are advised to do this (see PURM & NUMSAS)

Funding and efficiency: The NHS 10 Point Efficiency Plan
The two points with major relevance for community pharmacy –

i. Get the best value out of medicines and pharmacy (NHS England is the lead organisation)

• NHS Clinical Commissioners and CCGs are reviewing the appropriateness of expenditure on medicines, identifying areas of prescribing that are of low clinical value or are available over-the counter often at a lower price - such as for minor conditions such as indigestion, travel sickness, cough remedies and upset stomachs (see Minor Ailments)
• the Department of Health is 'continuing to drive savings in the supply chain for dispensing medicines' (Funding cuts)

Office: Sentinel House | Harvest Crescent | Fleet | GU51 2UZ
Telephone: 01252 413 778 | Fax: 08716 613 991 | Web: www.cpsc.org.uk

ii. Reduce avoidable demand and meet demand more appropriately (PHE and NHS England lead with local authorities(LAs))

Prevention (see HLP)

NHS England will now take action, including:

• Expanding the Diabetes Prevention Programme
• Tackling obesity in particular in children through tougher action on sugar and junk food
• NHS provider trusts will have to screen, deliver brief advice and refer patients who smoke and/or have high alcohol consumption (see Alcohol Brief Advice & Smoking Cessation)
• By 2018/19, PHE will lead work with LAs to reach over 2.8 million more people with an NHS Health Check (see Health Checks)
• Further work on prevention of cardiovascular disease
• A programme to promote healthy communities and support disabled people and those with long-term conditions to manage their own health, care and wellbeing (see CPF2)
• Further action to identify and support carers
• Maintaining a focus on diagnosis and post-diagnosis support for people with dementia and their carers (see Dementia Friendly Pharmacy Framework)

TCAM – transfer of care around medicines

Statistics linked to medicines when patients are admitted to hospital

• There were roughly 16 million people admitted to into the NHS last year and the majority of these would have been prescribed medicines to improve their care
• It is estimated that 60% of patients have three or more changes made to their medicines during a hospital stay. The transfer of care process is associated with an increased risk of adverse effects
• 30-70% of patients experience unintentional changes to their treatment or an error is made because of a lack of communication or miscommunication
• Only 10% of elderly patients will be discharged on the same medication that they were admitted to hospital on
• 20% of patients have been reported to experience adverse events within 3 weeks of discharge, 60% of which could have been ameliorated or avoided

Community pharmacists are well placed to support patients recently discharged from hospital. Evidence from research into community pharmacy post-discharge medicines services has demonstrated significant increases in medicines adherence, leading to improved health outcomes for patients and fewer admissions and re-admissions to hospital. Recent work from Newcastle showed that community pharmacists were able to contact the majority of patients referred to them and results indicate that patients receiving a follow-up consultation may have lower rates of readmission and shorter hospital stays.
A formal process is now being implemented, in stages across Wessex, supported by the AHSN (Academic Health Science Network) and the LPC which, according to the Newcastle data, could save the local health economy £1.4 million in Southampton alone.

PURM & NUMSAS

NHS England – South (Wessex) commissions the Pharmacy Urgent Repeat Medicines (PURM) Service in conjunction with Clinical Commissioning Groups (CCGs) in the Wessex area. The purpose of the PURM Service is to ensure that patients can access an urgent supply of their NHS prescribed repeat medicines where they are unable to obtain a prescription before they need to take their next dose. The service may be needed because the patient has run out of a medicine, or because they have lost or damaged their medicines, or because they have left home without them. The aims of this service are to relieve pressure on urgent and emergency care services and to educate patients so that the need for the service is minimised. This is a walk-in service.

Patients contacting NHS 111 to request access to urgently needed medicines or appliances will be referred to a pharmacy that is providing the NHS Urgent Medicines Supply Advanced Service (NUMSAS) for assessment and potentially the supply of a medicine or appliance previously prescribed for that patient on a NHS prescription, where the pharmacist deems that the requirements of the Human Medicines Regulations (HMR) are met, e.g. the patient has immediate need for the medicine or appliance and that it is impractical to obtain a prescription without undue delay. For the purposes of this service, any medicine or appliance that has previously been prescribed to the patient on an NHS prescription can be supplied as long as the requirements of the HMR are met. Where the HMR refers specifically to a Prescription Only Medicine (POM), the same requirements are made for medicines or appliances that are not a POM.
The aims and intended outcomes of the service are to

- appropriately manage NHS 111 requests for urgent supply of medicines and appliances
- to reduce demand on the rest of the urgent care system, particularly GP Out of Hours (OOHs) providers
- to identify problems that lead to individual patients running out of their regular medicines or appliances and to recommend potential solutions that could prevent this happening in the future
- to increase patients' awareness of the electronic Repeat Dispensing (eRD) Service
- to ensure equity of access to the emergency supply provision irrespective of the patient's ability to pay for the cost of the medicines or appliances supplied

Minor Ailments Service

Minor ailments are defined as common or self-limiting or uncomplicated conditions which can be managed without medical intervention. The management of patients with minor self-limiting conditions impacts significantly upon GP (General Practitioner) workload. The situation is most acute where patients do not pay prescription charges and may not have the resources to seek alternatives to a prescription from their GP. It is estimated that one in

five GP consultations are for minor ailments, and by reducing the time spent managing these conditions it would enable them to focus on more complex cases.

Each year 8% of A&E department visits involve consultations for minor ailments, costing the NHS £136 million annually. With the change in NHS systems architecture, and the prevailing economic climate, services such as Community Pharmacy based Minor Ailments schemes, which reduce costs, create GP time for the management of more complex long-term conditions and have a positive impact on urgent and emergency services are increasingly important.
A minor ailments scheme has been in place within Portsmouth since 2005. In 2015 the scheme was expanded to cover more conditions and was made available to all pharmacies within Portsmouth City. In 2016 more than 2,900 consultations were made through the scheme at a cost of £26,000. It was estimated that if only 50% of these cases had presented at an alternative minor ailments centre e.g. St Mary's Treatment centre, then costs would have exceeded £50,000.

The NHS England Board has decided a full consultation should be held in early 2018 on a proposal that the prescribing of over-the-counter (OTC) products, currently prescribed at NHS expense, should be restricted in the future. Views are now being sought on stopping the routine prescribing for 33 minor conditions, as well as on probiotics and vitamins and minerals. The prescribing of products would be restricted because they meet one of the following criteria:

- They treat a condition which is self-limiting and therefore does not require treatment
- They treat a condition which could be managed by self-care, i.e. a person suffering does not normally need to seek medical care
- They have low clinical effectiveness but high cost to the NHS, e.g. vitamins/minerals and probiotics

As the NHS grapples with its funding crisis, it is becoming more important than ever that we develop support for self-care, so that people can manage their health without the need to visit their GP or hospital. Once again, as it launches this consultation the NHS looks to community pharmacies to do this, promoting them as a first port of call and a place for patients to go for advice and self-care treatments.
This is right, as pharmacies offer advice and treatment at convenient locations and long opening hours, without the need for an appointment. But those looking to transfer the burden from GP practices and urgent care towards pharmacy must acknowledge that without proper resourcing, community pharmacy will also not be able to manage. The current financial pressures facing community pharmacies mean their ability to soak up pressures on the health service is already faltering. Many are struggling to survive. Community pharmacies can do much more to help, but they are not an infinite resource. Without recognition and support community pharmacies will be unable to provide the safety net that the NHS so desperately needs and wants to rely on. It is therefore essential that services such as the Minor Ailment service continue.
As well as the impact on community pharmacies, we are particularly concerned about the impact of any changes for those on low incomes. For these families, the NHS provides a vital

service which, if removed, could lead to increased use of more expensive urgent care services and increased health inequalities.

Funding Cuts

On 20th October 2016 the Government imposed a two-year funding package on community pharmacy, with a £113 million reduction in funding in 2016/17. This was followed by a further reduction of £95 million for the year 2017/18.

The imposed cuts have had a profoundly damaging effect on contractors' finances, weakening a sector on which the NHS and its patients rely heavily. This was particularly so given the decision to make heavy cuts in the last four months of the 2016/17 financial year, resulting in a cut in income for a typical contractor of around 15% from December 2016. Combining this with a recovery of margins from the previous year through reimbursement price reductions was punitive. It provided a damaging blow to contractors' cash flow which may well be impossible to manage. Contractors have a high fixed cost base and little discretionary spend so may have little option but to make reductions in staffing levels. We are currently aware of four upcoming closures and some pharmacies are reducing their opening hours.

Healthy Living Pharmacy (HLP)

- HLPs improve the public's health and drive improvements in service quality and innovation.

- People walking into an HLP are twice as likely to set a quit date than if they walked into a non- HLP.
- HLPs consistently deliver high-quality public health services – NHS health checks, weight management, sexual health, etc.
- HLPs reach out to local communities (universities, businesses, schools, community centres, etc) with health improvement advice and services.
- 99% of people are comfortable and happy with the service provided by HLPs.
- 98% of people would recommend HLPs to their families and friends.
- 60% of people would make an appointment with their GP if the health improvement service was not available at a HLP.
- 20% of people would not have gone to another provider (i.e. they would have received no support for improving their health).

HLP is now a national programme, having started in Portsmouth in 2009.

Alcohol Brief Advice, Smoking Cessation, Health Checks

Alcohol - Alcohol Brief advice consists of the use of a simple evidence based screening tool and the delivery of appropriate brief advice. Where the person is a high risk drinker a formal referral is made to an appropriate specialist alcohol service.

The aim of this service is to increase the delivery of identification and brief advice (IBA) in community settings. IBA in turn should help to reduce the amount of people consuming alcohol at increasing or high risk levels. Other objectives include: improving access to, and choice of, alcohol screening and intervention support services particularly in the parts of our communities exposed to increased deprivation; providing information about alcohol units and the nationally recommended safe levels of drinking; providing quicker access to early assessment of potential alcohol related harm; providing an early intervention to reduce the number of people who may become alcohol dependent; reducing alcohol related illnesses and deaths by helping people to reduce or give up drinking; helping service users access additional treatment by offering timely referral to specialist services where appropriate; minimising the impact on the wider community by reducing the levels of alcohol related crime and anti-social behaviour, thereby improving community safety.

Smoking cessation - The percentage of successful quitters attending NHS smoking cessation services in Portsmouth increased year-on-year from 49% in 2009/10 to 51% in 2010/11 and to 60% in 2011/12. This increase has slowed down in the subsequent years, in part due to the national rise in the use of e-cigarettes. However, smoking remains one of the most significant preventable causes of ill-health and premature death for Portsmouth residents and the public

health strategy is to ensure as many people as possible are supported to quit smoking using nationally recommended treatment and support.

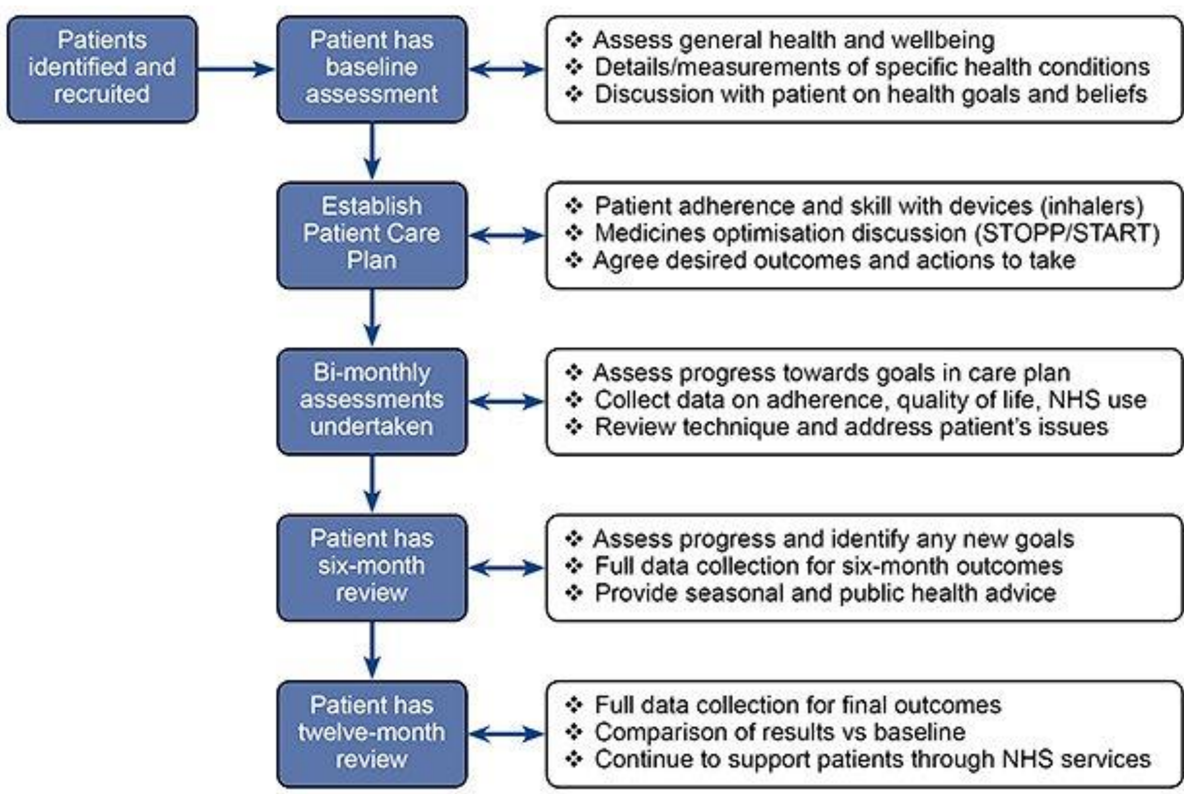
Health checks - NHS Health Checks are a systematic prevention programme that assesses an individual's risk of heart disease, stroke, diabetes and kidney disease, once every five years. It is for people aged between 40 and 74 who have not been previously diagnosed with one of the above conditions, hypertension, or are currently receiving certain medications.

The aim of NHS Health Checks in Portsmouth is to provide a quality service that will help people live longer, healthier lives. The longer-term aim is a reduction in incidence or early detection of heart attacks and strokes, type II diabetes, chronic kidney disease and vascular dementia. There are three main elements to the delivery of the NHS Health Check; Risk Assessment, Communication of Risk and Risk Management.

Community Pharmacy Future (CPF)

Pharmacy Care Plan service

- Aimed at developing individually tailored care plans that help patients aged over 50 years to achieve their health goals.



Read more about this project and others that supported COPD and polypharmacy at http://www.communitypharmacyfuture.org.uk/

Dementia Friendly Pharmacy Framework

Over 850,000 people in the United Kingdom have dementia and this number is rising. There is currently no cure and as dementia is a progressive disease, the symptoms will get worse. Alzheimer's Society recently reported that dementia costs over £26 billion a year. The Dementia Friends initiative was launched by Alzheimer's Society to raise awareness of dementia and how people can be supported to live well with dementia. Pharmacy teams are ideally positioned to help patients and their carers to make positive choices about their health, optimise their use of medicines and signpost to other forms of support.

The Wessex Pharmacy Local Professional Network has developed a framework for pharmacy teams to work through to become a Dementia Friendly Pharmacy. The framework is categorised into seven elements:

1. The pharmacy environment

2. The pharmacy team

3. Public health messages including lifestyle

4. Over the counter medicines

5. Prescription ordering and collection / delivery of medicines

6. Medicines adherence

7. Signposting

The Value of Community Pharmacy

Community pharmacies contributed £3 billion to the NHS, public sector and wider society in England in 2015 through just 12 services, according to a PricewaterhouseCoopers (PwC) study released in September 2016.
This means that community pharmacies deliver substantially more in benefits than they receive in compensation, providing excellent value to the Department of Health. In fact it is a return of around £21 for every £1 invested in Community Pharmacy.
The study, which was commissioned by the Pharmaceutical Services Negotiating Committee (PSNC), analysed the value to the NHS, public sector organisations, patients and wider society of 12 key services provided by community pharmacies.

Services analysed included supervised consumption, emergency hormonal contraception provision, minor ailments, delivering prescriptions and managing drug shortages. Pharmacies made more than 150 million interventions through the services in 2015 and there was a benefit of more than £250,000 per pharmacy, or £54.61 for every resident of England.

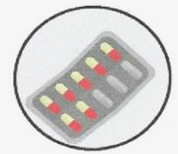
Community pharmacy: providing great value for communities

Community pharmacies are vital parts of local communities, offering a range of services to support people's health and wellbeing. New research from PricewaterhouseCoopers (PwC) has shown just how important some of these services are to public spending.

The research

The research analysed 12 community pharmacy services acoss:

Public health



Medicines support

Support for self-care

The savings

The 12 services in 2015 delivered £3bn worth of net benefit to the NHS, public sector, patients and wider society.

This included:

£1.1bn NHS cash savings

£600m benefits to patients

£1bn benefits to the public sector and wider economy

£242m avoided NHS treatment costs

The benefits

Avoided NHS treatment costs

Avoided GP appointments

Cost efficiencies

Avoided social care costs

Reduced travel time

Increased economic output

Find out more at: psnc.org.uk/valueofpharmacy

Support the campaign for community pharmacy: supportyourlocalpharmacy.org

CCG Headquarters
4th Floor
1 Guildhall Square
Portsmouth PO1 2GJ
Tel: 023 9289 9500

22 January 2018

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 provide you and the members of the Portsmouth Health Overview and Scrutiny Panel with an overview of some of the 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 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 Winter resilience and flu

You will be aware that demand on NHS and care services has intensified locally, regionally and nationally over winter, with sustained pressure being experienced over Christmas and the New Year in particular due to a combination of circumstances.

In spite of a comprehensive and coordinated local plan being in place to manage surge and escalation pressures over winter, the Christmas and New Year period was extremely difficult for health services across the Portsmouth and South East Hampshire system. As with the position nationally, higher than expected demand and high flu levels impacted on staffing and capacity across the system. The efforts and dedication of frontline care staff over this period warrant special mention, alongside the support from many other staff behind the scenes, which should also be recognised.

All local partners continue to work on delivering the plan, which includes the implementation of a number of schemes to enhance our response across the area. This has included enhanced access to primary care, greater support to care homes for when they need to deal with emergency situations, reducing some elective activity at QA Hospital, creating a designated frailty unit at the hospital and many others. A number of these were developed as a result of lessons learned from last winter.

We were also able to secure around £2m additional investment to provide extra capacity (although this was not received until early December). This has, though, enabled us to implement a further set of initiatives which are now beginning to have an impact.

2 Health and Care Portsmouth: working with the voluntary sector

We have been working closely with Portsmouth City Council and organisations within the Voluntary and Community Sector (VCS), on a range of issues to support the development of Health and Care within Portsmouth.

Through a joint initiative known as Project Bridge, plans for a Sitting Service to help people who are cared for, and their carers, are being developed by a range of organisations working together on a collaborative basis.

Additional plans are also underway to reshape existing services in the city for an integrated social prescribing service. We are committed to commissioning an integrated social prescribing service available to all adults, regardless of age, who need it within the city. We have tested a couple of schemes already over the past couple of years (the Living Well and Signposting Services programmes), and whilst these will not be continuing beyond their existing contracts they have proved very useful in helping us further shape our thoughts for the future.

A bid for funding by The YOU Trust, with support from the CCG and the Council, has been submitted to the Department of Health and we should hear soon whether or not this has been successful. If it is, we will instigate a procurement process for an integrated Social Prescribing Service.

In the future, we want to provide a stronger Single Point of Contact providing advice and information for health and care professionals to access the VCS for patients.

The objectives of this will enable patients to learn about the possibilities open to them and to help ‘co-produce’ their own social prescription for social, emotional or practical needs, with an anticipated outcome of improving their health and wellbeing.

This should result in reduced reliance on statutory health and care services whilst further strengthening relationships between statutory and non-statutory organisations, with the potential for the VCS to play an increased role in future in helping people manage their own conditions within a community setting, and maximise independent living.

Once the DH has announced the outcome of the application process for the initiative, we will ensure that ongoing plans are shared with wider stakeholders and referrers. In the meantime, we are extremely grateful to the VCS for engaging with us and the Council on these projects, and for all their hard work within the City.

3 Your Big Health Conversation Engagement Programme

We are embarking on Phase 2 of our 'Your Big Health Conversation' engagement programme in the city, and across Gosport, Fareham and South East Hampshire too.

Our intention behind this programme is to do two specific things. Firstly, to begin a 'plain English' conversation with local people (across Portsmouth and South East Hampshire) 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.

As you will recall the first phase was conducted as an online survey that provided us with lots of useful information about what local people want to see from their local NHS.

This next phase will help us further as we use the feedback we have already received, alongside other key factors such as funding, staffing, demand and clinical evidence to consider how the NHS will need to change in the future.

We know our broad outline in terms of strategy – building up stronger teams of staff in the community, moving care out of major hospitals, doing more to keep people healthy and independent, while funding and staffing will remain tight – but we now want people to remain involved in helping us build the more detailed picture.

Our plans for phase 2 focus on discussing different scenarios with people about how care is delivered now, and what it might look like in future, for example:

- A person with one or more long term illnesses
- A person with a long term mental health condition
- A person who is particularly frail – elderly, vulnerable to sudden health crisis and at risk of needing emergency hospital care
- A person who is usually healthy, with only occasional health problems, who may need to access help quickly

These have been chosen because they are relevant to large numbers of people, and are likely to be the areas where we could see the biggest changes. For each we will set out a current and possible future model of care and ask people about what does or doesn't feel right, any concerns they have or anything that the NHS may be missing out on.

Our intention is to offer people a range of different opportunities to engage with us over these scenarios but we envisage much more face to face discussion and activity than with phase 1.

Ultimately this engagement activity will support the development of new systems of NHS care both within Portsmouth, and across the wider local health economy. We will of course be happy to share the results of this phase of the programme in due course.

4 Surgery moves and changes

Practice merger: Trafalgar Medical Group and Eastney Practices

In November 2017 the CCG's Primary Care Commissioning Committee, which meets in public, approved an application from the Trafalgar Medical Group and Eastney Practices to merge.

Planning for this merger has been in place for quite some time and involved ongoing patient engagement in line with guidance from the CCG and NHS England. The merger will provide both practices with a greater degree of resilience and will also have a number of benefits to patients, including regular Saturday morning opening with the potential to review further extended hours access with additional nursing staff, and an increase in services available to all patients with each being able to benefit from services run by its partner, with potential to develop more. The practices are already co-located on the same site (Eastney Health Centre) and are currently on the same IT system (SystmOne).

Yours sincerely,

Dr Elizabeth Fellows
Chair, NHS Portsmouth Clinical Commissioning Group

Southern Health NHS
NHS Foundation Trust

Portsmouth City Council
Health Overview and Scrutiny Panel
January 2018

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.

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 trust has faced significant challenge and criticism over the last two years following the findings of the independent Mazars review in December 2015. This found 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 Care Quality Commission (CQC) subsequently carried out an inspection of the Trust in January 2016, which resulted in a warning notice issued in April 2016.

These developments precipitated a comprehensive and ongoing series of actions and improvements by the Trust to respond to these concerns, which include:

- Overhauling the process for reporting and investigating serious incidents
- Improving the way we involve service users, carers and families (including the appointment of a dedicated family liaison officer)
- Developing and implementing a comprehensive quality improvement strategy
- A detailed action plan to respond to concerns raised by the CQC, including improvements to our buildings to reduce risks and improve the environment
- Strengthening of the board and leadership team, including the appointment of new, substantive chair and chief executive
- Working closely with a number of families to listen to their concerns and help us further improve
- Developing a strategy for the future of mental health and learning disability clinical services

As a result of these actions the CQC lifted their warning notice in September 2016. Following a further series of inspections in March 2017, a report published by the CQC on 28 July 2017 recognised that, whilst some concerns remained, significant improvements had been made and that the Trust had 'turned a corner'. While we are not complacent and appreciate the challenge ahead, we are increasingly confident we are taking the right approach to deliver the changes that people in our care deserve.

Recent progress

Leadership changes

On 25 May 2017 Lynne Hunt was appointed as Chair of Southern Health and is now in post. 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.

Dr Nick Broughton has now begun his role as substantive Chief Executive. A consultant forensic psychiatrist by background, Dr Broughton was previously Chief Executive of Somerset Partnership NHS Foundation Trust. A new Medical Director has been recruited and will start working with the Trust in April 2018.

The Trust has also confirmed the appointment of four new Non-Executive Directors who are now in post; David Kelham, David Monk, Jeni Bremner and David Hicks. We have also appointed a substantive Director of Workforce, Paul Draycott who has joined the Trust from North Staffordshire Combined Healthcare NHS Trust. This set of appointments provides the organisation with a permanent Chair, a permanent Chief Executive and four newly appointed Non-Executive Directors.

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 almost 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%. 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.

Assessing effectiveness

- In order to ensure the effectiveness of the new measures put in place, an interim external assessment into the quality of investigation reports has been carried out by Niche Grant Thornton. This identified improvements in the narrative and context given in investigations but also highlights some areas where improvements could still be made.

- Niche has presented a positive draft assurance report on the Serious Incident and Mortality Action Plan to Quality and Safety Committee. Grant Thornton is currently completing assurance checks and the final report is due for presentation to the Trust Board on 30 January.

Patient and Family Engagement (Appendix B)

- 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.
- 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, Chief Nurse, 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.

Progress on CQC actions and Quality Improvement (Appendix C)

- The trust continues to provide evidence of completion and assurance against selected actions to the Quality Oversight Committee (chaired by NHS Improvement, our regulator) on a monthly basis.

- In March 2017 CQC carried out a focussed inspection of adult mental health community services, older people's mental health inpatient and community services, inpatient, urgent care, end of life and community services in the Integrated Service Division.

- CQC published an overall Provider Quality Report and individual reports per service on 28 July 2017. CQC concluded the trust had 'turned a corner' and that the interim Chief Executive and Chair had a clear vision and understanding of what was required to bring about improvements in a timely manner. There was recognition that while significant improvements had been made, there were still concerns in certain areas.

- An action plan to address the outstanding concerns has been developed in collaboration with clinical and corporate leads and will be monitored at the weekly Quality Improvement and Planning Delivery Group with validation of actions being completed by executive directors.

- Between March and June 2017 CQC carried out a review of Elmleigh and Antelope House in relation to whistle-blowing concerns and their seclusion processes. This was outside of the March inspection process and was reported on separately. The final report was published on the CQC website last week. There were no compliance actions or 'must do' actions raised within the draft report and only five 'should do' actions. A draft action plan has been developed to address these points which will be finalised and added to the trust CQC improvement plan.

- There have been no other inspections by CQC since the above, however a comprehensive CQC inspection is anticipated in the first half of 2018.

Quality Improvement Strategy

- 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 domains (safe, effective, caring, responsive, well-led).
- 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 domains, 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 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.
- The Quality Improvement Strategy was re-launched in August 2017 and we asked for a support worker from each team to be identified as a Quality Ambassador to support the implementation of the strategy at local level. Recruitment of Quality Ambassadors commenced in September and the first training workshops have now taken place.
- The Quality Ambassadors will share learning with their teams and will carry out at least one team quality improvement each quarter supported by the quality governance team.
- A dedicated online resource is being set up to support the Quality Ambassadors and as a central place to share learning. This will be further developed as more staff become ambassadors and will include a discussion forum and library of resources.
- The success of this initiative will be measured via a quarterly event where all Quality Ambassadors will share their quality improvement achievements and learning.

Prosecutions by the CQC and the Health and Safety Executive

Following the publication of the Mazars review in December 2015 the CQC and Health and Safety Executive began to look at past incidents to determine if there had been any breaches of Health and Safety law.

- In October 2017, the CQC successfully prosecuted the Trust under health and safety legislation in relation to an incident which took place at Melbury Lodge, Winchester, in 2015. The Trust pleaded guilty to the charges and received a fine of £125,000 plus costs. Since the incident in 2015, significant improvements to the building have been carried out to mitigate the risk of a similar incident occurring, as part of the CQC action plans discussed in this paper.
- The Health and Safety Executive is prosecuting the Trust in relation to the death of Connor Sparrowhawk at a specialist inpatient unit in Oxford in 2013, and also in relation to the death of Teresa Colvin at a mental health inpatient unit in Hampshire in 2012. The Trust has pleaded guilty in these cases and will be sentenced for both in March 2018.

Next steps for Southern Health services (Appendix D)

Southern Health NHS Foundation Trust published its Clinical Services Strategy in May 2017; 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 to develop 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 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. The strategy is now being implemented, including, for example, through the development of a new single point of access into mental health services in East Hampshire.

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.

The Trust is also working closely with commissioners and the emerging STP local delivery systems to understand the future of community physical health services currently provided by Southern Health.

Theme	Mazars Recommendations	SHFT Actions	Responsible Lead	Divisional Responsible Lead	Executive Accountability	Process Completion Date	Process Status	Process Progress Evidence	Evidence of Outcome Achieved	Measuring Success Date	Recovery Date	Outcome Status	Outcome Measure
Board Leadership and Oversight	1. The Board needs to address the culture of lack of review and reporting of unexpected deaths, ensure staff at all levels recognise the need for timely, high quality investigation, how to include families and to ensure learning is demonstrated. a. The Board needs to ensure the processes of reporting and investigating unexpected deaths are consistent and robust throughout the organisation and to improve the quality of investigations and the involvement of families in those investigations. The Trust needs to prioritise the review of deaths as part of a wider mortality review process making better use of data available. b. The Board needs to understand and make full use of the data available and the underlying information required for assurance that unexpected deaths are being properly identified and investigated.	1.1a The Board will address the culture to stimulate improvement in the reporting of deaths and the recognition for high quality and timely investigations by launching the new procedure - Procedure for Reporting and Investigating Deaths - in all types of Trust-wide communications, discussing the process at all executive roadshows and cascade training through all the Trust managers. This is supported by the Trust-wide bulletin, an executive level video on the internet and executive level site visits. 1.1b Cultural change to continue to be addressed through the Trust-wide 'Viral' programme of events advertised by LEaD - this will make reference to the Mazars review and the behaviourally requirement to learn from incidents which have been investigated in a timely manner with the production of a quality report. 1.1c Clinical leadership will adopt 'Back to the Floor' visits on Thursday mornings overseen by the Chief Nurse. This will provide the opportunity for face to face discussions with staff, patients and their relatives regarding improvement activities and actions.	Anna Williams, Company Secretary and Head of Corporate Governance (1.1a) Emma McKinney, Associate Director of Communications (1.1a & 1.1b) John Monahan, Talent and Business Development Partner (1.1b) Paula Hull, Divisional Director of Nursing (1.1c) Debra Moore, Deputy Director of Nursing MH/LD (1.1c)	N/A	Sara Courtney, Acting Chief Nurse (1.1a & 1.1c)	30.06.16	Complete	Evidence obtained: Communication of new process cascading through the Trust, bulletin, video and executive site visits (1.1a) Viral programme of events (1.1b) Communication related to 'Back to the Floor events' (1.1c)	Compliance to the death reporting procedure numerically monitored by the Flash report. (1.1a) Compliance to the death reporting procedure Qualitatively monitored through the monthly 20% audit. (1.1a) Quality audit of the investigations to ascertain that families and loved ones were involved in investigations where is was appropriate and they wished to be.(1.1b & 1.1c) From the information ascertained via the peer review reports - focused question related to the death reporting procedure to which individuals positively describe the process. (1.1a, 1.1b & 1.1c)	30.10.16		Complete	Evidence required: Minutes of TEG to confirm that the Flash report and mortality is discussed (1.1a) Compliance to reporting. monitored by the Flash and Tableau reports and actively discussed with Divisions where action is required. (1.1a) Results of the monthly 20% IMA audit which review quality. (1.1a, 1.1b & 1.1c) Results of the external enquiry around family involvement. (1.1b & 1.1c) Results of the SI report audit to support whether families where involved in investigations where appropriate. (1.1b & 1.1c) Results of the peer review 1 to 1 staff questions related to the mortality process (1.1a, 1.1b & 1.1c) 1.1a-1 A message from Julie Dawes-team brief-Board site visit OPMH Parklands Apr17 ....
		1.2a The Board will lead in forming a structure for mortality oversight within the Trust. A Quality and Safety Committee (QSC) (previously handled by the Serious Incident Oversight and Assurance Committee-SIOAC) will be formed (Board sub-committee) to monitor mortality and the implementation of the Serious Incident and Mortality Improvement Plan. 1.2b Formal reporting will be provided to the QSC/SIOAC - Serious Incident Trajectory Report, Mortality Flash Report and the Mortality Process Audit Report. The QSC/SIOAC will hear reports on a monthly basis, agenda coordinated by the Chair. The Chair will report to the Board on a monthly basis.	Anna Williams, Company Secretary and Head of Corporate Governance (1.2a & 1.2b)	N/A	Julie Dawes, Acting Chief Executive Officer (1.2a & 1.2b)	29.02.16	Complete	Evidence obtained: Terms of Reference for QSC / SIOAC (1.2a & 1.2b) Meeting invitations (1.2a & 1.2b) Circulation / Meeting attendance request (1.2a & 1.2b)	Minutes of the meeting will provide assurance of the scrutiny applied to ensure that the changes within the action plan are implemented and embedding. (1.2a & 1.2b) Serious Incident and Mortality feature within the Board papers and minutes and is clearly an improvement priority for the Trust. (1.2a & 1.2b)	31.07.16		Complete	Evidence required: SIOAC agendas x 3 (1.2a & 1.2b) SIOAC minutes x 3 (1.2a & 1.2b) Chairs report to the Board - Board Papers x 3 (1.2a & 1.2b)
		1.3a A Trust-wide Mortality Working Group to be formed to report to the SIOAC which, under Executive Chair, monitors the performance of the Divisional Mortality Meetings and assures that the death reporting procedure supported by the Ulysses system is embedding. 1.3b The meeting is supported by Terms of Reference and: 1.3c There is Divisional attendance.	Helen Ludford, Associate Director of Quality Governance (1.3a and 1.3b)	Mary Kloer, Clinical Services Director (AMH) Mayura Deshpande, Clinical Services Director (Specialised Services) Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Peter Hockey, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Liz Taylor, Associate Director of Nursing (Childrens and Families) (1.3c - all leads are responsible for Divisional attendance)	Lesley Stevens, Medical Director (1.3a and 1.3b)	29.02.16	Complete	Evidence obtained: Terms of Reference (1.3b) Meeting invitations (1.3a) Circulation / Meeting attendance request (1.3a)	Minutes of the meeting will provide assurance of the scrutiny applied to ensuring that the changes within the action plan are implemented and embedding. (1.3a, 1.3b & 1.3c) Results of the qualitative monthly audit will feature as a standing agenda item and stimulate discussion which will promote improvement. (1.3a & 1.3c) Key performance indicator - that audit will show that in 95% of death reviews through IMA and the 48 hr panel process the decision to investigate and at what level is correct. (1.3a & 1.3c)	31.07.16		Complete	Evidence Required: Terms of Reference for the Mortality (1.3b) Working Group Agendas of the Mortality Working Group x 3 (1.3a) Minutes of the Mortality Working Group x 3 (1.3b) Attendance register for the Mortality Working Group (1.3c) Results of the Mortality IMA audit (1.3a)
		1.4a Weekly 'flash' report to be developed to describe the status and timelines for every SIRI investigation inclusive of deaths - this will be embedded into the Trust BI System. 1.4b The Flash report will be circulated to the Executive team and all Divisional leads accountable for ensuring that investigations are completed to timescales. The detail in the report will contain the stage the investigation is at and whether it has been rejected by the quality assurance panel at corporate level. 1.4c This will be discussed by the Executive team each week at the Wednesday meeting.	Helen Ludford, Associate Director of Quality Governance (1.4a & 1.4b) Anna Williams, Company Secretary and Head of Corporate Governance (1.4c)	N/A	Julie Dawes, Acting Chief Executive Officer (1.4a, 1.4b & 1.4c)	31.12.15	Complete	Evidence obtained: Flash report (1.4a) Flash report circulation list (1.4b) TEG minutes (1.4c)	This will be evidenced through position monitoring of the compliance to the process behind incident, serious incident, risk and complaints by the executive team. (1.4a, 1.4b & 1.4c) The TEG minutes will provide an indicator that a worsening position is developing and a related action to deal with this. (1.4c)	31.07.16		Complete	Evidence Required: Flash report (1.4a) TEG minutes (1.4c) Trust dashboard related to reduction in overdue serious investigation (1.4c)
		1.5a Lead Investigators to be appointed for each Division who will track compliance to timescales and support investigators to achieve this. 1.5b Job Description to be standardised with a 20% Corporate and 80% Divisional governance focus and: 1.5c An initial priority objective to deliver clearance of any SIRI backlogs which will be evidenced in the Flash report.	Helen Ludford, Associate Director of Quality Governance (1.5a, 1.5b & 1.5c)	Paula Hull, Deputy Director of Nursing ISDs John Stagg, Associate Director of Nursing, LD TQ21 Carol Adcock, Associate Director of Nursing, AMH Rachel Coltart (1.5a) and Nicola Bennett, Associate Director of Nursing, Specialised Services Liz Taylor, Associate Director of Nursing, Childrens and Families (1.5a -all leads are responsible for Divisional recruitment)	Sara Courtney, Acting Chief Nurse (1.5a, 1.5b & 1.5c)	30.11.15	Complete	Evidence obtained: Job Description for Lead Investigators (1.5b) Demonstration of individuals in post (1.5a)	Dashboard results supporting the Key Performance Indicator of submission of a quality investigation report within 60 working days. Achievement will 90% and above sustained for a 6 month period. (1.5a & 1.5c)	30.11.16		Complete	Evidence Required: Dashboard of performance for a 6 month period demonstrating 90% compliance with submission of a quality investigation within 60 days (1.5a, 1.5b & 1.5c) 1.5b-1 Quality Governance Divisional Lead Investigator - final (2) 1.5c SIRI overdue action tracker review

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		1.6a Executive support to be sought and agreed to ensure that investigators are given sufficient time to investigate serious incidents as part of their job plans. 1.6b If improvement trajectories are not being met a divisional review of capacity will take place.	Helen Ludford, Associate Director of Quality Governance (1.6a)	Paula Hull, Deputy Director of Nursing ISD's John Stagg, Associate Director of Nursing, LD TQ21 Carol Adcock, Associate Director of Nursing, AMH Nicky Bennet, Associate Director of Nursing, Specialised Services Liz Taylor, Associate Director of Nursing, Childrens and Families (1.6a & 31.6b - all leads are responsible for investigator capacity issues in their relevant Divisions and for escalation to their Director when issues arise)	Mark Morgan, Director of Operations AMH, LD & TQ21 Gethin Hughes, Director of ISDs, OMPH and Childrens and Families (1.6a & 1.6b - Divisional Director have ultimate responsibility and accountability for ensure that investigator capacity in their Division is 'fit for purpose')	30.11.15	Complete	Evidence obtained: WTE centralised lead investigators in post for each Division - mapping document (1.6a) Registers of trained investigators in each Division (1.6a) Flash report - weekly compliance review (1.6a & 1.6b) Serious Incident trajectory report provided to QSC / SIOAC and monthly dashboard of compliance to 60 days (1.6b)	The trajectory report provided to SIOAC and the Flash report provided to the business and reviewed at TEG will assure that there are processes in place to monitor compliance to the 60 day submission of quality reports to reach a target of submission of 90% and above to this standard. (1.6a & 1.6b)	31.07.16		Complete	Evidence required: Flash report - weekly compliance review (1.6a & 1.6b) Serious Incident trajectory report provided to SIOAC and monthly dashboard of compliance to 60 days (1.6b) TEG minutes (1.6a)
		1.7a Serious Incident Investigation Training to include the National timescale requirement. Clarify and agree with Commissioners the reporting and achievement of the 60 day SIRI timescale includes/does not include Commissioner sign off. Obtain written agreement to enable benchmarking to other Trusts.	Helen Ludford, Associate Director of Quality Governance (1.7a)	N/A	Sara Courtney, Acting Chief Nurse (1.7a)	30.06.16	Complete	Evidence Required: Extract from the Serious Incident Framework 2015 plus training requirement from the Questions and Answer document 2016 (1.7a) Written agreement and clear definition of the 60 days pathway from the Commissioners - quality investigation to be undertaken, produced and submitted - 60 days provider, 20 days for Commissioner sign off and closure (1.7a)	Dashboard results supporting the Key Performance Indicator of submission of a quality investigation report within 60 working days. Trust to achieve 90% and over, sustained for a 6 month period. (1.7a) Framework checklist to be utilised at each SI panel - divisional, corporate and CCG closure panels: supplied as evidence of recognised good practice proven by recorded observation (1.7a)	30.11.16 (6 months following first achievement of above 90%)		Complete	Evidence Required: Minutes of the Strategic Oversight Group June 2016 (1.7a) Dashboard of performance for a 6 month period demonstrating 90% compliance with submission of a quality investigation within 60 days (1.7a) Evidence proved by recorded observation that the Framework checklist is used at all SI closure panels - internal and external (1.7a) 1.7a-1 Quality schedule - serious incident reporting 1.7a-2 SH NCP 60 Procedure for the Reporting and Managing Serious Incidents-Jul17V4
		1.8a Provide Investigator Training to Divisional Lead Investigation Officers and those staff who undertake Investigating Officer roles. The course will be advertised and booked through the LEaD training system. The training will be a two day 'face to face' course and meet the requirements of the 2016 Serious Incidents Framework questions and answers publication, NHS England. This training will include: All related SHFT policies NPSA guidance tools on report writing in training Root cause analysis tools and how to use these to extract a root cause National Serious Incident Framework guidance inclusive of timescales Requirement for reporting deaths in detention Duty of Candour inclusive of involving families and other parties within investigations Human Factors Complaints management Ulysses system training	Kay Wilkinson, SI and Incident Manager Helen Ludford, Associate Director of Quality Governance (1.8a)	Sara Courtney, Associate Director of Nursing East ISD Paula Hull, Associate Director of Nursing West ISD John Stagg, Associate Director of Nursing, LD TQ21 Carol Adcock, Associate Director of Nursing, AMH Nicky Bennet, Associate Director of Nursing, Specialised Services Liz Taylor, Associate Director of Nursing, Childrens and Families (1.8b - all Divisional ADoNs are responsible and accountable for ensuring that registers are kept and capacity issues are escalated)	Sara Courtney, Acting Chief Nurse (1.8a)	31.04.16	Complete	Evidence obtained: Course programme and timetable (1.8a) Course attendance register (1.8a) Divisional investigating officers registers (1.8b)	Register of trained investigators for all Divisions who have attended the trained which is offered via LEaD every 6 months - 2 day course. (1.8a & 1.8b) Compliance to the 60 day target via monitoring of the Key Performance Indicator of submission of a quality investigation report within 60 working days. 90% achievement to be sustained over a 6 month period. (1.8a & 1.8b)	30.11.16		Complete	Evidence Required: Dashboard of performance for a 6 month period demonstrating 90% compliance with submission of a quality investigation within 60 days (1.8a & 1.8b) Divisional investigating officers registers - September 2017 (1.8b) 1.8a-1 assurance re Serious Incident IO Training ... 1.8a-7 Review - Investigating Officer role - final
		1.9a Quality of the investigation reports will be monitored through the Divisional and Corporate Panels with executive Chair. Feedback will be provided at the panel on the standard of the report. The panels will utilise the 'checklist' from the National Framework document to aid the judgement on quality. 1.9b Corporate Panels booked weekly but can be increased as per demand. 1.9c Learning from serious incidents will take place in a timely manner as a result of improved lessons learnt, recommendations and actions.	Kay Wilkinson, SI and Incident Manager (1.9a, 1.9b & 1.9c)	N/A	Sara Courtney, Acting Chief Nurse (1.9a & 1.9b)	31.01.16	Complete	Evidence obtained: Quality checklist used at all Corporate panels including of the grading tool and the National Framework checklist document arranged with the CCGs. (1.9a) Corporate panel diary and schedule (1.9b)	Increase in quality with 85% of reports gaining Corporate Panel approval on 1st hearing. (1.9a) Managed Corporate Panel capacity which meets the demand. (1.9b) Policy and procedures changes resulting from serious incidents (1.9c) Please note timescale for outcome for action 1.9c, Policy and procedures changes resulting from serious incidents is 31.10.16	31.07.16 31.10.16		Complete	Evidence required: Dashboard indicator monitoring the investigation reports which gain Corporate Panel approval on the 1st hearing - target 85%. (1.9a) The trajectory report supplied to SIOAC provides assurance of activities to enable the Corporate Panel capacity to be increased during period of high demand. (1.9b) Policy and procedures changes resulting from serious incidents (1.9c) Learning form incidents bulletin produced by the Medicines Management team (1.9c)

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		1.10a The involvement of families within investigations is of paramount importance. Early conversations with family members will ensure that the correct information is ascertained and that their questions are included as part of the investigation. The 48 hr mortality panel as part of the death process includes defining of family members, establishing their involvement in the process and participation in the investigation. 1.10b This will be assured through the audit of the process with the results being feedback to the Head of Patient Engagement and Experience.	Helen Ludford, Associate Director of Quality Governance (1.10a) Chris Woodfine, Head of Patient Engagement and Experience (1.10b)	Mary Kloer, Clinical Services Director AMH Mayura Deshpande, Clinical Services Director, Specialised Services Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Peter Hockey, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Liz Taylor, Associate Director of Nursing Childrens and Families Jennifer Dolman, Clinical Services Director, LD (1.10a - all Divisional leads are responsible for the 48 hr panels which will include addressing family involvement)	Lesley Stevens, Medical Director (1.10a & 1.10b)	31.01.16	Complete	Evidence obtained: Death reporting process includes guidance on defined family involvement which is discussed as the 48 hr panel (1.10a) Ulysses 48 hr panel questionnaire includes a check for family involvement (1.10a) The IMA / 48 hr panel audit has a specific question to test family communication (1.10b) Terms of reference for external review (1.10b)	The external review into the quality of the experience of Duty of Candour / family involvement in SIRI investigations. To be completed and reported by 30.10.16. This will review the involvement of families and enable to the Trust to evidence improvement and plan further improvement actions. (1.10b) The Trust will self-monitor the inclusion of families where appropriate through monthly audit of 48hr panel this will provide internal evidence that the process is being correctly followed (1.10a & 1.10b) Please note timescales - Internal review through audit - 30.06.16 External review through commissioned enquiry 30.09.16 Internal thematic review due for completion 30.09.16	30.06.16 30.09.16		Complete	Evidence obtained: Monthly IMA / 48 hrs panel results produced and improvement activities to be discussed at MGW - audit results and MGW minutes this will provide evidence that discussions with families have occurred early on in the investigation process (1.10a &1.10b) Result of external review and related improvement plan (1.10b) Internal thematic review of Serious Incidents will prove that families have been included in 100% of investigations where appropriate and they wish to be involved (1.10b) 1.10b Patient experience engage caring mins 150617
		1.11a Identify and deliver appropriate training for all non clinical Trust Board members to ensure they are able to interpret mortality data.	Anna Williams, Company Secretary and Head of Corporate Governance (1.11a)	N/A	Julie Dawes, Acting Chief Executive Officer (1.11a)	30.06.16	Complete	Required Evidence: Schedule for Board training in relation to mortality data interpretation (1.11a)	Scrutiny and challenge regarding mortality to be evidenced in the Board minutes and resulting actions. (1.11a)	30.10.16		Complete	Required evidence: Board papers and minutes where mortality has been presented and discussed (1.11a)
Board Leadership and Oversight	2. The Board or its sub-committees should receive regular reports of all incidents of deaths. The report should: a. provide data on all deaths of people using a Mental Health or Learning Disability service including service users of the social care service - TQ21. b. outline how many unexpected deaths there have been and in which areas. c. outline how many IMAs have been written as a result and how many have progressed to CIR and then onto SIRI. d. include a summary of how many deaths are 'pending' for the purposes of investigation with a reason why. This would make the decision-making more transparent as regards to delays in reporting to StEIS. e. provide information to enable trends to be identified and for Board members to become familiar with the information f. provide information which includes the categorisation of all deaths reported to Ulysses g. provide data at least twice a year on all deaths. Themes should be reported on which covers at least the previous 6 quarters (or a sufficient number to provide a reasonable sample from which to identify themes). This is particularly important for the Learning Disability arena where numbers of deaths in each quarter will be low and in areas that may not meet SIRI criteria e.g. non-suicide Mental Health deaths.	2.1a Weekly 'flash' report to be developed to describe the status and timelines for every SIRI investigation inclusive of deaths - this will be embedded into the Trust BI System. 2.1b The Flash report will be circulated to the Executive team and all Divisional leads accountable for ensuring that investigations are completed to timescales. The detail in the report will contain the stage the investigation is at and whether it has been rejected by the quality assurance panel at corporate level. 2.1c This will be discussed by the Executive team each week at the Wednesday meeting.	Helen Ludford, Associate Director of Quality Governance (2.1a & 2.1b) Anna Williams, Company Secretary and Head of Corporate Governance (2.1c)	N/A	Sara Courtney, Acting Chief Nurse (2.1a, 2.1b & 2.1c)	31.12.15	Complete	Evidence obtained: Flash report (2.1a) Flash report circulation list (2.1b) TEG minutes (2.1c)	This will be evidenced through position monitoring of the compliance to the process behind incident, serious incident, risk and complaints by the executive team. (2.1a, 2.1b & 2.1c) The TEG minutes will provide an indicator that a worsening position is developing and a related action to deal with this. (2.1c)	31.07.16		Complete	Evidence Required: Flash report (2.1a) TEG minutes (2.1c) Trust dashboard related to reduction in overdue serious investigation (2.1c) 2.1a Outstanding and Current SIRI status analysis 7Jul17
		2.2a The Board will lead in forming a structure for mortality oversight within the Trust. A Quality and Safety Committee (QSC) (previously handled by the Serious Incident Oversight and Assurance Committee-SIOAC) will be formed (Board sub-committee) to monitor mortality and the implementation of the Serious Incident and Mortality Improvement Plan. 2.2b Formal reporting will be provided to the QSC/SIOAC - Serious Incident Trajectory Report, Mortality Flash Report and the Mortality Process Audit Report. 2.2c Oversight of Serious Incidents is through the Quality	Anna Williams, Company Secretary and Head of Corporate Governance (2.2a & 2.2c) Helen Ludford, Associate Director of Quality Governance (2.2b)	N/A	Julie Dawes, Acting Chief Executive Officer (2.2a, 2.2b & 2.2c)	29.02.16	Complete	Evidence obtained: Terms of Reference for SIOAC (2.2a) Meeting invitations (2.2a) Circulation / Meeting attendance request (2.2a & 2.2c) SIAOC agenda / papers (2.2b)	Minutes of the meeting will provide assurance of the scrutiny applied to ensure that the changes within the action plan are implemented and embedding. (2.2a) Serious Incident and Mortality feature within Board sub-committee papers (2.2b & 2.2c) Serious Incident and Mortality feature within the Board papers and minutes and is clearly an improvement priority for the Trust. (2.2a)	31.07.16		Complete	Evidence required: SIOAC & QSC agendas x 3 (2.2a, 2.2b & 2.2c) SIOAC & QSC minutes x 3 (2.2a, 2.2b & 2.2c) SIOAC Chairs report to the Board - Board Papers x 3 (2.2a, 2.2b & 2.2c))
		2.3a The Quality Governance team to provide a monthly report to the Medical Director and the Chief Nurse on Mortality and Serious Incidents for inclusion in the Board report to provide oversight and assurance.	Helen Ludford, Associate Director of Quality Governance (2.3a)	N/A	Sara Courtney, Acting Chief Nurse (2.3a) Lesley Stevens, Medical Director (2.3a)	30.01.16	Complete	Evidence obtained: Monthly COO and Director of Patient Safety and the Director of Nursing reports (2.3a)	Detailed assurance narrative featuring within the Board report.(2.3a)	30.09.16		Complete	Evidence required: Board report x 3 (2.3a) 2.3a-1 Serious Incident and Mortality Report May 2017 2.3a-2 Serious Incident and Mortality Paper May June 2017 2.3a-3 Serious Incident and Mortality Paper -
		2.4 a Each Division will provide mortality data inclusive of all elements of the recommendation in the report submitted to their monthly Divisional Performance Review (DPR).	Julie Giles, Performance Manager (2.4a)	Paula Hull, Deputy Director of Nursing ISD's John Stagg, Associate Director of Nursing, LD TQ21 Carol Adcock, Associate Director of Nursing, AMH Nicky Bennet, Associate Director of Nursing, Specialised Services Liz Taylor, Associate Director of Nursing, Childrens and Families (2.4a - Divisional Leads are responsible for the reporting which is associated with their DPR)	Mark Morgan, Director of Operations AMH, LD & TQ21 Gethin Hughes, Director of ISDs, OMPH In Patients, East and West ISD's and Childrens and Families (2.4a - Each Divisional Director is accountable for their own Division)	31.07.16	Complete	Evidence required: DPR papers from each Division (2.4a)	Divisional Performance Review reports and associated minutes will ensure that management of mortality is a key focus for improvement. (2.4a)	30.09.16		Complete	Evidence required: DPR minutes where mortality and serious incident improvement and assurance has been discussed (2.4a) Peer review reports where understanding of the mortality / death process is discussed with staff members (2.4a)

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Board Leadership and Oversight	3. The 2015/16 Annual Report should provide a more transparent breakdown of deaths including a analysis of the themes that occur for people with Mental Health and Learning Disability challenges.	3.1a A review of the annual report should be undertaken to establish which inclusion around mortality can be made. Inclusions into the Quality Account will be the priority for improvement in year 2016/17 related to mortality and undertaking investigations.	Anna Williams, Company Secretary and Head of Corporate Governance Tracey McKenzie, Head of Compliance, Assurance and Quality (3.1a - joint responsibility)	Gina WinterBates, QG Business Partner ISD's Enzani Nyatoro, QG Business Partner MH	Sara Courtney, Acting Chief Nurse (3.1a)	31.07.16	Complete	Evidence required: 2015/16 Annual Report which includes the Quality Account (3.1a) 2016/17 Quality Account priorities (3.1a)	Quality Account publication will result in clear transparency of improvement indicators for 2016/17. (3.1a)	31.07.16		Complete	Evidence required: 2015/16 Annual Report which includes the Quality Account (3.1a) 2016/17 Quality Account priorities (3.1a) both to be published on NHS Choices as of 30.06.16 Schedule of monitoring QA priority related to Mortality /Serious Incident Improvement (3.1a) 3.1a Final V13 - Quality Report 17
Board Leadership and Oversight	4. There is clear national and Trust policy guidance on reporting and investigating deaths. Trust policy includes a full set of templates and processes - the Board should ensure these policies are being followed and templates being used.	4.1a Serious Incident Management policies and procedures to be rewritten to reflect the National Framework inclusive of flowcharts to assist staff. The Trust will follow the guidance of the newly created Procedure for Reporting and Investigating Deaths which is inclusive of flowcharts to assist staff in their decision making. Staff will be able to refer to both of these documents: The Procedure for Reporting and Investigating Deaths is prescriptive of what deaths to report and how to do it. The Serious Incident policy and procedure describes what a serious incident is and provides guidance of how to report with the support of the centralised team. The policy makes reference to the use of the NHS England Serious Incident Framework within the	Thomas Williams, Ulysses Systems Developer Kay Wilkinson, SI and Incident Manager (4.1a - joint responsibility) David Batchelor, Compliance Officer (4.1a - review evidence)	Mandy Slaney, Lead IO AMH Eileen Morton, Lead IO AMH Georgie Townsend, Lead IO Childrens and Families and West ISD Angela O Brien, Lead IO East ISD Nic Cicutti, Lead IO LD & TQ21 (4.1a - responsible for assuring the promotion and monitoring of the policy an procedure use in Divisions)	Sara Courtney, Acting Chief Nurse (4.1a)	31.01.16	Complete	Evidence obtained: Serious Incident Management Policies and Procedures rewritten(4.1a) Procedure for Reporting and Investigating Deaths created (4.1a)	Audit of the decision making process as to the level of investigation required will prove in 95% of cases the decision was correct. Please note timescale for outcome for action Peer review reports to provide assurance that staff know about the death reporting and serious incident procedures and how to use them. (4.1a) is 31.10.16	31.08.16 31.10.16		Complete	Evidence required: Compliance to the procedure via the mortality Flash report (4.1a) Achievement of 95% correct clinical decision to investigate a death and at what level, assurance gained by audit (4.1b) Peer review reports to provide assurance that staff know about the death reporting and serious incident procedures and how to use them. (4.1a)
		4.2a Create an investigation template for the Ulysses Safeguard system to guide investigators with the process of report writing and ensure that additional tools / supplementary documents can be stored with the investigation. The use of prescribed electronic tools will ensure that all elements of the investigation are accurately recorded which ensure the richness in the quality of the investigation report. 4.2b Include scenario based system use within the Investigating Officers training to ensure that all investigators are trained to use the system embedded templates. Support to be provided by the Lead Investigating Officers	Thomas Williams, Ulysses Systems Developer (4.2a) Kay Wilkinson, SI and Incident Manager (4.2b)	Mandy Slaney, Lead IO AMH Eileen Morton, Lead IO AMH Georgie Townsend, Lead IO Childrens and Families and West ISD Angela O Brien, Lead IO East ISD Nic Cicutti, Lead IO LD & TQ21 (4.2a - all are responsible for assuring that Divisional Investigation Officers are trained to use the system correctly)	Sara Courtney, Acting Chief Nurse (4.2a & 4.2b)	31.01.16	Complete	Evidence obtained: Investigation Template (ERCA) within Ulysses Safeguard system developed (4.2a) All investigating officers receive systems training and further 1 to 1 support from their Central Lead Investigating Officer (4.2b)	Compliance to use of the standard system checked at each Corporate Panel. Bi-annual audit to be undertaken. (4.2a & 4.2b) Please note timescale for outcome for action Policy and procedures changes resulting from serious incidents is 31.10.16	31.08.16 31.10.16		Complete	Evidence required: Audit of the Serious Incident investigation reports to assure that the Ulysses template in being used and completed correctly, quality indicator (4.2a & 4.2b) Policy and procedures changes resulting from serious incidents (4.2a) 4.2a SI RCA 2nd Thematic review Report 17 Final S Tomkins 4.2b-1 Ulysses SIRI RCA User Guide 4.2b-2 Completed report guide
		4.3a The Board are to be assured of the use of the system and embedded templates through the reports which include the audit of the death reporting process and the Corporate SI Panel monitoring that all investigation reports post 01.01.16 are embedded into the Ulysses system.	Thomas Williams, Ulysses Systems Developer Kay Wilkinson, SI and Incident Manager (4.3a - joint responsibility)	Mandy Slaney, Lead IO AMH Eileen Morton, Lead IO AMH Georgie Townsend, Lead IO Childrens and Families and West ISD Angela O Brien, Lead IO East ISD Nic Cicutti, Lead IO LD & TQ21 (4.3a - all are responsible for assuring that their respective Divisions use the Ulysses ERCA for all investigation report)	Sara Courtney, Acting Chief Nurse (4.3a)	31.01.16	Complete	Evidence obtained: Report style checked at every Corporate SI Panel for compliance with the Ulysses system. (4.3a)	Audit of the compliance to the use of Ulysses and review of the quality to be included in Board reports. (4.3a & 4.3b)	31.08.16		Complete	Evidence Required: Audit of the Serious Incident investigation reports to assure that the Ulysses template in being used, completed correctly and the Board have been assured of this (4.3a & 4.3b)
Monitoring mortality and unexpected deaths / attrition	5. Unexpected deaths should be defined more clearly. We suggest the Trust uses, as a starting point, the classification outlined in this report to identify the potential need for review or investigation in each case. In particular, the definition of an 'unexpected death' needs to be refined to be more applicable to the circumstances of people with a Learning Disability regardless of setting.	5.1a Through consultation with the Clinical Leadership of each division create a Trust-wide Procedure for Reporting and Investigating Deaths which clearly defines the reporting criteria, review process as to what level of investigation should be undertaken and involves families. 5.1b Monitoring of this procedure will be through the Mortality Working Group under executive chair which reports to Quality and Safety Committee (QSC) (Previously handled by the Serious Incident Oversight and Assurance Committee-SIOAC) (Board sub-committee). 5.1c Audit of the process is to be shared with the CCG commissioners on a quarterly as an assure of how the decision to investigate deaths and at what level is made. This information is reported internally on a monthly basis.	Helen Ludford, Associate Director of Quality Governance (5.1b & 5.1c) Thomas Williams, Ulysses System Developer (5.1a)	Mary Kloer, Clinical Services Director AMH Mayura Deshpande, Clinical Services Director, Specialised Services Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Peter Hockey, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Liz Taylor, Associate Director of Nursing (Childrens and Families) Jennifer Dolman, Clinical Director (LD) (5.1a & 5.1b - all are responsible for assuring that their respective Divisions use the procedure appropriately and have a member on the MWG)	Sara Courtney, Acting Chief Nurse (5.1a, 5.1b & 5.1c)	31.12.15	Complete	Evidence obtained: Procedure for Reporting and Investigating Deaths written and published (5.1a) MWG membership, Terms of Reference and agenda (5.1b) Audit tool created , audit completed on 20% of reported deaths per month (5.1c)	Compliance to the procedure will be monitored through the weekly Flash report. (5.1a) Detail of the decision making will be through monthly audit of 20% of the reports. (5.1c) SIOAC papers will demonstrate monitoring of compliance to the procedure (5.1b)	30.09.16		Complete	Evidence required: Mortality audit results above 90% correct decision making as to the level of investigation and compliance to the procedure at 90% (5.1a and 5.1c) Assurance evidence obtained demonstrated to the Board through SIOAC papers (5.1b)

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Theme	Mazars Recommendations	SHFT Actions	Responsible Lead	Divisional Responsible Lead	Executive Accountability	Process Completion Date	Process Status	Process Progress Evidence	Evidence of Outcome Achieved	Measuring Success Date	Recovery Date	Outcome Status	Outcome Measure
Monitoring mortality and unexpected deaths / attrition	6. The Trust should develop a Mental Health and Learning Disability Mortality Review Group which includes reviewing unexpected deaths which do not constitute a serious incident. Clear terms of reference should be developed. This group should serve a number of purposes: a. to provide oversight of all deaths occurring amongst the Trusts Mental Health and Learning Disability service users b. develop a mortality dashboard which is provided to stakeholders and reported in the annual report that provides a full picture of all deaths, themes, CIRs and serious incidents c. monitor causes of deaths amongst its service users by using the 2013/14 MHMDS data release to see if the ICD 10 chapters show any trend d. provide an evidence base to share with Local Authority commissioners and other providers highlighting themes that are arising relating to social care and other agencies issues e. to ensure that liaison with acute provider colleagues can take place at a clinical and managerial level where the Trust has concerns raised with it about care in acute settings f. should include a GP as part of its membership g. the formation and progress of this new group should be monitored at Board level h. the group must aim to improve the transparency of reporting levels of unexpected deaths.	6.1a ALL Divisions inclusive of Mental Health and Learning Disability to introduce regular Mortality Review Meetings (minimum of once a quarter) to review and identify learning from ALL deaths (not just SIRIs)	Helen Ludford, Associate Director of Quality Governance (6.1a)	Mary Kloer, Clinical Services Director (AMH) Mayura Deshpande, Clinical Services Director (Specialised Services) Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Peter Hockey, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Liz Taylor, Associate Director of Nursing (Childrens and Families) Jennifer Dolman, Clinical Director (LD) (6.1a - each lead responsible for the meeting in their Division)	Lesley Stevens, Medical Director (6.1a - for ensuring Divisional clinical leadership) Chris Gordon, COO and Director of Patient Safety (6.1a - for devising process and supporting tools)	30.01.16	Complete	Evidence obtained: SharePoint site of planned Mortality Meetings (6.1a)	Robust evidence of mortality review recorded through the minutes of the meetings which are shared through a central SharePoint site which are auditable. (6.1a) Audit of these minutes will prove that there is a richness of clinical discussion occurring about causes of deaths and improvements which could be made. (6.1a)	30.09.16		Complete	Evidence required: Audit of the contents of the SharePoint site record of Mortality Meetings (6.1a)
		6.2a Terms of Reference and standardised agenda inclusive of case study review to be drawn up by the Governance Workstream of the Quality Programme and implemented within each group.	Helen Ludford, Associate Director of Quality Governance (6.2a)	N/A	Chris Gordon, COO and Director of Patient Safety (6.2a)	30.01.16	Complete	Evidence obtained: Terms of Reference (6.2a) Standardised agenda (6.2a)	Robust evidence of mortality review recorded through the minutes of the meetings which are shared through a central SharePoint site which are auditable. (6.2a) Audit of these minutes will prove that there is a richness of clinical discussion occurring about causes of deaths and improvements which could be made. (6.2a)	30.09.16		Complete	Evidence required: Audit of the contents of the SharePoint site record of Mortality Meetings (6.2a) 6.1a-1 AMH Mortality Meeting Minutes 2017.04.27 FINAL V1 6.1a-2 AMH Mortality Meeting Minutes 2017.05.25 FINAL v1 6.1a-3 Mortality Meeting Minutes 2017.06.22 FINAL v1
		6.3a Divisional Mortality Meetings to be chaired by the senior clinician in a senior leadership role. 6.3b The Senior Clinician Chair should attempt to recruit membership from primary care (GP), external stakeholders such as the Local Authority and a representative for patients this should be supported by the Head of Patient Engagement and Experience.	Chris Woodfine, Head of Patient Engagement and Experience (6.3b)	Mary Kloer, Clinical Services Director (AMH) Mayura Deshpande, Clinical Services Director (Specialised Services) Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Peter Hockey, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Jennifer Dolman, Clinical Services Director (LD & TQ21) Liz Taylor, Associate Director of Nursing (Childrens & Families) (6.3a & 6.3b - each lead responsible for the actions in their Division)	Lesley Stevens, Medical Director (6.3a & 6.3b - for ensuring Divisional clinical leadership)	30.01.16	Complete	Evidence obtained: Terms of Reference (6.3a) Standardised agenda (6.3b)	Robust evidence of mortality review recorded through the minutes of the meetings which are shared through a central SharePoint site which are auditable. (6.3a) Non SHFT attendees should be clearly auditable within the minutes.(6.3b)	30.09.16		Complete	Evidence required: Audit of the contents of the SharePoint site record of Mortality Meetings (6.3a & 6.3b) 6.3b-2 Incident 113726 MDT Investigation Approach
		6.4a Divisional Mortality Meetings to report into the Mortality Forum under Executive Chair which in turn reports through to the Quality and Safety Committee (QSC) (previously handled by the Serious Incident Oversight and Assurance Committee) (Board sub-committee). 6.4b Themes and trends should be escalated and consideration for 'deep dive' thematic analysis to be undertaken. On completion findings should be shared with external stakeholders where appropriate.	Helen Ludford, Associate Director of Quality Governance (6.4a) Tracey McKenzie, Head of Compliance and Assurance (6.4b)	Mary Kloer, Clinical Services Director AMH Mayura Deshpande, Clinical Services Director, Specialised Services Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Peter Hockey, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Jennifer Dolman, Clinical Services Director (LD & TQ21) Liz Taylor, Associate Director of Nursing (Childrens and Families) (6.4a & 6.4b) - each lead responsible for the reporting and thematic analysis in their Division)	Lesley Stevens, Medical Director (6.4a & 6.4b)	31.10.16	Complete	Evidence obtained: Terms of Reference (6.4a) Standardised agenda (6.4a) Evidence required: Completed thematic analysis linked to mortality (6.4b)	Robust evidence of mortality review recorded through the minutes of the meetings including the Mortality Working Group which are shared through a central SharePoint site.(6.4a) Bi-annual audit of the minutes to be reported to the SIOAC will provide assurance that mortality and serious incidents are being scrutinised and lesson learnt throughout the Trust.	30.09.16		Complete	Evidence required: Audit of the contents of the SharePoint site record of Mortality Meetings (6.4a) Audit of the minutes of the SIOAC (6.4a) Thematic review reports and documented changes to practice (6.4b)

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		6.5a Data for Mortality Meetings to be produced by the Ulysses systems analyst (monthly). Data Quality Audit to be implemented for cross checking Ulysses data against Tableau live data to ensure all deaths are accurately recorded and included in Divisional Mortality Reviews	Simon Beaumont, Head of Informatics Thomas Williams, Ulysses Systems Developer (6.5a - joint responsibility)	N/A	Sara Courtney, Acting Chief Nurse Paula Anderson, Chief Finance Officer (6.5a - joint accountability)	30.01.16	Complete	Evidence obtained: Screen shot of mortality data reports on Tableau (6.5a)	Robust evidence of mortality review recorded through the minutes of the meetings including the Mortality Working Group which are shared through a central SharePoint site which are auditable. (6.5a) Bi-annual of the minutes will ensure that this is being utilised appropriately at the meetings to highlight themes for further investigation. (6.5a)	30.09.16		Complete	Evidence required: Audit of the contents of the SharePoint site record of Mortality Meetings (6.5a) Audit of the minutes of the SIOAC (6.5a) Thematic review reports and documented changes to practice (6.5a)
		6.6a All Divisions to use 'Hot Spots', 'Learning Matters' and 'Could it happen here?' templates to share thematic review findings and enhance organisational, divisional and team learning. This should include learning from family involvement.	Tracey McKenzie, Head of Compliance and Assurance (6.6a)	Mandy Slaney, Lead IO AMH Eileen Morton, Lead IO AMH Georgie Townsend, Lead IO Childrens and Families and West ISD Angela O Brien, Lead IO East ISD Nic Cicutti, Lead IO LD & TQ21 (6.6a responsible for their allocated Division)	Lesley Stevens, Medical Director Sara Courtney, Acting Chief Nurse (6.6a - joint accountability)	31.03.16	Complete	Evidence required: Publications for the Divisions - Hotspots, Learning Matters and Could it Happen Here (6.6a)	Reduction in themed root causes which described a SHFT related failing over a 12 month period, data provided by audit. (6.6a)	31.12.16	26.05.17 revised recovery date 30.06.17	Complete	Evidence required: Results of audit tracking the themes from root causes (6.6a) 6.6a-1 AMH Evidence of Improvement Presentation AC ..... 6.6a-30 ISD Weekly Focus-Information Governance W18
Thematic reviews	7. A template for a thematic review should be produced. All thematic reviews should be undertaken in an agreed format which meets best practice standards and includes follow up, evaluation and demonstration of lessons learned and practice change.	7.1a Creation and publication of a template to support thematic review this will be implemented through the Mortality Working Group for mortality related reviews and will be implemented through the Clinical Audit Facilitator responsible for Trust-wide thematic reviews. 7.1b Pilot use in the divisions and promote via the Mortality Working Group.	Tracey McKenzie, Head of Compliance and Assurance (7.1a & 7.1b)	N/A	Sara Courtney, Acting Chief Nurse (7.1a & 7.1b)	31.03.16	Complete	Evidence obtained: Thematic review template (7.1a) Mortality Working Group minutes (7.1b)	Quality thematic reports which can be shared as learning throughout the Trust. (7.1a) Reduction in incidents with identical root causes to be evidenced by audit. (7.1b) Please note detail behind timescale: 30.06.16 31.12.16 - for audit to prove reduction in incidents with identical root causes (7.1b)	31.10.16 31.12.16	26.05.17 revised recovery date 30.06.17	Complete	Evidence required: Mortality Forum minutes - presentation of a thematic review (7.1a & 7.1b) Audit of root causes to prove reduction (7.1a & 7.1b) (results not expected until 31.12.16) 7.1a SI Thematic Review Template V2 7.1b SI Thematic Review Template V2 inclusion in Bulletin
Thematic reviews	8. There should be further work undertaken to establish whether all deaths of people over the age of 65 are being appropriately reported and investigated - in particular amongst inpatients.	8.1a The Procedure for Reporting and Investigation Deaths includes the reporting of all Older Persons Mental Health (OPMH) inpatient deaths. A 48 hour panel is to be established with Senior Clinical Chair at Divisional to decide the level of investigation which is require for each death on a case by case basis. Panel decision to reported within the Ulysses system as per process.	Thomas Williams, Ulysses System Developer (8.1a)	Sarah Constantine, Clinical Services Director, OPMH inpatients and East Division Gina WinterBates, QG Business Partner, OPMH (8.1a)	Lesley Stevens, Medical Director (8.1a)	29.02.16	Complete	Evidence obtained: Procedure for Reporting and Investigating Deaths created and in use within OPMH (8.1a)	Improved levels of investigation into OPMH inpatient deaths over a 12 month period evidence by audit and thematic review. (8.1a) Please note detail behind timescales: 30.06.16 - Externally commissioned thematic review 31.01.17 - Audit after 12 month working under the new process to assess the level of reporting	31.10.16 31.01.17	26.05.17 revised recovery date 30.06.17	Complete	Evidence required: Thematic review results (8.1a) Audit of all reports deaths (8.1a) - evidence not due until 31.01.17 Monthly audit of 20% of the mortality / death reports / IMA which is inclusive of OPMH Externally commissioned targeted audit on Daedalus ward (GWMH) expected in June 2017.
Thematic reviews	9. The Trust, CCG and local authority should undertake a retrospective review of all Learning Disability unexpected deaths regardless of place of residence with particular reference to: a. the quality, timing and follow up of dysphagia assessments b. the level of support provided by hospital liaison services and the challenges faced in acute liaison c. the decision-making process for PEG insertion d. the hydration and nourishment of service users refusing to eat e. delays in decision-making for treatment - including primary care, decisions by care staff and responses in A&E and on wards f. the inclusion of carers and	9.1a Engage all stakeholders in a workshop to discuss the appropriateness, the capacity for and ownership of the terms of reference for retrospective and forward planned thematic review. 9.1b SHFT to commission an external appreciative enquiry into the experience of families in the investigation process over the last 2 years.	Helen Ludford, Associate Director of Quality Governance (9.1a) Chris Woodfine, Head of Patient Experience and Engagement (9.1b)	Mary Kloer, Clinical Services Director AMH Mayura Deshpande, Clinical Services Director, Specialised Services Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Peter Hockey, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Jennifer Dolman, Clinical Services Director (LD & TQ21) Liz Taylor, Associate Director of Nursing (Childrens and Families) (9.1a & 9.1b - responsible for Divisional participation in thematic reviews)	Sara Courtney, Acting Chief Nurse (9.1a) Lesley Stevens, Medical Director (9.1b)	29.02.16 (9.1a) 31.08.16 (9.1a) 01.06.16 (9.1b)	Complete	Evidence required: Workshops with CCG Commissioners to discuss multi-agency retrospective and forward planned thematic review (9.1a) Commissioning documents for external appreciative enquiry (9.1b)	Meetings to be held to discuss any joint thematic reviews that are to be jointly commissioned and Terms of reference shared. (9.1a) Results of the appreciative enquiry (9.1b)	30.09.16		Complete	Evidence required: Report from externally commissioned thematic review.(9.1a) Outcome of wider stakeholder discussion re thematic review. (9.2b) 9.1a-1 LD Mortality Review V0.3 9.1a-2 170530 SHFT QOC MEETING NOTES 9.1a-3 May 2017 SHFT QOC - Action Tracker 9.1a-4 invitation to meeting re Mazars recommendation 9 9.1a-5 Circulation List with regards to letter 9.1a-6 Oxford response Recommendation 9 9.1a Mazars Recommendation 9 - CCG discussion July2017

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Thematic reviews	10. The Trust and CCG should undertake thematic reviews in Mental Health on a number of the issues raised in this review, including: a. A joint review of the circumstances of death of people with serious mental illness on long term antipsychotic drugs encompassing a review of safeguarding alerts, self neglect and physical health management. b. A joint review of all deaths relating to people with a drug related death in conjunction with local providers encompassing a review of referral processes between agencies. c. A joint review with the CCG of recent cases of death relating to serious eating disorders to understand how services need to improve by	10.1a Engage all stakeholders in a workshop to discuss the appropriateness, the capacity for and ownership of the terms of reference for retrospective and forward planned thematic review.	Helen Ludford, Associate Director of Quality Governance (10.1a)	Mary Kloer, Clinical Services Director AMH Mayura Deshpande, Clinical Services Director, Specialised Services Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Peter Hockey, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Jennifer Dolman, Clinical Services Director (LD & TQ21) (10.1a - responsible for Divisional participation in thematic reviews)	Sara Courtney, Acting Chief Nurse (10.1a) Lesley Stevens, Medical Director (10.1a)	29.02.16 1st workshop 30.09.16 2nd workshop	Complete	Evidence required: Workshops with CCG Commissioners to discuss multi-agency retrospective and forward planned thematic review (10.1a)	Meetings to be held to discuss any joint thematic reviews that are to be jointly commissioned and Terms of reference shared. (10.1a)	30.09.16		Complete	Evidence required: Report from externally commissioned thematic review (Carolan report).(10.1a) 10.1a-1 Mazars Rec 9 10 11 paper - mortality forum 10.1a-2 Thematic review schedule July 2017
Thematic reviews	11. The Trust should provide staff with regular training and guidance to help them manage physical health conditions of long-term mental health service users. Diabetes management stands out as an area for greater awareness from a number of cases we reviewed.	11.1a Review the content of the five day physical health course which LEaD provide. Course content and learning outcomes which will be reviewed. 11.1b Ensure that there is the correct percentages of staff attending from each service. 11.1c Attendance data recorded per service. 11.1d Review of the published Physical Assessment and Monitoring Policy and Procedure for Mental Health and Learning Disability Services which includes a reference to diabetic monitoring. 11.1e The physical health monitoring policy will be reissued to all clinical staff within the Adult Mental Health division (AMH), Learning Disabilities (LD) and Older Persons Mental Health (OPMH).	Bobby Moth, Associate Director of LEaD Steve Coopey, Head of Clinical Development (11.1a, 11.1b and 11.1c) Simon Johnson, Head of Essential Delivery (11.1d and 11.1e)	Carol Adcock, Associate Director of Nursing AMH (11.1a, 11.1b & 11.1c) Mary Kloer, Clinical Services Director AMH (11.1a, 11.1b & 11.1c) Kate Brooker, Associate Director AMH (11.1a, 11.1b, 11.1c, &11.1d) John Stagg, Associate Director of Nursing LD (11.1a, 11.1b & 11.1c)	Mark Morgan, Director of Operations AMH, LD & TQ21 Sara Courtney, Acting Chief Nurse (11.1a, 11.1b & 11.1c - joint accountability)	31.07.16	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 show that staff have been trained. (11.1b & 11.1c) Achieve 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	30.06.2017 revised recovery date 31.10.17 revised recovery date 30.11.17	Complete	Evidence required: Course attendance records - site / service percentage (11.1b & 11.1c) - Saved 20Feb 17 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. 11.1 Physical Health Report LD v0.2 11.1 Physical Health Report AMH v0.2 11.1 Physical Health Report SS (2) v0.2 11.1 TEC CQUIN update Report 26.07.2017 V6 11.1a-1 Physical health 5 day course reviewv3 11.1a-2 Mapping of deteriorating patient coursesv4 11.1a-3 Physical Observations workbook 11.1b Physical Health Strategy Nov 16 Draft V0.1 (2) 11.1c-1 screenshot Physical Observation training 13.7.17
Thematic reviews	12. The Trust should undertake thematic reviews of the issues raised in the review, including: a. Medical input and senior medical oversight b. The role of the care co-ordinator c. The need for pharmacy colleagues to be more explicitly involved in cases involving drug toxicity and polypharmacy.	12.1a Review the themes which the Mortality Report suggests require further investigation such as, the role of the care coordinator. Undertake review and report the findings and the actions taken to Quality and Safety Committee. The requirement for thematic reviews will be discussed at the Divisional and Corporate panels and will be specifically aimed at the themes resulting from the Serious Incidents. By undertaking thematic reviews quality improvement plans will be created that will lead to improvement.	Mayura Deshpande, Associate Medical Director, Patient Safety and all Clinical Service Directors (12.1a)	Mary Kloer, Clinical Services Director AMH (12.1a)	Lesley Stevens, Medical Director (12.1a)	31.10.16	Complete	Evidence required: Minutes of a meeting where these issues have been discussed (12.1a)	Thematic review reports will provide the evidence base for quality improvement activities at service level which will be documented in improvement plans.(12.1a)	30.11.16	26.05.17 revised recovery date tbc	Complete	Evidence required: Thematic reviews which do include clinical expert opinion and role scrutiny (12.1a) Serious investigation reports which contain expert opinions (12.1a) Quality Improvement plans which have been developed from thematic reviews (12.1a) Policy and procedures changes resulting from thematic reviews - Did not engage policy and physical health policy (12.1a) 12.1a-1 Thematic review - action plan - SI 12.1a-2 Thematic Review Role of CCO Action Plan 12.1a-3 OPMH thematic review action plan updated 9.6.17 12.1a-5 Dual Diagnosis presentation 8.5.17 12.a-4 Dual diagnosis review - NH
		12.2a Provide evidence of thematic review to the CCG commissioners through CQRM's and SOG.	Tracey McKenzie, Head of Compliance and Assurance (12.2a)	Mary Kloer, Clinical Services Director AMH Mayura Deshpande, Clinical Services Director, Specialised Services Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Peter Hockey, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Jennifer Dolman, Clinical Services Director (LD & TQ21) (12.2a - responsible for Divisional participation in thematic reviews)	Mark Morgan, Director of Operations AMH, LD & TQ21 Sara Courtney, Acting Chief Nurse (12.2a - jointly accountable for ensuring thematic reviews take place and are shared)	31.10.16	Complete	Evidence required: Thematic review template (12.2a) Completed thematic review (12.2a)	Thematic review reports will provide the evidence base for quality improvement potential for the wider health economy therefore evidence of sharing and the associated quality improvement activities discussed with be evidenced through minutes. (12.2a)	30.11.16		Complete	Evidence required: Thematic reviews which have been undertaken (12.2a) Minutes of meetings where thematic reviews have been discussed (12.2a) Learning from incidents bulletin produced by the Medicines Management team (12.2a) 12.2a SI RCA 2nd Thematic review Report 17 Final S Tomkins 12.2a CQRM MHLD Mins 170426 12.2a SHFT MHLD CQRM 170426 Agenda Pack 12.2a SHFT SIRI workshop agenda 25 April 2017

Theme	Mazars Recommendations	SHFT Actions	Responsible Lead	Divisional Responsible Lead	Executive Accountability	Process Completion Date	Process Status	Process Progress Evidence	Evidence of Outcome Achieved	Measuring Success Date	Recovery Date	Outcome Status	Outcome Measure
Thematic reviews	13. A regular review of all sudden deaths of OPMH inpatients should be carried out. This should include a review of whether care treatment decisions are taken quickly enough, whether cooperation and liaison with acute medical staff is adequate and whether staff feel confident in managing and identifying sudden physical deterioration including CPR.	13.1a The Procedure for Reporting and Investigation Deaths includes the reporting of all OPMH inpatient deaths. 13.1b A 48 hour panel is to be established with Senior Clinical Chair at Divisional to decide the level of investigation which is require for each death on a case by case basis. Panel decision to reported within the Ulysses system as per process. 13.1c Within the Terms of Reference for investigations physical health deterioration with be explored.	Helen Ludford, Associate Director of Quality Governance (13.1a)	Sarah Constantine, Clinical Services Director, OPMH inpatients and East Division (13.1b & 13.1c)	Chris Gordon, COO and Director of Patient Safety (13.1a & 13.1b) Lesley Stevens, Medical Director (13.1c)	30.06.16	Complete	Evidence obtained: Procedure for Reporting and Investigating Deaths created (13.1a) Ulysses template for mortality 48 hour panel in OPMH (13.1b) Ulysses incident report for OPMH with physical health related Terms of Reference (13.1c)	Improved levels of investigation into OPMH inpatient deaths over a 12 month period evidence by audit. (13.1a & 13.1b) Reduction in contributor factors associated with the management of physical health will be seen over a year an evidenced by audit. (13.1c)	31.12.16	26.05.17 revised recovery date 31.07.17	Complete	Evidence required: Audit of 12 months of OPMH related serious incident investigation reports to prove a reduction in physical health related contributory factors. (13.1a, 13.1b & 13.1c) 13.1c Final Approved for External Sharing 102116 13.1c-1 119268 updated
Reporting and Identifying Deaths	14. The Trust should review the way that deaths are categorised under the incident reporting policy so that: a. All relevant deaths are re-graded accurately before and after investigations have taken place (14.1a, 14.2a, 14.2b) b. All relevant deaths are reported on regardless of impact grading to ensure that deaths have greater prominence in the Trust's reporting systems. (14.3a) c. Accurate information is provided for future Trust Mortality Reviews. (14.4a) d. That immediate work with the NRLS team is undertaken to ensure the changes to the local risk management system map as expected to NRLS and on to CQC. (14.5a)	14.1a Re-write SHFT incident policy to include enhanced information on impact grading as defined by the National Reporting and Learning Service (NRLS). This is a national requirement and processes need to be correct to gain accurate benchmarking data.	Kay Wilkinson, SI and Incident Manager (14.1a)	N/A	Sara Courtney, Acting Chief Nurse (14.1a)	30.03.16	Complete	Evidence obtained: Serious Incident Management Policies and Procedures rewritten (14.1a)	Benchmarking NRLS data should evidence that SHFT is not a data outlier. Please note NRLS data is published 6 months in arrears therefore improvement cannot be measured until the April 2017 publication. (14.1a)	01.04.17		Complete	Evidence required: Screenshot evidence of uplift of to the NRLS (14.1a) Published NRLS data April 2017 (14.1a)
		14.2a Create a Corporate Panel tool that records the impact grading which is applied to the investigation at the point of final sign off by the panel under the executive director Chair. 14.2b Serious Incident support officers to update the impact grade in the Ulysses system following panel.	Kay Wilkinson, SI and Incident Manager (14.2a & 14.2b)	N/A	Sara Courtney, Acting Chief Nurse (14.2a & 14.2b)	30.03.16	Complete	Evidence obtained: Corporate tool which records impact grading (14.2a) Corporate panel SOP which required the officers to update the impact grade (14.2b)	Benchmarking NRLS data should evidence that SHFT is not a data outlier. . Please note NRLS data is published 6 months in arrears therefore improvement cannot be measured until the April 2017 publication. (14.2a & 14.2b)	01.04.17		Complete	Evidence required: Published NRLS data April 2017 (14.2a & 14.2b) Audit of corporate panel grading tool results with comparison to the uplifted reports to StEIS with provide assurance of accurate grading (14.2 & 14.b)
		14.3a Through consultation with the Clinical Leadership of each division create a Trust-wide Procedure for Reporting and Investigating Deaths which clearly defines the reporting criteria, review process as to what level of investigation should be undertaken and involves families. 14.3b Monitoring of this procedure will be through the Mortality Working Group under executive chair which reports to Quality and Safety Committee (QSC) (previously handled by the Serious Incident Oversight and Assurance Committee) (Board sub-committee).	Helen Ludford, Associate Director of Quality Governance Thomas Williams, Ulysses System Developer (14.3a & 14.3b)	Mary Kloer, Clinical Services Director AMH Mayura Deshpande, Clinical Services Director, Specialised Services Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Peter Hockey, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Jennifer Dolman, Clinical Services Director (LD &TQ21) Liz Taylor, Associate Director of Nursing (Childrens and Families) (14.3a & 14.3b - responsible lead for their own Divisions)	Sara Courtney, Acting Chief Nurse (14.3a & 14.3b)	31.12.15	Complete	Evidence obtained: Procedure for Reporting and Investigating Deaths written and published (14.3a) MWG membership, Terms of Reference and agenda (14.3b) Audit tool created , audit completed on 20% of reported deaths per month (14.3b)	Compliance to the procedure will be monitored through the weekly Flash report. (14.3a) Detail of the decision making will be through monthly audit of 20% of the reports. (14.3b) QSC / SIOAC papers will demonstrate monitoring of compliance to the procedure (14.3b)	30.09.16		Complete	Evidence required: Mortality audit results above 90% correct decision making as to the level of investigation and compliance to the procedure at 100% this audit will also demonstrate the involvement of families (14.3a & 14.3b) Assurance evidence obtained demonstrated to the Board through QSC / SIOAC papers (14.3a & 14.3b)
		14.4a The death reporting procedure is to be supported by the Safeguard Ulysses system enabling accurate and auditable extractions of mortality information. Supporting data input screens to be developed and users to be educated.	Lottie Turner, Practice Development Lead East ISD Thomas Williams, Ulysses System Developer (14.4a - joint responsibility)	N/A	Chris Gordon, COO and Director of Patient Safety (14.4a)	31.12.15	Complete	Evidence obtained: Screenshots of the Ulysses System for mortality reporting and 48 hour panels (14.4a)	Compliance to the procedure will be monitored through the weekly Flash report. Detail of the decision making will be monitored through monthly audit of 20% of the reports. (14.4a)	31.04.16		Complete	Evidence obtained: Flash report compliance to the procedure (14.4a) Monthly audit of 20% of the mortality 48 hr panel information (14.4a)
		14.5a Governance team to meet with the NRLS centralised team to ensure that the SHFT impact grading and uplift processes are occurring within the required criteria. This upload is electronic supported through a system extraction of all patient safety incidents. The information is onwardly shared with the CQC.	Ryan Taylor, Head of Incident Management and Patient Safety Thomas Williams, Ulysses System Developer (14.5a - joint responsibility)	N/A	Sara Courtney, Acting Chief Nurse (14.5a)	30.03.16	Complete	Evidence obtained: Minutes to support meeting with NRLS to verify Trust procedure for uplift (14.5a)	Assurance that SHFT is managing the national NRLS uplift process correctly demonstrated by uplift confirmation messages directly from the NRLS. (14.5a)	31.04.16		Complete	Evidence obtained: System confirmation messages of successful uplift to the NRLS (14.5a)
Quality of Investigation Reporting	15. The Serious Incident investigation process needs a major overhaul in the Trust. Improvements are needed in: a. Separation of people responsible for quality assurance and those undertaking investigations. This would enable training in review processes and quality	15.1a Rewrite of SHFT Serious Incident Management policy and procedures to be more inclusive of flowchart to provided guidance to staff.	Kay Wilkinson, SI an incident Manager (15.1a)	N/A	Sara Courtney, Acting Chief Nurse (15.1a)	30.03.16	Complete	Evidence obtained: Serious Incident Management Policies and Procedures rewritten (15.1a)	Compliance to policy and procedure to checked by audits: mortality IMA monthly audit and the bi-annual SI report audit. From the information ascertained via the peer review reports - focused question related to the death reporting procedure and serious incident management.	30.09.16		Complete	Evidence required: Extract from peer review results - specific question about mortality reporting (15.1a) Monthly 20% audit of the mortality reports and 48 hr panel information (15.1a)

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	assurance to be targeted at senior staff and in investigation techniques at a dedicated group of investigators. (15.5a, 15.5b, 15.5c, 15.5d) b. Quality assurance processes including independent review and sign off (15.5a, 15.5b, 15.5c, 15.5d, 15.6d) c. Achieving high professional standards in written presentation (15.1a, 15.2b, 15.3a, 15.3b, 15.3c, 15.4a)	15.2a Recruit centralised Serious Incident Investigator team to be known as the Divisional Lead Investigation Officers.	Helen Ludford, Associate Director of Quality Governance (15.2a)	Paula Hull, Deputy Director of Nursing ISD's John Stagg, Associate Director of Nursing, LD TQ21 Carol Adcock, Associate Director of Nursing, AMH Nicky Bennet, Associate Director of Nursing, Specialised Services Liz Taylor, Associate Director of Nursing, Childrens and Families (15.2a - responsible for the Lead IO's for their Division)	Sara Courtney, Acting Chief Nurse (15.2a)	30.11.15	Complete	Evidence obtained: List of Lead IO's in post per Division (15.2a)	Dashboard results supporting the Key Performance Indicator of submission of a quality investigation report within 60 working days. (15.2a)	30.06.16		Complete	Evidence obtained: Dashboard demonstrating to Trust's performance against submitting quality reports within 60 days (15.2a)
		15.3a Create a register of Trust-wide Investigating Officers to ensure all have been trained and competency assessed by undertaking a minimum requirement of one investigation per annum. 15.3b Investigating Officer to receive post-panel feedback on the quality of their investigation report following Corporate Panel. 15.3c Investigation skills to be discussed within the appraisal with the line manager.	Helen Ludford, Associate Director of Quality Governance (15.3a & 15.3b)	Mandy Slaney, Lead IO AMH Eileen Morton, Lead IO AMH Georgie Townsend, Lead IO Childrens and Families and West ISD Angela O Brien, Lead IO East ISD Nic Cicutti, Lead IO LD & TQ21 (15.3a and 15.3c - responsible for their own Division)	Sara Courtney, Acting Chief Nurse (15.3a, 15.3b & 15.3c)	30.11.15	Complete	Evidence obtained: Trust-wide register of trained IO's which is maintained (15.3a) Corporate panel feedback sheet (15.3b) Appraisal paperwork (15.3c)	Quality investigations which stimulate learning to prevent reoccurrence. This will be evidenced in a reduction in the reoccurrence of themes over a 12 month period. (15.3a, 15.3b & 15.c)	31.12.16	26.05.17 revised recovery date 30.06.17	Complete	Evidence required: Audit of serious incident investigations 12 months after IO's have been in post to ascertained that learning has taken place and themes have reduced (15.3a, 15.3b & 15.c) 15.3c objectives for IO in appraisal 2017-18
		15.4a Develop a Divisional Lead Investigating Officers supervision session for case study learning from Panels and updates to National guidance.	Helen Ludford, Associate Director of Quality Governance (15.4a)	Mandy Slaney, Lead IO AMH Eileen Morton, Lead IO AMH Georgie Townsend, Lead IO Childrens and Families and West ISD Angela O Brien, Lead IO East ISD Nic Cicutti, Lead IO LD & TQ21 (15.4a - responsible for their own Division)	Sara Courtney, Acting Chief Nurse (15.4a)	30.03.16	Complete	Evidence obtained: Schedule of IO supervision meetings (15.4a)	Continued increased quality of the investigation reports which adhere to national standards proven by audit. (15.4a)	31.12.16	26.05.17 revised recovery date 30.06.17	Complete	Evidence required: Audit of serious incident investigations 12 months after IO's have been in post to ascertained that learning has taken place and themes have reduced (15.4a) 15.4a Lead Investigator Team -Supervision Meeting agenda 0617 15.4a Lead Investigator Team -Supervision Meeting agenda 0717 15.4a-1 Lead Investigator Team-Supervision agenda 0517 15.4a-2 ISD Focus - Key facts about Clinical Supervision
		15.5a Create a system of Divisional and Corporate Review Panels which assess each investigation report for quality and compliance to the Nationally set criteria. These panels will apply scrutiny and challenging to the findings of the investigation. 15.5b The Divisional Panel will be Chaired by a Senior Clinician. 15.5c The Corporate Panel will be chaired by an Executive Director. 15.5dThere will be fixed Terms of Reference in place for both levels of panel. These actions will facilitate a process of quality assurance which is separated from the investigating officer undertaking the investigation. The panels will be comprised of members who are not involved in the investigation. The panels will use the closure checklist extracted from the national framework document to judge quality compliance.	Helen Ludford, Associate Director of Quality Governance (15.5a, 15.5c & 15.5d)	Mary Kloer, Clinical Services Director AMH Mayura Deshpande, Clinical Services Director, Specialised Services Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Peter Hockey, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Jennifer Dolman, Clinical Services Director (LD & TQ21) Liz Taylor, Associate Director of Nursing (Childrens and Families) (15.5b - responsible for their own Division)	Julie Dawes, Acting Chief Executive Officer (15.5a, 15.5c & 15.5d) Mark Morgan, Director of Operations AMH, LD & TQ21 Gethin Hughes, (15.5b) Director of ISDs, OMPH and Childrens and Families (15.5b)	31.12.15	Complete	Evidence obtained: Serious Incident Management Policies and Procedures rewritten (15.5a) Death reporting Procedure (15.5a) Approved Chair list for all panels (15.5b) Corporate panel schedule with allocated Chairs (15.5c) Terms of Reference (15.5d)	Continued increased quality of the investigation reports which adhere to national standards proven by audit. (15.5a, 15.5b, 15.5c & 15.5d) Please note dates for measuring success are: 31.03.16 production of monthly dashboard monitoring tool 31.12.16 for 12 month audit	31.03.16 31.12.16	26.05.17 revised recovery date 30.06.17	Complete	Evidence required: Dashboard of the percentage of reports approved by corporate panel on the first occasion, monthly collection of data. Audit of serious incident investigations 12 months after IO's have been in post to ascertain that quality has increased. (15.5a, 15.5b, 15.5c & 15.5d)
		15.6a All serious incident investigation reports to be subject to CCG lead closure panel scrutiny and challenge. This is an independent panel comprising of Quality Managers external to the Trust and representative of the commissioners. This is a framework stipulated independent quality assurance action. All Lead IO's to be present at the panel to assist with presenting cases.	Kay Wilkinson, SI and incident Manager (15.6a)	Mandy Slaney, Lead IO AMH Eileen Morton, Lead IO AMH Georgie Townsend, Lead IO Childrens and Families and West ISD Angela O Brien, Lead IO East ISD Nic Cicutti, Lead IO LD & TQ21 (15.6a - responsible for their own Division)	Chris Gordon, COO and Director of Patient Safety (15.6a)	30.03.16	Complete	Evidence obtained: Minutes of CCG closure panels x 3 (15.6a)	Continued increased quality of the investigation reports which adhere to national standards proven by audit. (15.6a) Please note timescale for measuring success is: 30.06.16 production of monthly dashboard monitoring tool 31.12.16 for 12 month audit	30.06.16 31.12.16	26.05.17 revised recovery date 30.06.17	Complete	Evidence required: Dashboard of the percentage of reports approved by external closure panel on the first occasion, monthly collection of data. Audit of serious incident investigations 12 months after IO's have been in post to ascertain that quality has increased.(15.6a)
Timeliness of Investigations	16. Reporting to StEIS should be undertaken within the 2 working days of notification as required by the national guidance.	16.1a Serious Incidents will be recorded on StEIS within 2 working days of the occurrence being reported on the Safeguard Ulysses system as specified by the National Framework by the SI and Incident Team. 16.1b The 48 hr panels at Divisional Level will decided on the level of investigation required to support the prompt reporting and this will be documented on the Safeguard Ulysses system.	Kay Wilkinson, SI and Incident Manager Mandy Rogers, SI Officer Sam Clark, SI Officer (16.1a - joint responsibility)	David Kingdon, Clinical Services Director AMH Mayura Deshpande, Clinical Services Director, Specialised Services Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Rachel Anderson, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Jennifer Dolman, Clinical Services Director (LD & TQ21) Liz Taylor, Associate Director of Nursing, Childrens and Families (16.1b - responsible for their Division)	Sara Courtney, Acting Chief Nurse (16.1a) Mark Morgan, Director of Operations AMH, LD & TQ21 Gethin Hughes, (16.1b) Director of ISDs OMPH In Patients and Childrens and Families (16.1b)	30.06.16	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 revised to 31.10.17 revised to 31.12.17	Complete	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) 16.1a Number and Percentage of SIs reported onto STEIS within 48 hours 16.1a Sept17 - Mazars Action Plan KPIs Dashboard Comprehensive

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Timeliness of Investigations	17. There should be more explicit action to commence investigations promptly even when a coroner conclusion is not immediately available unless there is a specific reason to delay; any delay should have senior sign off.	17.1a The SHFT Procedure for Reporting and Investigating Deaths will stipulate that there is no delay in commencing an investigation whilst waiting for a Coroner decision on cause of death. Each death will reviewed as an individual case and the decision to investigate and at what level of investigation will be made on the clinical presentation. Each 48 hour panel Chair will be made aware of this requirement.	Kay Wilkinson, SI and Incident Manager (17.1a)	Mary Kloer, Clinical Services Director AMH Mayura Deshpande, Clinical Services Director, Specialised Services Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Peter Hockey, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Jennifer Dolman, Clinical Services Director (LD & TQ21) Liz Taylor, Associate Director of Nursing, Children's and Families (17.1a - responsible for their own Division)	Sara Courtney, Acting Chief Nurse (17.1a)	31.01.16	Complete	Evidence obtained: Serious Incident Management Policies and Procedures rewritten (17.1a)	6 monthly audit of reasons for delays in reporting to StEIS should show a reduction in cases where an investigation has only commenced after a Coroners ruling. (17.1a) Please note that the timescale for measuring success is: 30.03.16 for dashboard monitoring 31.08.16 for initial audit results	30.03.16 31.08.16		Complete	Evidence required: Dashboard monitoring of monthly percentage of achievement against the 48 hour target. (17.1a) Audit of delays in reporting to StEIS will show that no serious incident investigation has waited for a Coroners ruling, the decision has been made earlier. (17.1a)
Involvement of Families	18. The involvement of families in investigations requires improvement. In particular, improvements are needed in: a. developing clear guidelines for staff, including expected timescales and core standards, which recognise the need for iterative engagement when the family is ready (18.1a, 18.2a, 18.5a) b. ensuring that the investigation process is clearly defined and separate from the support and assistance offered by local treatment teams (18.3a, 18.4a, 18.5a) c. the Trust should ensure that investigators talk to families as early as possible in the process to identify any concerns and take these into account in the ensuing investigation (18.1a, 18.3a, 18.3b) d. provide reports to coroners in time for inquests (18.2a and also links to 17.1a) e. explicitly demonstrating why families are not involved (18.6a) f. identifying next of kin details for all service users as part of a core assessment including where consent to share has not been provided to enable investigators to find relatives more easily. (18.9a) g. working with primary care to identify family members (18.9b) h. where the Trust delays the commencement of an investigation due to inquests or other investigations this should be made explicit to families and the reasons explained. (18.2a) I. the performance of divisions in involving families and securing feedback (18.6a)	18.1a Process to be developed (and included in first revision of new Death reporting procedure) which formally invites any concerns from families to be raised following a death that meets the criteria set out in the new procedure and advises families as to whether an investigation will take place. (this will be over and above the actions already required by Trust policy when it is clear from the outset that the death constitutes a SIRI and Duty of Candour is engaged as well as the requirement to invite families to participate in the investigation) The Duty of Candour policy includes a flowchart for the involvement of families and points of communication. This is over and above the legal requirements of Duty of Candour and meets the requirements of the CQC regulation 20 dealing with the important factor of the involvement of families and lived ones. The Death Reporting procedure includes a guidance section specific to the involvement of families and the communication which should take place and differing points. 18.1b the Serious Incident policy and procedure specifies timescales for investigations and the sharing of reports with Coroners. There should no longer be any reason why an investigation should be delayed until an inquest is heard. It is now the approach of the trust that when required an investigation will run in tandem with police investigation unless otherwise instructed by the police and this will be	Helen Ludford, Associate Director of Quality Governance (18.1a)	Mary Kloer, Clinical Services Director AMH Mayura Deshpande, Clinical Services Director, Specialised Services Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Peter Hockey, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Jennifer Dolman, Clinical Services Director (LD & TQ21) (18.1a - responsible for their own Division)	Sara Courtney, Acting Chief Nurse (18.1a)	31.07.16	Complete	Evidence required: Rewritten Duty of Candour policy inclusive of flowcharts (18.1a) Death reporting Procedure (18.1a)	The external review into the quality of the experience of Duty of Candour and the involvement of families in SIRI investigations will provide information which will be reviewed by the Trust. There is an expectation that the Trust has improved in this area however the report will be analysed and improvement actions applied as required. (18.1a) To be completed and reported by 30.09.16 Quarterly report on family involvement to be provided by the FLO to aid focus improvement activities (18.1a) deadline for quarterly reporting to be established 31.03.17 KPI dashboard - reporting on compliance of family involvement in SIs (18.1a)	30.09.16 31.03.16		Complete	Evidence required: Report from externally commissioned thematic review - Carolan Review (18.1a) Internal thematic review of Serious Incidents will prove that families have been included in 100% of investigations where appropriate and they wish to be involved (18.1a) 3 x example of serious incident investigation reports where families have been involved in the investigation and received the report (18.1a, 18.2a) SIOAC minutes where case studies have been presented to show the involvement of families and the provide a richness of information to the investigation (18.1a, 18.1b) Quarterly report to be provide by the FLO on family involvement (18.1a) 18.1 FLO training on sharing reports with families 18.1 Investigation leaflet for families 18.1The Being Open Policy including Duty of Candour
		18.2a Duty of Candour policy to be reviewed and rewritten to be specific about the involvement of families in investigations in an open and transparent manner. Non-family members will also be considered within this policy as will the involvement of other important others such as care staff.	Helen Ludford, Associate Director of Quality Governance (18.2a)	N/A	Sara Courtney, Acting Chief Nurse (18.2a)	31.07.16	Complete	Evidence required: Rewritten Duty of Candour policy inclusive of flowcharts (18.2a) Death reporting Procedure (18.2a)	The external review into the quality of the experience of Duty of Candour and the involvement of families in SIRI investigations will provide information which will be reviewed by the Trust. There is an expectation that the Trust has improved in this area however the report will be analysed and improvement actions applied as required. (18.2a) To be completed and reported by 30.09.16 The monthly DoC audit will supply information as to the quality of the recording of DoC related activities on the Ulysses system. (18.2a) Quarterly report on family involvement to be provided by the FLO to aid focus improvement activities (18.2a) deadline for quarterly reporting to be established 31.03.17	30.09.16 31.03.17		Complete	Evidence required: Report from externally commissioned thematic review.(18.2a) Monthly report from the validation of the DoC information. (18.2a) Internal thematic review of Serious Incidents will prove that families have been included in 100% of investigations where appropriate and they wish to be involved (18.2a) Quarterly report to be provide by the FLO on family involvement (18.2b)
		18.3a Role description for the Lead Investigator (centralised team) to include the specific role of oversight of communication and involvement of families. Investigation officers training involves a continuous golden thread through out the two day course about involving families: how to involve them, how to communication with them, how to record the communication and how to feedback to report to them. 18.3b There is a responsibility of the Divisional 48 hour panel to discuss Duty of Candour and involvement of families to ensure that there is a contact plan defined. 18.3c Scope the role, create a job description and recruit a Family Liaison Officer to directly liaise with families regarding their involvement in investigations, the questions which they would like addressing and to support the process through an agreed and structured communications plan. This role will predominantly support the families but will also support the 48 hour panels and the investigating officers. (action added 04.08.16 therefore input achievement timescale extended until 31.10.16)	Helen Ludford, Associate Director of Quality Governance (18.3a and 18.3b)	Mandy Slaney, Lead IO AMH Eileen Morton, Lead IO AMH Georgie Townsend, Lead IO Children's and Families and West ISD Angela O Brien, Lead IO East ISD Nic Cicutti, Lead IO LD & TQ21 (18.3a and 18.3b)	Sara Courtney, Acting Chief Nurse (18.3a and 18.3b)	31.10.16	Complete	Evidence obtained: Lead Investigator Role Description (18.3a and 18.3b) Recruitment of FLO (18.3c)	The external review into the quality of the experience of Duty of Candour and the involvement of families in SIRI investigations will provide information which will be reviewed by the Trust. There is an expectation that the Trust has improved in this area however the report will be analysed and improvement actions applied as required. To be completed and reported by 30.09.16. (18.3b) The corporate panel process ensures that the DoC has been achieved where possible for each individual case and this is recorded on the panel checklist. (18.3b) Quarterly report on family involvement to be provided by the FLO to aid focus improvement activities (18.3b) deadline for quarterly reporting to be established 31.03.17	30.09.16 31.03.17		Complete	Evidence required: Report from externally commissioned thematic review.(18.3b) Corporate panel checklist, random selection of 10 records (18.3b) Internal thematic review of Serious Incidents will prove that families have been included in 100% of investigations where appropriate and they wish to be involved (18.3c) Quarterly report to be provide by the FLO on family involvement (18.3b) 18.3a-1 Band 7 - Family Liaison Officer 18.3a-2 FLO Report - Caring Group 07.06.17 18.3a-3 FLO presentation - CQRM 28.06.17 18.3a-4 survey family involvement in investigation

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		18.4a Leaflet to be created which explains the Duty of Candour requirements and how families are welcomed to be involved in investigations to service users / patients / staff / next of kin.	Helen Ludford, Associate Director of Quality Governance (18.4a)	N/A	Sara Courtney, Acting Chief Nurse (18.4a and 18.4b)	31.03.16	Complete	Evidence obtained: Duty of Candour Leaflet (18.4a)	The external review into the quality of the experience of Duty of Candour and the involvement of families in SIRI investigations will provide information which will be reviewed by the Trust. There is an expectation that the Trust has improved in this area however the report will be analysis and improvement actions applied as required. To be completed and reported by 30.09.16 (18.4a) The monthly DoC audit will supply information as to the quality of the recording of DoC related activities on the Ulysses system. (18.4a) Internal thematic review of Serious Incidents will prove that families have been included in 100% of investigations where appropriate and they wish to be involved (18.4a) Quarterly report on family involvement to be provided by the FLO to aid focus improvement activities (18.4a) deadline for quarterly reporting to be established 31.03.17 3x minutes of the Family First involvement group (18.4a)	30.09.16 31.03.17		Complete	Evidence required: Report from externally commissioned thematic review.(18.4a) Monthly report from the validation of the DoC information. (18.4a) Internal thematic review of Serious Incidents will prove that families have been included in 100% of investigations where appropriate and they wish to be involved (18.4a) Quarterly report to be provide by the FLO on family involvement (18.4a) 3x minutes of the Family First involvement group (18.4a)
		18.5a The Trust will seek to engage lay people, families and service users to oversee the development of documents in relation to Duty of Candour and the investigation processes. This will ensure that the documents - policies, procedures and leaflets are written to easily understood by all parties and process followed.	Emma McKinney, Associate Director of Communications Chris Woodfine, Head of Patient Engagement and Experience (18.5a - joint responsibility)	N/A	Lesley Stevens, Medical Director (18.5a)	31.03.16	Complete	Evidence obtained: Role descriptions for lay persons (18.5a)	Evidence of lay involvement in the ratification of policy and procedures through clear documentation of the ratification groups. To be overseen by the patient engagement and experience workstream. (18.5a)	30.11.16		Complete	Evidence required: Minutes of SIOAC x 3 (18.5a) Minutes of MWG x 3 (18.5a) 18.5a-1 Minutes Families First 100217 18.5a-2 Minutes Families First 17022017 18.5a-3 Minutes Families First 06032017 18.5a-4 Minutes Families First 31032017 18.5a-5 20170509 Families Involvement notes 18.5a-6 20170606 Families Involvement notes 18.5a-7 20170711 Agenda Family First 18.5a-8 Invitation to information sharing workshop 18.5a-9 CS45064 SHFT Information Sharing DL leaflet- 03-17 18.5a-10 ISD week focus Duty of Candour 18.5a-11 ISD Org'n support patients and service users 18.5a-12 SH01377 Duty of Candour CRC-1 18.5a-13 extract Q1 (draft) Progress Report Quality Account
		18.6a Ulysses Safeguard screens to be further developed to map the Duty of Candour and family involvement and to record full compliance with each stage. This information will include why families are not involved. Audit of data capture will be used as an evidence base for assuring family involvement or reviewing cases where it has not been appropriate to facilitate involvement. This will be reported back to the different divisions as a performance check.	Thomas Williams, Ulysses Systems Developer (18.6a)	N/A	Sara Courtney, Acting Chief Nurse (18.6a)	30.06.16	Complete	Evidence obtained: Screenshot of DoC capture screens on Ulysses (18.6a) Guide to use (18.6a)	Monthly audit to ascertain that the Duty of Candour is being undertaken and there is documentation to support this. (18.6a) The Corporate Panel checklist will ensure that the correct level of engagement where appropriate has taken place and that this is documented on a case by case basis for serious incidents. There is an expectation that the Trust will achieve 100% compliance undertaking DoC requirements as per Regulation 20 CQC and that this is clearly documented. Internal thematic review of Serious Incidents will prove that families have been included in 100% of investigations where appropriate and they wish to be involved (18.6a)	30.09.16		Complete	Evidence required: Monthly report from the validation of the DoC information. (18.6a) Corporate panel checklist, random selection of 10 records (18.6a) Internal thematic review of Serious Incidents will prove that families have been included in 100% of investigations where appropriate and they wish to be involved (18.6a)
		18.7a Data from Ulysses Safeguard to be used to report the Duty of Candour and regulation 20 (CQC) compliance to Commissioners via CQRM process. This will include the involvement of families in investigations which is over and above what is required by the regulations.	Helen Ludford, Associate Director of Quality Governance (18.7a)	N/A	Sara Courtney, Acting Chief Nurse (18.7a)	31.03.16	Complete	Evidence obtained: Monthly report from the validation of the DoC information. (18.7a)	Monthly audit to ascertain that the Duty of Candour is being undertaken and there is documentation to support this. The Corporate Panel checklist will ensure that the correct level of engagement where appropriate has taken place and that this is documented on a case by case basis for serious incidents. There is an expectation that the Trust will achieve 100% compliance undertaking DoC requirements as per Regulation 20 CQC and that this is clearly documented and reported externally to commissioners. (18.7a)	30.09.16	30.06.17	Complete	Evidence required: Achievement of 100% on the monthly report from the validation of the DoC information. (18.7a)

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Theme	Mazars Recommendations	SHFT Actions	Responsible Lead	Divisional Responsible Lead	Executive Accountability	Process Completion Date	Process Status	Process Progress Evidence	Evidence of Outcome Achieved	Measuring Success Date	Recovery Date	Outcome Status	Outcome Measure
		18.8a Commission an external review of the current quality of the experience of the involvement of families in SIRI investigations over a 2 year period. The Review will use a mixture of Appreciative Inquiry and Experience Based Design methodology to understand the experience for staff, families, carers, patients and service users involved in SIRI investigations in the mental health and learning disability directorate. The review will provide recommendations to improve the experience of investigations for families and staff and to achieve an excellence standard of engagement.	Lesley Stevens, Medical Director (18.8a - commissioner) Helen Ludford, Associate Director of Quality Governance (18.8a - data contact)	N/A	Lesley Stevens, Medical Director (18.8a)	31.05.16	Complete	Evidence obtained: Commissioning agreement / scoping document. (18.8a)	The external review into the quality of the experience of Duty of Candour and the involvement of families in SIRI investigations will provide information which will be reviewed by the Trust. There is an expectation that the Trust has improved in this area however the report will be analysed and improvement actions applied as required. To be completed and reported by 31.10.16 (18.8a) Quarterly report on family involvement to be provided by the FLO to aid focus improvement activities (18.8a) deadline for quarterly reporting to be established 31.03.17	30.09.16 31.03.17		Complete	Evidence required: Report from externally commissioned thematic review.(18.8a) Quarterly report to be provide by the FLO on family involvement (18.8a)
		18.9a The electronic patient records where possible and at the consent of the patient or service user will contain up to date next of kin contact details and there is an information sharing agreement in place. These should be checked at each appointment. This facilitates the correct contact in the case of an emergency. 18.9b In instances where there is no recorded next of kin detail the investigation should approach other agencies to assist such as the Coroners officer or GP however they have no obligation to share. Please note - in death, there is a legal challenge that patient / service user confidentiality no longer applies in the absence of a sharing agreement however the nature of the death and the information within the investigations should be reviewed for appropriate sharing and the approach should be discussed with the Coroner. Families my still participate in the investigation and be supported to pose their specific questions. New action as of 04.08.16	Paula Hull, Deputy Director of Nursing (18.9a) Simon Beaumont, Head of Informatics (18.9a - compliance monitoring)	Sara Courtney, Associate Director of Nursing East ISD Paula Hull, Deputy Director of Nursing ISD's John Stagg, Associate Director of Nursing, LD & TQ21 Carol Adcock, Associate Director of Nursing, AMH Nicky Bennet, Associate Director of Nursing, Specialised Services Liz Taylor, Associate Director of Nursing, Children's and Families	Sara Courtney, Acting Chief Nurse (18.2a)	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	30/09/17	Complete	Evidence required: Informatics report showing that 80% of patient records have a next of kin listed (18.9a) Serious incident investigation report where next of kin details have been obtained through an alternative means (18.9b) 18.9a outcome measure Tableau reports on NoK 3jul17 18.9a Next of Kin performance 3 July 2017 18.9b-2 next of kin details from coroner November 2015 18.9b-1 next of kin details from coroner May 2017
		18.10 Following the receipt of the external appreciative enquiry into the current quality of the experience of the involvement of families in SIRI investigations over a 2 year period the Trust will: 18.10a Create a task and finish group to review the report in detail and focusing on continuing improvement create an action plan to address the recommendations this will include representative from the cohort of families involved 18.10b Re-review the engagement and duty of candour policies and procedures updating where necessary 18.10c Review the Trust-wide training of family engagement and duty of candour, how this is delivered and to whom in the workforce	Paula Hall, Deputy Director of Nursing Mayura Deshpande, Associate Medical Director - Patient Safety Chris Woodfine, Head of Patient Engagement and Experience Bobby Moth, Associate Director of LEaD Family Liaison Officer	N/A	Lesley Stevens, Medical Director (18.10a & 18.10b)	30.11.16	Complete	Evidence required: Minutes of the task and finish group (18.10a) Minutes of CARING group (18.10a) Review of the Trust-wide training re family engagement and duty of candour (18.10c) Reviewed and updated family engagement and duty of candour policy / procedures (18.10b)	The quantitate research undertaken within the first appreciative enquiry will be repeated to evidence improvement. (18.10) The involvement of families and next of kin will continue to be checked and challenged at divisional and corporate panels. (18.10) That staff are able to follow policy and procedures fully understanding the content and application in practice (18.10b and 18.10c) Quarterly report on family involvement to be provided by the FLO to aid focus improvement activities (18.10) deadline for	30.09.17 31.03.17		Complete	Evidence required: Internal thematic review report on serous incident investigation reports to be undertaken at 6 monthly intervals will review family involvement (18.10a) Appreciative enquiry to be repeated for cohort April2016 to April 2018 in two years time (18.10a, 18.10b and 18.10c) Monthly report to the Caring group produced by the FLO on family involvement (18.10) 18.10a Family Involvement Action Plan v4.620170703 18.10a-2 Minutes 230317-Review of Family Experience in Engage
Multi-agency working	19. The Trust Board should seek co-operation with other providers and commissioners to agree a framework for investigations in preparation for future incidents regarding escalation. Divisions should then apply this framework where the incident report suggests another organisation should review or investigate the circumstances of a death.	19.1a As part of a wider stakeholder group comprising of CCGs, Acute Trust and the Local Authority create a process framework for undertaking multi-agency Serious Incident investigations. The issue regarding differences between the health and social care investigation frameworks should also be clearly defined. This group is being lead by the CCG. When this process is defined it will be adopted into the SHFT Serious Incident management policies. Whilst the process is being clearly defined by the CCG there is in place an interim process of communication with the CCG when another provider fails to engage with SHFT in a joint investigation.	Helen Ludford, Associate Director of Quality Governance (19.1a)	N/A	Sara Courtney, Acting Chief Nurse (19.1a)	30.06.16	Complete	Evidence obtained: Agenda and minutes related CCG lead meetings to define the process for multi-agency investigations (19.1a)	Quarterly report which stipulates which Serious Incident investigation have had multi provider which is shared with the CCGs. It is anticipated that SHFT will always respond to a request to be involved in a multi provider investigation and will be able to document this through audit. (19.1a)	31.09.16		Complete	Evidence required: Audit of Q1 SI's stipulating which have been multi-agency focused (19.1a) Example of a multi-agency investigation in which SHFT have participated or led (19.1a) 19.1a multi agency SI ToR 09.06.17 - V5
Deaths in detention and inpatient deaths	20. The Trust should retain a contemporaneous list of all inpatient deaths mapped to Mental Health Act status to enable Trust-wide oversight of all inpatient deaths and deaths in detention.	20.1a A Ulysses Safeguard / Tableau extraction report to be written to provide a quarterly report of all deaths in detention under the Mental Health Act. Report to be validated by the Senior Clinical Chairs of the 48 hr mortality review panels to ensure that the system information capture is correct and all deaths of this type have been reported as Serious Incidents. 20.1b SHFT will follow the Coroners documented and published guidance into investigating 'deaths in custody'.	Simon Beaumont, Head of Informatics Thomas Williams, Ulysses Systems Developer (20.1 a - joint responsibility) Kay Wilkinson, SI and Incident Manager (20.1b)	Mary Kloer, Clinical Services Director AMH Mayura Deshpande, Clinical Services Director, Specialised Services Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) (20.1a and 20.1b - each responsible for their own Divisions)	Mark Morgan, Director of Operations AMH, LD & TQ21 Gethin Hughes, Director of ISDs, OMPH In Patients, ISD's and Children's and Families (20.1a and 20.1b - each accountable for their own Divisions)	30.06.16	Complete	Evidence obtained: Serious Incident Management Policies and Procedures rewritten (20.1a and 20.1b)	Quarterly report which provides audit information stipulating that each death in detention has been reported as an Serious Incident and investigated. (20.1a and 20.1b)	31.08.16		Complete	Evidence required: Ulysses extraction report proving that all inpatient deaths of those under a section have been investigated as a Serious Incident. (20.1a and 20.1b) 20.1 Deaths in detention Jan 16 to July 17 20.1a-2 Deaths of Patients in MH Inpatient Apr16-Jun17 20.1a-1 SI Incident and Mortality Paper - June 2017 V6

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Deaths in detention and inpatient deaths	21. All deaths of service users in detention should be investigated, whether expected or not. These investigations should occur regardless of inquest conclusions. This will give assurance that the 24/7 nature of the care required has been of the highest standard. Specific issues addressed in the Terms of Reference for these investigations should include: a. to ensure that physical health care symptoms are not dismissed where challenging behaviour presents; b. that delays in seeking physical health care are not apparent; c. that service users are fully aware of decisions regarding whether to treat or investigate chronic or acute symptoms and that these are made in an informed manner; d. that access to full care and treatment is not restricted in any way; e. that staff are adequately supported to provide physical health care and trained to do so.	21.1a The death of a service user under detention must be investigated as per the Serious Incident Framework 2015. A 'flag' will be apparent on the Ulysses Safeguard risk management system which will trigger a decision to investigate at the 48 hr panel by the panel Chair. This process will be supported by SHFT Death reporting process where it is specific that all deaths of detained patients are reported and investigated as a Serious Incident. Terms of Reference for the investigation will be constructed on a case by case basis but will include a review of both of the mental health and physical health care which has been provided to a service user or patients. In situations where SHFT may not be the main provider of physical health care the opinions of that provider will be sought, if engagement in the investigation cannot be gained this will be reported to the CCG commissioners. This may be the case is a patient is transferred from SHFT inpatient services to an acute trust	Helen Ludford, Associate Director of Quality Governance Kay Wilkinson, SI and Incident Manager (21.1a)	Mary Kloer, Clinical Services Director AMH Mayura Deshpande, Clinical Services Director, Specialised Services Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) (21.1a - each responsible for their own Divisions)	Mark Morgan, Director of Operations AMH, LD & TQ21 Gethin Hughes, Director of ISDs, OMPH In Patients, ISD's and Children's and Families (21.1a - each accountable for their own Divisions)	30.03.16	Complete	Evidence obtained: Serious Incident Management Policies and Procedures rewritten (21.1a)	Quarterly report which provides audit information stipulating that each death in detention has been reported as an Serious Incident and investigated. (21.1a)	31.08.16		Complete	Evidence required: Ulysses extraction report proving that all inpatient deaths of those under a section have been investigated as a Serious Incident. (21.1a) 21.1a-1 reminder on Ulysses re death SU in detention is SI
		21.2a Review the content of the five day physical health course which LEaD provide and ensure that there is the correct percentages of staff attending from each service. Course content and learning outcomes which will be reviewed. 21.2b Attendance data recorded per service.	Bobby Moth, Associate Director of LEaD Steve Coopey, Head of Clinical Development (21.1a and 21.1b)	Carol Adcock, Associate Director of Nursing AMH (21.1a and 21.1b) Mary Kloer, Clinical Services Director AMH (21.1a and 21.1b) Kate Brooker, Associate Director AMH (21.1a and 21.1b) Kathy Jackson, Head of Nursing Inpatient (OPMH)	Mark Morgan, Director of Operations AMH, LD & TQ21 Sara Courtney, Acting Chief Nurse Julie Dawes, Acting Chief Executive (21.1a and 21.b - joint accountability)	31.07.16	Complete	Evidence required: Review of course content and learning outcomes (21.2a) Attendance records by service by team (21.2b)	Divisional and service level training records to that staff have been trained. (21.2b) Achieve of 90% compliance to clinical audit of physical health needs. (21.2a) Physical health audit to be undertaken in Q3. Audit of SI contributory factors to be undertaken in Q2. (21.2a) Please note the timescales for measuring success are: 31.12.16 for Q3 audit and training records 30.09.16 for SI Q2 audit	31.12.16 30.09.16		Complete	Evidence required: Results of Q3 physical health audit (21.2a) Attendance records by service by team (21.2b) SI contributory factors audit for Q2 (21.2a) additional evidence above 5-day course to show broader range of training conducted (21.2a)
		21.3a As part of service redesign, ensure that integrated teams contain physical expertise as part of the staffing component.	Liz Skeats, HR Business Partner (MH) Kerry Salmon, HR Business Partner (ISD's) Jane Pound, Head of HR	Carol Adcock, Associate Director of Nursing AMH Mary Kloer, Clinical Services Director AMH Kate Brooker, Associate Director AMH Sarah Constantine (OPMH), Clinical Services Director Kathy Jackson, Head of Nursing Inpatients (OPMH) (21.3a - responsible for own Divisions)	Mark Morgan, Director of Operations AMH, LD & TQ21 Sara Courtney, Acting Chief Nurse (21.3a - joint accountability)	31.07.16	Complete	Evidence required: Service redesign plans to include physical health nursing staff in a mental health setting (21.3a) SHFT Staffing meeting with West Hants CCG - minutes (21.3)	Divisional and service level training records to that staff have been trained. Achieve of 90% compliance to clinical audit of physical health needs. Physical health audit to be undertaken in Q3. Audit of SI contributory factors to be undertaken in Q2. (21.3a) Please note the timescales for measuring success are: 31.12.16 for Q3 audit and training records 30.09.16 for SI Q2 audit	31.12.16 30.09.16		Complete	Evidence required: Results of Q3 physical health audit (21.3a) Attendance records by service by team (21.3a) SI contributory factors audit for Q2 (21.3a) 21.3a-1 MH LD Workforce Strategy 2017 - 2020 Final v1 (4) 21.3a-2 Further expansion on divisional priorities 21.3a-3 AMH summary business plan activities v2 21.3a-4 CQUIN 2017 -18 physical healthcare 21.3a-5 CQUIN 17-18 prevent ill health by risky behaviour
		21.4a A clinical audit to be undertaken within Q3 of 2016/17 to evidence that physical health needs of mental health and learning disability patients are being met.	Mayura Deshpande, Associate Medical Director, Patient Safety and all Clinical Service Directors Helen Alger, Clinical Audit Facilitator (21.4a - joint responsibility)	Carol Adcock, Associate Director of Nursing AMH Mary Kloer, Clinical Services Director AMH Kate Brooker, Associate Director AMH Jennifer Dolman, Clinical Services Director LD John Stagg, Associate Director of Nursing LD (21.4a - responsible for own Divisions)	Mark Morgan, Director of Operations AMH, LD & TQ21 Sara Courtney, Acting Chief Nurse (21.4a - joint accountability)	31.11.16	Complete	Evidence required: Physical audit proforma (21.4a)	90% to be achieved through clinical audit of physical health needs to provide assurance that the Trust is providing the correct level of physical health care by skilled doctors and nurses. (21.4a)	31.12.16		Complete	Evidence required: Results of Q3 physical health audit (21.4a)
Information management	22. The Trust should develop an agreed RiO extract and Ulysses reporting protocol to capture all deaths of Adult Mental Health, Older People Mental Health and Learning Disability service users including community and inpatient locations to form the basis of future mortality review.	22.1a Tableau based reports to be devised by informatics team which extract data from the Ulysses system. The content of this reports will be incident / mortality data extracted from Ulysses triangulated with the mortality data which is extracted from the National Spine. This will ensure that the Mortality Meetings have knowledge of all service users and patients who are on an active caseload and have died.	Simon Beaumont, Head of Informatics Thomas Williams, Ulysses Systems Developer (22.1a - joint responsibility)	N/A	Sara Courtney, Acting Chief Nurse Paula Anderson, Chief Finance Officer (22.1a - joint accountability)	30.03.16	Complete	Evidence obtained: Tableau based mortality reports (22.1a)	High quality correct data which informs the Mortality Meeting evidenced through the minutes on SharePoint. This is to ensure that all deaths are know to the Trust and that the procedure is applied with the outcome being that all deaths which need to be investigated are investigated. This will be evidenced through the Mortality Meeting minutes. (22.1a)	30.09.16		Complete	Evidence required: Minutes of the mortality meetings x 3 ALL DIVISIONS (22.1a) Observed attendance at the mortality meetings (22.1a)

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Theme	Mazars Recommendations	SHFT Actions	Responsible Lead	Divisional Responsible Lead	Executive Accountability	Process Completion Date	Process Status	Process Progress Evidence	Evidence of Outcome Achieved	Measuring Success Date	Recovery Date	Outcome Status	Outcome Measure
Information management	23. The spreadsheet arrangement currently in place in TQ21 is insufficient to monitor deaths at corporate level as part of the whole Learning Disability service provision. TQ21 service users should be incorporated into Trust administration systems in a	23.1a Devise and replace the current process in TQ21 with a more robust and complete process agreed by all parties. Report solution to the Mortality Forum. TQ21 is a social care provider does not have a 'patient administration system' which can be triangulated against the National Spine data. Case load NHS numbers should be investigated as a solution.	Simon Beaumont, Head of Informatics (23.1a)	Carol Cleary, Head of Service TQ21 Jennifer Dolman, Clinical Service Director (LD & TQ21) Debbie Robinson, Associate Director TQ21 (23.1a - joint responsibility)	Mark Morgan, Director of Operations AMH, LD & TQ21 Paula Anderson, Chief Finance Officer (23.1a - joint accountability)	30.06.16	**Complete**	Evidence required: Process for TQ21 to be inserted into the Death reporting Procedure at the next review (23.1a)	High quality correct data which informs the Mortality Meeting evidenced through the minutes on SharePoint. This is to ensure that all deaths are know to the Trust and that the procedure is applied with the outcome being that all deaths which need to be investigated are investigated. This will be evidenced through the Mortality Meeting minutes. (23.1a)	30.09.16		**Complete**	Evidence required: Minutes of the mortality meetings x 3 TQ21 (23.1a) Observed attendance at the mortality meeting (23.1a)

UIN	Carolan Theme	Recommendation	Trust Actions	Process Input (measures)	Responsible Lead	Essential Partners	Executive Accountability	Process Completion Date	Process Status	Recovery date	Expected Outcome	Measuring Success Date (Outcome Completion)	Outcome Status	Recovery date	Outcome Measure
1.1a	Recognising that family involvement begins with the very first patient contact, and that it is critical to delivering effective healthcare services	1.1aWorking 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-1 Establishment of a Task and Finish Group for the Family Involvement Action Plan and the family first involvement group 1.1a-2 Contacting and engaging with service users, families and staff to establish a network of stakeholders interested in working with the Trust 1.1a-3 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~~ Liz James, Area Head of Nursing and AHPs ~~Pam Sorensen, Engagement Advisor~~	Sara Courtney, Chief Nurse	30/04/17	Complete		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.	30/04/17	Complete		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.
1.1b	Recognising that family involvement begins with the very first patient contact, and that it is critical to delivering effective healthcare services	1.1b 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-1 Carer involvement in developing and co-producing plans and actions as described in actions 1.1 1.1b-2 Creating a communications plan 1.1b-3 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~~ Paul Draycott, Head of HR	Sarah Cole, Family Therapist Specialised Services	Sara Courtney, Chief Nurse	30/09/17	Completed-unvalidated		In the identification of best practice methodologies, there are a set of enabling strategies that need to be delivered.	30/04/18	On track		Co-produced plans which are coherent
1.1c	Recognising that family involvement begins with the very first patient contact, and that it is critical to delivering effective healthcare services	1.1c 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-1 Co-produce a carer's charter/statement of principle that aligns with HCC development of a carers strategy 1.1c-2 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)~~ from September 2017 John Stagg	Chris Woodfine, Head of Patient Experience and Engagement External carer groups Hampshire County Council MH/LD/SS	Sara Courtney, Chief Nurse	30/06/17	Completed-unvalidated		Staff understand what is expected of them with regards to family involvement; Equally, families understand what to expect from our services	30/04/18	On track		Staff understand what is expected of them with regards to family involvement; Equally, families understand what to expect from our services
1.1d	Recognising that family involvement begins with the very first patient contact, and that it is critical to delivering effective healthcare services	1.1d 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	30/04/18	On track		Divisional champions and accountable leads will work with service users, patients and families to encourage development of practice	30/04/18	On track		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	1.1e 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)									On track		
1.1f	Recognising that family involvement begins with the very first patient contact, and that it is critical to delivering effective healthcare services	1.1fWorking 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~~ Liz James, Head of Nursing and AHPs AMH Kathy Jackson, Head of Nursing - Inpatients OPMH	Carer groups	Sara Courtney, Chief Nurse	30/08/17	Overdue	31/12/17	Families know who to contact if they have any questions	28/02/18	On track		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	1.1g 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 Insure that familys are involved in the process of the clinical services strategy redesign 1.1g To clearly identify when familys should be engaged and support offered	Chris Woodfine, Head of Patient Experience and Engagement		Sara Courtney, Chief Nurse	28.02.18	On track		Carers needs are assessed and support provided		On track		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	1.1h 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	1.1h-1 map out exsisting support posts, identifying strenghts and weaknesses. 1.1h-2 describe an ideal model	Chris Woodfine, Head of Patient Experence and Engagement		Sara Courtney, Chief Nurse	30.06.18	On track		Within services there is a local lead/champion		On track		Within services there is a local lead/champion

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				1.1h-3 develop plans to implement model				31.03.19	On track						
2.1a	Improving the way the Trust communicates and engages with families	2.1a 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-1 Undertake a review of all policies and procedures relating to SIRI and complaint investigations with input from front-line clinical staff 2.1a-2 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	31/07/17	Complete	31/10/17	All Trust policies and procedures relating to investigations are aligned to ensure that communication with families is meaningful.	30/09/17	Complete	31/10/17	Involvement of families' in the review of the SIRI policy and procedure and complaints policy, as identified by the reviewers/contributors within the policies.
2.1b	Improving the way the Trust communicates and engages with families	2.1b 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)~~ Julia Lake ADON BU2 (Sarah Olley) MCP		Sara Courtney, Chief Nurse	30/09/17	Overdue	31.01.18	All Trust policies and procedures relating to investigations are aligned to ensure that communication with families is meaningful.	30/10/17	Complete		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	2.2a 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	30/04/17	Complete		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.	30/04/18	On track		Compliance with the standards outlined in the overarching Trust strategy.
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 Review holistic assessment tools in use across all Trust services to ensure there is appropriate fields for involvement of family. Audit use of assessment tools in practice.	~~Paula Hull, Divisional Director of Nursing and AHPs and chair of Record Keeping and Care Planning work stream.~~ John Stagg now chair of Record Keeping work stream (added Oct 2017)	Record Keeping and Care Planning Work stream	Sara Courtney, Chief Nurse	31/10/17	Complete		Better clinical outcomes and patient experience as well as reduced spend	30/04/18	On track		Staff are directly involving families in care-planning.
2.2c	Improving the way the Trust communicates and engages with families	2.2c 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-1 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-2 Duty of Candour module in the Investigating Officer training workshop 2.2c-3 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	30/06/17	Complete		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	31/03/18	On track		Compliance with Duty of Candour as monitored through the SI and mortality KPI dashboard and audit of records

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2.2d	Improving the way the Trust communicates and engages with families	2.2d 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-1 Review the Being Open policy incorporating the legal Duty of Candour 2.2d-2 Review the SI policy and procedure 2.2d-3 Review the complaints policy 2.2d-4 Review the safeguarding policy 2.2d-5 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	30/09/17	Complete	31/10/17	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	31/12/17	Completed-unvalidated		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
2.3a	Improving the way the Trust communicates and engages with families	2.3a 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	31/05/17	Complete		Staff are consistently documenting the involvement of families during/following an investigation	30/11/17	Complete		Investigation and reports demonstrate involvement of families where families wish to be involved.
2.3b	Improving the way the Trust communicates and engages with families	2.3b 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 questionnaire as a reference guide at the 48 Hour Panel and the CCG Quality checklist to 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	31/07/17	Complete		Staff are consistently documenting the involvement of families during/following an investigation	30/11/17	Complete		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	2.3c 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	30/06/17	Complete		Staff are prompted to document the involvement of families during an investigation	31/08/17	Complete		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	2.3d Add family engagement and its recording to SIRI training workshop	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	31/05/17	Complete		Investigating Officers are trained on steps taken to engage families and how to record onto Ulysses	31/12/17	Complete		Investigating Officers feel confident on engaging families in investigations
2.4a	Improving the way the Trust communicates and engages with families	2.4a 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	31/03/17	Complete		Families feel involved in the investigation as they wish to be.	31/12/17	Complete		Families understand how investigations will be conducted, how they can get involved and be signposted to appropriate support and advice
2.4b	Improving the way the Trust communicates and engages with families	2.4B 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	31/12/17	Complete		Families feel involved in the investigation as they wish to be.	30/04/18	On track		Families report positive feedback in their involvement and support offered

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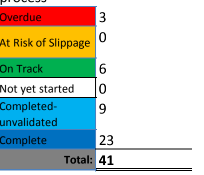
2.5a	Improving the way the Trust communicates and engages with families	2.5a Improving the recording of next of kin data, including where consent to share has not been provided	2.5a Ensure that the Next of Kin section on Rio is made a mandatory field and the Change Control Board oversee a range of training and guidance to ensure that Next of Kin data is completed in all care records	2.5a-1 Amend the Next of Kin section on Rio to ensure that this field is made mandatory 2.5a-2 Embed review of training and guidance for Next of Kin data within the Change Control Board Terms of Reference 2.5a-3 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)~~ John Stagg, chair of Record Keeping and Care Planning work stream	Change Control Board Technology Transformation Team	Paula Anderson, Director of Finance Sara Courtney, Chief Nurse	31/10/17	Complete		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.	31/10/17	Complete		Next of kin recording is in place consistently across the Trust
2.5b	Improving the way the Trust communicates and engages with families	2.5b 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 (Julia Lake, Susanna Preedy, Helen Leary, Carol Adcock, John Stagg, Nicky Bennet)	Divisional Records User Group	Paula Anderson, Director of Finance	31/10/17	Complete		A strengthened process for Next of Kin monitoring is in place across the Trust	31/10/17	Complete		A metric is developed on Tableau for monitoring next of kin data
2.5c	Improving the way the Trust communicates and engages with families	2.5c 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-1 Deliver a families workshop to understand their perspective on barriers to engage 2.5c-2 Understanding the staff perspective on blocks to information sharing 2.5c-3 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		31/10/17	Completed-unvalidated		Staff are competent in managing confidentiality and information sharing with families	31/03/18	On track		RiO records show the judgements staff have made on information sharing when working with families and service users
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-1 Scoping of improved training for Commissioning Managers on the SIRI procedure which should be standardised across the Trust 2.6a-2 Ensure roll out of improved training for Commissioning Managers 2.6a-3 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	31/12/17	Completed-unvalidated		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	31/12/17	Completed-unvalidated		Robust and clear descriptors and expectations of Trust staff roles who are involved in the investigation process
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	2.6b 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	31/07/17	Complete		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	31/12/17	Completed-unvalidated		Robust and clear descriptors and expectations of Trust staff roles who are involved in the investigation process Review of FLO role underway
2.7a	Improving the way the Trust communicates and engages with families	2.7a 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-1 FLO to attend governance and business meetings across divisions to raise awareness of her role and follow up after 6 months 2.7a-2 Investigating Officer makes contact with the FLO via the IMA panel	Elaine Ridley, Family Liaison Officer	Investigating Officers	Sara Courtney, Chief Nurse	31/12/17	Complete		FLO post is embedded within the Trust	30/06/17	Complete		FLO receives referrals from Investigating Officers in a timely manner. 31.07.17 SC validated action as complete.

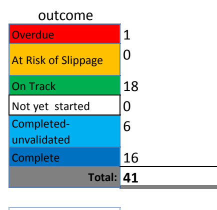
UIN	Carolan Theme	Recommendation	Trust Actions	Process Input (measures)	Responsible Lead	Essential Partners	Executive Accountability	Process Completion Date	Process Status	Recovery date	Expected Outcome	Measuring Success Date (Outcome Completion)	Outcome Status	Recovery date	Outcome Measure
2.7b	Improving the way the Trust communicates and engages with families	2.7b 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-1 Family Liaison Officer to identify the key resources that families may need access to 2.7b-2 FLO to develop a resource bank of community resources	Elaine Ridley, Family Liaison Officer	Third sector networks (external)	Sara Courtney, Chief Nurse	31/12/17	Complete		Families receive information for support according to their needs	30/06/18	On track		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. 2.8 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	2.8 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	31/10/17	Complete		Staff provide the right contact details to the families and that there are clear processes of handover when a staff member changes their role	31/12/17	Complete		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	3.1 Conduct a review of training for staff on the importance of engaging with families in investigations with input from the Family First Involvement Group.	3.1-1 Conduct a review of training for staff on the importance of engaging with families in investigations with input from the Family First Involvement Group. 3.1-2 Conduct a training needs analysis with IOs and CMs 3.1-3 Review of the training programme	Helen Ludford, Associate Director of Quality Governance	Chris Woodfine, Head of Engagement and Experience	Sara Courtney, Chief Nurse	31/10/17	Complete		Training for Investigating Officers and CMs are co-produced with families	31/12/17	Completed-unvalidated		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.	3.2 The training content includes personal stories, videos, case studies/testimonies	3.2-1 Scope improved training programme including training content 3.2-2 The training content includes personal stories, videos, case studies/testimonies 3.2-3 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	31/12/17	Completed-unvalidated		Training resources includes personal accounts of families	31/12/17	Completed-unvalidated		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 3.3 Deliver the training programme as defined by action 3.2	3.3-1 Training to be made available online or a folder resource 3.3-2 Ensure roll out of training programme through LEaD	Helen Ludford, Associate Director of Quality Governance	Learning, Education and Development (LEaD)	Sara Courtney, Chief Nurse	31/03/18	On track		Staff have a detailed resource on training for their roles as Commissioning Manager and Investigating Officer	30/06/18	On track		Undertake an audit on implementation of improved training for Commissioning Managers 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 3.4 Review the role description and person specification for the CM and IO role and develop specific competencies	3.4-1 Undertake a review job descriptions of the IO, CM and FLO 3.4-2 Ensure clarity of roles and responsibilities 3.4-3 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	31/07/17	Complete	08/09/17	IOs and CMs are clear about their roles and meet the person specification	31/07/17	Complete	31.03.18	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: 3.5 To review the capacity of the central investigation team	3.5-1 To review the capacity of the central investigation team 3.5-2 Produce a business case following the review as appropriate	Helen Ludford, Associate Director of Quality Governance	SIRI team	Sara Courtney, Chief Nurse	30/06/17	Complete	30/09/17	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	31/10/17	Complete	31.03.18	Robust and clear descriptors and expectations of Trust staff roles who are involved in the investigation process
3.6	Increasing the competency of staff to engage with families	3.6 Providing peer support opportunities and administrative help for Investigating Officers	3.6 To assess the IOs need for supervision and support and devise a programme	3.6-1 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 3.6-2 Commission Psychologists to review roles and conduct an analysis and feedback 3.6-3 Develop a peer support network of lead Investigating Officers 3.6-4 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	31/10/17	Complete		Staff have a strong network of support and information sharing to enable their role competencies	31/12/17	Complete		Staff have a strong network of support and information sharing to enable their role competencies

UIN	Carolan Theme	Recommendation	Trust Actions	Process Input (measures)	Responsible Lead	Essential Partners	Executive Accountability	Process Completion Date	Process Status	Recovery date	Expected Outcome	Measuring Success Date (Outcome Completion)	Outcome Status	Recovery date	Outcome Measure
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					Complete				Complete		
4.2	Improving the quality of reports	4.2 Giving families access to findings of any investigation including interim findings.	4.2 Establish a protocol on sharing interim findings with families whilst maintaining factual accuracy and adhering to timescales	4.2 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	30/09/17	Completed-unvalidated		Reports are accurate and sensitive to the feelings of the families	31/12/17	Completed-unvalidated		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	4.3 Ensure that families are given the opportunity to comment on the findings and that this is a clear step in protocol	4.3 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	31/12/17	Completed-unvalidated		Reports are accurate and sensitive to the feelings of the families	31/03/18	On track		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	4.4 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: 4.4-1 Action planning with families to be monitored at the WAGs and MOMs 4.4-2 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	31/12/17	Overdue		Families are informed where they wish to be of progress made on agreed actions	31/12/17	Overdue		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	4.5 Ensure that the reports are written in plain English, avoiding jargon, or provide comprehensive glossary of terms and a list of abbreviations	4.5-1 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 4.5-2 Each divisional SIR panels and corporate SIRI panel will have a lay member representative 4.5-3 Provision of a checklist for Ulysses, to ensure that the author includes a glossary 4.5-4 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	31/12/17	Completed-unvalidated		All reports are clear and easy to understand for families	30/06/18	On track		All reports are clear and easy to understand for families Children's and LD already have lay members on panel, AMH mortality have a lay person about to start
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	4.6 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: 4.6-1 Communications plan to include detail/note of family preference for timely contact 4.6-2 Ensuring that SIRI procedure details clear arrangement for point of contact following closure of an investigation	Investigating Officer		Sara Courtney, Chief Nurse	31/12/17	Completed-unvalidated		Families are able to be involved at a time that is suitable to them	31/03/18	On track		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	4.7 Develop mechanisms for feedback from families to enable Trust to measure changes in involvement of families in investigations	4.7-1 Generate qualitative data from surveys and interviews with families to evidence families' involvement 4.7-2 Evidence of families attending the Improvement Panel to observe the improvements made as a result of the recommendations from the investigations 4.7-3 Inviting families to visit the service to illustrate the changes 4.7-4 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	31/03/18	On track		Families are assured that the improvement within the services are embedding following the actions developed from the investigation have been completed	31/06/2018	On track		Survey responses are positive and attendance levels of families at improvement panels



process

Status	Count
Overdue	3
At Risk of Slippage	0
On Track	6
Not yet started	0
Completed-unvalidated	9
Complete	23
Total:	**41**



outcome

Status	Count
Overdue	1
At Risk of Slippage	0
On Track	18
Not yet started	0
Completed-unvalidated	6
Complete	16
Total:	**41**

Incorporating: Produced by: Updated 31.12.17

UIN	Requirement Notice	Core Service	Location	CQC Action (from the Inspection Report)	Regulation Breached	Cause of Regulation Breach	Trust Wide Actions Required	Responsible Leads	Executive Accountability	Action to be completed by (date)	Action to be completed by recovery date	Required Evidence to show completion	Action Progress Update	completed actions (e.g. meeting
RN001 1.1	MUST	Wards for older people with mental health problems	Beaulieu Ward, Western Community Hospital	The trust must ensure that where patients are on one to one nursing observations, staff maintain and review these in line with organisational policy and they do not change them in order to manage low staffing levels.	Regulation 12 (1) and (2)(a)(b)(e)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safe care and treatment	Beaulieu Ward staff reduced patient observation levels to manage low staff numbers.	1.1 Safer Staffing Lead to review red flagged staffing incidents and escalate to Associate Directors of Nursing if staffing levels have impacted on one to one nursing observations.	Kathy Jackson, Head of Inpatients supported by Sue Jewell, Safer Staffing Lead.	Sara Courtney, Acting Director of Nursing	**30.11.17**		Monthly Safer Staffing reports.	Monthly Safer Staffing reports include all red flagged staffing incidents which are reviewed by Deputy Director of Nursing & AHPs.	Complete
RN001 1.2							1.2 Circulate correct escalation process for inadequate staffing levels. Staff to report staffing incidents as per Safer Staffing Policy.			**31.10.17**		Escalation process circulated. Staffing incidents are reported - review Ulysses. Safer Staffing reports	Escalation process circulated to staff. Staffing incidents reported onto Ulysses and included in Safer Staffing reports.	Complete
RN001 1.3							1.3. Ensure robust procedure is in place for the review of patient one to one observations within MDT. Identify other staff groups who could support one to one observations eg OTs.			**31.10.17**		Review sample of patient records for one to one observations in MDT discussions.	Random sample of patient records on Beaulieu ward found 9/10 had one to one observations discussed at MDT - indicates that practice has changed since inspection. New template has been developed for use on RiO which supports the recording of observations.	Complete
RN001 1.4							1.4. Ensure compliance with E-Roster checklist.			**31.10.17**		Completed e-roster checklist.	All local team leads/ward managers are completing monthly checklist of e-roster compliance. Checklists are then reviewed by matrons to understand any staffing issues.	Complete
RN002 2.1	MUST	Wards for older people with mental health problems	Stephano Olivieri, Melbury Lodge, Berrywood/Beaulieu wards, Western Community Hospital	The trust must ensure that all do not attempt cardiopulmonary resuscitation (DNACPR) records and sharing of DNACPR information are correct and consistent at all times.	Regulation 12 (1) and (2)(a)(b)(e)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safe care and treatment	We found on Stefano Olivieri, Berrywood and Beaulieu ward issues relating to best interest meetings and covert medication practices and the sharing of correct information amongst staff related to DNACPR procedures.	2.1 To review the best interests section in the DNACPR Policy and strengthen as required. This will include the development and circulation of flowcharts for staff on a) how to complete DNACPR forms b) what information to check on DNACPR forms completed elsewhere for patients transferring into our care.	Simon Johnson, Head of Essential Training Delivery supported by Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary Carol Adcock, John Stagg, Nicky Bennett added Clinical Directors Oct 2017: Robin Harlow BU1 Rachel Anderson BU2 Juanita Pascual BU3	Sara Courtney, Acting Director of Nursing	**30.09.17**		Revised guidance is circulated to staff. Flowcharts are developed and in place.	Revised Policy published which includes flowcharts on how DNACPR forms are to be completed as appendices.	Complete
RN002 2.2							2.2 The resuscitation team to complete an initial audit of the DNACPR process with actions developed based on audit findings.			**30.09.17**	**30.11.17**	Results and report of DNACPR audit and action plan.	Baseline audits completed with good practice and improvements identified. Actions are required by medical and nursing staff.	Complete
RN002 2.3							2.3 The resuscitation team to complete 3 x bi-monthly DNACPR audits (Oct/Dec 17/Feb 18) to ensure any actions required are embedded into everyday practice. At end of this period review need for further audit.			**28.02.18**		Results and reports of DNACPR audits and action plans per audit.	Audits repeated in December 2017. Results currently being fedback to teams.	On track
RN002 2.4							2.4 To include the importance of patient and family involvement in DNACPR decisions and documentation of mental capacity in trust training.			**30.11.17**		Training materials.	DNACPR flowcharts in Policy higlight importance of discussion with patient & family/assessment of mental capacity. Basic and advanced life support training include section on DNACPR and reviewing how to include in mental capacity training.	Completed-unvalidated
RN003 3.1	MUST	Wards for older people with mental health problems	Stephano Olivieri, Melbury Lodge	The trust must ensure that the privacy and dignity of the patients on Stefano Olivieri ward is adequately protected.	Regulation 10 (1) and (2) (a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Dignity and respect	There were privacy and dignity issues relating to the bathroom facilities on Stefano Olivieri. Patients from the adjoining acute admissions ward were able to see into the toilet and bathrooms on Stefano Olivieri ward.	3.1 New windows are on order which will resolve privacy issues. These should be installed by end November 2017.	Kathy Jackson, Head of Inpatients supported by Scott Jones, Deputy Head of Estates Services Gary Rollings, Estates	Paula Hull, Acting Director of Operations (ISD)	**30.11.17**		Site visit to confirm installation of windows in place and privacy issues resolved.	New windows installed.	Complete
RN003 3.2							3.2 To review privacy and dignity PLACE results for Stephano Olivieri (SOU) ward and implement actions based on feedback as appropriate.			**31.10.17**		PLACE feedback and action plan where appropriate.	PLACE site assessments completed with mostly positive feedback for SOU. Service use 'swing' bedrooms for either male or female patients only when it is appropriate to do so with regard to surrounding patient cohort. There have been no breaches of same sex accommodation guidance on SOU.	Complete
RN003 3.3							3.3 Estates team to review the current position of the garden boundary between SOU and adjacent wards and provide options of alternative configurations.			**30.09.17**		Results of estates review and options proposal.	Estates reviewed garden boundary with services and proposed widening flowerbed so patients unable to get close to windows and put up privacy screen by office windows to ensure confidentiality.	Complete
RN003 3.4							3.4 Estates solution to be implemented once decision made regarding options at senior level.			**28.02.18**		Site visit to confirm estates work completed per decision made.	Proposal costed and approved with work to be completed by March.	On track
RN004 4.1	MUST	Wards for older people with mental health problems	Wards for older people with mental health problems	The trust must ensure that it continues with and completes all outstanding ligature works.	Regulation 17 (1) and (2) (b)(c) Health and Social Care Act 2008 (Regulated Activities)	The environmental improvement plan had not been completed across some wards improvement plan was not yet complete. The trust	4.1 Estate Services will conduct a review of all OPMH wards to ensure that all remaining ligature works have been undertaken and /or are in progress and that the environmental work plans have been updated to reflect the accurate position.	Kathy Jackson, Head of Inpatients supported by Karen Thomas, Ligature Manager (left Oct 2017) Scott Jones, Deputy Head of Estates Services	Mark Morgan, Director of Operations Mental Health & Learning Disabilities	**30.11.17**		Completed capital projects signed off in ligature management group.	Capital works programme underway with all OPMH wards visited to ensure ligature works are being completed - Berrywood, Dryad and SOU works are completed with work ongoing for Beechwood ward.	Completed-unvalidated
RN004 4.2							4.2 To complete estates works to provide all OPMH functional wards with 2 'safe' bedrooms.			**31.12.17**		Site visit to confirm bedrooms are completed.	Capital works programme underway with OPMH functional wards visited to ensure ' safe' bedrooms works are being completed - Berrywood and Dryad works are completed with work due to start on Beechwood.	Overdue
RN005 5.1	MUST	Wards for older people with mental health problems	~~Stephano Olivieri, Melbury Lodge, Berrywood~~/Beaulieu wards, Western Community Hospital	The trust must ensure that staff use covert medication in a manner that is in line with organisation's policy and procedure.	Regulation 12 (1) and (2)(a)(b)(e)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safe care and treatment	We found on ~~Stefano Olivieri, Berrywood~~ and Beaulieu ward issues relating to best interest meetings and covert medication practices and the sharing of correct information amongst staff related to DNACPR procedures.	5.1 To review current covert medicines guidance, strengthen where required and circulate to staff.	Raj Parekh, Chief Pharmacist	Dr Sarah Constantine, Interim Medical Director	**31.10.17**		Revised covert medicine guidance completed and circulated.	Covert medicines guidance revised and included in the Medicines Control, Administrtaion and Prescribing Policy (MCAPP)(SHCP1). Communication to staff summarising revisions to policy due to be circulated.	Complete
RN005 5.2							5.2 Retrain registered nurses on ~~SOU, Berrywood and~~ Beaulieu wards in administration of covert medicines.			**31.10.17**	**31.12.17**	Training sessions evidenced.	Training completed.	Completed-unvalidated
RN005 5.3							5.3 OPMH ward managers to complete weekly checklists which include covert medicines and take to monthly OPMH managers meeting for review and escalation as required.	Kathy Jackson, Head of Inpatients		**30.11.17**		Minutes of monthly OPMH managers meeting.	Weekly checklists are discussed at monthly OPMH managers meetings with any issues addressed.	Complete

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RN005 5.4							5.4 Medicines Management Committee (bi-monthly) to review incidents across the trust for re-occurrence of covert medication/best interests incidents.	Raj Parekh, Chief Pharmacist		**31.12.17**		Minutes of Medicines Management Committee.	Section on covert medication added to quarterly Medicine Safety Officer report for Q2 - report submitted to Patient Safety Group meeting in November.	**Complete**
RN006 6.1	**MUST**	Community-based mental health services for older people	Gosport team	The trust must assess staff caseloads in the Gosport team and ensure there is sufficient staff capacity to manage allocated caseloads.	Regulation 18 (1) and (2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations	The provider had not ensured there were sufficient members of staff at Gosport to meet the numbers of patients on the caseload.	6.1 To complete a caseload review with the Gosport team, comparing to other OPMH team caseloads and implement actions where required, including discussions with commissioners about the service needs/capacity.	Helen Neary, Associate Director of Nursing and AHPS supported by Sue Jewell, Safer Staffing Lead	Paula Hull, Acting Director of Operations (ISD)	**28.02.18**		Results of caseload review and action plan in place.	Ongoing work in collaboration with Safer Staffing Lead and linking to development of OPMH services as a separate business unit.	**On track**
RN006 6.2							6.2 Caseload review to include active discharge of patients where appropriate.			**28.02.18**		Results of caseload review - caseload figures on tableau to evidence discharge process.	Caseload review is part of work in 6.1 . Memory clinics can make caseloads look large.	**On track**
RN007 7.1	**MUST**	Community-based mental health services for older people		The trust must ensure that next of kin details are clearly recorded on the patient care records	Regulation 17 (1) and (2) (b)(c) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Good governance	There was inconsistent completion of next of kin details in care records	7.1 Review Next of Kin compliance at monthly divisional governance/performance meetings to ensure target '80% of patients have next of kin/other relationships recorded' is met and maintained over 3 months. Aug NoK: ISD 80.8%; OPMH 85.1%; AMH 74.0%; LD 84.5%. Nov NoK: ISD 83.5%; OPMH 86.2%; AMH: 76.6%; LD 85.2%.	Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary Carol Adcock, John Stagg, Nicky Bennett Liz Taylor	Sara Courtney, Acting Director of Nursing	**31.12.17**		Minutes of divisional governance/performance meeting with NoK compliance minuted.	All divisions meeting 80% target to record next of kin/relevant other relationship with exception of Adult Mental Health services (78.6%). Compliance is discussed at monthly performance meetings.	**Overdue**
RN008 8.1	**MUST**	Community-based mental health services for adults of working age		The trust must ensure that staff update relevant care records fully and in a timely manner when changes to a patients' risks are identified.	Regulation 17 (1) and (2) (b)(c) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Good governance	There was poor completion of crisis plans and there was risk information missing from care records we reviewed for people accessing the service.	8.1 Every patient must have an up to date and individualised risk assessment which is clearly accessible within the clinical records (Quality Account Priority). Risk assessment completion to continue to be monitored using Tableau including timeliness. Quarterly record keeping audit will monitor compliance. Target is 95% of patients have a risk assessment as per Risk Assessment Policy.	Associate Directors of Nursing and AHPs: Carol Adcock, John Stagg, Nicky Bennett	Mark Morgan, Director of Operations Mental Health & Learning Disabilities	**31.03.18**		Results of record keeping audits and actions to be implemented based on recommendations.	Learning Disabilities, Older People's Mental Health and Specialised Services are meeting 95% target for risk assessments to be completed. Adult Mental Health Services are close to target with 94.4% completed. AMH risk assessments and compliance reviewed at monthly performance meetings and in clinical supervision with individual clinicians.	**On track**
RN008 8.2							8.2 Development of a framework and guidance tool to support clinicians developing crisis contingency plans with patient and carer/family input (Quality Account priority).			**completed**		Framework and guidance tools in place.	Framework and guidance tools in place and circulated to staff.	**Complete**
RN008 8.3							8.3 Audit of Risk summary to be analysed for quality as part of clinical audit programme and subsequently as part of supervision. The record keeping and holistic assessment audits will be strengthened to focus on the quality of risk assessment and crisis contingency plans and the programme will facilitate a quarterly audit (Quality Account priority).			**31.03.18**		Results of record keeping audits and actions to be implemented based on recommendations.	Risk assessment audits complted -s till some improvements to quality to be made. Customised audit developed for Learning Disabilities.	**At risk of slippage**
RN008 8.4							8.4 Associate Directors of Nursing and AHPs (ADONS) will complete a sample review of 2 patients per month using a standard template on risk assessment and crisis plan completion. ADONs will take action as required to address compliance issues.			**31.01.18**		Exception reporting for sample cases reviewed.	Sample review of patients using standard template is ongoing.	**On track**
RN008 8.5							8.5 Clinical staff to undertake mandatory risk training as per policy.			**31.12.17**		Training compliance figures (tableau).		**Complete**
RN009 9.1	**MUST**	Community-based mental health services for adults of working age		The provider must ensure that there are crisis plans in place for patients accessing the service, where risk assessments indicate this is required.	Regulation 12 (1) and (2)(a)(b)(e)(g) of the Health and Social Care Act 2008 (Regulated Activities)	There was poor completion of crisis plans and there was risk information missing from care records we reviewed for people accessing the service.	9.1 A communication plan to be developed to ensure staff are aware of how to be adherent to the policy: specifically when to complete crisis, safety or combined plans.	Carol Adcock, Associate Director of Nursing and AHPs	Mark Morgan, Director of Operations Mental Health & Learning Disabilities	**31.10.17**		Copy of the communication plan	Following feedback that having two separate care plans ('my safety' and 'my crisis') is not beneficial and decision made to have single crisis/risk plan.	**Completed-unvalidated**
RN009 9.2							9.2 Monthly compliance with completion of crisis plans to be reported at the Mental Health Quality and Safety Meeting (QSM).			**30.11.17**		Minutes of QSM	Mental Health Quality and Safety Meetings review compliance with completion of crisis plans - close to achieving 95% target with 94.6% completion for November to date.	**Complete**
RN010 10.1	**MUST**	Community-based mental health services for adults of working age		The trust must ensure that next of kin details are clearly recorded on the patient care records	Regulation 17 (1) and (2) (b)(c) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Good governance	There was inconsistent completion of next of kin details in care records	see actions in 7	Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary Carol Adcock, John Stagg, Nicky Bennett Liz Taylor						**Duplicate**
RN011 11.1	**MUST**	Community-based mental health services for adults of working age		The trust must ensure there are sufficient numbers of suitably qualified/trained and competent staff to meet the needs of the numbers of	Regulation 18 (1) and (2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations	There were insufficient members of staff to meet the numbers of patients on the caseload in some of the teams.	11.1 To bring acuity and dependency measurement for Community Mental Health Teams (CMHTs) in line with existing trust establishment review process as identified within the Safer Staffing Policy.	Carol Adcock, Associate Director of Nursing and AHPs supported by Sue Jewell, Safer Staffing Lead	Mark Morgan, Director of Operations Mental Health & Learning Disabilities	**30.11.17**		Results of acuity and dependency review.	Ongoing work in collaboration with Safer Staffing Lead - validation exercise of acuity and dependency measurements due end November.	**Complete**

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RN012 12.1	MUST	End of life care		The trust must ensure that do not attempt cardiopulmonary resuscitation (DNACPR) forms are completed in line with national guidance.	Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Need for consent	All of the do not attempt cardio-pulmonary resuscitation (DNACPR) forms we reviewed were not completed in line with national guidance.	see actions in 2	Simon Johnson, Head of Essential Training Delivery supported by Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary Carol Adcock, John Stagg, Nicky Bennett						Duplicate
RN013 13.1	MUST	End of life care		The trust must improve appraisal rates for community nursing staff.	Regulation 18 (1) and (2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Staffing	Appraisal rates for community nursing staff were low	13.1 Appraisals to be completed for community teams and to be in line with Trust target.	Julia Lake, Associate Director of Nursing & Allied Health Professionals	Paula Hull, Acting Director of Operations (ISD)	31.12.17		Appraisal performance data for community teams.	Appraisal rates for Integrated Service Division close to achieving 95% target (94.5%).	Complete
RN014 14.1	MUST	End of life care		The trust must ensure that individualised care for patients at end of life is planned and delivered for patients cared for at home.	Regulation 9 (1) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Person-centred care	Care was not always provided person centred because: The trust did not use individualised end of life care plans for patients cared for at home.	14.1. Roll out of the end of life care plan for use in the community team.	Julia Lake, Associate Director of Nursing & Allied Health Professionals	Sara Courtney, Acting Director of Nursing	31.10.17		End of Life Care Plan for use in community.	End of LIfe Steering Group has led on development of end of life care plans for use with inpatients/in patients home with ongoing work to add onto RiO. End of Life Steering Group is reviewing feedback from staff re use of these plans.	Complete
RN014 14.2							14.2. undertake road shows to promote the use of end of life care plan.			completed		Dates and attendance at roadshows.	Roadshows taken place in May 2017. Will look to repeat these in early 2018.	Complete
RN014 14.3							14.3. Audit the use of the end of life care plan in quarter 3 thematic review.			28.02.18		Results and report on the audit/thematic review.	Thematic review of end of life care is ongoing with data review to be completed by year end and report by end January 2018.	On track
RN015 15.1	MUST	End of life care		The trust must ensure that community staff have access to up to date information in the record of patients at end of	Regulation 12 (1) and (2)(a)(b)(e)(g) of the Health and Social Care Act 2008	All community staff did not have access to up to date information in the record of patients at the end of life.	15.1. Improve compliance with completion of patient record on the day of care.	Julia Lake, Associate Director of Nursing & Allied Health Professionals	Sara Courtney, Acting Director of Nursing	28.02.18		RiO change request is actioned.	Ulysses amended so that can review end of life incidents separately. Change request made to add end of life care plan onto RiO so that information available to staff.	On track
RN015 15.2							15.2 To scope the numbers of staff that are able to use Store and Forward; maximise the use of existing licences and develop a business case for additional licenses if required.			31.12.17		Results of scoping exercise- may be part of thematic review.	End of Life Steering Group reviewing electronic document management system with paper records written in patient home to be scanned onto RiO and then destroyed.	On track
RN016 16.1	MUST	End of life care	Romsey Hospital	The trust must ensure that appropriate support is available to community hospital staff to respond to end of life care patients who deteriorate.	Regulation 12 (1) and (2)(a)(b)(e)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations	Staff at Romsey Hospital did not have access to timely support to respond to end of life care patients who deteriorated.	16.1. Review pathway for transfer of care between Romsey hospital and the acute services.	Julia Lake, Associate Director of Nursing & Allied Health Professionals	Sara Courtney, Acting Director of Nursing	31.01.18		Pathway Review completed.	Service Level Agreement for pathways regarding transfer of care is being reviewed..	On track
RN016 16.2							16.2. Raise with Consultant responsible for Romsey hospital the importance for having clear plans in place for escalation of care and document in the medical notes.			30.11.17		Individual escalation plans for patients at end of life in place.	Clear care plans and escalation process in place.	Complete
RN016 16.3							16.3. To discuss with staff at team meetings the escalation plans in place for patients and the need to act on these as required.			30.11.17		Staff follow escalation plans for individual patients.	Escalation processes discussed in team meetings.	Complete
RN016 17.1	MUST	Community Inpatient services	Gosport War Memorial Hospital	The trust must have appropriate measures in place to ensure that staffing levels are safe for every shift and in particular at Gosport War Memorial hospital.	Regulation 18 (1) and (2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations	There was not always adequate staffing to meet the assessed needs of people receiving care and treatment. This included patients who required 1:1 support	17.1 To review daily staffing levels in line with Safer Staffing Policy and escalate as per real time management of staffing levels guidance. Bespoke policy training can be provided if required.	Helen Neary, Associate Director of Nursing supported by Sue Jewell, Safer Staffing Lead	Sara Courtney, Acting Director of Nursing	31.10.17		Safer Staffing Policy	Matrons review staffing levels on daily basis and escalate any staffing issues. Staffing levels for stand alone wards can be challengin if staff off sick. Change of pathways in April 2017 by QAH has had impact on GWMH and Petersfield.	Complete
RN016 17.2							17.2 Implementation of SafeCare which will provide live staffing status of safe staffing levels based upon patient needs and actual staffing levels.			31.03.18		SafeCare is in place.	Pilot started at LNFH.	On track
RN018 18.1	MUST	Community Inpatient services		The trust must ensure that staff complete mandatory training, including basic and advanced life support, to safeguard patients receiving care.	Regulation 18 (1) and (2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Staffing	All clinical staff had not completed basic life support training which could impact of the welfare and safety of patients receiving care at the service.	18.1 LEaD to continue to review the 5 teams per division with the lowest training compliance and contact managers/individual staff to action where required. Bespoke training can be arranged if whole ward/large team requires training update.	Associate Directors of Nursing Julia Lake, Susanna Preedy, Helen Neary supported by Simon Johnson, Head of Essential Training Delivery	Sara Courtney, Acting Director of Nursing	31.01.18		Training compliance data per team/division - training target 95% within trust. E-mail reminders to staff /automatic reminders to staff of training requiring completion.	LEaD were circulating information about the teams with lowest training compliance on monthly basis but are now also looking at teams with highest number of non compliant staff to capture that some larger teams can have higher number of non compliant staff.. They will send out info on each in alternate months.	On track
RN019 19.1	MUST	Community Inpatient services		The trust must ensure that all medicines are managed in line with manufacturers guidelines, and that when opened they are labelled with the patient's name and administered accordingly.	Regulation 12 (1) and (2)(a)(b)(e)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safe care and treatment	Staff did not follow policies and procedures about managing medicines. Medicines were not stored safely and systems were not effective to ensure medicines were used within the recommended timescale once opened. Patients were put at risk of receiving medicines	19.1 To review current guidance on single use of medicines and strengthen where required and circulate to staff.	Raj Parekh, Chief Pharmacist	Dr Sarah Constantine, Interim Medical Director	31.10.17		Revised single use of medicines guidance.	Revised guidance on single use of medicines included in revised MCAPP (SHCP 1) Poster on use of creams/lotions circulated to staff.	Complete
RN019 19.2							19.2 To include single use of medicines in the annual Safe and Secure Medicines audit.			30.11.17		Audit tool - Safe and Secure Medicines	Safe and Secure Medicines audit - results circulated Dec 2017.	Completed-unvalidated
RN019 19.3							19.3 Audit to be completed across all inpatient units/wards with action plans developed based on audit recommendations.	Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary Carol Adcock, John Stagg, Nicky Bennett Liz Taylor		31.12.17		Audit results/reports and completed action plans.	Safe and Secure Medicines audit - results circulated Dec 2017.	Completed-unvalidated

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RN019 19.4						that had expired.	19.4 To review the current Medicines Management Quality Checklist and add information to check that correct procedure to follow for single use medicines is followed.	Raj Parekh, Chief Pharmacist		30.09.17		Revised Medicine Management Quality Checklist.	Checklist amended to include single use of medicines. Safe and Secure audit includes compliance with single use of medicines.	Complete
RN019 19.5							19.5 Medicines Management Committee (bi-monthly) to review progress with completion of audit actions.	Raj Parekh, Chief Pharmacist		31.12.17		Minutes of Medicines Management Committee.	Audit results presented to the Medicines Management Committee in January.	Completed-unvalidated
RN020 20.1	MUST	Community Inpatient services		The trust must ensure that staff adhere to policies and procedures for the safe management of medicines at all times to protect patients from the risk of harm.	Regulation 12 (1) and (2)(a)(b)(e)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safe care and treatment	Staff did not follow policies and procedures about managing medicines. Medicines were not stored safely and systems were not effective to ensure medicines were used within the recommended timescale once opened. Patients were put at risk of receiving medicines that had expired.	20.1 To develop guidance on expiry dates for medicines for use by staff on wards and circulate. This guidance to include use of stock insulin.	Raj Parekh, Chief Pharmacist supported by the Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy,	Dr Sarah Constantine, Interim Medical Director	30.09.17	13.10.17	Expiry date guidance.	Guidance on expiry date of medcines included in revised MCAPP (SHCP 1).	Complete
RN020 20.2							20.2 To design and order expiry date labels for use with all patients' liquid medicines and insulin.	Raj Parekh, Chief Pharmacist		31.08.17		Expiry date labels.	Labels ordered and distributed to wards for use.	Complete
RN020 20.3							20.3 To review the current Medicines Management Quality Checklist and add information to check that correct procedure to follow for medicine expiry dates is followed.	Raj Parekh, Chief Pharmacist		30.09.17		Revised Medicine Management Quality Checklist. Audit results	Sept: Checklist reviewed/revised and approved by MMC 20/09/17. Safe and Secure Medicines audit includes expiry date compliance - data collection in October with report being written..	Complete
RN020 20.4							20.4 Medicines Management Committee (bi-monthly) to review progress with completion of action.	Raj Parekh, Chief Pharmacist		31.12.17		Minutes of Medicines Management Committee.	Medicines Management Committee reviews progress with actions.	Complete
RN021 21.1	MUST	Community Inpatient services	Gosport War Memorial Hospital	The trust must ensure that all staff follow effective infection control procedures when dealing with and disposing of infected materials. In particular, at Gosport War Memorial Hospital.	Regulation 12 (1) and (2)(a)(b)(e)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safe care and treatment	Some staff did not follow effective infection control procedures in particular when dealing with and disposing of infected materials at Gosport War Memorial Hospital	21.1 Include CQC feedback and actions in quarterly IPC Report and Newsletter.	~~Theresa Lewis, Lead Nurse~~ Jacky Hunt, Lead Nurse Infection, Prevention and Control supported by the Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary Carol Adcock, John Stagg, Nicky Bennett supported by Bob Beeching, Contracts and Project Manager and Sally Banberry(Trust Waste Manager), Karen Poting (GWMH site waste manager)	Sara Courtney, Acting Director of Nursing	31.12.17		21.1 IPC Quarterly Report /IPC Newsletter IPC Matters (Quarter 3)	' Infection Prevention Matters' newsletter includes range of information.	Complete
RN021 21.2							21.2 Infection Prevention and Control (IPC) team to discuss best practice /CQC feedback at 'face to face' training sessions.			31.12.17		21.2 IPC Quarterly Report to include training sessions.	Infection Control and PreventionTeam discuss best practice at all site/team visits.	Complete
RN021 21.3							21.3 IPC team to add CQC feedback and actions for next IPC Link Advisor meeting .			31.10.17		Minutes of IPC Link Advisor Meetings due in October 2017.	Presentation to Link Advisors in October includes feedback from CQC actions as well as results of audits/best practice guidance on key topics.	Complete
RN021 21.4							21.4 IPC advisors to observe staff practice when undertaking 'back to the floor' visits.			31.12.17		Back to the floor' visit timetable and feedback by exception from any visit.	Infection Control and Prevention Team observe staff and discuss best practice at all site/team visits.	Complete
RN021 21.5							21.5 IPC team to circulate waste disposal guidance summary to teams.			01.09.17		Waste Disposal Guidance circulated.	IPC lead circulated waste disposal guidelines to teams. Waste disposal guidance also in IPC Q2 Infection Prevention Matters newsletter.	Complete
RN021 21.6							21.6 IPC team to monitor that staff are in date with their IPC training (> 95%) and raise low compliance with team managers.			31.12.17		IPC training compliance.	IPC training compliance 96%.	Complete
RN021 21.7							21.7 Ensure that IPC is part of the organisational induction checklist for non-permanent staff (in Organisational Induction Policy).			30.09.17		Local Induction Checklist in place.	Amendments made to Organisational Induction Policy with appendix C - Record of local induction for non permanent staff which includes IPC requirements.	Complete
RN021 21.8							21.8 Estates services to develop and circulate poster with all relevant laundry guidance and links to web pages which has all the information on linen handling.			30.09.17		Poster in place.	Laundry poster with guidance re waste disposal and signposting for further support for use at all inpatient sites circulated by Estates.	Complete
RN021 21.9							21.9 Estates services to lead on completion of laundry audit based on Laundry Policy by site managers and to support development of action plan by teams based on results where required.			30.11.17		Results of audit and action plan based on recommendations.	Laundry audit completed by Estates with walk round of GWMH site in Nov 2017.	Complete
RN022 22.1	MUST	Community Inpatient services		The trust must ensure that all equipment used for providing care or treatment is safe for use at all times and meets the needs of the patients.	Regulation 12 (1) and (2)(a)(b)(e)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safe care and treatment	Equipment was not maintained safely and the drug fridge which was in use had not been serviced in line with recommendations and the trust policy.	22.1. Review the specific fridge in Gosport War Memorial Hospital and check service history with BCAS - complete service if it is overdue.	Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary Carol Adcock, John Stagg, Nicky Bennett Liz Taylor supported by Tracey Hammond, Medical Devices Advisor Sally Banberry, BCAS contract manager	Sara Courtney, Acting Director of Nursing	31.08.17		All equipment has been serviced and is in date - evidenced by the BCAS equipment list.	BCAS contract meeting in September minuted that fridge at GWMH is in date for servicing and agreed process to ensure all equipment is labelled with correct service sticker.	Complete
RN022 22.2							22.2. Ensure all equipment is labelled with the correct service sticker.			31.10.17		Spot check audits.	BCAS contract meeting in August agreed process to ensure all equipment is labelled with correct service sticker.They will remove any old service or PAT testing stickers as they service equipment. Medical Devices advisor completes mini site audits and checks are included in peer reviews.	Complete
RN022 22.3							22.3. Meet with BCAS to agree that they will check each piece of equipment as they service it and remove any old service to PAT testing stickers.			31.08.17		Minutes of Meeting 16.08.17.	BCAS contract meeting in August agreed process to ensure all equipment is labelled with correct service sticker.They will remove any old service or PAT testing stickers as they service equipment.	Complete
RN022 22.4							22.4. Monitor at BCAS contract meetings.			31.10.17		Any issue are raised at BCAS contract meetings and actions agreed and minuted.	Monthly meetings with BCAS in place and issues are raised and actioned.	Complete

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RN023 23.1	SHOULD	Community Inpatient Services		(none in report)	Regulation 17 (1) and (2) (b)(c) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Good governance	The governance process to assess, monitor and improve the quality of the service was not robust. Risks were not consistently assessed in order to mitigate these. There was a lack of oversight where services were not performing.	**CQC agreed via e-mail to Trust to remove this action.**							no action required
RN024 24.1	MUST	Community health services for adults		The trust must ensure that all staff understand and recognise safeguarding concerns	Regulation 13 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safeguarding service users from abuse and improper treatment	Staff did not always recognise and escalate safeguarding concerns.	24.1 Communications to staff: 1. Distribute of NHS England Safeguarding 'Pocket Principles' Cards to all service areas. 2.Design and distribute Safeguarding Poster – when to make a referral (to complement the existing poster about how to make a referral).	Caz MacLean, Associate Director of Safeguarding supported by the Corporate Safeguarding Communications Group; Safeguarding Quality Workstream	Sara Courtney, Acting Director of Nursing	**1. 31.08.17** **2. 31.10.17**		Communications to staff: 1. Confirmation of receipt of Pocket Principles and dissemination. 2.Safeguarding Poster – when to make a referral on display	'Pocket Principles' have been being distributed at Safeguarding Training since May 2017 and continue to distribute. Safeguarding poster with details of team and how to make a referral circulated to teams for their use.	Complete
RN024 24.2							24.2 Training: 1.Design and deliver Safeguarding learning set – how to recognise abuse, neglect, and self-neglect. Bespoke training can be provided as required to identified teams. 2.The team will be carrying out a comprehensive review of mandatory training material, delivery and learning methods, and review compliance on an ongoing basis. An incremental review of Safeguarding Adults sections is underway.	Caz MacLean, Associate Director of Safeguarding supported by the Corporate Safeguarding Training Group; Safeguarding Quality Workstream		**1. 30.09.17** **2. 31.08.17**		Training: 1.Learning set materials and attendance sheet 2.Incremental Course Material (in powerpoint presentation. Training compliance data (Tableau system)	Learning sets delivered regularly monthly from March 17. Variety of topics including how to recognise abuse, neglect. Incremental Review completed and first delivered 04/10/2017. Training ongoing.	Complete
RN024 24.3							24.3 Team Processes: 1.Confirm that Safeguarding is a standard agenda item in Multi-Disciplinary Team (MDT) meetings. 2. Confirm that Safeguarding is a standard item in all clinical supervision templates. 3.Scope the development of a network of Business Unit Safeguarding Champions, Representatives and Coordinators.	Caz MacLean, Associate Director of Safeguarding supported by the Corporate Safeguarding Team; Safeguarding Quality Workstream		**31.10.17**		Team Processes: 1. Blank template of MDT Agenda, sample audit 2. Blank clinical supervision templates, sample audit 3. Report to Safeguarding Forum	Safeguarding Team have scoped that safeguarding is standard within clinical supervision. Have scoped developement of network of safeguarding champions.	Complete
RN025 25.1	MUST	Community health services for adults		The trust must ensure that all staff escalate safeguarding concerns following the trust and local authority safeguarding procedures	Regulation 13 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safeguarding service users from abuse and improper treatment	Staff did not always recognise and escalate safeguarding concerns.	25.1 Communications to staff: Confirm Safeguarding Poster on how to make a referral and access to Trust Safeguarding support are prominently displayed in all service staff areas.	Caz MacLean, Associate Director of Safeguarding supported by the Corporate Safeguarding Communications Group; Safeguarding Quality Workstream	Sara Courtney, Acting Director of Nursing	**31.10.17**		Communications to staff: 1.Safeguarding Poster – when to make a referral on display	Safeguarding poster with details of team and how to make a referral circulated to teams for their use. Display of posters is checked via peer reviews.	Complete
RN025 25.2							25.2 see 24.2	Caz MacLean, Associate Director of Safeguarding supported by the Corporate Safeguarding Training Group;						Duplicate
RN025 25.3							25.3 see 24.3	Caz MacLean, Associate Director of Safeguarding supported by the Corporate Safeguarding Team;						Duplicate
RN026 26.1	MUST	Community health services for adults	Alton Hospital	The trust must ensure that staff store medicines at the Alton intravenous clinic securely and that only staff that need to access the medicines are able to access them.	Regulation 12 (1) and (2)(a)(b)(e)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safe care and treatment	Storage of medicines in the intravenous clinic and Alton Hospital was not secure and some medicines had passed their expiry date	26.1 To review current guidance on safe and secure storage of medicines on wards and in clinics and strengthen where required and circulate to staff.	Raj Parekh, Chief Pharmacist	Dr Sarah Constantine, Interim Medical Director	**31.12.17**		Revised safe storage of medicines guidance.	Guidance on safe and secure storage of medicines reviewed and is part of Safe and Secure audit of medicines completed at end 2017.	Completed-unvalidated
RN026 26.2							26.2 Alton Hospital to implement a process whereby the door codes are changed at agreed intervals and there are signs on medicine storage rooms 'doors must be closed'.	Susanna Preedy, Associate Directors for Nursing and AHPs		**31.10.17**		Signs in place - site visits required to check. Process to change door codes in place.	Estates visited Alton Hospital and changed door codes as part of 6 month ongoing programme.	Complete
RN027 27.1	MUST	Community health services for adults		The trust must work with the commissioners to improve wheelchair provision for community service patients.	Regulation 17 (1) and (2) (b)(c) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Good governance	Systems were not in place to ensure equipment (wheelchairs) was supplied by the service provider, ensuring that there were sufficient quantities to ensure the safety of the service user and to	27.1. To meet with CCG and wheelchair providers to agree improvements to wheelchair provision.	Helen Ludford, Associate Director Quality Governance supported by the Associate Directors of Nursing and AHPs:	Sara Courtney, Acting Director of Nursing	**30.09.17**		Minutes of contract meetings.	Initial meeting took place in August - wheelchair provider are committed to working with us to improve services to patients. Monthly meetings with wheelchair provider and clinical representatives now in place.	Complete
RN027 27.2							27.2. Trust to send Millbrook any incidents that are reported regarding their wheelchair service with the requirement to respond within 1 week. Services to raise any issues related to wheelchair provision on Ulysses.	Julia Lake, Susanna Preedy, Helen Neary		**30.09.17**		All incidents relating to wheelchairs reported on Ulysses and forwarded to Milbrook.	Incidents are being sent to wheelchair provider and themes discussed at meetings.	Complete

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RN027 27.3						meet their needs.	27.3. Trust to monitor service provision and raise any on-going concerns with the CCG and Millbrook as part of the contract meetings.			**31.10.17**		Minutes of monthly contract meetings with issues and actions minuted.	Contract meetings with wheelchair are positive with opportunity to raise any ongoing concerns.	**Complete**
RN028 28.1	**MUST**	Community health services for adults		The trust must ensure that all staff understand their responsibilities in respect of the Mental Capacity Act.	Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Need for consent	Not all staff demonstrated a full understanding of the mental capacity act or their responsibility towards it.	28.1 Communication to staff: To provide service areas with pocket guides to the Mental Capacity Act 2005. (These should continue to be issued at mandatory training sessions and by distribution to all service areas).	Caz MacLean, Associate Director of Safeguarding supported by the Corporate Safeguarding Communications Group	Sara Courtney, Acting Director of Nursing	**completed**		Communications to staff: 1. Copy of pocket guides to the Mental Capacity Act 2005.	Pocket guides on Mental Capacity Act circulated to staff.	**Complete**
RN028 28.2							28.2 Training to staff: 1. To deliver bespoke training sessions on MCA & DoLS to identified teams across the Trust as required. 2. The team will be carrying out a comprehensive review of mandatory training material, delivery and learning methods, and review compliance on an ongoing basis.	Caz MacLean, Associate Director of Safeguarding supported by the Corporate Safeguarding Training Group		**30.09.17**		Training: 1. Training materials, session dates 2. Training materials	Safegurading team have delivered learning sets monthly from March 17 with MCA & DoLS sessions. Incremental review of training completed and first delivered 04/10/2017. Training ongoing. Impact of training reviewed via peer reviews.	**Complete**
RN029 29.1	**MUST**	Community health services for adults		The trust must ensure that patient records are accurate and up to date	Regulation 17 (1) and (2) (b)(c) Health and Social Care Act 2008 (Regulated	Delays in staff making entries in patients' records increased the risk of incorrect information being recorded.	29.1 To complete an annual programme of record keeping audits with action plans developed and implemented based on results.	Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary Carol Adcock, John Stagg, Nicky Bennett Liz Taylor	Sara Courtney, Acting Director of Nursing	**31.03.18**			Record keeping clinical audit programme in place.	**On track**
RN029 29.2							29.2 To complete monthly Quality Assessment tool in ISDs which has record keeping elements. Where required, take actions to address any shortfalls in record keeping standards.			**31.12.17**			Quality Assessment tool (QAT) in ISD has record keeping questions to check compliance.QAT used by increasing number of teams with aim that all teams use monthly but is not yet consistent. Streamlined QAT to be launched 1 Feb 2018.	**Overdue**
RN030 30.1			Trust wide	The trust must comply with requirements to provide data as requested by the CQC as a regulatory body.			**REMOVED BY CQC IN REVISED REPORT**							**no action required**
SD031 31.1	**SHOULD**	Wards for older people with mental health problems		The trust should review the ligature risk care plans to ensure that that they are individualised to patients needs and risks.	none	none	31.1 Ligature Risk Management Group to review (environmental ligature) care plan in use by OPMH wards.	Kathy Jackson, Head of Inpatients Karen Thomas, Ligature Manager added Oct 2017 John Stagg ADON for LD co-chair of LRMG Andy Mosley AD for Estates co -chair of LRMG	Mark Morgan, Director of Operations Mental Health & Learning Disabilities	**31.10.17**		Minutes of Ligature Risk Management Group.	Assessment and Management of Ligature Care Policy has been updated and published on intranet. Review of policy included review of environmental ligature care plan by OPMH. OPMH patients are not high risk for ligatures. Individual care plans would capture risks and actions for specific patients as required.	**Completed-unvalidated**
SD031 31.2							31.2 Review use of individualised Ligature Care plan in practice - working with Karen Thomas, Ligature Manager.			**31.10.17**		Results of review.	Assessment and Management of Ligature Care Policy has been updated and published on intranet. Review of policy included review of environmental ligature care plan by OPMH. OPMH patients are not high risk for ligatures. Individual care plans would capture risks and actions for specific patients as required.	**Completed-unvalidated**
SD032 32.1	**SHOULD**	Wards for older people with mental health problems		The trust should consider including, in all induction packs for all new starters and agency staff, information relating	none	none	32.1 Ligature Risk Management Group to set minimum standards on ligature information to be included in local induction packs by teams.	Kathy Jackson, Head of Inpatients Karen Thomas, Ligature Manager	Mark Morgan, Director of Operations Mental Health & Learning Disabilities	**31.10.17**		Standard information for inclusion in local induction packs is circulated.	Assessment and Management of Ligature Care Policy has been updated and published on intranet. It includes guidance on ligature information to be included in local induction packs.	**Complete**
SD032 32.2							32.2 Wards to ensure local induction packs including ligature information as per trust guidance are available to new staff /agency staff.	Kathy Jackson, Head of Inpatients		**31.12.17**		Local induction packs are in place.	Ligature Risk Management Group checking local induction packs are in place.	**On track**
SD033 33.1	**SHOULD**	Wards for older people with mental health problems		The trust should review the trust mitigation plans for areas that are considered locked and inaccessible to patients.	none	none	33.1. Ward assessment to determine which non patient areas are not currently locked.	Kathy Jackson, Head of Inpatients	Mark Morgan, Director of Operations Mental Health & Learning Disabilities	**31.12.17**		Ward assessments completed	All non patient areas reviewed across trust as part of ligature risk programme.	**Complete**
SD033 33.2							33.2 Ligature Risk Management Group to circulate mitigation guidance on areas in inpatient settings which are non patient areas eg staff rooms, sluice rooms.	Karen Thomas, Ligature Manager added John Stagg, ADON LD/Andrew Mosley co -chairs		**31.12.17**		guidance circulated	Assessment and Management of Ligature Care Policy has been updated and published on intranet and includes guidance on non patient areas. Environmental risk assessments have been updated and identify issues to non patient areas eg requirement for self locking doors.	**Complete**
SD034 34.1	**SHOULD**	Community-based mental health services for older people		The trust should review the provision of psychology in Chase/Petersfield.	none	none	34.1 Review of psychology provision and if this is in line with national standards and that of other Trusts and discuss with commissioners (service not currently commissioned).	Helen Neary, Associate Director of Nursing and AHPs	Paula Hull, Acting Director of Operations (ISD)	**31.12.17**		Results of review and discussions with commissioners.	Additional psychology post in Petersfield area approved.	**Completed-unvalidated**
SD035 35.1	**SHOULD**	Community-based mental health services for older people	Chase Petersfield Gosport	Staff should record all multidisciplinary discussions in patient records at Chase / Petersfield and Gosport.	none	none	35.1 Template to be devised for community mental health teams /older people's mental health teams to use to record information at MDT meetings in Chase/Petersfield and Gosport.	Helen Neary, Associate Director of Nursing and AHPs Supported by Head of Nursing and AHP East ICT	Sara Courtney, Acting Director of Nursing	**completed**		template in place.	Template to record MDT meetings developed and in place.	**Completed-unvalidated**

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SD036 36.1	SHOULD	Community-based mental health services for older people	Chase Petersfield Gosport	The trust should review the caseloads across the service to ensure that there is equity of safe workloads and that the CPA framework is consistently applied.	none	none	36.1 To bring acuity and dependency measurement for Community Older People's Mental Health Teams in line with existing trust establishment review process as identified within the Safer Staffing Policy. See 37 for CPA actions.	Helen Neary, Associate Director of Nursing and AHPs supported by Sue Jewell, Safer Staffing Lead	Sara Courtney, Acting Director of Nursing	**28.02.18**			Ongoing work with Safer Staffing Lead with validation exercise of acuity and dependency measures planned at end of November.	On track
SD037 37.1	SHOULD	Community-based mental health services for adults of working age		The trust should complete its review to ensure that the CPA framework is consistently applied and ensure that	None	None	37.1 CPA(Care Programme Approach) audit tool to be amended to include question on correct application of CPA and Care Planning Frameworks.	Carol Adcock, Associate Director of Nursing and AHPs (MH)	Mark Morgan, Director of Operations Mental Health & Learning Disabilities	**30.09.17**		Amended CPA audit tool	CPA audit tool amended	Complete
SD037 37.2							37.2 CPA Audit to be completed. (To include OPMH community services too).			**28.02.18**		CPA audit report	CPA audit in clinical audit programme.	On track
SD037 37.3							37.3. CPA and care plan SOP to be shared with Adult Mental Health staff.			**30.11.17**		Email cascade trail	CPA and care plan standard operating procedures completed.	Completed-unvalidated
SD038 38.1	SHOULD	Urgent care		The trust should ensure that all staff report all incidents that occur.	none	none	38.1 To raise staff awareness in MIUs of the need to report incidents as per incident reporting policy (*NB: 58 re incidents reporting across Trust*).	Helen Neary, Associate Director of Nursing and AHPs	Sara Courtney, Acting Director of Nursing	**completed**		Petersfield MIU has seen increase in number of incidents reported.	Incident analysis report from Tableau shows increased incident reporting: July =28, Aug = 25 and Sept = 16.	Complete
SD039 39.1	SHOULD	Urgent care		The trust should implement, across both MIUs, an audit plan on the use of national guidance's locally.	none	none	39.1 Develop an audit tool to measure implementation of national guidance in MIU services.	Helen Neary, Associate Director of Nursing and AHPs supported by Tracey McKenzie, Head of Compliance, Assurance and Quality	Sara Courtney, Acting Director of Nursing	**30.11.17**		Audit tool in place.	Audits have been developed based on the relevant NICE guidance.	Complete
SD039 39.2							39.2 Carry out audits using tool developed in 39.1.			**31.12.17**		Results and report of audits with action plan developed based on recommendations.	Audits in 39.1 completed.	Complete
SD040 40.1	SHOULD	Urgent care		The trust should develop children's waiting area at Petersfield MIU to provide visual and audible separation from the adult waiting areas.	none	none	40.1 The proposal regarding separate children's waiting area (scheme costings £1.7m) to be presented through Capital Funding process for approval.	Helen Neary, Associate Director of Nursing and AHPs Rob Guile, General Manager Scott Jones, Deputy Head of Estates Services	Paula Anderson, Finance Director	**31.03.18**		Minutes of Trust Executive Committee with decision minuted. Options proposal.	MIU/Estates have reviewed children's waiting area and have proposed alternative option which involves redesign of use of existing rooms. Discussions are ongoing.	On track
SD040 40.2							40.2 Estates services to review the waiting areas at Petersfield MIU and establish if a temporary install of separation screens could provide a temporary solution whilst the permanent scheme is awaiting a decision and funding. (£1K)	Helen Neary, Associate Director of Nursing and AHPs Scott Jones, Deputy Head of Estates Services		**31.10.17**		Site visit to confirm area segregated with screens in place.	Pilot use of temporary screens.	Completed-unvalidated
SD041 41.1	SHOULD	Urgent care	Petersfield MIU	The trust should continue to embed its complaints systems to ensure complainants are responded to in a timely manner.	none	none	41.1 To complete review of Complaints Policy and Procedures and circulate to all staff.	Chris Woodfine, Head of Patient Experience and Engagement supported by Associate Directors of Nursing and AHPs: Julie Lake, Susanna Preedy, Helen Neary Carol Adcock, John Stagg, Nicky Bennett Liz Taylor	Sara Courtney, Acting Director of Nursing	**31.12.17**		Revised complaints/ policy/procedure	Revised Policy and procedures published on intranet.	Complete
SD041 41.2							41.2 To provide a weekly breach report to the Chief Executive/Divisional leads on complaints which are not meeting timescales for the stages of the complaints process. Divisions to address breaches in timescales.			**31.12.17**		Weekly breach reports.	Weekly breach report sent to CEO. Complaints data is part of executive flash report that is reviewed weekly. Pressures on meeting timescales continue to be addressed.	Complete
SD041 41.3							41.3 To improve the visibility of the customer experience team by attending regular divisional governance meetings and other activities.			**31.12.17**		Meeting attendance.	Manager/advisors attending divisional meetings.	Complete
SD041 41.4							41.4 To undertake a 3 month trial starting August 1st where the customer experience advisors write the final letter of response to the complainant (rather than the service). After 3 months review the effectiveness of the trial in allowing the Investigating Officer more time to focus on the investigation itself.			**31.12.17**		Results of trial.	Complaints advisors now write final response letter rather than Investigating officer (IO).	Complete
SD041 41.5							41.5 To improve response times to complaints with 80% of complaints receiving a response within 30/40 days. To work with divisions to resolve issues and barriers.			**31.12.17**		Complaints response times.	There has been increase in complaints being completed within 30/40 day timeframe but continued improvement required.	Overdue
SD042 42.1	SHOULD	Urgent care		The trust should ensure staff across the urgent care provision are informed of the trust plans for the service, including those arising from discussions with the CCGs	none	none	42.1 To discuss and agree the future of Petersfield MIU with commissioners as part of wider plans for health care in that area.	Helen Neary, Associate Director of Nursing and AHPs Rob Guile, General Manager	Sara Courtney, Acting Director of Nursing	**31.03.18**		Minutes of meetings with commissioners and any agreements made re future of MIU.	Clinical Lead presentation to commissioners in June and site visit by commissioners in October which was very postive.	On track
SD042 42.2							42.2 To have updates as a standard agenda item in monthly team meetings on the plans for refurbishments and future of the service at Petersfield MIU as agreed with commissioners.	Helen Neary, Associate Director of Nursing and AHPs	Sara Courtney, Acting Director of Nursing	**30.11.17**		Examples of communication shared with staff.	Team meetings include updates on plans for Petersfield Hospital.	Complete
SD043 43.1	SHOULD	Urgent care	Petersfield MIU	The trust should review the governance reporting framework for the MIU in Petersfield.	none	none	43.1 To embed MIU Governance reporting for Petersfield MIU through the Business Unit 1 locality governance frameworks and feeding into the ISD governance framework.	Helen Neary, Associate Director of Nursing and AHPs	Sara Courtney, Acting Director of Nursing	**31.10.17**			Ward manager attends BU1 governance/business meetings which feed up to ISD governance meetings. New template at team level introduced in locality governance process so information feeds both both up/down.	Complete

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SD044 44.1	SHOULD	Urgent care	Petersfield MIU	The trust should ensure there is clear support structure in place with clear lines of accountability for the MIU in Petersfield.	none	none	44.1 To review the MIU support and line management structures through the Quality element of the Business Plan. Currently the line of accountability reporting is through Rob Guile as General Manager and Helen Neary as Associate Director for Nursing and AHPs.	Helen Neary, Associate Director of Nursing and AHPs Rob Guile, General Manager	Sara Courtney, Acting Director of Nursing	30.09.17			There are clear lines of accountability for MIU in place with MIU part of BU1 reporting and governance structures. Agreed these lines of accountability at present are appropriate but that there are ongoing discussions as to where MIU best sits within division as largely provides a primary care function so in future may sit with Willow Group.	Complete
SD045 45.1	SHOULD	Urgent care	Petersfield MIU	The trust should review the staffing levels at the MIU in Petersfield to ensure they are able to offer a safe service at all times.	none	none	45.1 To review progress made with actions on risk register re staffing at Petersfield MIU and aim to downgrade risk.	Helen Neary, Associate Director of Nursing and AHPs Rob Guile, General Manager supported by Sue Jewell, Safer Staffing Lead	Sara Courtney, Acting Director of Nursing	30.11.17		Minutes of BU1 performance/governance meetings to evidence risk is discussed. Risk downgraded on risk register	Staffing issues being resolved - recruitment to Band 7 post unsuccessful therefore relooked at team structure and developing staff within team to provide additional Band 6 and 4 capacity. Risk still on risk register but reduced severity.	Complete
SD045 45.2							45.2 Staffing has been reviewed and monies allocated to fulfil Practitioner B7 underfunding. Advert out for recruitment.			30.11.17		B7 post recruited to.	as 45.1	Complete
SD045 45.3							45.3 B4 gap in service provision to be presented and discussed with CCG regarding commissioning requirements of this service.			30.11.17		Minutes of meetings with commissioners.	as 45.1	Complete
SD045 45.4							45.4 As there no national tool for MIU's around staffing, work is currently being undertaken to develop a Trust tool.			31.03.18		Trust staffing tool in place.	Ongoing discussions with Safer Staffing Lead - looking to have 2 emergency practitioners and 1 x support staff on each shift.	On track
SD046 46.1	SHOULD	Urgent care	Petersfield MIU	The trust should ensure there are sufficient numbers of staff trained in the care of a sick child, on duty at all times in MIUs.	none	none	46.1 Training needs analysis (TNA) for MIU's to be completed by LEaD in partnership with service leads. Identified training needs to be met during 2017/18 via the CPPD/Learning Beyond Registration budget.	Helen Neary, Associate Director of Nursing and AHPs supported by Simon Johnson, Head of Essential Training Delivery Sue Jewell, Safer Staffing Lead	Sara Courtney, Acting Director of Nursing	30.09.17		Results of TNA with recommendations.	TNA completed for Petersfield MIU.	Complete
SD046 46.2							46.2 Review staffing to understand the gap that may be present in achieving this recommendation.			31.12.17			Learning Beyond Registration training request made for specific external course.	Complete
SD046 46.3							46.3 To develop and implement an action plan based on the outcome of 46.1 and 46.2.46.4 .			31.03.18		Action plan in place and minutes of meeting to show progress being monitored.	Courses/training based on TNA are mapped out per team member.	Complete
SD046 46.4							46.4 LEaD to review attendance at 'Recognising the Unwell Child' training and raise awareness of this course to MIU managers. (This training course is already in place - is not mandatory).	Simon Johnson, Head of Essential Training Delivery		30.09.17		Attendance data.	All staff at Petersfield MIU completed 'Recognising the Unwell Child' training by end November.	Complete
SD047 47.1	SHOULD	End of life care		The trust should consider analysing themes of incidents in relation to the provision of end of life care for all	none	none	47.1 Amend the Ulysses system to enable end of life to be recorded on incidents reported to ensure that themes can be analysed.	Julia Lake, Associate Director of Nursing and AHPs supported by Jake Pursaill, Risk Manager and Simon Beaumont, Head of	Sara Courtney, Acting Director of Nursing	30.09.17		Evidence that Ulysses system has been amended to show end of life data.	Ulysses amended to record 'was this patient receiving end of life care?' which would enable incidents to be filtered by E of L.	Complete
SD047 47.2							47.2. Amend Tableau to ensure that the incidents can be filtered to end of life.			31.10.17		Tableau reports can be filtered by end of life incidents.	Tableau amended to include 'palliative care' incidents. These incidents will be reviewed in End of Life Steering Group.	Complete
SD048 48.1	SHOULD	End of life care		The trust should work to improve the provision of beds to end of life patients.	none	none	48.1. AD Quality Governance and Medical Devices advisor to attend Patient User Group (PUG) meeting with CCGs and Hampshire Equipment Store (HES).	Helen Ludford, Associate Director Quality Governance	Sara Courtney, Acting Director of Nursing	30.09.17		Minutes of PUG meetings.	Patient User Group attended in September and will attend next meeting in December.	Complete
SD048 48.2							48.2. SLA to be reviewed with commissioners to ensure it meets the needs of our patients.	Kate Smith, General Manager		31.12.17		Review of SLA.	Contract is not with HES but via Local Authority therefore SHFT can raise issues but difficult to resolve.	Complete
SD048 48.3							48.3. All incidents of delays in receiving equipment from HES to be reported on Ulysses, reported to HES and reviewed at PUG meeting.	supported by Julia Lake, Associate Director for Nursing and AHPs		31.12.17		All incidents reported on to Ulysses and forwarded to CCG	Incidents being recorded on Ulysses and shared with HES and will be discussed at Patient User Group.	Complete
SD049 49.1	SHOULD	End of life care		The trust should collate and monitor locally held data on the uptake of staff training on end of life care and syringe driver	none	none	49.1 LEaD to develop e-verification process for monitoring compliance with the End of Life and syringe driver training and competency requirements.	Simon Johnson, Head of Essential Training Delivery	Sara Courtney, Acting Director of Nursing	31.12.17		Training compliance data.	E-verification and competency requirements for EoL /syringe driver training lainched.	Completed-unvalidated
SD049 49.2							49.2 Relevant staff to complete e-verification process with team managers monitoring compliance.	Julia Lake, Associate Director of Nursing & Allied Health Professionals		31.03.18		Training compliance data.	Once 49.1 launched, compliance will be monitored within teams.	On track
SD049 49.3							49.3 End of Life Steering Group to review training figures on a quarterly basis.			31.03.18		Minutes of End of Life Steering Group.	Once 49.1 launched, End of Life Steering Group will monitor training compliance.	On track
SD050 50.1	SHOULD	End of life care		The trust should evaluate the provision of end of life care.	none	none	50.1 Undertake a thematic review of End of Life care across the Trust in Oct - December 2017 - to include what services we are commissioned to supply and any gaps in that provision.	Julia Lake, Associate Director of Nursing & Allied Health Professionals	Sara Courtney, Acting Director of Nursing	28.02.18		Report from Thematic review and evidence that shared through appropriate committees.	Thematic review is underway until end of year with report due by end January 2018.	On track
SD050 50.2							50.2 To develop recommendations for any actions based on outcome of above review.			31.03.18		Action plan in place based on review recommendations.	End of Life Steering Group will review recommendations from the thematic review and develop into actions as appropriate.	On track
SD051 51.1	SHOULD	Community Inpatient Services		The trust should ensure that all staff are fully trained in the assessment and competent in the use of the Mental Capacity Act.	none	none	51.1 see 28.2.1	Caz MacLean, Associate Director of Safeguarding supported by the Corporate Safeguarding Communications Group						Duplicate

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SD051 51.2							51.2 see 28.2.2	Caz MacLean, Associate Director of Safeguarding supported by the Corporate Safeguarding Training Group						Duplicate
SD052 52.1	SHOULD	Community Inpatient Services		The trust should ensure that all staff complete and sign all patient clinical records with all relevant information.	none	none	52.1 To review inpatient records in Community Hospitals with clear guidance circulated to staff on completion of patient records, including the signing and adding of staff designation to record.	Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary	Sara Courtney, Acting Director of Nursing	**31.12.17**		Results of review of records.	Record keeping clinical audits as part of audit programme. Record keeping questions added to Quality Assessment Tool.	Completed-unvalidated
SD052 52.2							52.2 To complete record keeping audits with action plans developed and implemented to address shortfalls in practice.			**31.03.18**		Results of record keeping audits. Implementation of action plans based on audits.	Record keeping clinical audits as part of audit programme.	On track
SD053 53.1	SHOULD	Community Inpatient Services		The trust should ensure that all staff follow the process for identifying and managing clean and dirty equipment in line with the trust policy.	none	none	53.1 see 21.1	Theresa Lewis, Lead Nurse Infection, Prevention and Control Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary	Sara Courtney, Acting Director of Nursing					Duplicate
SD053 53.2							53.2 see 21.2							Duplicate
SD053 53.3							53.3 see 21.3							Duplicate
SD053 53.4							53.4 see 21.4							Duplicate
SD053 53.5							53.5 IPC audit programme to be completed for 2017/18 - including isolation audit due February 2018.			**31.03.18**		results of audits	Presentation to link advisors includes the results of audits and recommendations for actions and those audits planned for next quarter.	On track
SD054 54.1	SHOULD	Community Inpatient Services		The trust should ensure that staff review the ward environment taking into account the needs of people living with dementia.	none	none	54.1 To review the ward environment taking into account the needs of people living with dementia and review the results of the PLACE audits.	Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary supported by Scott Jones, Deputy Head of Estates Services Nov 2017 added Annette Chalmers, PLACE project lead.	Sara Courtney, Acting Director of Nursing	**31.10.17**		Results of the review of wards re dementia needs. Results of PLACE audits with regard to needs of people living with dementia.	PLACE audits of all inpatient sites completed. Project lead for PLACE has developed a PLACE tracker for issues raised relating to dementia. New Dementia Group has had inaugral meeting and will review issues raised and agree actions to be taken. There are planned refurbishment programmes for wards in place as well.	Complete
SD054 54.2							54.2 An action plan is developed and implemented based on the above reviews to meet the needs of people living with dementia. This will include a list of works in priority order to be completed by Estates services.			**31.03.18**		Action plan is in place and is being implemented.	Dementia Group to review PLACE results and agree actions to be taken.	On track
SD055 55.1	SHOULD	Community Inpatient Services	Gosport War Memorial Hospital	The trust should review the washing and toilet facilities at Gosport hospital to ensure that they promote the privacy and dignity of patients.	none	none	55.1 To complete a joint review of the toilet and washing facilities in Ark Royal and Sultan wards, GWMH by the clinical service leads and estates managers.	Helen Neary, Associate Director of Nursing and AHPs Gary Goodman, Estates Services Capital Projects Manager	Paula Hull, Acting Director of Operations (ISD)	**30.09.17**		Results of review of wards.	Review completed and recommendation made to refurbish all toilets and bathrooms in these wards under PLACE capital funding.	Completed-unvalidated
SD055 55.2							55.2 An action plan is developed and implemented based on the recommendations from the above review to resolve issues in discussion with commissioners.			**31.03.18**		Action plan in place and being implemented.	Estates work plan to include refurbishment as in 55.1.	On track
SD056 56.1	SHOULD	Community Inpatient Services		The trust should ensure that there is appropriate pharmacy support for medicines reconciliation.'	none	none	56.1 To set up a Task and Finish Group to review medicines reconciliation across the trust - to include staffing, accuracy of data reported on tableau, roles and responsibilities of various staff groups, use of the summary care record, training for staff, policy.	Raj Parekh, Chief Pharmacist	Dr Sarah Constantine, Interim Medical Director	**31.12.17**		Task and Finish Group - terms of reference, minutes and action logs.	Pharmacy Lead is reviewing the training provided by an external company as to feasibility.	On track
SD056 56.2							56.2 Based on results of Task and Finish group, produce an options paper for medicines reconciliation in line with national guidance for discussion at the Trust Executive Committee.			**31.01.18**		Medicine Reconciliation action plan.	Plan will be developed based on outcome of 56.1	On track
SD056 56.3							56.3 Medicines Management Committee (bi-monthly) to monitor Task and Finish group progress including action plan; to monitor performance against KPI - 80% of inpatients have their medicines reconciled within 2 working days.			**31.03.18**		Minutes of Medicines Management Committee.	Medicine Management Committee review progress with actions.	On track
SD057 57.1	SHOULD	Community Inpatient Services		The trust should ensure that staff support and enable patients to administer their medicines as part of the discharge process in the rehabilitation wards.	none	none	57.1 To identify where patient own drugs (POD) lockers are in place on rehabilitation wards and where there are gaps.	Raj Parekh, Chief Pharmacist to support not lead. supported by the Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary	Dr Sarah Constantine, Interim Medical Director	**30.09.17**		Results of review of POD lockers.	Review completed and POD lockers in place or ordered (Alton Hospital).	Completed-unvalidated
SD057 57.2							57.2 To implement Self Administration Policy on wards with risk assessment of wards and individual patients completed.			**31.08.17**		Evidence that risk assessments completed. Results of audit of Self Administration Policy.	In MH/OPMH there is individual risk assessment re self admin of medicines with care plans developed to capture actions required. New Meds Administration Pharmacy Technician posts x3 funded. 2 posts started mid October in Western Hospital and Romsey Hospital. 1 post out to advert for Petersfield Hosp. Pilot to start in February 2018 on 2 wards where pharmacy technicians will complete risk assessment re self admistration of medicines as part of admission process.	Overdue
SD057 57.3							57.3 To scope additional staffing resources required in order to implement self administration of medicines during inpatient stay and on discharge.			**31.12.17**		Results of scoping review of staffing requirements.	Review of 57.2 will inform this action.	Overdue
SD057 57.4							57.4 Medicines Management Committee (bi-monthly) to review progress with completion of actions.	Raj Parekh, Chief Pharmacist		**31.03.18**		Minutes of Medicines Management Committee.	Medicine Management Committee review progress with actions.	On track

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SD058 58.1	**SHOULD**	Community health services for adults		The trust should ensure that staff report incidents in a timely manner	none	none	58.1 To ensure staff complete incident reports within the policy timeframes.	Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary Carol Adcock, John Stagg, Nicky Bennett, Liz Taylor supported by Sarah Pearson,	Sara Courtney, Acting Director of Nursing	**31.10.17**		Increased number of incidents reported - particularly from areas where reporting is noted to be lower than expected. Staff bulletin to be evidenced to show additional communication re incident reporting.	Incident Reporting Policy and guidance in place. Incident data down to team level available on Tableau and so is easy to review. Incident team will pull reports on those teams which are no/low reporters and circulate.	**Completed-unvalidated**
SD059 59.1	**SHOULD**	Community health services for adults		The trust should ensure that staff follow infection prevention best practice guidelines while providing care in patients' homes.	none	none	59.1 see 21.1	~~Theresa Lewis, Lead Nurse~~ Jacky Hunt, Lead Nurse Infection, Prevention and Control supported by the Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary	Sara Courtney, Acting Director of Nursing					**Duplicate**
SD059 59.2							59.2 see 21.2							**Duplicate**
SD059 59.3							59.3 see 21.3							**Duplicate**
SD059 59.4							59.4 To continue hand hygiene audits across the trust including community teams.	Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary supported by the Infection,		**31.12.17**		IPC Quarterly Report has hand hygiene audit results.	Hand hygiene audits completed regularly with results included in quarterly IPC report to Patient Safety Group.	**Complete**
SD060 60.1	**SHOULD**	Community health services for adults		The trust should introduce an appropriate tool to monitor and detect deterioration in the condition of patients, receiving care and treatment in their own homes, who have long term conditions who may routinely have abnormal	none	none	60.1 To review Track and Trigger Tool and the National Early Warning Score (NEWS) to ensure that boundaries for escalation are the same.	Simon Johnson, Head of Essential Training Delivery supported by: Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary	Dr Sarah Constantine, Interim Medical Director	**30.08.17**		Review of early warning systems.	Review of compatibility of early warning systems has been completed. Results shared at Resuscitation Committee May 2017. Physical Assessment and monitoring policy has kept the documents for escalation unchanged, however mental health staff now have competency assessments for using the tool.	**Complete**
SD060 60.2							60.2 To roll out use of NEWS across the Community Hospitals. To evaluate impact of NEWS prior to consideration for a tool to introduce to community services.			**31.03.18**		Confirmation of use of NEWS in community hospitals.	NEWS in use at LNFH. Resusciattion committee to discuss roll out to CHs.	**On track**
SD060 60.3							60.3 To communicate to staff the training courses available on LEaD relevant to the deteriorating patient and monitor training attendance at staff one to ones.			**30.11.17**		communication - emails/newsletter/team minutes.	Training ocurses are on LEaD website.	**Complete**
SD061 61.1	**SHOULD**	Community health services for adults		The trust should review whether there is a need for a night nursing service across all areas.	none	none	61.1 To set up a Task and Finish Group out of the End of Life Steering Group to review the need for a night nursing service across the Trust - including a review of population needs, current access to spot purchase service.	Associate Director of Nursing and AHPs: Julia Lake	Paula Hull, Acting Director of Operations (ISD)	**31.12.17**		Task and Finish Group - terms of reference, minutes and action logs.	EOL Steering Group and Senior managers in ongoing discussions.	**Completed-unvalidated**
SD061 61.2							61.2 To discuss the outcome and recommendations from the Task and Finish Group regarding the need for a night nursing service with commissioners.			**28.02.18**		Minutes of meetings with commissioners.	Action will be informed by 61.1.	**On track**
SD062 62.1	**SHOULD**	Community health services for adults		The trust should ensure all medicines are in date.	none	none	62.1 see 20.1	Raj Parekh, Chief Pharmacist supported by the Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy,	Dr Sarah Constantine, Interim Medical Director					**Duplicate**
SD062 62.2							62.2 see 20.2	Raj Parekh, Chief Pharmacist						**Duplicate**
SD062 62.3							62.3 see 20.3	Raj Parekh, Chief Pharmacist						**Duplicate**
SD062 62.4							62.4 Inpatient units/wards audit that the correct procedure regarding expiry dates for medicines is followed. ISDs to use Quality Assessment Tool on monthly basis to provide assurance re compliance.	Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary Carol Adcock, John Stagg, Nicky Bennett		**31.10.17**		Quality Assessment Tool results (ISD). Safe and Secure Meds audit results and action plans	Expiry date guidance now included in MCAPP. Safe and Secure Medicines audit includes compliance with expiry dates. Results of audit circulated to staff in Decemebr 2017.	**Completed-unvalidated**
SD062 62.5							62.5 Medicines Management Committee (bi-monthly) to review compliance to guidance and completion of audit actions.	Raj Parekh, Chief Pharmacist		**31.12.17**		Minutes of Medicines Management Committee.	Medicine Management Committee review progress with actions.	**Completed-unvalidated**
68 CQC jan 16 ref WN004 4.10	**MUST**	Provider / Trust	Trust wide	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.	Regulation 17 HSCA (RA) Regulations 2014 Good governance This is a breach of Regulation 17 (2) (a) (b)Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)	The trust did not have effective governance arrangements to deliver robust incident investigation	4.10 The Trust will upskill frontline staff in quality improvement methodologies using the existing Team Viral programme to support this	Paul Streat Support from: Organisational Development Graeme Armitage		**31.12.17**			Paper submitted to Board in November with options for Quality Improvement Methodlogy. There are 4 main options although each option has an upper and a lower option: 1) Full procurement of an external solution 2) Investment in external support eg NHS Elect, NTW 3) Buddying with expert organisation eg ELFT 4) Internal solution – scoping questionnaire underway	**Completed-unvalidated**

UIN	Requirement Notice	Core Service	Location	CQC Action (from the Inspection Report)	Regulation Breached	Cause of Regulation Breach	Trust Wide Actions Required	Responsible Leads	Executive Accountability	Action to be completed by (date)	Action to be completed by recovery date	Required Evidence to show completion	Action Progress Update	completed actions (e.g. meeting
69 CQC jan 16 ref SD028 28.4	**SHOULD**	Child and adolescent mental health wards.	Bluebird House	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.	na	na	28.4 Implement the changes to the training programme and roll-out to relevant staff groups	Simon Johnson, Head of Essential Training Delivery		**31.10.17**			Revised training agreed and fisrt course in early December.	**Completed-unvalidated**
70 CQC sept 16 ref RN043 43.1	**MUST**	n/a	Trust-wide	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.		Sara Courtney - Interim Chief Nurse	**31.12.17**			Niche and Grant/Thornton presented draft audit findings to QSC (Sept) and Board on 31.10.17. Draft assurance opinion received from Grant/Thornton with factual accuracy check completed by SHFT. Final Grant Thornton report due Board meeting January.	**Completed-unvalidated**
71 CQC sept 16 ref RN043 43.4	**MUST**						EXTERNAL REVIEW: Niche / Grant Thornton Phase 2 review and testing of Mortality & Serious Incident Action plan			**30.11.17**			Niche and Grant/Thornton presented draft audit findings to QSC (Sept) and Board on 31.10.17. Draft assurance opinion received from Grant/Thornton with factual accuracy check completed by SHFT. Final Grant Thornton report due Board meeting January.	**Complete**

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Building confidence

Improving care today, planning for the future

Includes a summary of our annual report 2016/17

Welcome

This booklet aims to give you a brief overview of who we are and what we've been doing over the last 12 months to provide the best possible care for patients, service users, carers and families.

It's also a look forward to the year ahead and how we'll continue to build on this progress for the benefit of the communities we serve.

Our organisation has faced many challenges and we have been the subject of sustained criticism. We have taken this extremely seriously and know we need to make significant improvements to the quality of our care and the way we involve patients and their families. Achieving this has been the focus of all our efforts during the last year, and remains of paramount importance. We are encouraged that our regulators have recognised that we have turned a corner and are taking the right approach to improve.

As you will have seen in the national news, the NHS is facing some real difficulties and these are affecting local services like ours, too. This includes limited resources, increasing demand for care, and challenges in recruiting and keeping our nurses, doctors and other staff. We also know that too many people are receiving mental health care far from home which is simply unacceptable.

But despite these obstacles, there is much cause for hope and optimism.

PATIENTS RECEIVED CARE IN OUR HOSPITAL BEDS FOR A TOTAL OF

247,000 days in 2016/17

At its heart the NHS is about people, and we remain indebted to our fantastic staff who work tirelessly to provide the best possible care.

We are confident we have addressed many of the concerns raised about our care. We have considerably more to do, but have a clear approach that sets out how we're going to make the necessary progress.

As well as making the urgent improvements to our services today, we now have the right foundations in place to make more fundamental changes that patients, carers, and their families deserve in the longer term. We call this our Clinical Services Strategy.

At its heart the NHS is about people, and we remain indebted to our fantastic staff who work tirelessly to provide the best possible care. Supporting and involving our workforce is pivotal to improving care. So we now have comprehensive plans to recruit more people, nurture our existing staff, and develop new job roles to meet the changing needs of our patients.

Our teams have played a big part in finding new ways to work alongside colleagues and communities to deliver better care out of hospital, and better mental health care. This success is now being taken forward across Hampshire and is a testament to their hard work and commitment.

The expertise and input of people using our services and their support networks has been invaluable. We must continue to work even more inclusively in the months ahead and now have a strategy which will guide us to do just that.

We thank everyone who has worked with us and welcome the scrutiny, feedback, support and expertise of countless staff, patients, families and partners.

The year ahead will be about how we build your confidence in the services we provide. We will do this by demonstrating the quality and safety of our care, and by striving to work more openly and collaboratively with all those whose lives we touch. If you want to join us in this mission, we would love to hear from you – ways to get in touch can be found on page 23.

With best wishes,
Lynne and Julie

Lynne Hunt (CHAIR)

Julie Dawes (CEO)

About us

We are an NHS Foundation Trust providing community physical, mental and learning disability health services across Hampshire. This includes some community hospitals and specialist inpatient units. In 2016/17 we also provided learning disability services in Oxfordshire, which we transferred to Oxford Health NHS Foundation Trust in July 2017. **Our aim is to improve the health, wellbeing, independence and confidence of the people we serve.**

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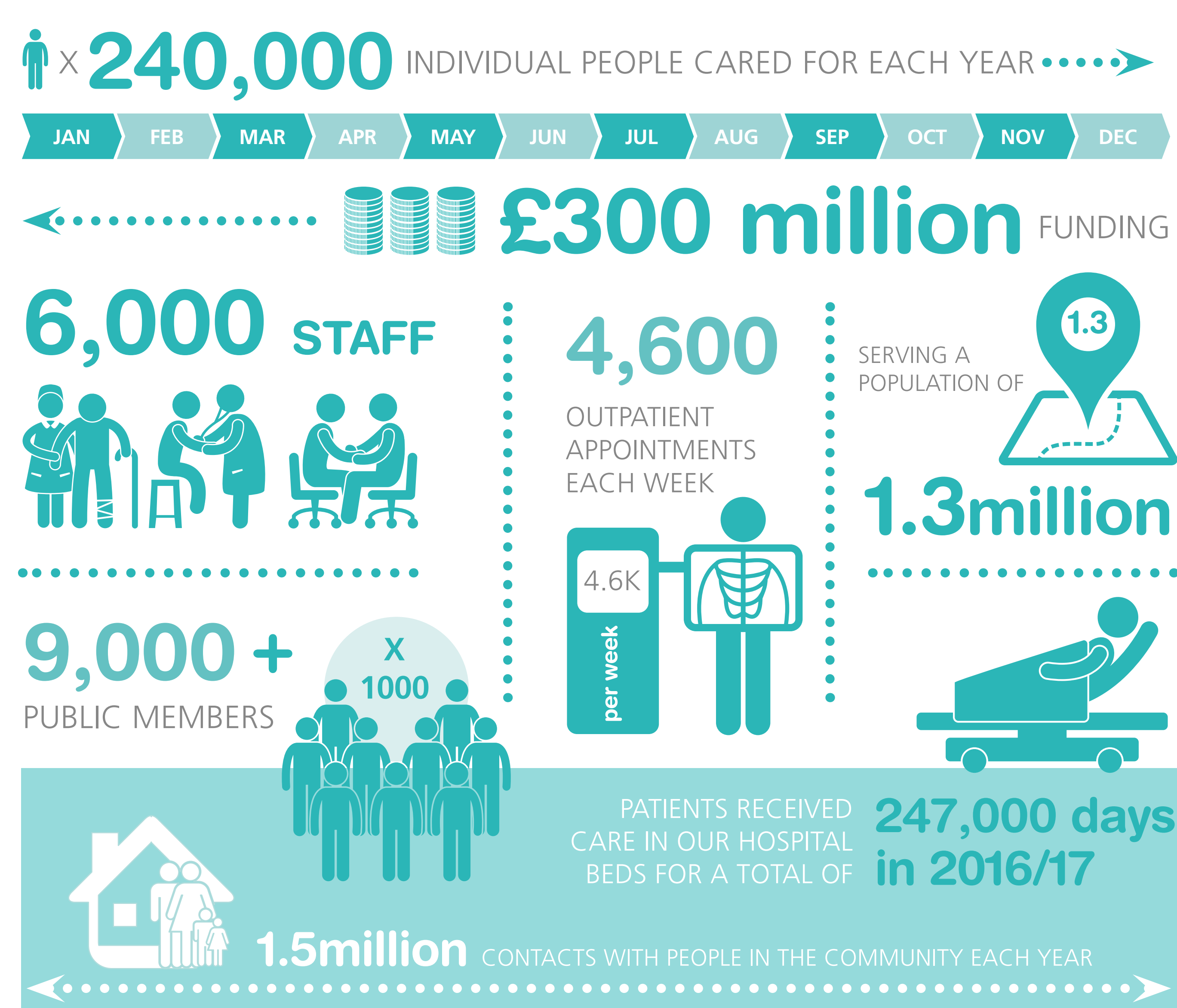
Southern Health in numbers:

We provide care to around 240,000 people each year, and serve a population of 1.3million people. Over 6,000 people work for us, including doctors, nurses, therapists and support staff. As a Foundation Trust, we have over 9,000 public Members drawn from local communities, who elect a council of Governors which holds our Board to account. We are funded by NHS England, local NHS commissioners and local authorities, receiving around £300million each year. We deliver over 4,600 outpatient appointments each week, and patients received care in our hospital beds for a total of 247,000 days in 2016/17. We provide nearly 1.5million contacts with patients in the community each year.

in numbers



What drives us:

Our values

Last year we worked with hundreds of our staff to better describe what drives us as individuals and as an organisation. This resulted in three simple yet meaningful values that will guide everything we do from the frontline to the Board. They are already being used in staff appraisals and all new recruits are assessed against these values:

Patients and People First

- Providing compassionate, safe care
- Listening to each other
- Doing the right thing
- Appreciating each other
- Delivering quality

Partnership

- Communicating clearly
- Supporting each other
- Working as a team
- Building relationships
- Making things happen

Respect

- Acting with honesty and integrity
- Respecting each other
- Taking responsibility
- Getting the best from our resources
- Doing what we say we will do

Progress we've made and priorities ahead

We know that we have many areas that we need to make better for our patients. The quality of care, the way we involve people in it, and the way we investigate and learn when things go wrong have all been highlighted as in need of improvement. This section describes some of the big developments we've made in 2016/17, and how we are building on this in 2017/18.

Quality

Improving the quality and safety of our care

2016/17

Over the last year we made significant progress to improve the quality and safety of our care and our buildings, and the way we report, investigate and learn. We have also been working to better involve staff, patients, families and cares in decisions and in developing services. Our regulator the Care Quality Commission (CQC) has recognised that we have turned a corner in recent months which gives us confidence we are heading in the right direction.

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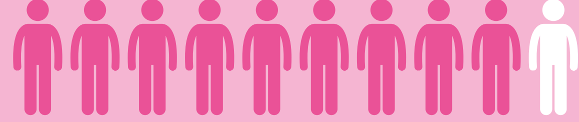
Some important examples of this progress include:

- Working with a group of families to understand their experiences of being involved in investigations where a loved one has died, which led to a series of recommendations which we are now carrying out.
- Ensuring all reports into serious incidents are completed within 60 days, and that 95% of investigations are reviewed within 48 hours.
- Appointment of a Family Liaison Officer to provide impartial support when someone comes to harm whilst under our care.
- We launched our quality improvement strategy and priorities.
- We launched our patient engagement strategy describing how we will work more inclusively to develop services now and in the future
- More than nine out of ten (93%) of patients who completed the 'friends and family test' would recommend our services to a loved one.
- Ensuring more people at the end of their lives are able to die in the place of their choosing
- We improved the safety and quality of the physical environment at a number of our hospital sites, to reduce the risks to patients with severe mental health problems.

"More than 9 out of 10 people would recommend our care to friends and family"



> **Although improvements have been made we must keep up the momentum.**

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2017/18

Although improvements have been made we must keep up the momentum. We still have much to do to become the organisation our patients, communities and our staff deserve.

What are we focused on now?

- Continuing to deliver our CQC, mortality and serious incident action plans – making sure they are giving the results our patients and services users want and need.
- Delivering our strategy to better involve service users, families and carers
- Supporting staff to improve quality in a consistent and measureable way across the whole organisation.
- Focused efforts to make the best use of mental health beds, so more people can get the care they need closer to home.
- Ensure every patient and service user, and their families and carers (where appropriate) are offered the opportunity to be involved creating a care plan, in a format they understand and own.
- Improving the consistency and quality of our community physical health services across Hampshire, so staff know exactly what their role is and how best to do it.
- Make sure we are doing more to improve the physical health of people using our mental health services
- Improving the timeliness and the quality of our response to complaints and concerns

If we can achieve the above, we aim to receive a rating of at least 'good' by the Care Quality Commission when they carry out their next comprehensive inspection later on in 2017/18.

x **240,000** PEOPLE CARED FOR EACH YEAR

JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC

SPOTLIGHT:

Meet Elaine, our Family Liaison Officer

Hello my name is Elaine Ridley and I'm the Family Liaison Officer. I started at the Trust in December 2016.

My role is pretty varied but the main part is to support families and loved ones through the difficult process of an investigation into a serious incident or complaint. I also work closely with Investigating Officers to ensure that families are treated appropriately.

Having worked in the Coroners service for 15 years I could see that there was a need for this type of role. I was aware of the criticisms of the Trust before I applied and was a little apprehensive but I like a challenge! So far it has been massively rewarding and I'm very much enjoying it.

I am involved in a lot of the groups the Trust has set up to help it improve the way it works with families. I've learned so much from these and it has been a real privilege to be involved. I'm really keen to use the feedback and ensure families have a voice.

Over the last few months I have been developing some training with the Trust Chaplain which I am really proud of. The training is for Investigating Officers, and will help them when sharing reports with families following an investigation into a death. The Trust has improved its reporting process but I think there are lots we can do to improve how we share reports with families.

SERVING A POPULATION OF **1.3million**

SPOTLIGHT:

Mental health support for mums in Andover

One in five women will experience some form of mental health difficulty during pregnancy or the first year following the birth of their baby. Our Health Visiting Team in Andover is working hard to find new ways of supporting these women that help make a real difference.

The team, in partnership with Andover Mind, has set up a group called "Knowing Me, Knowing You", for mothers with mild to moderate perinatal mental health problems. The group provides up to eight mothers and their babies with a two-hour group session, which runs for seven weeks with the aims of supporting mothers to talk about their feelings and develop new coping strategies.

The group has had positive results, with reduced levels of depression and anxiety, and mums feeling more confident at the end of the sessions.

One mum said, "Until the group I felt like I was the only one and was very isolated which made me scared to ask for help as I didn't really understand what was wrong. The group helped me do something about what was wrong and understand my feelings and reactions. For the first time I feel that I can tell someone how I feel safely, without anyone telling me I'm wrong, or I should be happy, or I'm a bad person."

We're now looking at how we can share the Knowing Me Knowing You concept with other NHS Trusts who are interested in learning from us.

> **For the first time I feel I can tell someone how I feel safely**

People

Supporting and developing our workforce

2016/17

We know that staff who feel included by their employer contribute to improved patient care, and staff involvement in the organisation is an area where we identified we could do better. We have introduced several staff engagement initiatives this year including a new forum for staff to feedback directly to the Executive team. We have increased the number of visits the Executive team and Board make to front line teams, and we have also launched a trust-wide Team Brief session to discuss key issues as well as providing an opportunity for two-way communication.

This year we:

- Achieved a small overall improvement in the results of the annual staff survey, which also helped us target key areas to focus on.
- Appointed Freedom To Speak Up Guardian to support staff to raise concerns
- Started a range of initiatives to increase staff health and wellbeing, included fast-track schemes to access physiotherapy and psychological support programmes
- Saw over 2,000 staff (about a third of our workforce) nominated for a Star Award, our reward and recognition scheme.

OVER
6,000
STAFF WORK FOR US

2017/18

Next year will see us take staff engagement to the next level with a series of big topics, the development of a staff engagement group and the introduction of new ways to empower staff to innovate and resolve issues locally. We will also bring to bear a new plan to tackle our recruitment and retention challenges.

Priorities for the year ahead include:

- Launching a Trust-wide staff engagement programme 'Your Voice', led by a steering group of staff from all levels and services. This is improving how involved staff feel in their Trust, and giving them more confidence to carry out local changes.
- Finding new ways to recruit the right workforce to meet the needs of our patients, including new roles such as nurse consultants and nurse associates.
- Better understanding the reasons people leave the Trust, so we retain and develop our skilled and experienced health workers
- Improving the number of staff who would recommend Southern Health as a place to work to their friends and family
- Building on our reward and recognition schemes, for example launching an Employee of the Month award.
- Launching a new clinical leadership programme to ensure our doctors, nurses and other clinicians play a lead role in the trust and their talent and skills are properly developed.

9,000 +
PUBLIC MEMBERS

X 1000

Living life with a learning disability

James Elsworthy from Winchester has used our learning disability services to help identify and manage his needs. James is also working with us by taking part in service user groups, interview panels and he presented one of our staff awards at last year's ceremony.

"My support worker says I have complex needs. Having a learning disability affects me most when there's a lot going on. I tend to get quite upset. One minute I'm happy and the next minute I'm sad. It takes me a little while to process things.

"I have lived on my own since I was 18, but I have support workers twice a week. Before that I lived in a house for people with learning disabilities. They still have some houses for people with learning disabilities, but I think they should get their own places really – you've got to learn to live on your own.

"I have a cleaning job at the police headquarters. I do that from 6.00am to 9.30am every day, Monday to Friday. I've worked there since 2004. I like my job but I don't like cleaning at home.

"I do football on a Monday and Tuesday at River Park Leisure Centre with the Saints Foundation. It's open to people with Learning Disabilities, as well as everyone else. We warm up first and play a match at the end. I can be really competitive. I'm also doing a play – it will be at the Theatre Royal.

"I really enjoy working to help Southern Health. Southern Health has had a lot of bad news lately, but the only way is up and we've got to promote the good things. I run a service user group. That is to do with how the NHS can help us – people with learning disabilities."

> **Southern Health has had a lot of bad news lately, but the only way is up**

SPOTLIGHT:

The importance of care at home: Peter's story

Peter, 90, has a number of health conditions related to being frail and elderly. But he's adamant he wants to stay at home. His daughter Lis tells us how her family has been working closely with Southern Health's community team to support Peter at home.

"Dad is a true gentleman, so full of life and thrives on making people laugh. He has vascular dementia and is very frail. Over the years his memory has got worse and he doesn't remember a lot of things. We knew from previous experience that Dad doesn't do well in hospital and deteriorates both mentally and physically.

"Ally [from Southern Health] was fantastic; she completely understood our situation, knew that dad wanted to be at home and did everything she could to make this happen. She referred us to Abigail Barkham [Consultant Frailty Practitioner] who met both me and Dad and immediately started to put together a wellbeing plan based on dad's needs to help us care for him at home.

"Since the plan has been put in place, dad has been doing really well. In fact from October to April, we had to call an ambulance out to him more than 11 times. But since April we haven't had to call anyone out and I truly believe it's because he is happy and has all the help he needs.

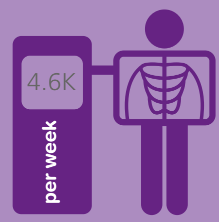
"I just can't thank the team enough. We feel so supported and the care we have received has been first class, we have felt involved right from the start and really feel they genuinely care about my father. Meeting Ally and Abby and her team, it's so evident that for them it's not a job, it's a passion."

Peter's care package

- An Occupational Therapist inspected the house and identified the equipment that Dad needed.
- A tissue viability and community nurse ensured that dad had the right mattress, and gave advice to help prevent him from getting pressure sores.
- A nurse gave advice about nutrition and medication an even prescribed dietary supplements to keep him healthy.
- We were advised by the team to create a memory book for dad about key aspects of his life - it really helps him especially when he is having a bad day.

4,600

OUTPATIENT APPOINTMENTS EACH WEEK



Transformation

Changing our services to better meet people's needs

2016/17

The NHS is transforming to meet the growing needs of the population, and Hampshire is no exception. Towards the end of 2016/17 all the health and care organisations in Hampshire and the Isle of Wight published a joint plan called a Sustainability and Transformation Plan (STP). Services provided by Southern Health are included in the STP and we are committed to making sure we play our part. Since 2015 Southern Health staff have been leading a pilot called Better Local Care, to improve the way people are supported out-of-hospital. This has led to a number of benefits for patients and communities, and built stronger relationships between our staff and GPs, volunteers and other partners across the county. In October 2016 we carried out a major four-month review of our mental health and learning disability services which resulted in a new Clinical Services Strategy. Hundreds of staff, alongside service users, families and carers helped to shape this important work which will be one of the driving forces behind improving our care in 2017/18.

Here are some examples of how we have helped to transform care for local people:

- The Same Day Access Service in Gosport has helped over 60,000 people get the right care from the right professional, on the same day, preventing the need to wait many days for a GP appointment.
- We launched a new web-based service to connect patients across Hampshire with their GP practice. Called eConsult, the service has proved very popular with around 1,500 people using the service each week. With 60% of patients able to get the help they need without visiting their practice, it has also freed up 3,500 GP appointments, which can be spent supporting people with more complex health needs.
- Our health visitors teamed up with Barnardo's volunteers to deliver enhanced services for new parents in Hampshire.
- Our highly-regarded mother and baby mental health community services were awarded additional funding to expand into other parts of Hampshire, including Portsmouth, North East Hampshire and the Isle of Wight, where there were previously no specialist services.
- We've joined forces with Solent NHS Foundation Trust and the Isle of Wight Trust to form a Mental Health Alliance – to make sure we are planning together in the best interests of people who use these services: pooling our ideas and resources and aiming for more consistent and effective mental health care across the region.
- It became apparent that a number of our services would be able to develop further as part of other organisations, and we supported them to successfully transfer. This includes our community physical health services in North East Hampshire, our learning disability services in Buckinghamshire and Oxfordshire, and our social care services. We wish all staff and people using these services the very best for the future.

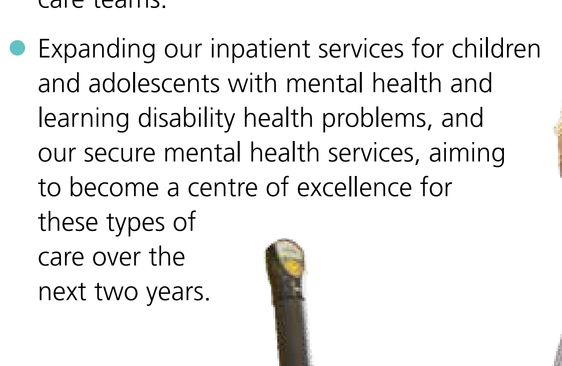
Find out more: **www.betterlocalcare.org.uk**

www.southernhealth.nhs.uk/futureservices

2017/18

We will continue to deliver the plans set out in the STP, the Mental Health Alliance, and our Clinical Services Strategy, including:

- Carrying out the priorities identified in the Clinical Services Strategy to make our mental health and learning disability services easier to access, more consistent, and better able to support people in a crisis. This will involve significant changes to current models of care and will continue beyond 2017/18.
- As part of the STP, a number of areas of Hampshire have been identified, around which all local organisations should try to deliver more joined up care. We will work with commissioners and partners to describe exactly which services belong in these 'Local Care Systems' and begin the process to move them into these new organisations.
- Building on the Better Local Care pilot, we will continue to work with GPs, clinicians, social care colleagues and volunteers who support the same people, to work as joined-up extended primary care teams.
- Expanding our inpatient services for children and adolescents with mental health and learning disability health problems, and our secure mental health services, aiming to become a centre of excellence for these types of care over the next two years.



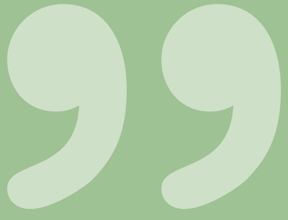
SPOTLIGHT:

Fantastic feedback for our Older People's Mental Health Team in Havant

"We support any older person living in Hampshire (normally aged 65+) who is experiencing mental health problems due to an organic mental illness such as Alzheimer's disease and a functional mental illness, which predominantly has a psychological cause such as depression, schizophrenia, mood disorders or anxiety. We are an integrated service and work closely with other services for example, social services, occupational health, physiotherapists, GPs and speech and language."

What do people say about this service?

My father died in February but he was supported wonderfully by your nurses. You even visited when I was at crisis point and looking back you really listened to my Dad about his physical symptoms as well as his mood. You were right to listen, as it was the physical symptoms that he told you about which led to his death a few weeks later. I would like to thank you and your team for the professional, kind and caring support.



What do our staff say?

I can speak up. My colleagues listen to me. No question is a silly question. We work closely together.

There is a lot of fun and laughter!

I'm learning about the service and being asked to contribute towards the future.

An opportunity to enhance my knowledge, and my skills whilst not being made to feel pressured and stressed.

Money

Making the best use of resources and balancing our books

This has been a difficult year for NHS finances, with around half of all Trusts spending more money than they received, to a total deficit of around £800million nationally. In order to balance our books, locally, we made savings of about £10million. We also benefited from extra funding which had been set aside for NHS Trusts which could demonstrate they were in control of their costs. This meant we finished the year with a surplus of £1.2million, and our auditors confirmed that we had provided sound financial management.

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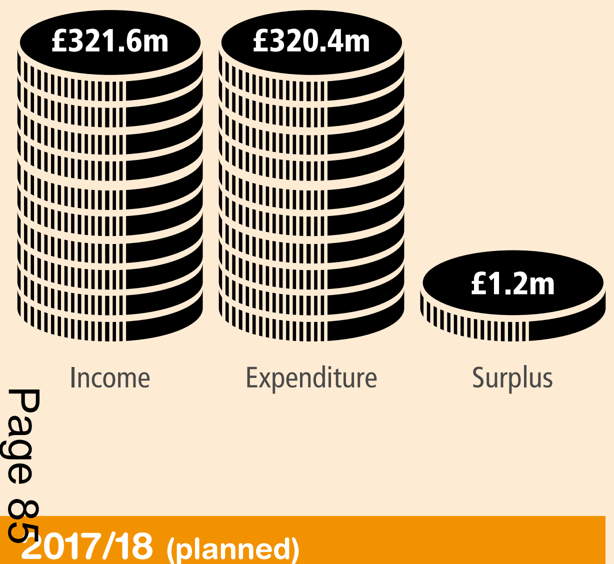
Some of the big challenges facing our finances include:

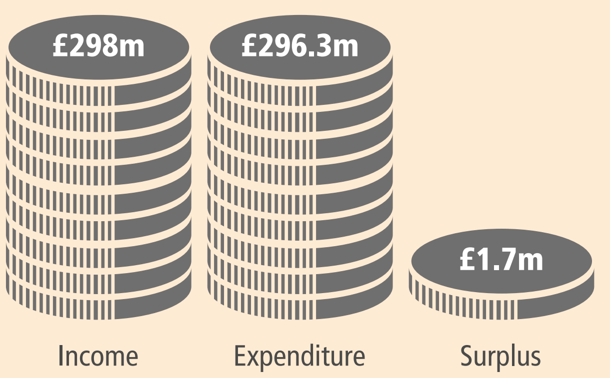
- The amount we spend on agency staff, including locum doctors and nurses, due to difficulties recruiting and retaining permanent staff.
- The cost of placing mental health patients in beds provided by other organisations, because we are unable to discharge patients from our own beds to the community swiftly once their treatment has finished.
- Delivering more care than we are paid for in some areas, or filling the 'gaps' in care that no other organisation is set up to provide, because contracts are not clear.

Tackling all of these problems will not only make sense financially – it will also lead to better care for people using our services. So it is vital we get this right.

2016/17



2017/18 (planned)



As a Foundation Trust we are required to make a surplus each year and in 2017/18 we plan for this to be £1.7million. Achieving this relies on us making £12.8 million savings which is even more than last year. These savings are planned to be delivered from internal efficiencies and will also require transformational change across the region, for example by developing the new models of care which we've described earlier in this booklet. It is only by doing this that services we provide will be sustainable in the future, enabling us to provide the best possible care.

The numbers:

	2016/17	2017/18 (planned)
Income	£321.6m	£298m
Expenditure	£320.4m	£296.3m
Surplus	£1.2m	£1.7m

Measuring our progress

As part of the NHS we have a number of important measures that help to show we are delivering good care. We are pleased to report that in 2016/17 we met all the targets set by the national regulator, NHS Improvement. We also have targets set by our commissioners (who fund our services) and we set our own internal targets, too. We met some of these and are working hard to achieve them all in the year ahead.

Targets set by the NHS national regulator:

Mental health and learning disabilities:	Target	Our Performance	Did we achieve it?	National average (if available)
Patients discharged from psychiatric hospital have a follow up contact within 7 days	95%	97.3%	✓	96.6%
Proportion of people admitted to psychiatric hospital who had prior access to crisis support in the community	95%	99.7%	✓	98.5%
Proportion of patients whose transfer of care to another service was delayed	7.5%	3.7%	✓	
Proportion of patients in secondary mental health care who've had at least one formal review in the last 12 months	95%	97%	✓	
Proportion of patients who have had the right identifying information about them recorded	97%	99.7%	✓	
Proportion of patients who have had important information about their outcomes recorded	50%	81.4%	✓	
Proportion of people experiencing a first episode of psychosis who have been treated within two weeks of referral	50%	85.4%	✓	74.4%
Proportion of people referred to our Improving Access to Psychological Therapies service treated within six weeks	75%	87.2%	✓	
Proportion of people referred to our Improving Access to Psychological Therapies service treated within 18 weeks	95%	99.9%	✓	

What people have been saying about their care:

"My husband was admitted to Hawthorns 2 almost 7 weeks ago into the armed forces section. I was very sceptical and scared for him. However my fears were unfounded from the first moment to the last, the staff were caring, compassionate and tailored his care to his needs. Their care and expertise has literally saved my husband's life and put our little family back together and I can't thank you enough."

– Hawthorns 2, Parklands Hospital

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Physical Health:	Target	Our Performance	Did we achieve it?	National average (if available)
Proportion of people waiting less than 18 weeks from referral to treatment	92%	93.9%	✓	90.3%
Proportion of patients using our minor injuries units treated/ transferred or discharged within four hours	95%	99.3%	✓	87.6%
Proportion of patients who received a diagnostic test within six weeks	99%	100%	✓	98.9%
Proportion of patient records completed in line with the Community Information Data Set	50%	98%	✓	

Health Visitor visits have been a pleasure. She is friendly, non- judgemental and made me feel that she had all the time in the world for me. As this is my second child, I did not think I would really need the service but I have been very glad of the support.

– Fareham Central, Health Visiting team

I have had 5* treatment of a broken ankle from staff today. Nothing was too much trouble. Everything was explained carefully and professionally. Wonderful. Thank you to all.

– Lymington Hospital

Just dropping my commendation for the continuous, excellent, professional support that my client, family and myself have received from the team. I found K very approachable, flexible, timely, knowledgeable, having good communications skills and always willing to impart her knowledge to other people in an empowering manner.

– Learning Disabilities North and Mid Hants Community Team

Targets set by our commissioners and those we set ourselves:

Mental Health:	Target	Our Performance	Did we achieve it?	National average (if available)
Proportion of people receiving an assessment within agreed timeframes	90%	94.3%	✓	
Proportion of patients who have had a risk assessment recorded	95%	92.0%	✗	

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Physical Health:	Target	Our Performance	Did we achieve it?	National average (if available)
People spending more time in hospital than they need	7.5%	13.4%	✗	
Proportion of people receiving an assessment within agreed timeframes	90%	75.2%	✗	
Proportion of patients seen within two hours of referral to our rapid response service	80%	97.3%	✓	
End of Life: Proportion of patients dying in preferred location	80%	88.4%	✓	
Health Visiting: Proportion of pregnant mothers who received an antenatal contact at 28 weeks or above	84.8%	82.5%	✗	
Health Visiting: Proportion of mothers who received a new birth visit within 30 days	99.6%	99.4%	✗	

Get in touch or join us

At a time of such change and challenge we need your involvement like never before. We also know it's an area we need to improve. Your views and ideas, no matter how big or small, positive or critical, are very welcome.

If you want to get involved or find out about opportunities to help shape your local services, contact our communications team by phone or email.

023 8087 4666

communications@southernhealth.nhs.uk

1.5million CONTACTS WITH PEOPLE IN THE COMMUNITY EACH YEAR

Become a Member

If you want to play an even more active role, becoming a member means you can have a much greater say in your local healthcare.

We're always striving to improve. As a member, you can help us do this. We want to hear your experience of our services. We want to know how you think we should invest our money, and where we should develop services further.

We want to know when things go well, and when they don't, so we can address issues and problems quickly. In order for our services to meet the needs of local people and communities, we need to know what you expect and want.

What our members do

You can be involved as little or as much as you'd like, and in a variety of different ways. You may just want to receive updates about what the Trust is doing, through our members magazine and website. Or you may want to come along to local meetings and focus groups, or take part in surveys and questionnaires.

Being a member won't affect the care and treatment you receive. You also don't have to agree with everything our Trust does, or share our views.

What are the benefits?

As a member you'll be able to:

- Present your ideas, feedback or concerns to the Trust
- Elect fellow members to become Governors (or stand for Governor yourself)
- Meet and interact with the Council of Governors
- Attend exclusive 'medicine for members' events to hear fascinating talks from our amazing clinicians.
- Go to constituency meetings to discuss health care in your local area
- Attend the Annual Members Meeting
- Register for Health Service Discounts, where you can find a huge range of offers and benefits

To learn more contact us on:

023 8087 4253

FTmembership@southernhealth.nhs.uk

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