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Hampshire County Council

NOTICE OF MEETING

Meeting Health and Adult Social Care Select Committee

Date and Time Tuesday, 21st November, 2017 at 10.00 am

Place Ashburton Hall, Elizabeth II Court, The Castle, Winchester

Enquires to members.services@hants.gov.uk

John Coughlan CBE
Chief Executive
The Castle, Winchester SO23 8UJ

FILMING AND BROADCAST NOTIFICATION
This meeting may be recorded and broadcast live on the County Council's website. The meeting may also be recorded and broadcast by the press and members of the public – please see the Filming Protocol available on the County Council's website.

AGENDA

Approx. Timings

1. APOLOGIES FOR ABSENCE

To receive any apologies for absence.

2. DECLARATIONS OF INTEREST

All Members who believe they have a Disclosable Pecuniary Interest in any matter to be considered at the meeting must declare that interest and, having regard to the circumstances described in Part 3 Paragraph 1.5 of the County Council's Members' Code of Conduct, leave the meeting while the matter is discussed, save for exercising any right to speak in accordance with Paragraph 1.6 of the Code. Furthermore all Members with a Non-Pecuniary interest in a matter being considered at the meeting should consider whether such interest should be declared, and having regard to Part 5, Paragraph 2 of the Code, consider whether it is appropriate to leave the meeting while the matter is discussed, save for exercising any right to speak in accordance with the Code.

3. MINUTES OF PREVIOUS MEETING (Pages 5 - 18)

To confirm the minutes of the previous meeting

4. DEPUTATIONS

To receive any deputations notified under Standing Order 12.

5. CHAIRMAN'S ANNOUNCEMENTS

To receive any announcements the Chairman may wish to make.

6. PROPOSALS TO VARY SERVICES (Pages 19 - 30)

To consider the report of the Director of Transformation and Governance on proposals from the NHS or providers of health services to vary or develop health services in the area of the Committee.

Items for Monitoring

- Guildford and Waverley CCG: West Surrey Stroke Services – update on implementation — 10 minutes

7. ISSUES RELATING TO THE PLANNING, PROVISION AND/OR OPERATION OF HEALTH SERVICES (Pages 31 - 118)

To consider a report of the Director of Transformation and Governance on issues brought to the attention of the Committee which impact upon the planning, provision and/or operation of health services within Hampshire, or the Hampshire population.

- Portsmouth Hospitals NHS Trust: Care Quality Commission Re-Inspection – consideration of action plan — 1 hour
- Southern Health NHS Foundation Trust: Care Quality Commissioner Re-Inspection – update on progress — 1 hour

8. ADULTS' HEALTH AND CARE: ADULT SAFEGUARDING UPDATE (Pages 119 - 132) — 30 minutes

To consider an annual update on Adult Safeguarding.

9. WORK PROGRAMME (Pages 133 - 144) — 5 minutes

To consider and approve the Health and Adult Social Care Select Committee Work Programme.

ABOUT THIS AGENDA:

On request, this agenda can be provided in alternative versions (such as large print, Braille or audio) and in alternative languages.

ABOUT THIS MEETING:

The press and public are welcome to attend the public sessions of the meeting. If you have any particular requirements, for example if you require wheelchair access, please contact members.services@hants.gov.uk for assistance.

County Councillors attending as appointed members of this Committee or by virtue of Standing Order 18.5; or with the concurrence of the Chairman in connection with their duties as members of the Council or as a local County Councillor qualify for travelling expenses.

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AT A MEETING of the Health and Adult Social Care Select Committee of HAMPSHIRE COUNTY COUNCIL held at The Castle, Winchester on Thursday, 21st September, 2017

PRESENT

Chairman:
p Councillor Roger Huxstep

Vice-Chairman:
p Councillor David Keast

p Councillor Martin Boiles
p Councillor Ann Briggs
a Councillor Adam Carew
p Councillor Fran Carpenter
a Councillor Charles Choudhary
a Councillor Tonia Craig
p Councillor Alan Dowden
p Councillor Steve Forster
p Councillor Jane Frankum
p Councillor David Harrison
a Councillor Marge Harvey
p Councillor Pal Hayre
p Councillor Mike Thornton
p Councillor Jan Warwick

Co-opted Members:
p Councillor Trevor Cartwright
p Councillor Barbara Hurst
a Councillor Alison Finlay
VACANT

In attendance at the invitation of the Chairman:
p Councillor Liz Fairhurst, Executive Member for Adult Social Care
p Councillor Patricia Stallard, Executive Member for Health and Public Health

20. **APOLOGIES FOR ABSENCE**

Apologies were received from Councillors Adam Carew and Marge Harvey, and district and borough co-opted member Councillor Alison Finlay.

The Chairman welcomed Cllr Trevor Cartwright to the meeting, as a newly appointed co-opted member representing district and borough councils.

21. **DECLARATIONS OF INTEREST**

Members were mindful that where they believed they had a Disclosable Pecuniary Interest in any matter considered at the meeting they must declare that interest at the time of the relevant debate and, having regard to the circumstances described in Part 3, Paragraph 1.5 of the County Council's Members' Code of Conduct, leave the meeting while the matter was discussed, save for exercising any right to speak in accordance with Paragraph 1.6 of the Code. Furthermore Members were mindful that where they believed they had a Non-Pecuniary interest in a matter being considered at the meeting they considered whether such interest should be declared, and having regard to Part 5, Paragraph 2 of the Code, considered whether it was appropriate to leave the

meeting whilst the matter was discussed, save for exercising any right to speak in accordance with the Code.

Councillor Jan Warwick declared a non-pecuniary interest in Item 7, as she is a part-time specialist pharmaceutical advisor to the Care Quality Commission.

22. MINUTES OF PREVIOUS MEETING

The Minutes of the meeting of the Health and Adult Social Care Select Committee (HASC) held on 21 July 2017 were confirmed as a correct record and signed by the Chairman.

23. DEPUTATIONS

The Committee did not receive any deputations.

24. CHAIRMAN'S ANNOUNCEMENTS

The Chairman made three announcements:

Dorset Clinical Services Joint Health Overview and Scrutiny Committee (JHOSC) update

The JHOSC last met on 3 August, where the Clinical Commissioning Group (CCG) presented the outcomes of the consultation on the proposals for the future of Dorset's clinical services. The consultation outcome was fairly balanced in terms of support for either of the main options (Option A being to centralise urgent care in Poole, and planned care in Bournemouth, and Option B to centralise urgent care in Bournemouth, and planned care in Poole), with Option B being Dorset CCG and the Hampshire HASC's preferred option. The JHOSC remained split on their support for the proposed model, with those representing Poole and West Dorset tending to speak more unfavourably of Option B. There remained disagreement about travel times. Hampshire's representatives would continue to monitor this issue, but remained supportive of Option B. The CCG had on 20 September taken the decision to implement Option B, and the JHOSC would need to meet to consider this decision. Should the JHOSC vote to refer this matter to the Secretary of State, Hampshire would play no part in this, as the Council did not delegate its referral power to the JHOSC.

Councillors Harrison and Keast agreed with the Chairman's comments, and noted their support for the chosen option.

Requests for Item consideration at Full Council

At the most recent Council meeting in July, a number of topics were referred to the HASC for consideration. The following action had been taken:

- Mental health in schools: Councillor Harrison had been contacted about this topic, which the Children and Young People Select Committee will review should there be any progress on this area from central government.

- Motor Neurone Disease Charter – Councillor Fairhurst was due to consider this at a future decision day, following Councillor Dowden's request.

Briefings and Updates

The Chairman noted that updates would be shared after the meeting with the Committee on:

- Antelope House Psychiatric Intensive Care Unit – update on staffing following urgent temporary closure *(Southern Health NHS Foundation Trust)*
- Low Secure Mental Health Beds for Children and Adolescents *(Southern Health NHS Foundation Trust)*
- Primary Care Prescribing *(via West Hampshire CCG)*

25. ADULTS' HEALTH AND CARE - TRANSFORMATION TO 2019

The Director of Adults' Health and Care spoke to the report and presentation, which set out the departmental transformation to 2019 savings proposals and public consultation feedback (see Item 6 in the Minute Book).

Members heard an overview of the key findings of the balancing the budget consultation held by the County Council the previous summer, and noted that all of departments in the Council had been asked to proportionately contribute a further 19% saving of their budget by April 2019, as part of the next 'Transformation to 2019' (T19) programme. For Adults' Health and Care, this resulted in an overall requirement of £55.9m. An overview was provided of the Department's 'Transformation to 2017' (T17) savings, which would see a total of £43.1m achieved by the end of the 2017/18 financial year. With the proposed T19 savings, this would bring the cumulative total to £191m by the end of 2020.

There were four principles that underpinned the Departmental approach to T19:

- Prevention: strengthening the prevention strategy to reduce and/or contain demand.
- Independence: increasing the number of clients living independently and reducing the cost of care.
- Productivity: improving the efficiency and productivity of the Department's operations.
- External spend: increasing outcomes and service efficiency from commissioned services.

Within these principles were four main blocks, which centred on the use of additional health and social care integration funding; living independently (older people's and physical disabilities); learning disabilities, children's to adults transition, mental health and social inclusion; and working differently. All of these were underpinned by the theme of demand management and prevention.

There were approximately 3,000 staff employed within Adults' Health and Care, and in due course it was expected that the Department would need in the region of 150 fewer full time equivalents, through natural attrition, redeployment and potentially voluntary redundancy. Through the T17 programme, it was expected that there would be a staffing reduction, but the requirements of the changes

implemented required additional growth in staffing in some areas, and this may be the case for T19.

An additional £18.9m was being made available in 2019/20 through the Integration and Better Care Pooled Fund, which would offset some of the savings required by the Department. These funds would be used to invest in joint and integrated service delivery programmes, and to protect core social care services.

The living independently proposals were centred on creating options so that people can live independently for as long as possible. Through intermediate care, such as reablement (both home and bed-based), individuals can be supported to re-learn the life skills that enable them to remain independent, and to need less ongoing support. As a result of this work, the number of people being admitted into acute care should reduce, which should improve flow through hospital and enable the limited social care resource to be targeted at those with higher needs. There were also greater opportunities for exploring how technology-enabled care can be used to reduce cost; innovative devices already in use in Hampshire had helped to reduce social isolation, reminded individuals to take their medication, and had sensors which alerted care staff if an individual had experienced a fall. Such technologies also allowed for care staff resource to be aimed at those with higher needs. The Council would also be continuing to invest in extra care, particularly focusing on younger adults with learning disabilities.

The proposals for the living independently programme would include a re-consideration of client contributions, particularly around what percentage of contribution the Council takes for providing care. Hampshire was unique in the south east, as currently only 95% of the maximum contribution was charged to clients. This area was considered under the T17 proposals, and it was determined at that stage not to move to 100%, but this would need to be reconsidered for T19. This work stream would also be reviewing and potentially redesigning day opportunities for clients, as these currently followed a traditional format of travel, activity in a day centre, and then travel home. There may be an opportunity to explore how more activities and groups can be supported in local communities, reducing the need for travel, improving social contact, and building community resilience at the same time.

The proposals around learning disabilities, children's to adults, mental health and social inclusion were also focused on choice and living independently, moving away from long term institutional care to, where appropriate, extra care and living independently. Taking this approach would open up other life opportunities for individuals, for example enabling employment. Joint work would be undertaken under this heading with Children's Service on the transition pathway, where previously there has been a potential for a cliff edge of service delivery between the two Departments, where services were previously delivered by Children's, which may not be there in Adult Services. The Department would be working with colleagues to create opportunities to experience greater independence and make choices about where support can be offered as teenagers, to make the transition process smoother. The Department would be working in partnership with District and Borough Councils to redesign services around social inclusion, and a working group of the Committee would aid this work.

The working differently T19 work stream would focus on the entire workforce of the Department, making better use of technology, rolling out greater modern and flexible working, making business processes more efficient and ceasing some activities. Through this, it was believed that approximately £4.1m could be saved, and a reduction of 150 full time equivalent staff. Annually the Department experienced around 300 staff leaving through natural churn, such as resignation and retirement, so this would provide the space to restructure teams and identify which areas needed additional support, and where posts would not need to be filled.

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Demand management and prevention was an underpinning work stream and impacted on all areas of the Department, therefore no sum of money had been placed against this area, as any further efficiencies released would be realised under the other key T19 areas. Work had already started under T17 in investing in initiatives that help individuals and communities to help themselves, with an example of this being the health and wellbeing centres being supported by the Council across Hampshire to provide services, information and a space for communities to use.

The Public Health grant continued to be ring-fenced, and this was due to be reduced by £4m by 2019/20, to bring the cumulative reduction to £8.3m. From 2019/20, Public Health would receive a grant of £49.5m. As these savings were on a different timescale to the rest of T19, these proposals would be brought forward in separate papers.

There were a number of risks inherent in changing the Department's offer, in managing these messages and ensuring outcomes are maintained. The Department had learnt from previous transformation programmes, and the importance of ensuring that staff are communicated with at the right time. The Council continued to have a clear duty to meet eligible needs, but it was not mandated as to how these are delivered, and therefore there was scope to review how services are organised. The Director was clear that he would not fetter discretion, and would always be cognisant of individual needs and circumstances, and changes in case law.

The outcomes of the balancing the budget consultation did show a high level of support for raising existing or levying new charges for services, although the Director was mindful that if this question had been posed solely on care contributions the response may have been different. Broadly, however, the strategy of the Council and Department had been supported. The Department were also keen to increase income in other ways where possible, such as through selling services such as that on client affairs, which provides advice on issues relating to those individuals who do not have capacity to make decisions.

The proposals had been discussed in co-production meetings and the Director was due to attend a number of meetings with stakeholders, including clients, to understand their views on the proposals and deliver messages around the T19 programme. Additionally, there was likely to be a new green paper on social care and how it is funded financially, so the Council would be alive to this when drafted.

The report contained Equality Impact Assessments for each saving proposal work programme, and some areas may require further consultation. The next steps after Select Committee would be for the Executive Member to consider the proposals and to submit them to Cabinet for further review. A final form of proposals would then be considered by County Council in November, and the further development of the proposals, and timetable for their implementation, would take place after this time, subject to any consultation work.

In response to questions, Members heard:

- Part of the focus for T19 is on communities, as Hampshire hosts over 5,000 community organisations and the Department can help to corral and bring these together, which would result in being able to access a more holistic approach to care.
- The Department were clear that meeting needs wasn't just about providing personal care, but also about a wider approach to reducing isolation and social need. The World Health Organisation had recently suggested that the impact of social isolation had the equivalent impact on health of smoking 15 cigarettes a day. Therefore, it was important that care plans accounted for reducing social isolation. In addition, most referrals to the Department were concerns about individuals living alone and being isolated, rather than physical care needs such as assistance with eating or dressing.
- That part of the exploration of new technology was to understand how devices might replace tasks that currently lead to the inefficient use of staff. For example, carer visits in order to ensure that service users have taken their medication, yet technology exists on the market that reminds individuals to take medication, and alerts carers if this has not been done. Similarly, the work being proposed around increasing community resilience may enable more voluntary assistance with issues such as these, such as neighbours undertaking a check to ensure an individual has eaten.
- That the Director accepted that social workers and other professionals don't always get it right, and that a further culture shift needed to take place to ensure that family wishes and those of the client are always at the centre of care decisions. There had been a number of serious case review enquiries nationally recently which presented similar findings around professionals not always listening to families, or sharing information, and Hampshire along with all other areas needed to learn lessons from these. The Department were undertaking work with health partners around independent personal commissioning and this will focus on giving younger adults greater choice about what support they have, and when. Additionally, work with co-production groups, which have membership made up of clients, families, previous service users as well as community representatives, is instrumental to the Department in learning how to do things better.
- There was a cohort of service users supported by the Department who could not live independently due to the complexity and severity of their needs. However, institutional long-term care was not the right approach to meet these individual's needs, as outcomes from reviews such as that focused on Winterbourne had shown. A significant amount of work is being undertaken with health on transforming care for people with profound disabilities, ensuring that care can be delivered locally, and

individuals can be part of the wider community, should they wish to be. One of the steps taken by Hampshire County Council to realise better integration between services for those with profound disabilities was the decision to integrate the learning disability and mental health services into a single line management support structure, which would ensure better co-working.

- There continued to be challenges and risks associated with the care market workforce, which at best would be described as fragile. This sector experienced high turnover and issues with retaining staff, and Hampshire County Council was continuing to work with partners to increase the attractiveness of 'care' as a career choice. In tandem, the exploration of technology to replace care workers where the use of staff was inefficient would release precious domiciliary care capacity.
- Reablement and intermediate care was generally for a period up to six weeks, but there were some exceptions where additional time was needed. This care was universal and not means tested, and it had been evidenced that investing in this type of care impacted positively on health and social care, with approximately 70% of service users returning to independence rather than further care.

The Chairman then moved to debate, where discussion was held on the information received to date and whether the Committee was able to take a view on the proposals at this stage. Some Members expressed their desire to defer taking a view on the proposals until a working group had been formed to consider each work stream in detail. Other Members noted that the proposals were still in a draft stage, and had been drawn together by officers who had the subject expertise to take a view on where the savings could be delivered. The Chairman noted that the Committee would have a further opportunity to consider the T19 proposals, once they had been through Council, in greater detail.

There was some concern from Members that some of the Department's aims of promoting independence and lessening social isolation would be impacted by savings proposed by other areas of the County Council. The Executive Member for Public Health assured the Committee that the Corporate Management Team had worked together on proposals to mitigate potential impact on other areas of the Council, but the Director of Adults' Health and Care agreed to hold further discussions in this area.

The Director noted that some of the T19 proposals were a continuation of what the Department were already doing, and that some might be subject to stage two consultation. Additionally, a working group was being formed to look at social inclusion.

The Chairman noted the possibility that Cabinet may make changes to the T19 proposals submitted by each Department, although the level of savings would need to be the same.

The Chairman moved to the recommendation as set out in the paper:

That the Committee support the submission to Cabinet of the proposed savings options contained in the report and its Appendix 1

A vote was taken on the proposed recommendation:

For:	8
Against:	4
Abstained:	0

RESOLVED

That the Committee support the submission to Cabinet of the proposed savings options contained in the report and its Appendix 1.

26. **ISSUES RELATING TO THE PLANNING, PROVISION AND/OR OPERATION OF HEALTH SERVICES**

Portsmouth Hospitals NHS Trust: Care Quality Commission Re-Inspection Enforcement Notice – Urgent Care Update

The Chief Executive and representatives of Portsmouth Hospitals NHS Trust, together with the Chief Executive and representatives of Hampshire Clinical Commissioner Group (CCG) Partnership, spoke to the recent Care Quality Commission (CQC) re-inspection report of the Trust (see Item 7 in the Minute Book).

The Chief Executive of the Trust outlined to the Committee the issues arising from the CQC report, which detailed the findings from two inspections that took place earlier in 2017. The report had made difficult reading for the Chief Executive, who had been in post for only a couple of weeks at the time of its publication, and for the Medical Director who had been in his role for a similar period of time. However, they both accepted its findings in full, and had worked closely with the Board to take a number of immediate actions, in addition to those taken when the CQC first provided an overview of its concerns post-inspection.

The Chief Executive outlined that a number of actions were being taken by the Trust, and the feedback from staff to date was that they were absolutely committed to addressing the issues at pace, and to providing the best care to patients. The challenges being faced by the hospital were not new, and those raised in relation to urgent care and flow through the hospital had been communicated previously to the Committee over the past two years. The Trust accepted that they were not getting their delivery of care 100% right, and were committed to changing this, and making sure that staff were able to meet this challenge. This was particularly the case in urgent care, where staff had faced an ongoing period of high demand for services, but remained resilient and focused on improvement.

The Chief Executive explained that in his view there were a number of conditions that weren't right in the organisation whilst the inspections took place, and part of his role was to create the right environment in the hospital to ensure that the best care could be provided. The Trust subsequently had a new quality improvement plan, which had been reviewed and refreshed to ensure it could meet the areas where action needed to be taken. A first draft of this had been submitted to the CQC and partners on 1 September, and this would be finalised for publication by 31 October. In the meantime, a Quality Summit would be held with partners and

the CQC to review the document, and ongoing engagement work would continue with staff to ensure they understand and can take ownership of the plan.

There had been a number of leadership changes in the Trust since the inspections were held, and since joining the organisation in July the Chief Executive had been impressed with how colleagues were working collaboratively at a senior level.

The Medical Director was also newly in post but had been a consultant at the Trust for nearly 20 years. His view was that the situation reported by the CQC was very uncomfortable for staff, but there was a clear sense of commitment from all levels that had at times been quite overwhelming. It was important that the Board continued to build a strong team to take ownership of the report and its actions.

In response to questions, the Committee heard:

- That the Trust were currently recruiting to the position of chairman following the retirement of the previous post-holder, and currently this position was held by an interim chairman. Interviews for this role would be held at the end of September, and the Trust hoped to make an announcement shortly after. In addition, the Trust had recently recruited new Non-Executive Directors who were better able to hold the Trust to account.
- The Executive Board was still in a transitional state and would be for the remainder of the year. Several positions were still held by interim placeholders, and further recruitment work would need to be undertaken.
- The new Chief Executive was previously the Chief Operating Officer for NHS Improvement and therefore had significant experience of commissioning Board capability reviews. This tool was usually used for assessing the ability of those who have been in post for a long period of time; the wider issue in the Trust was that many of the Board positions at the time of the inspection were filled by Interim or Acting Board Members, or there were vacant positions. The Chief Executive would therefore have the ability to recruit individuals to these roles who have the right values and skills, and potentially experience of working for, or with, a provider which had improved despite similar difficulties.
- That accountability for the day-to-day delivery of acute care in the hospital is with the Chief Operating Officer, and responsibility for aspects of how care is delivered also sits with the Chief Nurse and Medical Director. Ultimately, the Chief Executive was accountable for how the hospital operates and took responsibility for the findings of the CQC report.
- That one of the criticisms of the report related to how the Trust cared for patients with mental health issues, and this had been a deep dive element considered by the external review of the Trust's approach. This has been a particular focus of the Medical Director, who is the first nominated Executive Lead for mental health in the Trust. As part of this champion role, the Medical Director held fortnightly meetings to discuss the Trust's approach to the growing number of people with serious mental health issues attending the hospital, and how the hospital could implement best practice relating to their care
- The issues raised in the report around the incorrect recording of serious incidents, and safeguarding and wider governance concerns made

troubling reading, and the Trust were taking these very seriously. These parts of the report highlighted an alarming amount of inconsistency, especially where services were over-stretched or facing high levels of demand. In response to these findings, the Trust had commissioned an external review of patient management across all vulnerabilities, in order to be absolutely sure of where the issues are and what action needed to be taken. The aim was to ensure better and more embedded levels of understanding and standards amongst staff than the Trust were previously able to demonstrate. The Chief Executive felt that the Trust was already able to demonstrate significant improvements in this area already, but there was more to be done.

- The Chief Executive of the CCG noted that they were reassured by the Board's acceptance of the CQC report and their commitment to actioning the recommendations. The CCG would be working closely with the Trust, both to be assured as a commissioner that actions are being taken, and as a partner to ensure that the wider health and social care system also assists with the actions to be taken. A significant amount of work was progressing locally in relation to out of hospital care, which would see more traction in preventing individuals from being referred into acute care, and would improve flow out of the hospital. It was important that the focus was not just on the internal processes of Trust, but also about what the wider health and social care system can do.
- One of the benefits of the wide geography covered by the CCG was that lessons could be learnt from the organisation working with multiple hospital trusts, including outstanding Trusts such as Frimley Health, and applying these lessons, where appropriate, to Portsmouth. The dissemination of best practice across all of the hospitals in Hampshire was a key feature of the Sustainability and Transformation Plan programme.
- The CCG would be working in three ways to specifically hold the Trust to account. First, it would be monitoring the Ward to Board culture and requesting assurance that Non-Executive Directors are able to effectively hold the Board to account, which the CCG believed had already developed in a more open and transparent way. Secondly, the CCG had changed the conditions around contracting, and the Trust now worked to a new aligned incentive contract, which focused on rewarding the right behaviours. Thirdly, the CCG would be working with partners to ensure that there was the right level of capacity and support in the community. All of this work was not about trying to implement lots of new initiatives, but was more about getting the basics right.
- The CCG have given the Trust a contract performance notice, which was in place before the CQC report was published. This was one of the key focuses of the system wide urgent care delivery board, so some of the issues raised in the report were not of surprise to the CCG. However, the parts of the report the CCG was not so cognisant of, and found difficult to understand, were the cultural issues around care delivery.
- The Trust were aware of the need for a culture shift and better ownership by staff of the improvement journey. The Board had held meetings with staff which had been cathartic, with a spirit of openness allowing concerns to be expressed and emotion to be shown; many staff were upset that they and their colleagues were reported to not be getting it right, but accepted this finding. The meetings also showed a motivation to get it

right, and an energy and enthusiasm to improve both quickly and permanently.

- The issues raised around bullying and harassment had also been picked up in the staff survey, which was a surprise as the Trust were in the top quartile for staff satisfaction. Since joining the Trust, the Chief Executive had held a number of engagement sessions with staff, of where some of the feedback received was that staff do not always feel confident enough to, or able to, express concerns about poor care or not following Trust policy. This was not acceptable, to the Chief Executive, and he would be exploring how he could better encourage candour.
- The Trust does have a whistleblowing policy, and the Chief Executive wrote a weekly blog to all staff that provided them with his direct contact details should they wish to raise concerns with him directly. This had already seen a number of contacts
- The Medical Director had lobbied with the Director of Education to begin a Chief Registrar post in the Trust, which was 50% funded by the Wessex Deanery to enable a split between clinical and management time. The first Chief Registrar took up the post in August, and met at least once a week with the Medical Director to discuss concerns and upcoming issues. They had also set up a junior doctor forum, which enabled new doctors to discuss their experiences with their peers, and to confidentially raise concerns they may have about existing practice in the hospital. This forum recognised that the Trust needed to engage meaningfully in a way that was supportive with junior medical staff, especially as they often are a group that has intelligence from working in other care settings that should be tapped into.

The Chairman thanked the presenters for their honest answers to probing questions, and noted that the Committee would be keen to review the improvement plan of the Trust, and to understand timescales for delivering sustained improvements. Therefore, the Committee would invite the Trust back to their next meeting, in order to consider this plan in greater detail.

RESOLVED

That Members:

1. **Note the Care Quality Commission report and the update from the Trust.**

2. **Request the Trust's improvement plan setting out actions to be taken in response to the recommendations of the Care Quality Commission report, once published.**

3. **Request that the Trust be further invited to the 21 November meeting, in order to present and speak to the improvement plan.**

Councillors Alan Dowden, Jane Frankum, Steve Forster, and co-opted member Councillor Trevor Cartwright left the meeting at this point in proceedings.

27. **ADULTS' HEALTH AND CARE - SUBSTANCE MISUSE SERVICES**

This item was deferred at the request of the Chairman and agreed by the Committee.

28. 'SOCIAL INCLUSION AND TRANSFORMATION TO 2019' WORKING GROUP - TERMS OF REFERENCE

The Committee reviewed the draft Terms of Reference for the 'Social Inclusion and Transformation to 2019' working group of the Health and Adult Social Care Select Committee.

The Committee heard that the final membership would be:

- Cllr David Keast (Chair)
- Cllr Anne Briggs
- Cllr Alan Dowden
- Cllr Marge Harvey
- Cllr Barbara Hurst (District and Borough co-opted member)

RESOLVED

That the Terms of Reference are approved.

29. 'SUSTAINABILITY AND TRANSFORMATION PARTNERSHIPS' WORKING GROUP - TERMS OF REFERENCE

The Committee reviewed the Terms of Reference for the 'Sustainability and Transformation Partnerships' working group of the Health and Adult Social Care Select Committee.

The Committee heard that the final membership would be:

- Cllr Roger Huxstep (Chairman)
- Cllr Fran Carpenter
- Cllr Pal Hayre
- Cllr Mike Thornton
- Cllr Alison Finlay (District and Borough co-opted member)

RESOLVED

That the Terms of Reference are approved.

30. WORK PROGRAMME

The Director of Transformation and Governance presented the Committee's work programme (see Item 11 in the Minute Book).

RESOLVED:

That the Committee's work programme be approved, subject to any amendments agreed at this meeting.

Chairman, 21 November 2017

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HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Adult Social Care Select Committee
Date of Meeting:	21 November 2017
Report Title:	Proposals to Develop or Vary Services
Report From:	Director of Transformation & Governance

Contact name: Members Services

Tel: (01962) 847336 **Email:** members.services@hants.gov.uk

1. Summary and Purpose

1.1. The purpose of this report is to alert Members to proposals from the NHS or providers of health services to vary or develop health services provided to people living in the area of the Committee.

1.2. Proposals that are considered to be substantial in nature will be subject to formal public consultation. The nature and scope of this consultation should be discussed with the Committee at the earliest opportunity.

1.3. The response of the Committee will take account of the Framework for Assessing Substantial Change and Variation in Health Services agreed by the Hampshire, Isle of Wight, Portsmouth and Southampton Joint Committee in November 2010, last updated in July 2016 (due to be further updated in January 2018). This places particular emphasis on the duties imposed on the NHS by Sections 242 and 244 of the Health and Social Care Act 2006, includes new responsibilities set out under the Health and Social Care Act 2012, and takes account of key criteria for service reconfiguration identified by the Department of Health.

1.4. This Report is presented to the Committee in three parts:

a. *Items for action:* these set out the actions required by the Committee to respond to proposals from the NHS or providers of health services to substantially change or vary health services.

b. *Items for monitoring:* these allow for the monitoring of outcomes from substantial changes proposed to the local health service agreed by the Committee.

c. *Items for information:* these alert the Committee to forthcoming proposals from the NHS to vary or change services. This provides the Committee with an opportunity to determine if the proposal would be considered substantial and assess the need to establish formal joint arrangements

1.5. This report and recommendations provide members with an opportunity to influence and improve the delivery of health services in Hampshire, and to support health and social care integration, and therefore assist in the delivery of the Joint Health and Wellbeing Strategy and Corporate Strategy aim of maximising well being.

Items for Monitoring

2. NHS Guildford and Waverley Clinical Commissioning Group (CCG): West Surrey Stroke Services

Context

2.1 The NHS, or any provider of NHS services, is required to consult the health scrutiny committee on any substantial or temporary variations to the provision of the health service, and to provide any information that the Committee may require to enable them to carry out scrutiny of the planning, provision and operation of this service.

Background

2.2 Six Clinical Commissioning Groups (CCGs) in Surrey led a review of how stroke services are provided in their geography in order to deliver services that meet the South East Coast Stroke Services Specification, and to enhance care in the region.

2.3 Historically, three hospitals in West Surrey have provided some specialist stroke care; Frimley Park (Camberley), Royal Surrey County (Guildford), and St Peter's (Chertsey). The Surrey CCGs proposed a service model where there would be two larger hyperacute units providing highly specialist care at Frimley Park and St Peter's Hospital. Resultantly, there would be no specialist stroke care provided at Royal Surrey Hospital if the proposals were agreed. It should be noted that all providers supported this proposal.

2.4 Patients suspected of having a stroke in some parts of North East and South East Hampshire were previously conveyed by ambulance to either Frimley Park Hospital on the Surrey / Hampshire border, or Royal Surrey County Hospital in Guildford. The majority of the population of Hampshire were not affected by the proposals, as the hyperacute stroke unit provided by Hampshire Hospitals NHS Foundation Trust was not part of the review.

2.5 A paper was considered by the HASC in June 2017 detailing the background to the stroke review, engagement to date, consultation activities and next steps. It was resolved that whilst the proposals constituted a substantial change in service, it would have a positive impact on the affected population in Hampshire, and therefore the Committee supported the outlined model.

Update

2.6 An update report has been received from the CCGs (Appendix One) which details:

- The outcomes of the consultation
- The CCGs' response to the consultation feedback
- The decision taken by the 'West Surrey Stroke Services Committees in Common', including a number of amendments designed to respond to feedback from the public
- Implementation of the new model
- Impact on residents in South East Hampshire

2.7 Of the 402 questionnaire responses received as part of the consultation, 25 of these were from those residing in South East and North East Hampshire. The primary concern highlighted was the performance of South East Coast Ambulance NHS Foundation Trust (SECAMB), and travel times to Frimley Park Hospital. The report details the measures proposed by the CCGs to respond to these issues.

2.8 A decision was taken by the West Surrey Stroke Services Committees in Common meeting on 7 September, where an amended set of proposals were agreed. This included the amended recommendation to network the Hyperacute Stroke Unit located at Frimley Park Hospital with an Acute Stroke Unit and specialist bedded stroke rehabilitation at the Royal Surrey County Hospital, which would see some stroke service provision retained at this hospital.

2.9 Although the new service model has not yet been implemented, the CCGs continue to commission an interim model of stroke care, reported to the Committee in June, which sees patients in areas of South East and North East Hampshire suspected of suffering a stroke being conveyed to Frimley Park Hospital, instead of Royal Sussex County Hospital. Data provided on the last eight months of this arrangement show an improvement in ambulance response time for those living in the Bordon area compared to the previous model. Comparable data is not yet available for those in Liphook, as zero suspected strokes been recorded. It is intended that the new model will be fully implemented by March 2018.

Recommendations

2.10 That the Committee:

a. Note the outcomes of the consultation and final proposals for stroke services in West Surrey, which impact on some areas of South Eastern Hampshire..

b. Request a further update once the new service model has been fully embedded, to include monitoring information on the ambulance response times in the South East Hampshire area.

CORPORATE OR LEGAL INFORMATION:

Links to the Strategic Plan

Hampshire maintains strong and sustainable economic growth and prosperity:	No
People in Hampshire live safe, healthy and independent lives:	Yes
People in Hampshire enjoy a rich and diverse environment:	No
People in Hampshire enjoy being part of strong, inclusive communities:	Yes

Section 100 D - Local Government Act 1972 - background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

Document	Location
Proposals to Vary Services - NHS Guildford and Waverley and NHS North West Surrey CCGs: West Surrey Stroke Services	http://democracy.hants.gov.uk/ieListDocuments.aspx?CId=184&MId=348&Ver=4

IMPACT ASSESSMENTS:

1. Equalities Impact Assessment:

1.1 This is a covering report which appends reports under consideration by the Committee, therefore this section is not applicable to this covering report. The Committee will request appropriate impact assessments to be undertaken should this be relevant for any topic that the Committee is reviewing.

2. Impact on Crime and Disorder:

2.1 This is a covering report which appends reports under consideration by the Committee, therefore this section is not applicable to this covering report. The Committee will request appropriate impact assessments to be undertaken should this be relevant for any topic that the Committee is reviewing.

3. Climate Change:

3.1 How does what is being proposed impact on our carbon footprint / energy consumption?

This is a covering report which appends reports under consideration by the Committee; therefore this section is not applicable to this work report. The Committee will consider climate change when approaching topics that impact upon our carbon footprint / energy consumption.

3.2 How does what is being proposed consider the need to adapt to climate change, and be resilient to its longer term impacts?

This is a covering report which appends reports under consideration by the Committee, therefore this section is not applicable to this work report. The Committee will consider climate change when approaching topics that impact upon our carbon footprint / energy consumption.

Update Report for Hampshire Health and Adult Social Care Select Committee (HASC), Hampshire County Council, 21 November 2017

West Surrey Stroke Services: Update on Implementation

Authors

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Campbell Todd, Senior Commissioning Programme Officer, Portsmouth, Fareham and Gosport and South Eastern Hampshire Clinical Commissioning Groups

Background

Representatives of the two CCGs detailed above attended the HASC on 20 June 2017 to provide an overview of the Surrey Stroke Review and the public consultation that had been undertaken earlier in the year on proposals to improve provision of stroke care in West Surrey that would result in a service variation; this proposed variation would affect residents in parts of South East Hampshire bordering Surrey.

Members of this committee requested an update on the work undertaken to date with Hampshire's two ambulance providers to ensure that the proposals can be fully supported, as well as the full outcomes of the public consultation and the actions the CCG will take to meet feedback from this exercise.

Outcomes of the consultation

The Consultation Outcome Report, written by the independent NHS Transformation Unit following their analysis of the substantial feedback received during the consultation, was published on 28 June 2017.

Altogether 402 questionnaires were completed during the consultation; 25 of these were completed by residents of East Hampshire[1]. Of these, the majority of respondents disagreed with the following three statements, although there are a significant proportion of residents that support them:

[1] The NHS TU notes that "*the responses to any consultation will tend to be higher in areas most likely affected by proposals and as such this report is representative of those individuals who wanted their views to be taken into account and not representative of the population as a whole. In particular, the questionnaire responses from all areas demonstrate a higher proportion of responses from older members of the population and responses from Guildford and Waverley demonstrate a higher proportion of female responses than seen in their population overall. Those with caring responsibilities are more highly represented across all areas than would be seen in the population overall*".

- Statement 1: Access to seven day specialist stroke services should be provided at Frimley Park Hospital and St Peter's Hospital to enable more people to survive a stroke and minimise risk of disability
- Statement 2: Seven day clinics for transient ischaemic attacks (TIA) should be provided at Frimley Park Hospital and St Peter's Hospital as part of the specialist stroke service
- Statement 3: The reason for concentrating in-hospital stroke specialist rehabilitation services in fewer hospitals in West Surrey is justified and supported

The themes most commonly arising through comments are detailed below (for all respondents):

- Concerns about the removal of services from the Royal Surrey County Hospital, preference to position some of the stroke services at the Royal Surrey County Hospital and concerns about the future of that hospital. These comments about the change are particularly notable amongst the respondents from Guildford, Waverley and East Hampshire
- The importance of timely stroke treatment
- Recognition that creation of specialist units with specialist workforce and equipment has benefits, with differences of opinion on where these units should be located
- The importance of equitable access and concerns that the plans create inequity of access across the county
- References to travel distance and time, linked to implications for timely treatment, visitor access and patient wellbeing
- The importance of ambulance availability and concerns about SECAMB ambulance times in relation to the current service and the success of the proposed plans
- Other aspects of travel, such as public transport issues

The special interest groups additionally highlighted the following aspects:

- Consideration of care once stroke patients are discharged from hospital
- Provision of measures to help those with learning disabilities adapt to changes
- Expected population growth in south Surrey with related concerns about the service for this population under the plans
- Importance of access to finance and practical implementation in achieving plans

It is highly recommended that members of the committee read the consultation outcome report to find out finer details regarding feedback from residents of East Hampshire.

Response to consultation feedback

Guildford & Waverley CCG and North West Surrey CCG detailed their response to the consultation feedback in a report for the West Surrey Stroke Services Committees in Common, published on 31 August 2017.

West Surrey Stroke Services Committees in Common

The West Surrey Stroke Committees in Common met in public on 7 September 2017 in Woking with the aim of fulfilling the following remit, as described in its Terms of Reference:

1. Respond to the key themes of the public consultation, as presented in an independent report
2. Agree for the West system the hyperacute stroke unit (HASU)/acute stroke unit (ASU) provision and the TIA provision.
3. Agree for the West system – (for Guildford and Waverley resident population and for North West Surrey resident population respectively), the hospital/bedded rehabilitation facilities associated with the HASU/ASU provision.
4. Affirm commitment to the additional resource across the integrated stroke care pathway from onset of stroke to six month follow up.
5. Recognise commitment of South East Coast Ambulance Service (SECAMB) to support delivery of the model of care.
6. Take any other decisions required in relation to the West Surrey Stroke System and any of the key themes of the consultation that may emerge, that would otherwise be taken by the CCG Governing Bodies.

In response to the considerable feedback regarding concerns about emergency ambulance travel times to the proposed sites for the HASUs, South East Coast Ambulance Service were asked to present how they plan to support delivery of the proposed model of care and details of an audit undertaken by them in July and August 2017 focused on South Surrey (Waverley. This presentation can be found here.

The CCGs responded to the feedback received from the public by **making amendments** to the model of care consulted upon, through close working with providers.

In accordance with the Terms of Reference for the Committees in Common the following decisions were made regarding the future model of stroke care in West Surrey:

- A Hyperacute Stroke Unit (HASU) and an Acute Stroke Unit (ASU) will be co-located at St Peter's Hospital
    - This affects patients in North West Surrey and some parts of Guildford [2]
- Specialist bedded stroke rehabilitation for stroke patients in North West Surrey will be consolidated onto one site over a two-year period
- The Hyperacute Stroke Unit (HASU) located at Frimley Park Hospital will be networked with an Acute Stroke Unit (ASU) and specialist bedded stroke rehabilitation at the Royal Surrey County Hospital

[2] SECAMB committed to supporting the model of care which includes the commitment to convey patients who are FAST positive to their closest HASU.

    - **This affects patients in Waverley, some parts of Guildford and some parts of South East Hampshire[3]**

- Non-specialist rehabilitation will continue to be delivered as part of Adult Community Health Services.

In addition to the key decisions taken as detailed above, the Committees in Common affirmed commitment to the additional resource across the integrated stroke pathway from onset to six months and recognised the commitment of SECAmb to support the model of care.

Implementation of the new model of stroke care

A Stroke Oversight Group, created to provide oversight of the interim stroke service arrangements that commenced in January 2017, will continue to have oversight of the implementation of the above model of care. The first meeting since the above decisions took place on 24 October 2017.

The changes in the model of stroke care are being implemented over the next few months. These changes that will be introduced cover the entire stroke pathway and require specialist staff to be recruited and/or moved to new roles. In addition, new care pathways need to be fully operationalised e.g. the TIA pathway. Providers are now mobilising these changes under the contractual oversight of the CCGs. Full implementation is planned by the end of March 2018.

During this period of time, the interim model of stroke care introduced in January 2017 continues to operate whereby patients in Waverley and parts of South East Hampshire are taken to Frimley Park Hospital (FPH) for HASU care and transferred, if and when medically stable, to the Royal Surrey County Hospital (RSCH) for acute stroke care with bedded stroke specialist rehabilitation being provided at Milford Hospital.

Recognising the commitment of SECAMB to support the new model of stroke care; the concerns raised during the consultation regarding ambulance response and travel times and the current situation whereby SECAMB remains in special measures (as directed by the Care Quality Commission), performance is being closely monitored by North West Surrey CCG (lead commissioner across Surrey for 999 services) via monthly contractual meetings.

Impact on residents of South East Hampshire

NHS South East Hants CCG has carried out analysis of data with South Central Ambulance Service (SCAS) to determine the impact of the interim model of care on residents who are FAST positive at scene. This information is presented below.

Patients are getting to FPH quicker than they used to get to RSCH since Jan 2017 i.e. faster '*clock start to on-scene'* and '*clock start to hospital'.*

[2] SECAMB committed to supporting the model of care which includes the commitment to convey patients who are FAST positive to their closest HASU.

SUMMARY			Demand (no. of patients)	Clock start (call) to on-scene	Clock start (call) to hospital	% in 8 mins
a)	Bordon **to RSCH**	01/04/16 - 31/12/16 (Q1-3 of 16/17)	7	00:11:39	01:17:14	0%
b)	Liphook **to RSCH**	01/04/16 - 31/12/16 (Q1-3 of 16/17)	8	00:12:50	01:12:00	57.10%
c)	Bordon **to Frimley**	**01/01/17** - 30/09/17 (Q3 16/17 to Q2 17/18)	14	00:10:40	01:10:14	34.50%
d)	Liphook **to Frimley**	**01/01/17** - 30/09/17 (Q3 16/17 to Q2 17/18)	0			

Data Notes:

- *The data is based on patients from the exact postcodes for Bordon (GU35 0) and Liphook (GU30 7).*
- *The time and performance figures are based on the Red 2 incidents only.*

It can be seen from the table above that all patients conveyed from South East Hampshire to FPH have arrived there within less than two hours of clock start (call to 999), recognised as best practice in the South East stroke service specification.

FPH has achieved level A (top performance) for national stroke audit indicators in the last three quarters of data collection. This compares favourably to Queen Alexandra Hospital Portsmouth and Southampton General Hospital as can be seen in the summary table below.

	No. patients from your CCG admitted to this team:	Latest result for this team (all patients from all CCGs)	Previous result for this team (all patients from all CCGs)	Previous result for this team (all patients from all CCGs)
118 patients were submitted to SSNAP (Apr-Jul 2017):		Apr-Jul 2017	Dec 2016-Mar 2017	Aug-Nov 2016
Queen Alexandra Hospital Portsmouth	99 patients	SSNAP level D	SSNAP level C	SSNAP level B
Frimley Park Hospital	7 patients	SSNAP level A	SSNAP level A	SSNAP level A
Southampton General Hospital	4 patients	SSNAP level B	SSNAP level B	SSNAP level B

It can be summarised that the interim model of care, which will be replicated through substantive service changes in the coming months, has not negatively impacted the quality of stroke care received by residents in SE Hampshire.

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HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Adult Social Care Select Committee
Date of Meeting:	21 November 2017
Report Title:	Issues Relating to the Planning, Provision and/or Operation of Health Services
Report From:	Director of Transformation and Governance

Contact name: Members Services

Tel: (01962) 847336 **Email:** members.services@hants.gov.uk

1. Summary and Purpose

1.1. This report provides Members with information about the issues brought to the attention of the Committee which impact upon the planning, provision and/or operation of health services within Hampshire, or the Hampshire population.

1.2. Where appropriate comments have been included and copies of briefings or other information attached.

1.3. Where scrutiny identifies that the issue raised for the Committee's attention will result in a variation to a health service, this topic will be considered as part of the 'Proposals to Vary Health Services' report.

1.4. New issues raised with the Committee, and those that are subject to on-going reporting, are set out in Table One of this report.

1.5. The recommendations included in this report support the Strategic Plan's aims of supporting people to live safe, healthy and independent lives, and to enjoy being part of strong, inclusive communities, through the overview and scrutiny of health services in the Hampshire County Council area.

Topic	Relevant Bodies	Action Taken	Comment
Care Quality Commission (CQC) re-inspection of services *(Monitoring items)*	Portsmouth Hospitals Trust (PHT) CCGs and partner organisations CQC	Follows on from original CQC inspection in February 2015 (with re-inspections since this time). The HASC has monitored this item since this time – last reviewed in September 2017. The HASC requested that the Trust return once the quality improvement plan was publically available. This is attached as Appendix One and from the following link.	The CQC's remit was, amongst others, to make sure that the improvements required by previous inspections had been made. The CQC carried out a responsive focused inspection of the corporate and leadership functions of Portsmouth Hospital NHS Trust on 10 and 11 May 2017, inspecting the key question of 'well led'. Following the inspection of Queen Alexandra Hospital in May 2017, the CQC has served further action under Section 31 to protect vulnerable patients from immediate risks of harm. Details of these notices are included at the end of the CQC report.

Recommendations:

That Members:

a. Note the quality improvement plan from the Trust.

b. Determine a suitable date to further consider progress made against the recommendations of the Care Quality Commission report.

c. Make any further recommendations as appropriate.

Care Quality Commission (CQC) re-inspection of services Mazars report on 'deaths of people with a learning disability or mental health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015' *(Monitoring items)*	Southern Health NHS FT CCGs and partner organisations CQC	Follows on from original CQC report February 2015 (with re-since this time), and Mazars report published in December 2015. The HASC has monitored these items since this time – last reviewed June 2017 Southern Health's update report on these issues is attached as Appendix Two.	The CQC's remit was, amongst others, to review the Trust's governance, particularly relating to identifying, reporting, monitoring, investigating and learning from incidents with a particular focus on deaths, and review how the Trust was implementing the action plan required by Monitor (now NHS Improvement) in light of the Mazars review.

Recommendations:

That Members:

a. Note the update from the Trust.

b. Determine a suitable date to further consider progress made against the recommendations of the Care Quality Commission and Mazars report.

c. Make any further recommendations as appropriate.

CORPORATE OR LEGAL INFORMATION:

Links to the Strategic Plan

Hampshire maintains strong and sustainable economic growth and prosperity:	No
People in Hampshire live safe, healthy and independent lives:	Yes
People in Hampshire enjoy a rich and diverse environment:	No
People in Hampshire enjoy being part of strong, inclusive communities:	Yes

Section 100 D - Local Government Act 1972 - background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

Document	Location
None	

IMPACT ASSESSMENTS:

1. Equality Duty

1.1 The County Council has a duty under Section 149 of the Equality Act 2010 ('the Act') to have due regard in the exercise of its functions to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited under the Act;
- Advance equality of opportunity between persons who share a relevant protected characteristic (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, gender and sexual orientation) and those who do not share it;
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Due regard in this context involves having due regard in particular to:

a) The need to remove or minimise disadvantages suffered by persons sharing a relevant characteristic connected to that characteristic;

b) Take steps to meet the needs of persons sharing a relevant protected characteristic different from the needs of persons who do not share it;

c) Encourage persons sharing a relevant protected characteristic to participate in public life or in any other activity which participation by such persons is disproportionally low.

1.2 **Equalities Impact Assessment:** This is a covering report for items from the NHS that require the attention of the HASC. It does not therefore make any proposals which will impact on groups with protected characteristics.

2 Impact on Crime and Disorder:

2.1 This paper does not request decisions that impact on crime and disorder

3 Climate Change:

3.1 How does what is being proposed impact on our carbon footprint / energy consumption?

3.2 How does what is being proposed consider the need to adapt to climate change, and be resilient to its longer term impacts?

No impacts have been identified.

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NHS
Portsmouth Hospitals
NHS Trust

QUALITY IMPROVEMENT PLAN 2017

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Introduction

The Quality Improvement Plan (QIP) for Portsmouth Hospitals NHS Trust attempts to address a number of concerns into the quality of care received by patients. The Care Quality Commission (CQC) rated the trust as "Inadequate" for medical care and safety in Emergency Care.

The Board is committed to understanding the root causes behind the failings in care provision and to systemically address those underlying causes. This will ensure that changes are made so that patients receive consistent, high-quality care and Portsmouth Hospitals NHS Trust becomes the employer of choice.

The Board will apply focus and rigour to ensure the delivery of the plan. The Board will also start work to create the conditions that allow staff to do their job well by removing blocks to success and managing risks to delivery. Partner agencies have kindly offered their support to the Trust and this is warmly welcomed. The CCG, local authorities, Healthwatch, NHS Improvement, NHS England and others will play a key role in scrutinising the assurance processes to ensure they are robust.

A core facet of the plan is the engagement of frontline staff in the improvement journey and alignment to the Quality Improvement Strategy. This will ensure the impact of the Improvements is understood and take advantage of the expertise and knowledge of staff as well as patients to ensure the plan is delivered. It will also start to signal a common purpose and priority for the organisation that is owned by frontline staff.

The Board is committed to ensuring that the Quality Improvement Plan is delivered at pace. Working with all staff in the Trust and with the support of partner organisations and agencies, the Board is confident that the plan will deliver an improved outcome at the next CQC inspection. Furthermore, by developing and embedding a culture of continuous improvement and supporting frontline staff to improve services through innovation, the Board has set the ambition to be rated "Good" by 2019 and "Outstanding" by 2020.

Trust Profile

Queen Alexandra Hospital (QAH) started life more than a century ago as a military hospital. Today it is one of the largest, most modern hospitals in the region, with 1,200 beds housed in light, bright, infection resistant en-suite wards.

The current hospital was first opened by Princess Alexandra in 1980 before undergoing a major redevelopment to create a modern and 'fit for purpose' hospital, which was completed in 2009.

Included within our modern buildings are:

- 28 theatres - with four dedicated endoscopy theatres
- Two purpose-built interventional radiology suites, three MRI scanners, three CT scanners and a PET scanner
- State-of-the-art pathology laboratory
- Neonatal Unit, Level 3
- Hyper Acute Stroke Unit
- Superb critical care facilities

We provide comprehensive secondary care and specialist services to a local population of 675,000 people across South East Hampshire. We also offer some tertiary services to a wider catchment area in excess of two million people.

In the last year we saw:

- Over 73,000 planned admissions to hospital
- Over 141,000 Emergency Department attendances
- Over 566,000 outpatient appointments
- Over 54,000 emergency admissions
- Over 5,700 births in our maternity units
- We employ around 7,000 people making us the largest employer in Portsmouth

Recruiting and maintaining an effective workforce is a major priority and our strong partnerships with the Ministry of Defence, Carillion and NHS Professionals - who provide our temporary workforce helps us to achieve the goal of maintaining safe services for all of our patients.

Our Trust strategy has not been developed in isolation. We have an important role to play within the local health economy and we are a key player in the delivery plan of the Hampshire and Isle of Wight Health (HIOW) and Care System Sustainability and Transformation Plan (STP). This recognises the challenges we face, our vision for HIOW and the action we are taking to address our challenges and deliver our vision.

Single Item Quality Surveillance Group meeting

The Trust attended a Single Item Quality Surveillance Group on 22nd September 2017 led by NHS Improvement/NHS England involving partner organisations, commissioners and regulators. The purpose of the meeting was to look at wider surveillance and quality at a local, regional and national level and work with the Trust and System around identified quality concerns.

Actions identified from the meeting:

Action	Organisation
Quality Oversight Group to identify specific actions which will enable the group to close down	NHS Improvement/ NHS England
The system to identify what is required to enable self-regulation	System convener
System approach to resolve urgent care improvements	All Organisations
Trust to liaise with HEE re their offer of support	Portsmouth Hospitals NHS Trust
System to produce a work programme for each organisation	All organisations
Liaise with Chief of Service Acute Medical Unit (AMU) regarding Acute Frailty Network for the Quality Improvement approach for the whole system	NHS England

The Trust currently has three Section 31 Enforcement Notices imposed on the registration with the CQC:

1. Acute Medical Unit (AMU) regarding adequate staffing relating to patient acuity, crowding of the GP referral area with fortnightly reporting on compliance.
2. ED and Mental Health relating to suitably qualified and competent staff in EDU, risk assessment and care planning of patients with mental health problems, oversight of patients with mental health concerns or safeguarding issues, correct application of MCA and DoLS with weekly reporting against the conditions.
3. Diagnostic and screening procedures in relation to resolving the backlog of radiology reporting and ensuring robust processes to report images taken with weekly reporting against the conditions.

The Trust has also been issued with a Section 29a Warning Notice, which requires significant improvements to be madein various aspects of clinical care and governance by 31st October 2017.

Within the February and May 2017 CQC reports there were a number of ‘must do’ actions and one ‘should do’ action. To address the shortcomings identified within the reports the Trust has worked on identifying key aims and causes and has undertaken a number of staff and patient engagement events.

CQC Report Findings 2017

The reports following the CQC inspections inspected Urgent and Emergency Services and Medical Care at QAH on the 16th, 17th, 28th February and 10th and 11th May were published on 24th August.

The following ratings have been applied:

	Safe	Effective	Caring	Responsive	Well-led	**Overall**
Urgent and Emergency Services	Inadequate	Good	Good	Requires Improvement	Requires Improvement	**Requires Improvement**
Medical Care	Inadequate	Inadequate	Inadequate	Requires Improvement	Inadequate	**Inadequate**

Figure 1 identifies the persistent concerns raised by the CQC and the root causes identified by the Trust.

Persistent problems	Relevant root causes
Board ownership	A, B, F
Lack of strategic view	A, B
Valuing the basics of care	C, G, I, K, M
Medicines management	C, G, I, M
Care of vulnerable patients (mental health, safeguarding, dementia)	C, G, I, J, K, L, M
Low staff morale	A, B, C, D, H
Poor patient flow	A, B, C, D, E, H, J
Poor governance	C, F, I, J
Poor risk management	I, J, M
Culture of bullying and inability to raise concerns	A, B, D, H

Root causes identified following CQC report

A. Board portfolios unclear

B. High turnover and proportion of interims in the leadership team

C. Roles, responsibilities and accountability was not clear and not reinforced

D. Leadership not visible and leaders not responsive to incidents

E. Revised Medical Model not implemented

F. Trust has not maintained a usable Board Assurance Framework

G. Inconsistent application of fundamentals of care

H. Lack of performance management

I. Not knowing what good is or looks like

J. Controls and processes unclear or failing

K. Lack of risk assessment and care planning

L. Staffing establishment

M. Staff knowledge, competence and expertise

Trust Board Response

The Trust Board have acknowledged that the CQC reports made difficult reading and have accepted the findings without reservation; acknowledging that the Trust had clearly fallen short in some key areas.

Since the inspections in February and May 2017, the Trust has made some significant and important changes, including strengthening the joint working of our doctors and nurses in the emergency department and medical care. We have improved how we care for our most vulnerable patients, including those who have mental health issues. We now have active, early risk assessments in our ED, a Mental Health Liaison Team working closely together and stronger cross-organisational working practices with colleagues from partners. The Trust Board have made it clear that secrecy, not speaking up and not working together for the good of all our patients has no place in our Trust.

The Trust Board consider that we have the skills, dedication and ambition to address all the issues raised by the CQC and ensure we give the best possible care we can to every patient. The successful implementation of this Quality Improvement Plan linked to the Quality Improvement Strategy will ensure that improvements are made and sustained for all Trust's services.

Developing a Culture of Continuous Improvement

Patients are at the heart of everything we do at Portsmouth Hospitals NHS Trust and we are committed to improving quality and achieving excellence in all that we do. Our aim is to be one of the most successful NHS Trusts in Caring for Patients, Caring for Each Other and Working towards a Happier, Healthier Portsmouth Community. We are committed to developing A Culture Of Learning And Doing Things Differently and supporting continuous Quality Improvement (QI), as advocated within NHS Improvements "Developing People, Improving Care" (2016) document.

For QI to be successfully embedded by all staff at all levels, a culture of improvement that spans the organisation is required. Strong leadership is key to the development of an improvement culture, and organisations that have successfully implemented QI strategies have demonstrated improvements in standards and outcomes across all aspects of care. QI is distinctly different to audit and has been shown to bring about more sustained improvement as it enables those with the experiences to explore and co-create the process, resulting in it being more likely that the whole organisation will 'own' the approach.

Early Board level support and backing are cited as being critical success factors; at PHT the Board have committed to delivering the Quality Improvement Aims, which will be underpinned by the development of a new Quality Improvement Strategy (2018-2021).

Quality improvement aims

- Valuing the basics
- Moving beyond safe
- Supporting vulnerability in patients
- An organisation that learns
- Leading well through good governance

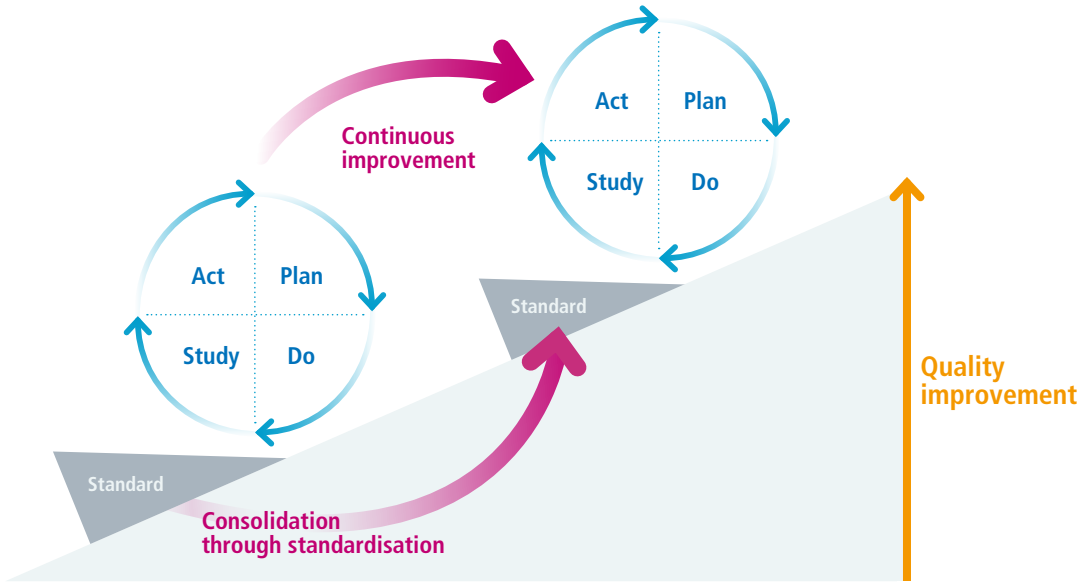
The Quality Improvement Strategy (2018-2021) is currently being developed with stakeholder engagement and once delivered will ensure that effective QI skills are embedded and locally owned. In order to support the implementation a number of actions have already been agreed:

The Quality Improvement Strategy stakeholder events have identified the QI aims and seven themes underpinning the aims.

The development of a virtual 'Portsmouth Improvement Academy' led by a triumvirate of a doctor, a nurse/midwife/ Allied Health Professional (AHP) representative and a service manager. This Triumvirate will support the delivery of the agreed QI Strategy using QI training to build capability and capacity amongst the workforce. The vision of the 'Portsmouth Improvement Academy' is to oversee a 'hub' of QI Facilitators whose role will be to train, mentor and support staff working through QI projects.

The Trust will adopt the Institute for Healthcare Improvement (IHI) Model for Improvement (MFI) as our chosen QI methodology. It is simple for all staff to use and is a widely understood methodology that has been successfully used in many healthcare settings. Furthermore it builds on the existing knowledge and skills of many of our staff, and harnessing that enthusiasm and knowledge from frontline staff will enable us to make progress faster. The MFI utilises the Plan, Do, Study, Act (PDSA) cycle to facilitate change from the front line, thus encouraging altered behaviours, working together, creative thinking, and fundamentally, using measurement to guide improvement (Figure 2).

Figure 2: Demonstrating Change by the use of the Model for Improvement (MFI) and Plan, Do, Study, Act (PDSA) Cycle



Quality Improvement Plan (QIP)

The QIP brings together all the actions that the Trust believes to be the most important. The Trust also believe that gaining traction on these will deliver the improvements necessary to achieve the short-term goal of an overall Trust CQC rating of at least "Requires Improvement" by March 2018 and the longer-term ambition of an overall Trust CQC rating of "Good" by 2019, and an "Outstanding" by 2020.

Whilst the issues were identified within the Urgent and Emergency Services and Medical Care, we acknowledge that these findings are potentially translatable across the whole organisation. The identified aims align to the Trust Quality Account Priorities for 2017/2018.

The plan to achieve "Requires Improvement" is very detailed and will form the basis of our work plan for the next year. Simultaneously, we will introduce, implement and start to embed the Quality Improvement Strategy.

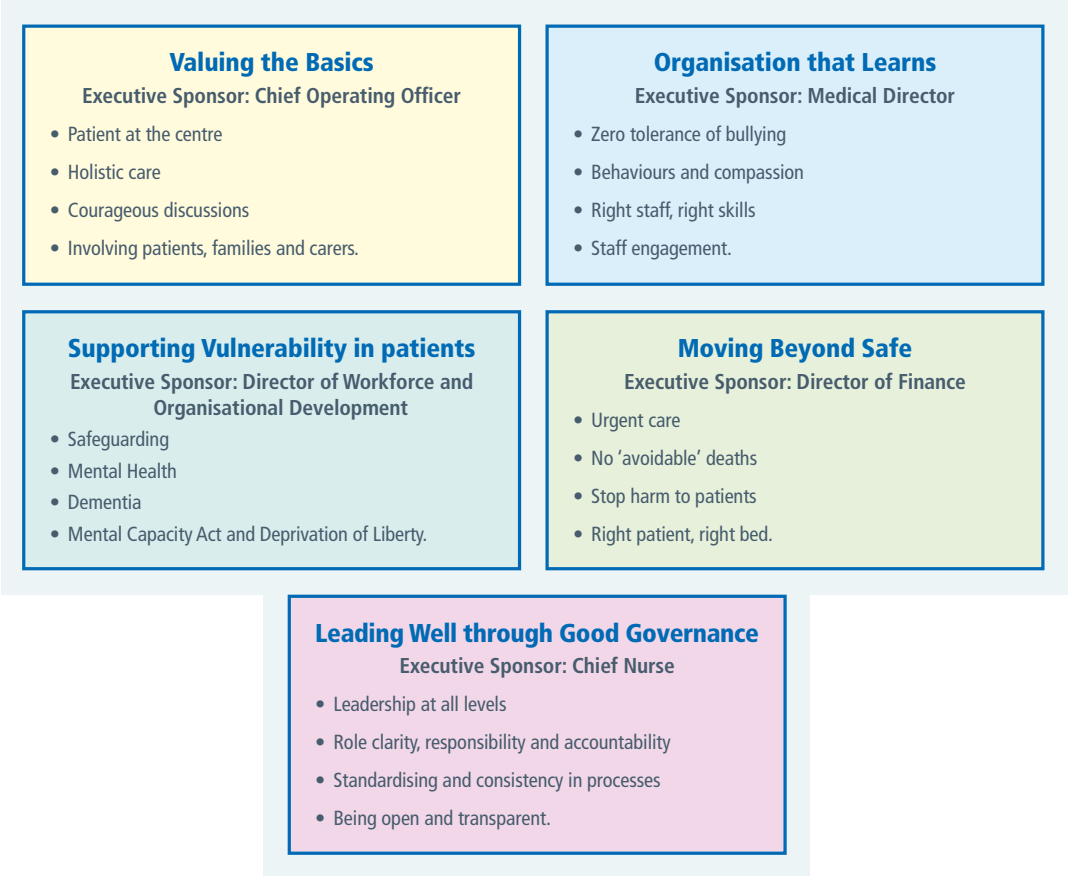
We will approach our Improvement Plan through:

- Robust leadership to drive recovery
- Focused Board oversight and scrutiny
- Executive Accountability for delivery of improvement plans
- Building strong leadership at all levels within the Trust
- Extensive staff engagement to drive innovation
- A rigorous QI approach throughout the organisation
- Supported Programme and Project management
- A single reporting structure for Board, Commissioners and Regulators
- Support and work with our partners
- Support and involvement from patients, service users and the public
- Relationships with the Acute and Mental Health Alliances
- External support from experts to address capability

We will be evidence-based and will systematically monitor and test progress as well as look to outstanding organisations elsewhere to see how they do things and learn from research.

Quality Improvement Aims

Once the five aims were identified, we held an engagement exercise to inform frontline staff and ensure they were all understandable. Each of the aims has an Executive Sponsor who will work with the Clinical Lead to ensure delivery of the improvements.



Governance and Assurance

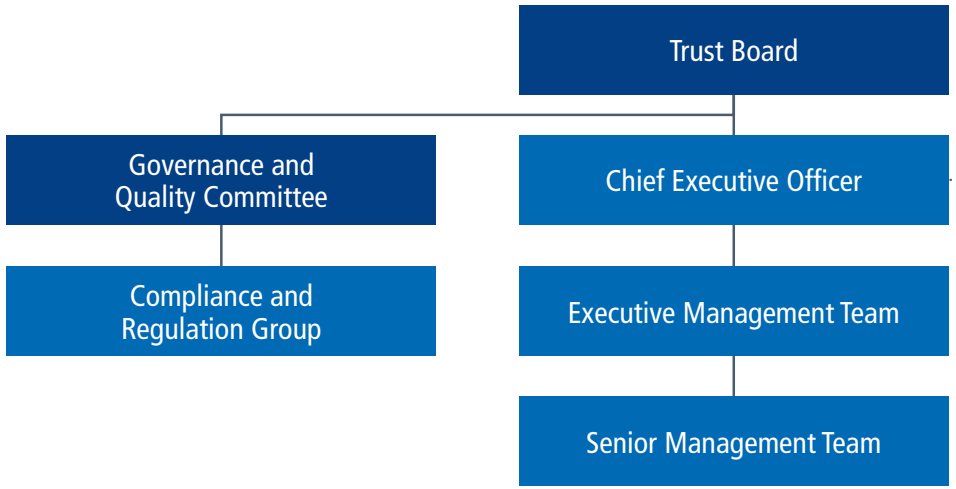
A rigorous reporting programme both internally and to key stakeholders is now in place.

The Trust has established a Compliance and Regulation Group (CRG) that meets weekly to provide oversight and seek assurance against operational delivery of improvement plans. Currently this is chaired by the Chief Nurse until the Director of Strategy, Governance and Performance is in post. The CRG reports to the Governance and Quality Committee, which is a sub-committee of the Board.

Sitting alongside the internal governance arrangements is the Quality Improvement Plan Oversight Group (QIPOG), which is responsible for ensuring that as a health system there is ownership of issues and action taken to deliver system-wide improvements. Whilst the QIPOG has no formal reporting line into the Trust it provides external assurance to the Chief Executive and Executive Management Team.

The Governance Structure

Reporting Structure



NHS Improvement/NHS England Quality Improvement Plan Oversight Group

- A Non-Executive Director chairs the Governance and Quality committee and will hold the executive sponsor to account for each area of the Quality Improvement Plan
- Regular updates will be provided by the executive sponsors to the senior management team and any issues will be escalated to the executive management team
- Five keys enablers have been set up to support the Quality Improvement Plan aims
- These enablers will be designed to establish the structures, capabilities, buy-in, and vision necessary to achieve change on a large scale.

Key Enablers

1. Valuing the Basics

The CQC raised significant concerns about the safety and care of vulnerable patient, such as frail older people or patients living with dementia. There were gaps in the care documentation for the most vulnerable patients who were at high risk of pressure sores. Patients, some of which deemed as high risk of malnutrition were not assisted with their meals. Staff did not always consistently follow infection control procedures. Staff the CQC spoke to did not have knowledge of the Trust pain assessment tool for patients who could not verbalise their pain.

We recognised that we had significant work to do to improve some fundamentals within basic nursing care. Immediately following the CQC inspection, all nurses were required to re-read their NMC - The Code and to report that they were practising within The Code.

The Trust held a 'Supporting vulnerable patient information event' on Friday 8th September 2017, with a focus on the fundamentals of care. This information day launched the start of a series of mandatory training sessions.

Specific actions

- 1.1 Patient at the centre
- 1.2 Holistic care
- 1.3 Courageous discussions
- 1.4 Involving patients, families and carers

1.1 Patient at the centre

Action	Outcome	Completion
Single sex accommodation requirements for patients are maintained and a system to report breaches is in place	All breaches are reported and investigated appropriately	Complete
Re-launch the protected meal time initiative	Ensure meal times are protected enabling improved nutrition	31/12/2017
Pilot patient centred questions as part of bedside handover to formally recognise patient involvement with every shift handover	Patients and their families or carers are involved in the care planning process	31/12/2017
Embed the principles of the "if you had 1000 days left to live" (TODAY programme) to value patient time as the most important currency in healthcare	Principles embedded in every day practice	31/03/2018
Following the End PJ Paralysis campaign embed the principles into practice	Principles embedded in every day practice	31/03/2018

1.2 Holistic care

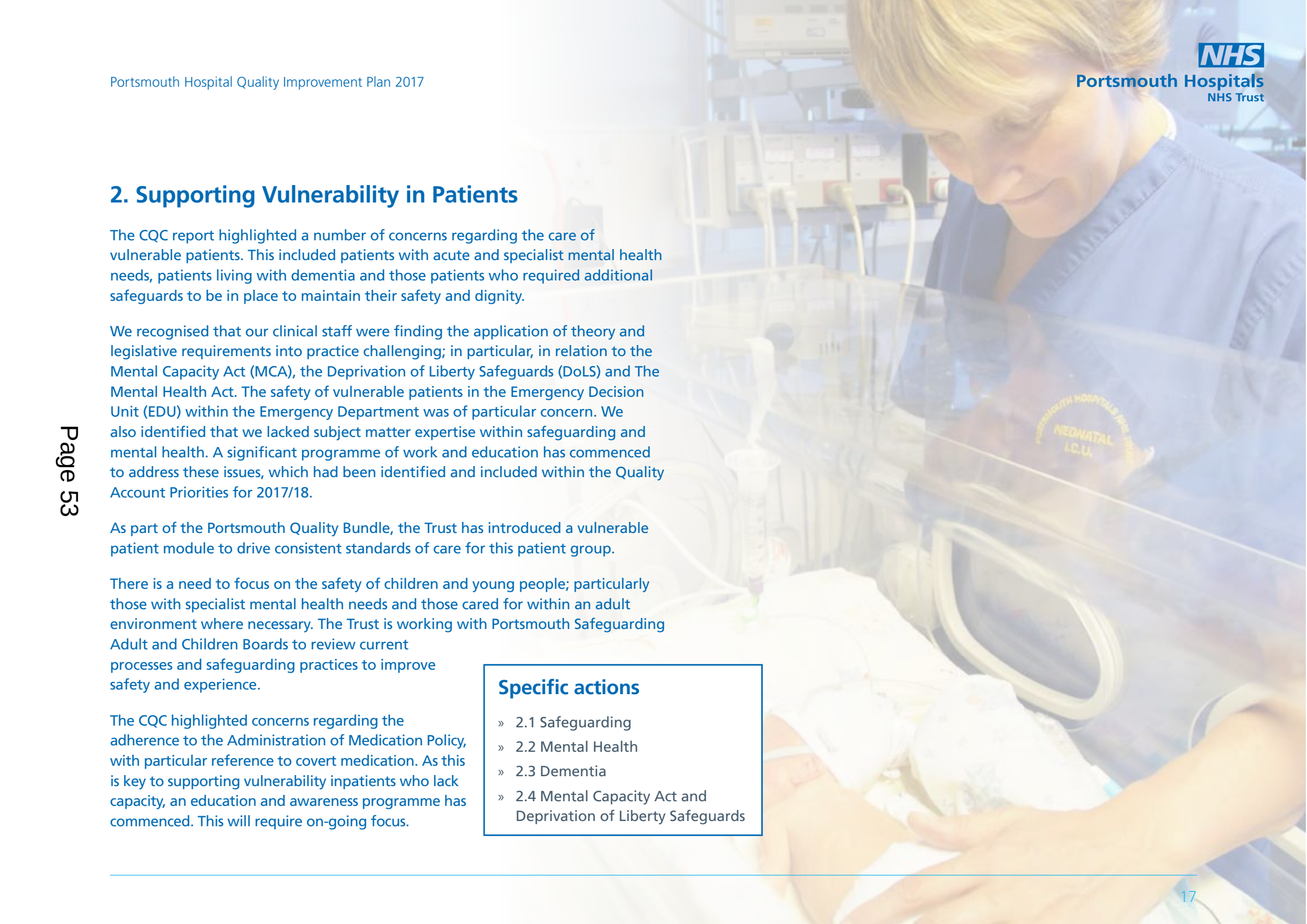
Action	Outcome	Completion
Patients receive individualised nursing care	Every patient has an individualised nursing care plan	31/12/2017
Improve dignity for patients through improvements in continence care	Dignity maintained for patients	31/03/2018
Review nursing documentation to facilitate the provision of holistic care	Streamlined documentation which supports and evidences care provision	31/03/2018

1.3 Courageous discussions

Action	Outcome	Completion
Embedding the principles of 'No decision about me without me' so patients are involved in making decisions about their care and treatment	Care will be delivered in partnership with patients to meet their needs and appropriate advocacy as required	30/06/2018
Implement the principles of Achieving Priorities of Care (APOC)	Allowing patients and families to have a dignified death in line with their wishes	30/06/2018

1.4 Involving patients, families and carers

Action	Outcome	Completion
Implement patient engagement strategy *Get Involved* (2017-2020) to strengthen patient engagement across all services at PHT	Patient engagement strategy to be ratified by the board so that patients and carers will be involved in all service re-design/improvement initiatives	31/12/2017
Promote the Friends and Family Test (FFT) throughout the organisation, with particular focus on the Emergency Department, to increase the response rate to at least the England average of 24% and to ensure compliance with the contractual requirements	Increased FFT response rate and positive recommendations for Emergency Department to be at, or above, the England average	31/03/2018
Strengthen and embed the Being Open Policy	Staff actively involve and discuss care issues with patients and families in an open and meaningful way as part of their everyday care	31/03/2018



2. Supporting Vulnerability in Patients

The CQC report highlighted a number of concerns regarding the care of vulnerable patients. This included patients with acute and specialist mental health needs, patients living with dementia and those patients who required additional safeguards to be in place to maintain their safety and dignity.

We recognised that our clinical staff were finding the application of theory and legislative requirements into practice challenging; in particular, in relation to the Mental Capacity Act (MCA), the Deprivation of Liberty Safeguards (DoLS) and The Mental Health Act. The safety of vulnerable patients in the Emergency Decision Unit (EDU) within the Emergency Department was of particular concern. We also identified that we lacked subject matter expertise within safeguarding and mental health. A significant programme of work and education has commenced to address these issues, which had been identified and included within the Quality Account Priorities for 2017/18.

As part of the Portsmouth Quality Bundle, the Trust has introduced a vulnerable patient module to drive consistent standards of care for this patient group.

There is a need to focus on the safety of children and young people; particularly those with specialist mental health needs and those cared for within an adult environment where necessary. The Trust is working with Portsmouth Safeguarding Adult and Children Boards to review current processes and safeguarding practices to improve safety and experience.

The CQC highlighted concerns regarding the adherence to the Administration of Medication Policy, with particular reference to covert medication. As this is key to supporting vulnerability inpatients who lack capacity, an education and awareness programme has commenced. This will require on-going focus.

Specific actions

- 2.1 Safeguarding
- 2.2 Mental Health
- 2.3 Dementia
- 2.4 Mental Capacity Act and Deprivation of Liberty Safeguards

2.1 Safeguarding

Action	Outcome	Completion
External review of Child Safeguarding in Emergency Department to identify any gaps in safeguarding procedures	Fully compliant with safeguarding children procedures.	31/12/2017
External review of safeguarding processes and training material (CCG, Safeguarding Boards and local authorities) for both adult and child safeguarding	External assurance of internal processes and education programmes	30/11/2017
Strengthen the Adult Safeguarding Team and leadership	To have the capacity and subject matter expertise to support the organisation in delivery of statutory requirements	31/01/2018

2.2 Mental Health

Action	Outcome	Completion
External review of Trust compliance against the requirements of the Mental Health Act	Identified areas for improvement and associated action plan	Complete
Ensure adequate staff with the correct skills to care for patients with acute and specialist mental health needs	Patients cared for by appropriately trained and skilled staff	Complete
Improve governance, oversight and key stakeholder relationships	Identify Executive lead for Mental Health and Establish Mental Health and Mental Capacity Board chaired by a Non-Executive Director	Complete

Ensure risk assessment of patients with acute and specialist mental health needs in the Emergency Department are undertaken	By March 2018 the percentage of patients being risk assessed will exceed 90% consistently	31/03/2018
Ensure appropriate care plan and intervention in place for patients with acute and specialist mental health needs in the Emergency Department	Individualised care plans and intervention based on accurate risk assessment to improve safety	31/03/2018
Trust-wide environmental review to assess the risks of managing patients with acute and specialist mental health needs	Completion of audit	31/03/2018
Enhance staff education and awareness regarding mental health	Staff can display improved understanding and awareness of their responsibilities under the Mental Health Act	31/03/2018

2.3 Dementia

Action	Outcome	Completion
Recruit a lead Dementia Nurse Specialist	Develop and delivery of a strategy in line with NHS Improvement Dementia Assessment and Improvement Framework (October 2017)	31/12/2017
Audit the consistent use of the 'This is Me' document	Completion of audit	31/12/2017
Implement reminiscence trolleys in every ward	Trolleys available in all wards	31/12/2017
Increase activities available for patients living with dementia	A variety of activities available to support stimulation and distraction therapies	31/03/2018

Review the dementia screening process to ensure it fits with clinical practice	Achieve the national standards for dementia screening to meet or exceed 90%	31/03/2018
Improve the support for carers of patients living with dementia	Appropriate signposting and improved awareness of the Carers Cafe	31/03/2018

2.4 Mental Capacity Act and Deprivation of Liberty Safeguards

Action	Outcome	Completion
Strengthen the governance arrangements around DoLS to ensure timely assessment	Discharge our legal responsibilities under the MCA/ DoLS to keep patients safe in our care	31/12/2017
Weekly clinical review of patients under MCA and DoLS, including documentation	Completion of audit and direct feedback to clinical staff to improve learning	31/03/2018
Implement a revised education and training programme for all clinical staff regarding MCA and DoLS	Staff have the confidence to translate the theory into clinical practice demonstrated through the improved care and safety for vulnerable patients	31/03/2018
Intensive focused training for all staff on application of the MCA in practice	Improved understanding and documentation regarding Mental Capacity Assessments and Best Interest Decision Making	31/03/2018

3. Organisation that Learns

The CQC reported that the staff perceived a culture of bullying and felt reluctant to speak up. This was expressed by different staff groups who raised concerns to the CQC before, during and after the inspection. The CQC reported that the processes for raising concerns internally were not open and free from blame. This discouraged staff from feeling free to raise concerns.

As an immediate response, the Trust refreshed the Freedom to Speak Up campaign and Respect Me initiative. As well as a Guardian, we now have an independent team of 16 Freedom to Speak Up advocates to support individuals with information, guidance and by listening. All have attended the national training and are actively promoting the importance of staff feeling safe and supported to speak up about anything that concerns them.

In addition, a programme to develop culture and leadership will be commencing in early 2018 using the NHS Improvement toolkit which is based on significant research and evidence and has been 'tested' with five pilot Trusts. The programmes aim is to develop and implement a collective leadership strategy to embed a culture that enables the delivery of continuously improving, high quality, safe and compassionate care for patients. Further work is required to respond to our challenges with recruiting and retaining our workforce, which includes a revised workforce strategy, a recruitment and retention steering group to support staff career development and education as well as a refresh of our marketing and attraction processes. New roles development is critical to underpinning our future workforce needs as is the continuation of building strong relationships with our partnering organisations and universities.

There will be a continuation of staff engagement methodologies such as Listening into Action. These are being strengthened to support the integration of a new senior leadership team with frontline staff, and build on giving staff a voice and the permission to make change happen in their own area of work and beyond.

Specific actions

- 3.1 Zero tolerance of bullying
- 3.2 Behaviours and compassion
- 3.3 Right staff, right skills
- 3.4 Staff engagement

3.1 Zero tolerance of bullying

Action	Outcome	Completion
Freedom to Speak Up promotion week	Staff feel confident and know how to raise concerns	Complete
Identification and training of 16 Freedom to Speak Up advocates	Staff feel confident to raise concerns without recrimination	Complete
Appointment of Freedom to Speak Up Guardian	Staff feel confident to raise concerns without recrimination	Complete
External review of leadership behaviours to identify areas to identify areas where leadership values and behaviours need challenging and improving	Improved national staff survey results and reduction in employee relations' cases. Reduction in bullying and harassment concerns raised by staff	31/03/2018

3.2 Behaviours and compassion

Action	Outcome	Completion
Implement Multidisciplinary Schwartz round	Provide a safe and supportive environment for staff to share and learn from their experiences, improve staff morale and team working	Complete
Provide education on embedding trust values and behaviours into Job Planning rounds with consultants	Increase compliance with Job planning on CRMS	31/03/2018
Map all recruitment processes and align to trust standard	Ensure value based recruitment process is applied to all staff groups	31/03/2018

Implement NHSI Culture and Leadership Programme	Develop a culture that enables and sustains continuous improvement of safe, high quality and compassionate care	31/08/2018
Revision of Nursing, Midwifery and Allied Health Profession Strategy	Improve compassionate care and engagement with frontline staff	31/12/2018

3.3 Right staff, right skills

Action	Outcome	Completion
Further overseas recruitment	Reduction in vacancy rate and temporary workforce spend	On-going
Implement plans for revised and new roles to support difficult to recruit posts	Reduction in vacancy rate and temporary workforce spend	31/01/2018
Audit compliance with local induction process	All staff will receive a supportive and helpful local induction	31/01/2018
Revision of workforce strategy	Clear and current written strategy in place to address workforce priorities	28/02/2018
Recruitment and Retention event	Improved understanding by staff of opportunities to develop their careers and the benefits available to new employees	31/08/2018
Board / Director development programme to be developed and implemented	New Board are clear on priorities, their shared and individual objectives and are effectively executing their responsibility as a board	31/08/2018

3.4 Staff engagement

Action	Outcome	Completion
Introduce monthly forums for the junior doctors to meet the Medical Director and Chief Registrar	To improve staff engagement with the Junior Medical staff who work in a transient role	Complete
Introduce monthly forums for the Consultants to meet the Medical Director and Chief Executive Officer	To improve staff engagement with the Senior Medical staff	Complete
Widen the attendance at the professional forum for Nurses and Midwives	To improve engagement with the Nursing and Midwifery force to strengthen Board to Ward	30/11/2017
Staff Big Conversations personally hosted by the CEO	Staff report feeling more engaged and able to make changes happen in their own area of work	31/12/2017
Introduce an annual staff engagement calendar of events	Staff report increased levels of engagement	31/12/2017

4. Moving Beyond Safe

The CQC reported many patient safety issues, which included concerns regarding the management of incidents, safety in the urgent care pathway, patient moves and outlying from speciality bed base and general concerns regarding the risk to patients in respect of safeguarding vulnerability.

As a minimum, the Trust must provide safe care to patients and so patient safety is of the highest priority to address. Patent safety is about working to prevent errors in healthcare that can cause harm to patients.

When patient's start to physically deteriorate, it is important that the change in vital signs is picked up and, that this change in the patient's condition is responded to with appropriate escalation in care so that the patient receives correct and timely monitoring, referral and treatment. Wessex Patient Safety Collaborative has partnered with the Trust to support patient safety scale up projects across Wessex. The Trust is implementing the Time to Act innovation.

In addition, there has been further focus on learning from deaths, including the introduction of Mortality Review Panels to review deaths. Patients are reviewed by a clinical panel, within 48 hours of death, and the 'Avoidability of Death'recorded, as well as Trust learning points. The cause of death and comorbidities are elucidated and recorded. Referrals are made to the coroner, as a Safety Learning Event, as a SIRI, or for the relevant department to review at their Mortality and Morbidity meetings.

The Trust is implementing a number of safety initiatives in relation to the urgent care pathway to improve safety and patient experience.

Specific actions

- 4.1 Urgent care
- 4.2 No 'avoidable' deaths
- 4.3 Stop harm to patients
- 4.4 Right patient, right bed

4.1 Urgent care

Action	Outcome	Completion
Implementation of revised Medical Model of care	100% of patients will be reviewed by a consultant within 14 hours of admission to hospital	Complete
Development of a robust urgent care transformation plan and a delivery structure	To improve the quality of care in the unscheduled care pathway	30/11/2017
Implementation of the patient flow bundle 'SAFER'	Improve patient journey and experience by reducing unnecessary waiting	31/03/2018
Implementation of the Red 2 Green day initiative	Reducing delays in hospital care and associated risks to patients	31/03/2018

4.2 No 'avoidable' deaths

Action	Outcome	Completion
Implementation of the Learning from Deaths policy	Policy published, implemented and embedded in practice	31/12/2017
Training in Structured Judgement Review	Consistent approach to reviewing patient deaths to improve learning	31/12/2017
Further roll-out of the Mortality Reviews across all specialities	All deaths are reviewed and any identified learning shared across the organisation	31/03/2018
Implementation of the Time to Act initiative	Patient's condition received appropriate escalation to ensure patients receive the correct and timely monitoring, referral and treatment	31/07/2018

4.3 Stop harm to patients

Action	Outcome	Completion
Pilot the Model for Improvement (MFI) and Plan, Do, Study, Act (PDSA) Cycle for reducing pressure damage	Aid staff in prioritising care, highlighting which patients are high risk of pressure damage	31/03/2018
Establish a senior safety team under the leadership of the Medical Director and Chief Nurse	Team in place to set the strategic direction for safety and drive the changes needed	31/03/2018
Standardisation of clinical handover documentation	Consistent completion of handover documentation to ensure patient safety	30/04/2018
Introduce a Six Month Safety Sprint concept	Improved outcome measures associated with » Deteriorating patients » Sepsis » Learning from events and feedback » Learning from deaths	31/08/2018
Initiate consultant ward round standards	Improved communication of patient pathway	31/05/2018
Undertake assessment of safety culture using the Cultural Barometer	Baseline assessment complete and improvements required identified with a reassessment date	31/08/2018

Trust-wide roll out of the NHS Improvement Falls Collaborative initiative	A prompt review of all patients who have fallen to ensure appropriate strategies are in place to prevent further patient falls A reduction in the number of injurious falls	31/12/2018

4.4 Right patient, right bed

Action	Outcome	Completion
Utilise the functionality within BedView to allocate the right patient to the right bed.	Right patient in the right bed every time, reducing the need for patient moves and outliers	31/12/2017
Revise all Standard Operating Procedures in relation to patient flow within the Operations centre	Clear procedures to reduce patient moves, outliers and length of stay	31/12/2017

5. Leading Well Through Good Governance

The CQC identified that the quality of incident investigations was very poor and that there was limited evidence or assurance that lessons learned from incidents were implemented. There were concerns highlighted relating to grading of incidents and the application of Duty of Candour. The CQC identified the need to review governance processes and reporting functions to ensure they are fit for purpose and to ensure risks were identified and managed, to include a review of the Board Assurance Framework.

The Trust has commenced an external review of its governance arrangements. This includes a full review of the Board Assurance Framework and Risk Management Strategy.

Specific actions

- 5.1 Leadership at all levels
- 5.2 Role clarity, responsibility and accountability
- 5.3 Standardising and consistency in processes
- 5.4 Being open and transparent

5.1 Leadership at all levels

Action	Outcome	Completion
Introduce Board to Ward Quality rounds	Standardised approach to Board to Ward rounds that demonstrate engagement with frontline staff	28/02/2018
Improve the compliance rate and quality of appraisals	Meeting or exceeding 85% target and that staff report a meaningful appraisal	31/03/2018
Support the Trust key leadership programmes	Staff in leadership roles will feel confident to lead and manage their services	31/03/2018
Recruit to board vacancies substantively	Substantive board will be in post	31/03/2018
Agree and introduce a Board Development Programme	Improved board relationships and establishment of a high performing board	31/08/2018

5.2 Role clarity, responsibility and accountability

Action	Outcome	Completion
All nursing staff to sign that they have read and understood the NMC – The Code	Nurses to be aware of their accountability as a Registered Nurse	Complete
Review and standardise nursing job descriptions	Nurses are clear about their role and responsibilities	30/11/2017
Improve the compliance rate and quality of appraisals	Meeting or exceeding 85% target and that staff report a meaningful appraisal	31/03/2018

5.3 Standardising and consistency in processes

Action	Outcome	Completion
Undertake an external governance review	Introduce revised Board Assurance Framework, Corporate Risk Register, Risk Management Policy and Strategy, Corporate Governance Arrangements and Divisional Governance arrangements to ensure a standardised integrated approach	31/01/2018
Investing in business intelligence which will enable triangulation of data to determine the quality of care being provided in individual care areas. Introduce a revised performance framework	Improved understanding of metrics and delivery against performance management framework	31/01/2018
Increase the number of staff trained in Root Cause Analysis methodology and risk management	Demonstrate organisational understanding of risk management and improve the quality and learning from incident investigations	31/03/2018
Improve incident management processes to foster learning and improve effectiveness	Consistent grading/investigation of incidents and ensuring there is shared, organisational learning	31/03/2018
Protect patients confidentiality through safe storage of records	Confidentiality maintained	31/03/2018
Define key nursing metrics (no more than 10) which measure the key component of care delivery and introduce standardised 'How are we doing boards'	Staff on the frontline nursing staff have a clear understanding of the care they are delivering to patients against defined standards	31/05/2018

5.4 Being open and transparent

Action	Outcome	Completion
Building relationships with stakeholders and partners in line with the Chief Executive's 100-Day Plan	Improved working relationships across the health economy that benefit patients	30/11/2017
When significant incidents are being investigated, patients or family will be asked for their input to setting the terms of the investigation, and updated as investigations progress"	Improved involvement of patients and family when significant incidents occur	30/11/2017
Investing in business intelligence which will enable triangulation of data to determine the quality of care being provided in individual care areas. Introduce a revised performance framework	Improved understanding of metrics and delivery against performance management framework	31/01/2018
Strengthen and embed the Being Open Policy including the application of Duty of Candour legislation	Staff actively involve and discuss care issues with Patients and families in an open and meaningful way as part of their everyday care. There are no breaches of Duty of Candour legislation	31/03/2018
Protect patients confidentiality through safe storage of records	Confidentiality maintained	31/03/2018
Define key nursing metrics (no more than 10) which measure the key component of care delivery and introduce standardised 'How are we doing boards'	Staff on the frontline nursing staff have a clear understanding of the care they are delivering to patients against defined standards	31/05/2018

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Southern Health
NHS Foundation Trust

Hampshire County Council
Health and Adult Social Care Select Committee
November 2017

Southern Health NHS Foundation Trust: Update on progress

Overview

Southern Health NHS Foundation Trust provides mental health, learning disability, and community services in Hampshire.

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.

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

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.

The Trust has also confirmed the appointment of three new Non-Executive Directors who are now in post; David Kelham, David Monk and Jeni Bremner. A fourth Non-Executive Director, David Hicks has also been appointed and will take up his post in the coming weeks. We have also appointed a substantive Director of Workforce, Paul Draycott who will be joining 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.

Progress on CQC actions and Quality Improvement

See appendix A for the full CQC action plan

- The action plan following the CQC inspection in January 2016 is now 98% completed and the September 2016 actions are 95% completed. 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.

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.

Patient and Family Engagement

- An Experience, Involvement and Partnership Strategy has been developed (as part of the wider Quality Improvement Strategy) and will soon be launched, to provide a greater focus and drive further improvements in how we engage patients, families and carers across the Trust.
- A Family Liaison Officer has been recruited and uses a referral process to support families throughout the serious incident investigation process. Members of the public have been recruited to attend the Mortality Working Group, and some of the Trust Mortality meetings, and further 'patient partners' are being sought.
- The Trust has commissioned an independent review of family involvement in investigations conducted following a death at Southern Health. The review highlighted the lack of communication with families as a key issue, and identified the need for a culture change across the organisation towards recognising the importance of family involvement in the care of loved ones. The Trust developed an action plan to address the recommendations made in the report, which is attached as Appendix C.

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

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

Mazars report: actions and progress
See appendix B for the full action plan

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 presented a positive draft assurance report on the Serious Incident and Mortality Action Plan to Quality and Safety Committee on 19 September 2017.

- Grant Thornton is currently completing assurance checks and the final report was presented to Board on 31 October 2017.

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 above.

The Health and Safety Executive is also prosecuting the Trust in relation to the death of Connor Sparrowhawk at a specialist inpatient unit in Oxford in 2013. The Trust has pleaded guilty in this case and will be sentenced at a future date.

Next steps for Southern Health services
See appendix D for more detail on our priorities ahead

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 (an overview of which is included as Appendix E) 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.

Incorporating: Produced by:

UIN	Location	Trust Wide Actions Required	Responsible Leads	Action to be completed by	Action to be completed by	Required Evidence to show completion	Action Progress Update	completed actions (e.g.	Outcome or Improvement the action will deliver	Outcome to be achieved by (date)	Required Evidence to show Outcome Met	Outcome Progress Update	Outcome Status blue
RN001 1.1	Beaulieu Ward, Western Community Hospital	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.	**30.11.17**		Monthly Safer Staffing reports.	Sept: Monthly safer staffing reports include exception report on red flagged staffing incidents. These are discussed at Patient Safety Group as required. May (Beaulieu 6 incidents) and June (Berrywood 1 incident) Safer Staffing reports highlight red flagged staffing incidents where there was an inability to maintain observations at required levels due to staffing levels. July Safer Staffing Report describes increase to funded establishment for OPMH as a result of previous acuity and dependency measures and ongoing work to reduce agency use. Impact	**On track**	Patients receive safe care and have one to one nursing observations completed as required with observation levels not reduced due to staffing issues.		There are no incidents where a patient is put at risk of harm if one to one observations are not completed as required.		
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	Oct: escalation process circulated to staff. Safer staffing reports show that staffing incidents are reported with all red flagged incidents reviewed by Acting Chief Nurse.	**Completed-unvalidated**					
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.	Oct: SM reviewed sample of 10 patient records and found 9/10 had one to one observations discussed at MDT. Will develop an action with ward to make sure all one to one observations are discussed at MDT.	**Completed-unvalidated**					
RN001 1.4		1.4. Ensure compliance with E-Roster checklist.		**31.10.17**		Completed e-roster checklist.	Oct: all local matrons/ward managers are completing monthly checklist of e-roster - checklists are sent to safer staffing generic inbox with Sue Jewell therefore having oversight of these. E-rosters for 5.11.17-2.12.17 are approved for all OPMH sites.	**Completed-unvalidated**					
RN002 2.1	Stephano Olivieri, Melbury Lodge, Berrywood/Beaulieu wards, Western Community Hospital	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	**30.09.17**		Revised guidance is circulated to staff. Flowcharts are developed and in place.	Sept: Policy reviewed re best interests and amendments proposed with revised wording checked and approved by trust solicitors. Flowcharts added as appendix 9 and 10 to policy which provides guidance on how DNACPR forms are to be completed. Oct: Revised policy presented to Resuscitation Committee on 5.10.17 for approval. Need to add to policy about cross border patients - Hampshire Hospitals started to use 'Respect ' form for EOL patients - will need to transfer onto lilac form used in trust as per policy. Request to SC/SC to approve policy - once Policy is approved and published, the recommendation is that these flowcharts are printed off and	**Completed-unvalidated**	Patients will have DNACPR forms completed effectively and in a timely manner.		There are no incidents where staff have not followed the DNACPR Policy. There are no complaints regarding use of DNACPR forms.		
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**		Results and report of DNACPR audit and action plan.	Sept: audits completed with good practice and improvements identified. Request for audit results to be cascaded to teams via Chief Nurse/Medical Director with request for teams to add actions to local plans. Audit results discussed at End of Life steering group in Sept. Oct: Audit results discussed at Resuscitation Committee on 05.10.17.SM to take audits to OPMH ward managers meeting on 11.10.17 for them to add actions to their local QIP. Resuscitation team have added specific actions relevant to their service. 24.10.17 QIPDG escalated to TEC need for actions to address issues from audits and a request that audits go to Clinical Directors for completion of actions re medical staff. Discussed at TEC and SJ to draft email for Sarah Constantine to send out. 26 .10.17 SJ drafted email and sent to Sarah Constantine to send out re action plans - latter have both medical and nursing issues to be actioned.	**Overdue**					
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.	Sept: further audits planned. Oct: agreed at Resuscitation Committee to use results from Sept audits as baseline measures with re-audits to take place in Dec and Feb to enable actions to be completed prior to re-audit.	**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.	Oct: Flowcharts include discussion with patient/assessment of mental capacity once Policy approved. Once Policy approved SJ will a) request SC/SG to send out flowcharts to all doctors with message re completion b) send to all staff who are required to complete ILS training. DNACPR covered in BLS /ILS training.	**On track**					
RN003 3.1	Stephano Olivieri, Melbury Lodge	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	**30.11.17**		Site visit to confirm installation of windows in place and privacy issues resolved.	August:Capital funding was secured and windows are on order. Site visit by SC on 18.7.17 to inspect issues/solutions proposed - agreed a temporary solution of opaque film on windows but still concerns that patients on another ward can access windows. Risk 1481 on risk register. Sept: new windows to be fitted week beg 16.10.17 - anti-ligature with solid mesh which will prevent passing of objects through window and will be frosted to meet privacy and dignity. To check perimeter plans for garden. Oct: email to Scott Jones for evidence of windows installed.	**On track**	The privacy and dignity of patients will be improved through environmental works.	**30.11.17**	Environmental works are completed.		
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.	Sept:annual PLACE report to be presented to Caring Group in October. PLACE site assessments completed, including SOU with most feedback positive. Some privacy and dignity issues identified and have been added to PLACE action tracker eg configuration of 'swing' bedrooms may give rise to different sexes passing through area for opposite sex. Actions need dates for completion. Oct: need wider discussion re use of 'swing' bedrooms across Trust. BC and SM to meet 1.11.17 to discuss. 1.11.17 BC and SM meeting - reviewed wording of PLACE feedback regarding 'swing' rooms which states there is potential privacy/dignity issue, however SM confirmed that bedrooms 'swing' 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.	**Completed-unvalidated**					
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.	Sept: estates team have reviewed the garden boundary with AMH. Further discussion with OPMH is required. Oct: OPMH to meet with estates and AMH on 17.10.17 to discuss issue. 24.10.17 positive meeting SM and GR with proposed options to widen flowerbed so patients unable to get close to windows and put up privacy screen by office windows to ensure confidentiality. GR currently costing proposals so that decision can be made. Once agreed, works can be completed following completion of window installation.	**Completed-unvalidated**					
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.		**Blank**					
RN004 4.1	Wards for older people with mental health problems	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	**30.11.17**		Completed capital projects signed off in ligature management group.	Aug: Capital funding was secured and programme was agreed and is underway. Oct: Ligature management report to Patient Safety Group in October summarises work completed to date. Berrywood/Dryad and SOU works are completed with new bathrooms that are ligature free. Ligature Manager is revisiting all sites to update environmental risk plans according to a schedule with inpatient sites prioritised. Beechwood - new windows to be completed by end Nov.	**On track**	The safety of patients will be improved through ligature environmental works.		Environmental works are completed. There are no incidents relating to ligature points in OPMH wards.		
RN004 4.2		4.2 To complete estates works to provide all OPMH functional wards with 2 'safe' bedrooms.	John Stagg, ADON LD and new co-chair of Ligature Management Group with Andrew Mosley AD for	**31.12.17**		Site visit to confirm bedrooms are completed.	Oct: estates works ongoing to complete 'safe' rooms. Berrywood,Western Hospital and Dryad, GWMH have 2 'safe' bedrooms each completed with anti-ligature fittings. Tender for 2 'safe' rooms at Beechwood, Parklands is due back at end Oct.	**On track**					

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RN005 5.1	~~Stephano Olivieri, Melbury Lodge, Berrywood~~/Beaulieu wards, Western Community Hospital	5.1 To review current covert medicines guidance, strengthen where required and circulate to staff.	Raj Parekh, Chief Pharmacist	**31.10.17**		Revised covert medicine guidance completed and circulated.	Oct: AW, OPMH Lead pharmacist working with OPMH leads to revise guidance which will be presented to Medicines Management Committee (MMC) 15 Nov for approval prior to publication.	**Completed-unvalidated**	All patients receive their medicines in a safe and effective way.		There are no incidents when staff have not followed covert medication guidance.		
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.	Sept: As discussed at QIPDG on 12/09/17, this action only applies to Beaulieu. Oct: Ward matron will cover guidance at team meeting- however needs to wait for revised guidance to be published. .	**Overdue**					
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.	Oct: weekly checklists are discussed at monthly OPMH managers meetings.	**On track**					
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.	Oct: section on covert medication added to quarterly Medicine Safety Officer report for Q2. Q2 report will be presented to November Patient Safety Group and MMC.	**On track**					
RN006 6.1	Gosport team	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	**28.02.18**		Results of caseload review and action plan in place.	Oct: a lot of work completed on OPMH caseloads - see Safer Staffing Reports.	**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.	Oct: Memory clinics can make caseloads look large.	**Blank**					
RN007 7.1		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. 22 August NoK ISD 80.8%; OPMH 85.1%; MH 74.0%; LD 84.5%.	Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary Carol Adcock, John Stagg, Nicky Bennett Liz Taylor	**31.12.17**		Minutes of divisional governance/performance meeting with NoK compliance minuted.	Oct: N of K discussed at RKCP meeting - JS to send communications to all staff with examples as to why the recording is important as reminder to support completion. Need to continue focus to ensure target met across all BUs - performance monitored at business performance reviews/team meetings. 12 Oct NoK/other relationship executive flash report of whole caseload: ISD 85.4%, AMH 76.4%, LD 84.9%. (Trust target 80%). AMH continue to focus on increasing this %.	**On track**	Next of kin/other relationship information will be recorded for the majority of patients thereby making it easier to contact family/close relationship if needed.	Once target met - maintain over following 3 months	Next of kin/other relationship performance data shows that 80% target is met and maintained over 3 months.		
RN008 8.1		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	**31.03.18**		Results of record keeping audits and actions to be implemented based on recommendations.	Oct: Q1 Quality Account report updates on progress - AMH close to 95% risk assessment target and have reviewed at performance meetings and identified that some individual staff need support to ensure completion.	**On track**	Patients will receive safe effective care if risk assessments are completed as per Trust policy		Risk assessments are completed and are up to date.?%		
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. Oct: Quality Conference Risk Management presentation by Prof. Kingdon	**Completed-unvalidated**					
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.	Oct: Mayura Deshpande is reviewing risk assessment audit tools.	**Blank**					
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.	Oct: draft standard template circulated - sample review to start in Oct/Nov.	**On track**					
RN008 8.5		8.5 Clinical staff to undertake mandatory risk training as per policy.		**31.12.17**		Training compliance figures (tableau).		**Blank**					
RN009 9.1		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	**31.10.17**		Copy of the communication plan	Oct: Quality Conference Risk Management presentation by Prof. Kingdon. Carole Adcock to complete communication plan.	**Overdue**	Crisis plans will be completed as per Trust policy				
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	Oct: CPA and Risk in minutes of QSM meeting 21.09.17 pages 6 and 7	**On track**					
RN010 10.1		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**					Duplicate
RN011 11.1		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	**30.11.17**		Results of acuity and dependency review.	Oct: Sue Jewell meeting with team leads to check if actions from previous acuity and dependency measurement exercise have been completed. To complete a validation exercise on Nov 29th.	**Blank**	Clear understanding of the staffing levels and skill mix required within the community teams.				
RN012 12.1		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**					Duplicate
RN013 13.1		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	**31.12.17**		Appraisal performance data for community teams.	Oct: Appraisal = 94 % completed on tableau (12.10.17). Increasing compliance shown over year.	**On track**	Appraisals target of 90% achieved for community teams. Increased number of staff are supported through appraisal process.		Appraisal performance data for community teams.		
RN014 14.1		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	**31.10.17**		End of Life Care Plan for use in community.	Sep: EofL Steering Group 28.09.17 individualised care plans - aiming to add to RiO with request for change made to RiO Change Board. Where applicable staff to continue to use paper form as per policy which will be reviewed once care plan on RiO. Eof L care plan for use by community staff is on intranet.	**Completed-unvalidated**	Patients who are at end of life at home are effectively supported via an individualised care plan.		Numbers/% of end of life patients at home who have individualised care plans.		
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 - weekly bulletin April 2017 refereences roadshows in May 2017.	**Completed-unvalidated**					
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.	Sep: terms of reference shared at EofL Steering Group 28.09.17 for thematic review Oct-Dec - will include use of care plans. Thematic review will also look at EOL incidents.	**On track**					
RN015 15.1		15.1. Improve compliance with completion of patient record on the day of care.	Julia Lake, Associate Director of Nursing & Allied Health Professionals	**28.02.18**		RiO change request is actioned.		**Blank**	Patients who are at end of life receive effective well planned care that is based on their wishes.		There are no incidents or complaints relating to availability of information in end of life care.		

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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.	Sep: EofL 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	Romsey Hospital	16.1. Review pathway for transfer of care between Romsey hospital and the acute services.	Julia Lake, Associate Director of Nursing & Allied Health Professionals	**31.01.18**		Pathway Review completed.		**Blank**	Patients who are at end of life receive effective well planned care that is based on their wishes.		There are no incidents or complaints relating to medical support for end of life patients who deteriorate.		
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.		**Blank**					
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.		**Blank**					
RN016 17.1	Gosport War Memorial Hospital	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	**31.10.17**		Safer Staffing Policy	Oct: matrons review staffing levels on daily basis - eroster guidance followed with aim to reduce bank/agency spend. Staffing levels can be difficult for stand alone wards if staff off sick etc.	**Completed-unvalidated**	Able to have real time information as to status staffing levels rather than retrospective. Rosters are compliant with best practice. No shifts where staffing was unsafe. Service:				
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.	HR are recruiting to project manager post.	**Blank**					
RN018 18.1		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	**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.	Oct: Tableau report ISD 93.7%, MH 93.2% for current month. BUs monitor training compliance via business performance review. Resuscitation Committee 5.10.17 BLS 84.2% 81.6%	**Blank**	Patients are safe in our care and are seen by staff who have completed the required mandatory training.		Training target of 95% for mandatory training is met.		
RN019 19.1		19.1 To review current guidance on single use of medicines and strengthen where required and circulate to staff.	Raj Parekh, Chief Pharmacist	**31.10.17**		Revised single use of medicines guidance.	Oct: draft poster on use of creams/lotions discussed at senior meds management team meeting and given final approval. Advice from IPC lead re single use received and implemented for poster. Poster circulated.	**Completed-unvalidated**	All patients receive their medicines in a safe and effective way.		There are no incidents or complaints when staff have not followed single use medicine guidance.		
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	Oct: audit tool amended to include single use medicines.	**On track**					
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.	Oct: Safe and Secure Medicines audit is out for data collection in Oct.	**On track**					
RN019 19.4		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.	25/09/17: email to Responsible lead for update 26/09/17: see QIPDG meeting minutes. 28/09/17: email from Responsible lead checklist has been reviewed and approved by MMC 20/09/17. Felt checklist was appropriate for inpatients. Sheila Gascoigne working with Meds team to look at a checklist for community teams.	**Completed-unvalidated**					
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.	Oct: results of audit will be presented to MMC and Patient Safety Group.	**Blank**					
RN020 20.1		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, Helen Neary Carol Adcock, John Stagg, Nicky Bennett Liz Taylor	**30.09.17**	**13.10.17**	Expiry date guidance.	Oct: senior Medicines Management team meeting on 03/10/17 approved expiry date guidance and has been added as appendix to Medicines Control, Administration and Prescribing Policy (MCAPP) which has been revised and published on website.NEED TO CHECK REVISED POLICY COVERS STOCK INSULIN.	**Completed-unvalidated**	All patients receive their medicines in a safe and effective way.		There are no incidents or complaints when staff have not followed expiry date medicine guidance.		
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.	Sept: labels ordered and distributed to wards.	**Completed-unvalidated**					
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 will include expiry date compliance - data collection in Oct.	**Completed-unvalidated**					
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.	Sept: MMC minutes re actions on plan.	**On track**					
RN021 21.1	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)	**31.12.17**		21.1 IPC Quarterly Report /IPC Newsletter IPC Matters (Quarter 3)	Oct: PMO email out to responsible lead requesting copy of quarterly report Q2' Infection Prevention Matters' newsletter includes range of information	**On track**	Patients receive safe care by staff following the correct process for dealing and disposing of waste materials.	**31.03.18**	Results of Isolation audit due in Feb 2018. Summary of Back to the Floor visits with no/minor concerns raised. There are no incidents or complaints regarding best practice for managing waste disposal not being followed.		
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.		**Blank**					
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.	Oct: presentation to Link Advisors includes feedback from CQC actions as well as results of audits/best practice guidance on key topics.	**Completed-unvalidated**					
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.		**Blank**					
RN021 21.5		21.5 IPC team to circulate waste disposal guidance summary to teams.		**01.09.17**		Waste Disposal Guidance circulated.	Aug: IPC lead circulated waste disposal guidelines to teams. Oct: waste disposal guidnace also in IPC Q2 Infection Prevention Matters newsletter.	**Completed-unvalidated**					
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.		**Blank**					
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.	Sept: amendments made to Organisational Induction Policy with appendix C Record of local induction for non permanent staff which includes IPC requirements.	**Completed-unvalidated**					

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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.	Sept: draft poster discussed QIPDG with slight amendments proposed. Poster sent to comms to rpoduec final version. Oct: poster circulated by BB to leads.	**Completed-unvalidated**					
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.	Sept: laundry audit underway	**On track**					
RN022 22.1		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	**31.08.17**		All equipment has been serviced and is in date - evidenced by the BCAS equipment list.	Review of the fridge observed during the inspection showed there was an old service check sticker on it and a current service one on another area of the fridge. The trust equipment inventory also concurred that the service had been completed. Sept: BCAS contract meeitng minuted that fridge at GWMH in date for servicing and agreed process to ensure all equipment is labelled with correct service sticker.	**Completed-unvalidated**	All equipment to be serviced and within date as per medical devices policy.	**Oct-17**	No equipment is outside of its service date as evidenced by the BCAS equipment list.		
RN022 22.2		22.2. Ensure all equipment is labelled with the correct service sticker.		**31.10.17**		Spot check audits.	Aug: BCAS contract meeting (16/08/17) 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. Oct: Medical Devices advisor completes mini site audits and checks are included in peer reviews.	**Completed-unvalidated**					
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.	Aug: BCAS contract meeting (16/08/17) 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.	**Completed-unvalidated**					
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.	Oct: monthly meetings with BCAS in place and issues are raised and actioned.	**Completed-unvalidated**					
RN023 23.1		**TM to seek clarity from CQC re this action.** **04/10/17 TM confirmed that CQC have verbally agreed to remove this action from the inspection report. CQC report on website on 04/10/17 continued to include this action.**						**no action required**					**no action required**
RN024 24.1		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	**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	15/09/17: email sent out to CM requesting update on actions/evidence in preparation for Tuesdays meeting 25/09/17: email to Responsible lead for update Sept: Safeguarding meeting on 05/10/17 to discuss/approve Oct: NHS 'Pocket Principles' have been being distributed at Safeguarding Training (since May 2017). Distribution is ongoing. Hotspots ongoing. october raised awareness of Modern Slavery.	**Completed-unvalidated**	Staff will recognise and escalate safeguarding concerns thus helping to provide protection to patients.		Safeguarding concerns are raised as incidents on Ulysses.	1. Distribution is ongoing. 2. Hotspots ongoing. October raised awareness of Modern Slavery.	
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)	15/09/17: email sent out to CM requesting update on actions/evidence in preparation for Tuesdays meeting. 25/09/17: email to Responsible lead for update. Sept: Safeguarding meeting on 05/10/17 to discuss/approve Oct: Learning sets delivered regularly monthly from March 17. Variety of topics, Safeguarding specific session delivered 7 times since March, across ISD areas. Incremental Review completed and first delivered 04/10/2017. Training ongoing.	**Completed-unvalidated**				Delivery of 7 Safeguarding sessions since March 2017 (monthly from April 2017). Additional sessions included the following topics: Self-neglect (multi-agency for Southampton SAB), professional boundaries, MCA and DoLS.	
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		**Blank**					
RN025 25.1		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	**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	Sept: Safeguarding team meeitng on 05/10/17 to discuss/approve	**On track**	Staff will recognise and escalate safeguarding concerns thus helping to provide protection to patients.		Safeguarding concerns are raised as incidents on Ulysses.		
RN025 25.2		25.2 see 24.2	Caz MacLean, Associate Director of Safeguarding supported by the Corporate Safeguarding Training Group; Safeguarding Quality Workstream					**Duplicate**					Duplicate

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RN025 25.3		25.3 see 24.3	Caz MacLean, Associate Director of Safeguarding supported by the Corporate Safeguarding Team; Safeguarding Quality Workstream					Duplicate					Duplicate
RN026 26.1	Alton Hospital	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	**31.12.17**		Revised safe storage of medicines guidance.	Oct: Safe and Secure medicines audit currently out for data collection. Results will highlight any areas where actions may be needed to rectify issues.	**On track**	All patients receive their medicines in a safe and effective way.		There are no incidents when staff have not followed safe storage of medicine guidance and left medicine doors open/unauthorised staff able to access room.		
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.	Oct: responsible lead to check with ward regardng action/evidence. 31.10.17 QIPDG Susanna Preedy confirmed that estates had visited and had changed door codes as part of a 6 month programme.	**Completed-unvalidated**					
RN027 27.1		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: Julia Lake, Susanna Preedy, Helen Neary	**30.09.17**		Minutes of contract meetings.	Aug:Meeting took place with the CCG 8/8/17. Millbrook are very committed to working with us to improve services to patients and their relationship with our teams however to do this they need to be aware of our issues and incidents. There is now a reporting route for any incidents but we need to improve the personal relationships to improve patient safety.WHCCG would like us to field a team for a monthly meeting with representatives from the ISD - BU 2 & 3, Childrens - BU 4, LD and Tissue Viability Nurses with Millbrook.Millbrook will be inviting all of the named representatives to visit their facility and understand their internal processes probably in September.	**Completed-unvalidated**	Patients all receive wheelchairs and services within the agreed timeframes.	**tbc**	There are no incidents where patients do not receive wheelchairs within agreed timescales.		On track
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.		**30.09.17**		All incidents relating to wheelchairs reported on Ulysses and forwarded to Milbrook.	Sept: joint application with CCG/Milbrook to Wessex Quality Improvement Fellowship 2017/18 to work collaboratively to improve wheelchair services. Regular meetings in place with issues discussed	**Completed-unvalidated**					
RN027 27.3		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.	Oct: contract meeting with Millbrook planned for 20/10/17. Poster circulated with details of Open Day Nov 20 at Millbrook. 24.10.17 QIPDG HL = meeting 20.10.17 very positive	**Completed-unvalidated**					
RN028 28.1		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	**completed**		Communications to staff: 1. Copy of pocket guides to the Mental Capacity Act 2005.	pocket guides circulated.	**Completed-unvalidated**	?		?		
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	Sept: Safeguarding team meeting on 05/10/17 to discuss/approve. Oct: Learning sets delivered regularly monthly from March 17. Variety of topics, MCA & DoLS session delivered on 8 ocassions since March, across ISD areas. Incremental review completed and first delivered 04/10/2017. Training ongoing.	**Completed-unvalidated**	Service users will be supported to make decisions. Where a person cannot make a decision their rights will be protected through the appropriate implementation of MCA 2005 - including best interests (s.4) and advocacy.	**1. March 2017** **2. 04.09.17**	Training registers, training presentation and learning materials	Delivery of 8 MCA & DoLS sessions since March 2017.	
RN029 29.1		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	**31.03.18**			Sept: annual clinical audit programme has record keeping audts planned. Oct: Record Keeping Care Planning workstream now co-chaired by JS and LT. Group now to focus on record keeping only - terms of reference revised with work plan reviewed and amended. Continued work required to ensure staff understand importance of record keeping and adhere to policies. Record keeping on risk register for BU1.	**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.	Liz Taylor supported by Tracey McKenzie, Head of Compliance, Assurance and	**31.12.17**			Sept: Quality Assessment tool being used by increasing number of teams but is not yet consistent across trust. Discussion underway re adding results to tableau. QAT presented to B7 development day in BU1 and received positive feedback.	**On track**				29.2 QAT Inpatient results 18.10.17	
RN030 30.1	Trust wide	**REMOVED BY CQC IN REVISED REPORT**						**no action required**					**no action required**
SD031 31.1		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	**31.10.17**		Minutes of Ligature Risk Management Group.	Oct: individualised ligature risk care plan reviewed across trust - Assessment and Management of Ligature Care Policy has been updated and will be presented to Patient Safety Group for approval in Oct. 24.10.17 QIPDG discussion - there is environmental ligature risk care plan which is standard one in use on RiO for all patients - it is not an individualised care plan. OPMH patients are not high risk for ligatures. Discussed that some requirements in Policy may need amending. Ligature Management Group now to be co-chaired by JS and Andy Mosley AD for Estates. Last LRMG had to be cancelled due to low attendance. Need to have rep from each BU on group. Extraordinary meeting date set. Feel need revision to environmental risk plan. Agreed every area should have ligature risk assessment completed and mitigation plans in place. 31.10.17 QIPDG - Nicky Bennett updated that revised Policy was approved subject to minor amendments and will have virtual sign off and then be published.	**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.	Oct: individualised ligature risk care plan reviewed for use across trust - ligature manager works closely with all wards.Fewer OPMH patients require ligature risk care plans. 31.10.17 QIPDG new template is included in revised Ligature Management Policy. Group discussed and agreed that OPMH patients are unlikely to require an individualised ligature risk plan and that it is appropriate for the ward to have an environmental ligature risk assessment. BC to request that Ligature Management Group discusses this recommendation from CQC with regards to OPMH patients and minutes decision made.	**Completed-unvalidated**					
SD032 32.1		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	**31.10.17**		Standard information for inclusion in local induction packs is circulated.	Oct: Assessment and Management of Ligature Care Policy has been updated and will be presented to Patient Safety Group for approval in Oct -includes guidance on information to be included in local induction packs. 31.10.17 QIPDG - Nicky Bennett updated that revised Policy was approved subject to minor amendments and will have virtual sign off and then be published.	**Completed-unvalidated**					
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.		**Blank**					
SD033 33.1		33.1. Ward assessment to determine which non patient areas are not currently locked.	Kathy Jackson, Head of Inpatients	**xxxxx**		Ward assessments completed	Sept: all non patient areas reviewed across trust as part of ligature risk programme.	**Blank**					

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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 of Ligature Management Group	xxxxx		guidance circulated	Oct: non patient areas /ligature risks discussed at the Ligature Risk Management Group in June 2017. Non patient areas reviewed across Trust. Assessment and Management of Ligature Care Policy has been reviewed and is being presented to Patient Safety Group for approval in Oct - includes reference to non patient areas.	Blank					
SD034 34.1		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	31.12.17		Results of review and discussions with commissioners.	Oct: some psychology provision in place but not sufficient to meet demands, however not commissioned to provide wider service. Additional psychology post in Petersfield area approved by RAP.	Blank					
SD035 35.1	Chase Petersfield Gosport	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	completed		template in place.	14/09/17: email sent to melanie poulter and sandra spong requesting evidence. 22/09/17: email from responsible lead inc. template	Completed-unvalidated					
SD036 36.1	Chase Petersfield Gosport	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	28.02.18				Blank					
SD037 37.1		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)	30.09.17		Amended CPA audit tool	CPA audit tool amended	Completed-unvalidated	Consistent approach to CPA via clearly defined criteria				
SD037 37.2		37.2 CPA Audit to be completed. (To include OPMH community services too).		28.02.18		CPA audit report		Blank					
SD037 37.3		37.3. CPA and care plan SOP to be shared with Adult Mental Health staff.		30.11.17		Email cascade trail		Blank					
SD038 38.1		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	completed		Petersfield MIU has seen increase in number of incidents reported.	Oct: Incident analysis report from Tableau for last three months saved to evidence folder: July =28, Aug = 25 and Sept = 16. Tableau report Oct 2015-17 shows increase in incident reporting.	Complete	Trust: Increased incidents reported, particularly in areas previously noted to be low reporters. Service:	**Trust:** **31.10.17** **Service:**	Trust: Service:	RETEST DECEMBER	
SD039 39.1		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	30.11.17		Audit tool in place.	Aug: there is no national guidance for MIU. TM checking with CQC re this action for clarification. Oct: PMO email out to Clinical Lead, requesting update/evidence. Five audits based on best practice drafted for review, with another three to be written. Audit programme in place and allocated to leads.	On track					
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.	Oct: see 39.1	On track					
SD040 40.1		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	31.03.18		Minutes of Trust Executive Committee with decision minuted. Options proposal.	Aug: Maintenance Manager will undertake a feasibility study - to have separate childrens waiting area will cost 1.7m and available budget £500k therefore exploring other options. Oct: email from Clinical Lead outlining options for MIU environment. Contract with dental services being explored and could release 8 rooms whcih would resolve issue.	On track	There are separate waiting areas for children and adults in MIU.		There are separate waiting areas for children and adults in MIU.		
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.	Oct: Estates/MIU Lead reviewed MIU and looking at options for redistribution of rooms to provide separate childrens area - there would be no need for temporary screens if option re rooms was agreed.	Completed-unvalidated					
SD041 41.1	Petersfield MIU	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	31.12.17		Revised complaints/ policy/procedure	Sept: final draft of revised policy/procedure being circulated for final comments. To go to Caring Group in October for final approval, once approved will be uploaded to website. Oct: revised Policy and procedures approved at Caring Group and published on website.	Completed-unvalidated	80% of complaints are responded to within 30 or 40 day timeframe depending on complexity. The satisfaction of complainants with how their complaint is handled and resolved will show improvement over time as measured by survey results.	31.12.17	Monthly reports on performance to meet 80% target. Quarterly reports on complainant satisfaction survey results.		
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.	Sept: weekly breach report sent to CEO. Complaints data is part of executive flash report that is reviewed weekly. There are still pressures on meeting timescales and issues with capcity of divisions to provide investigating officers.	On track		31.12.17			
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.	Sept: Manager attending divisional meetings/AGM.	On track		31.12.17			
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.	Oct: pilot ongoing - complaints advisors are able to write final response letter if Investigating officer (IO) completes comprehensive investigation but some lack detail so advisor unable to draft letter therefore need to go back to IO.	On track		31.12.17			
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.		On track		31.12.17			
SD042 42.1		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	31.03.18		Minutes of meetings with commissioners and any agreements made re future of MIU.	Oct: email from Clinical Lead outlining options for MIU environment. PMO email out to Clinical Lead, requesting update/evidence for actions.Clinical Lead presentation to commissioners in June and site visit by commissioners scheduled for 25.10.17.	On track	Staff are informed and aware of the future plans for MIU.		Communications regarding future of MIU circulated to staff.		

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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	**30.11.17**		Examples of communication shared with staff.	Oct: minutes of team meetings show future of MIU discussed with staff.	**On track**					
SD043 43.1	Petersfield MIU	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	**31.10.17**			Oct: ward manager already attends BU1 governance/business meetings which feed up to ISD governance meetings. New template at team level introduced in locality governance process so info feeds both both up/down.	**Completed-unvalidated**	?		?		
SD044 44.1	Petersfield MIU	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	**30.09.17**			Sept: 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.	**Completed-unvalidated**	?		?		
SD045 45.1	Petersfield MIU	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	**30.11.17**		Minutes of BU1 performance/governance meetings to evidence risk is discussed. Risk downgraded on risk register	Oct: risk 1233 re staffing added to risk register March 2017 due to B7 x 0.6 and B4 vacancies. Agreement to recruit to B7 but unsuccessful recruitment therefore developing B5 into B6 role and remaining funding to recruit B2. Risk remains at 12/major. Risk reviewed on monthly basis and due for review end Oct.	**On track**	Patients attending MIU receive safe care.		Staffing levels enable safe, effective and timely care. There are no incidents reported where staffing is recorded as an issue in the safe, effective and timely care provided to patients attending MIU.		
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.	Oct: Advert for B7 is on NHS jobs - no successful appointment therefore reviewing staffing with B5 developed to B6 post and remaining funding to be used to appoint B2.	**On track**					
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.	Oct: CCG visit to MIU on 25.10.17. Staffing changes as in 45.2	**Blank**					
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.	Oct: ongoing discussions - looking to have 2 emergency practitioners and 1x support staff on each shift.	**On track**					
SD046 46.1	Petersfield MIU	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	**30.09.17**		Results of TNA with recommendations.	25/09/17: email to Responsible lead for update. 27/09/17: responsible lead on leave until 02/10/17. Sept: LEaD have 2x 'managing the unwell child' courses in Nov and have circulated info re these. LEaD have collated spending on LBR funding within division and sent to ADONs. Oct: PMO email out to Clinical Lead, requesting update/evidence for actions Discussed in staff meetings, item 10a and 10b with training being identified by staff - needs to be formalised into TNA and then shared with LNFH MIU to check standardised. LNFH MIU have clear training plan for staff. TNA received from Petersfield MIU.	**Completed-unvalidated**			There are no incidents or complaints where a child did not receive safe care due to availability of appropriately trained staff. Compliments by children/families seen at MIU.		
SD046 46.2		46.2 Review staffing to understand the gap that may be present in achieving this recommendation.		**31.12.17**				**Blank**					
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.		**Blank**					
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.	25/09/17: email to Responsible lead for update. 27/09/17: email from responsible lead; MLE supplied data showing training courses scheduled and numbers booked onto for November. Oct: LEaD reminder email re training to Petersfield MIU - 16/20 Petersfield/LNFH MIU staff have completed 'Recognising the Unwell Child' training. 2/4 who have not completed this training booked onto course in Nov. LEaD put 'button' on MLE system for registered staff for this course.	**Completed-unvalidated**					
SD047 47.1		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 Information	**30.09.17**		Evidence that Ulysses system has been amended to show end of life data.	Aug:Request made to amend Ulysses system. Sep: Ulysses amended to include tick box Y/N 'was this patient receiivng end of life care?' which would enable incidents to be filtered by E of L.	**Complete**	Patients who are at end of life receive effective well planned care that is based on their wishes.		Incidents can be filtered by end of life so that appropriate action is taken to resolve issues.		
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.	Oct: tableau has been amended to include 'palliative care' incidents. These incidents will be reviwed as part of thematic review into EOL care.	**Completed-unvalidated**					
SD048 48.1		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 Kate Smith, supported by Julia Lake, Associate Director for Nursing and AHPs	**30.09.17**		Minutes of PUG meetings.	Sept: Helen Ludford and Tracy Hammond will be attending PUG meeting on 6/9/17.	**Completed-unvalidated**	Patients who are at end of life receive equipment within the agreed timeframes.		No incidents of patients not receiving equipment from HES within agreed timescales.		
SD048 48.2		48.2. SLA to be reviewed with commissioners to ensure it meets the needs of our patients.		**31.12.17**		Review of SLA.		**Blank**					
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.		**31.12.17**		All incidents reported on to Ulysses and forwarded to CCG		**Blank**					
SD049 49.1		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	**31.12.17**		Training compliance data.	Sept: EoL Steering Group initial discussion about e-verification and competency requirements for EoL /syringe driver training with further work to be completed.	**On track**	Patients receive safe effective care by appropriately trained staff.		There are no incidents or complaints where a patient did not receive safe effective care due to availability of appropriately trained staff. Compliments received for End of Life care.		
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.		**Blank**					
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.		**Blank**					
SD050 50.1		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	**28.02.18**		Report from Thematic review and evidence that shared through appropriate committees.	Sept: Thematic review is planned to start in Oct. End of LIfe Strategy 2016-2020 approved by QSC Dec 2016 and disseminated to divisional leads early 2017. Strategy sets out ambitions and actions required.	**On track**	Patients who are at end of life receive effective well planned care that is based on their wishes.		There are no gaps in end of life provision across the trust.		
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.		**Blank**					
SD051 51.1		51.1 see 28.2.1	Caz MacLean, Associate Director of Safeguarding supported by the Corporate Safeguarding Communications Group					**Duplicate**					Duplicate
SD051 51.2		51.2 see 28.2.2	Caz MacLean, Associate Director of Safeguarding supported by the Corporate Safeguarding Training Group					**Duplicate**					Duplicate

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SD052 52.1		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	**31.12.17**		Results of review of records.	Oct: CH steering group has reviewed records used in CH in both the Trust and by other trusts and have taken best parts of those records reveiwed to be used in CHs.	**On track**	Patients receive safe and effective care as their needs are recorded in a timely effective manner.		Results of record keeping audits.		
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.		**Blank**					
SD053 53.1		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					**Duplicate**					Duplicate
SD053 53.2		53.2 see 21.2						**Duplicate**					Duplicate
SD053 53.3		53.3 see 21.3						**Duplicate**					Duplicate
SD053 53.4		53.4 see 21.4						**Duplicate**					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	Sept: IPC audit programme in place. Oct: PMO chase-up for Quarterly IPC report Tel+Email Oct: 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		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	**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.	Sept: annual PLACE report to be presented to Caring group in October. Oct: Dementia group being set up by KJ - meeting with CCG to discuss dementia friendly environments. Rowan ward decorated in dementia friendly colours. PLACE audits for sites are on sharepoint. 1.11.17 Dementia Group had first meeting on 17.10.17 with OPMH /estates representatives - need to expand to include BU representatives. Looking at developing a dementia standard across trust.	**Overdue**	Patients living with dementia are on wards which meet their specific needs.		PLACE audit feedback in 2018.		
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.		**Blank**					
SD055 55.1	Gosport War Memorial Hospital	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	**30.09.17**		Results of review of wards.	26/09/17: see QIPDG meeting minutes. 27/09/17: email from Responsible lead, review completed and recommendation made to refurbish all toilets and bathrooms in these wards under PLACE capital funding (to be approved via PEG). Capital team provided indicative costs, awaiting decsion on funding from PEG October meeting 24.10.17 QIPDG - review completed however there are challenges as to whether privacy and dignity issues as per new EMSA guidance can really be met when using 'swing' bedrooms. Potential that there will be breaches of new guidance - will have large impact on taking patients from QAH.	**Completed-unvalidated**	Patients receive care that protects their privacy and dignity.		Action plan is implemented. There are no incidents where mixed sex accommodation guidance is breached.		
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.		**Blank**					
SD056 56.1		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	**31.12.17**		Task and Finish Group - terms of reference, minutes and action logs.	Oct: Meds Rec Group led by JW and G - Meds Rec policy has been revised and approved by MMC in Sept. TNA needs to be completed as part of policy. External company approached to provide costings for proviidng training for nurses/doctors - once quote received will be discussed as to feasibility.	**On track**	80% of inpatients will have their medicines reconciled within 2 working days.		Medicine Reconciliation figures per inpatient unit/ward.		
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.		**Blank**					
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.		**Blank**					
SD057 57.1		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	**30.09.17**		Results of review of POD lockers.	25/09/17: email to Responsible lead for update 26/09/17: see QIPDG meeting minutes. 28/09/17: email from Responible lead; not responsible this action, is for ADONs to lead on. Oct: HN reviewed availability of POD lockers at CHs (not yet visited Romsey CH). All CHs visited have POD lockers in place - Ford ward need to locate keys for the lockers. 31.10.17 QIPDG Vanessa Lawrenec confirmed Romsey Hospital has POD lockers in place. Susanna Preedy explained Anstey ward had put in bid for POD lockers to charitable funds.	**Completed-unvalidated**	Patients will have support to self administer medicines safely and effectively.		All inpatients have access to POD lockers and staffing support to self administer medicines safely.		
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.	Sept: self-administration guideline (SH CP168) is already in place and due for review in November 2017. Need to have POD lockers in place to implement self admin of meds. In MH/OPMH there is individual risk assessment re self admin of meds with care plans developed to capture actions required. New Meds Administration Pharmacy Technician posts x3 funded. 2 posts filled and due to start mid October in Western Hosp and Romsey Hosp. 1 post out to advert for Petersfield Hosp. Oct: QIPDG discussion re wording of action and whether need amendment to reflect issue raised in CQC report. Agreed that some patients on rehab wards would be able to self administer meds. ISD = not routine practice on wards at present to complete risk assessments and support self administration - would need staff training and resources. Current Policy is trust wide. Currently Southfield/Ravenswood/Forest Lodge/Hollybank are implementing self administration. 31.10.17 QIPDG discussed that 57.3 needs to take place prior to 57.2. Vanessa Lawrence/Julia Lake/Helen Neary are meeting to review this action and amend as required.	**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.		**Blank**				Trust: Increased incidents reported, particularly in areas previously noted to be low reporters. Service:	Trust: 31/10/17 Service:
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.		**Blank**					
SD058 58.1		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, Head of Legal Services, Risk and Patient Safety.	**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.	31.10.17 QIPDG - surveillance pilots in Childrens services and OPMH have reviewed incident reporting as part of pilot. OPMH pilot found that wards are very similar in the number/types of incidents reported. Pilot continues in AMH in early Nov. Results of pilot programme will be reviewed as to whether rolled out across trust.	**Completed-unvalidated**	Increased number of incidents reported without need for further prompting - particularly from areas where reporting is noted to be lower than expected.		Incident data at team level over time.		
SD059 59.1		59.1 see 21.1	~~Theresa Lewis, Lead Nurse~~ Jacky Hunt, Lead Nurse Infection, Prevention and Control					**Duplicate**	Patients will receive safe care in their own homes by trust staff following infection prevention best practice guidelines.		There are no incidents or complaints where IPC guidance was not followed appropriately in a patients home.		Duplicate

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SD059 59.2		59.2 see 21.2	supported by the Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary					Duplicate					Duplicate
SD059 59.3		59.3 see 21.3						Duplicate					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, Prevention and Control Team.	**31.12.17**		IPC Quarterly Report has hand hygiene audit results.	Sept: hand hygiene audits completed regularly with results included in quarterly IPC report to Patient Safety Group. Oct: PMO email out to responsible lead requesting copy of quarterly report. Oct: presentation to link advisors includes results of hand hygiene audits.	On track					
SD060 60.1		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	**30.08.17**		Review of early warning systems.	Aug: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 have now been competency assessed for using the tool. Oct: Resuscitation committee 5.10.17 discussed physical health compliance review and key findings - improvements to documentation required.	Completed-unvalidated	Patients who deteriorate receive timely and appropriate escalation to ensure all appropriate action is taken to meet their needs.		There are no major/catastrophic incidents where the deteriorating patient is not identified.		
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.	Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary	**31.03.18**		Confirmation of use of NEWS in community hospitals.	Aug: NEWS in use at LNFH. Oct: Resuscitation committee 5.10.17 discussed physical health compliance review and key findings - improvements to documentation required.	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.	Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary	**30.11.17**		communication - emails/newsletter/team minutes.		Blank					
SD061 61.1		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	**31.12.17**		Task and Finish Group - terms of reference, minutes and action logs.		Blank	Patients have access to a night nursing service as required.		Night nursing service available to identified patients.		
SD061 61.2		61.2 To discuss the outcome and recommendations from the Task and Finish Group regrading the need for a night nursing service with commissioners.		**28.02.18**		Minutes of meetings with commissioners.		Blank					
SD062 62.1		62.1 see 20.1	Raj Parekh, Chief Pharmacist supported by the Associate Directors of Nursing and AHPs: Julia Lake, Susanna Preedy, Helen Neary Carol Adcock, John Stagg, Nicky Bennett Liz Taylor					Duplicate	All patients receive their medicines in a safe and effective way.		There are no incidents where staff have not followed expiry date medicine guidance.		Duplicate
SD062 62.2		62.2 see 20.2	Raj Parekh, Chief Pharmacist					Duplicate					Duplicate
SD062 62.3		62.3 see 20.3	Raj Parekh, Chief Pharmacist					Duplicate					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	Oct: expiry date guidance now included in MCAPP. Expiry date has been added to Safe and Secure Audit which is out for data collection in Oct. Results will be reported to MMC and Patient Safety Group. QAT used by increasing number of teams but not consistently used across all of ISD yet. 31.10.17 QIPDG - data collection for Safe and Secure Medicines audit ends today.	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.		Blank					
SD0.63 63.1	Antelope House							Blank					
SD0.64 64.1	Antelope House							Blank					
SD0.65 65.1	Antelope House							Blank					
SD0.66 66.1	Elmleigh							Blank					
SD0.67 67.1	Antelope House							Blank					

UIN	Location	Trust Wide Actions Required	Responsible Leads	Action to be completed by	Action to be completed by	Required Evidence to show completion	Action Progress Update	completed actions (e.g.	Outcome or Improvement the action will deliver	Outcome to be achieved by (date)	Required Evidence to show Outcome Met	Outcome Progress Update	Outcome Status blue
68 CQC jan 16 ref WN004 4.10	Trust wide	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**			Carried over from January 2016 CQC Action Plan; part of the Business Delivery Unit activities. Sept: Proposal for procurement of external QI Methodology not approved at TEC and revised options proposal requested. Oct: first training session for Quality Ambassadors on 05/10/17 with 2x more dates in Oct/Nov. Quality Conference on 11/10/17. Quarterly meetings for Quality Ambassadors to share activities and good practice planned.	**On track**					
69 CQC jan 16 ref SD028 28.4	Bluebird House	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**			Carried over from January 2016 CQC Action plan; 16/8/17. Agreed at QIPDG to set recovery date as 31.10.17 as course expected to be written and delivery schedule agreed in October. 19.10.17 evidence review panel discussed that this action was at risk of slippage as revised training programme needed final approval by QSC/Board prior to roll out. 31.10.17 QIPDG - clarification by Simon Johnson that the course content has been agreed and the revised courses now on LEaD to book onto with first course in eraly Dec. The only decision required by board is whether the refresher training is required after 12 months v 18 months.	**Completed-unvalidated**					
70 CQC sept 16 ref RN043 43.1	Trust-wide	Fully deliver and embed all the actions from the January 2016 CQC inspection and the Mortality & Serious Incident Action plan.		**31.12.17**			Carried over from September 2016 CQC Action Plan: 14/7/17. Jan CQC16 action plan 98% completed, CQC sep16 Action plan 92% completed and SI &MIP action plan 96% completed. 1.8.17 revised date for completion as the action in Jan 2016 CQC action plan re Quality Improvement Methodology has a recovery date of 31.12.17. Sept: Niche presented draft audit opinion on SI and Mortality action to QSC with final report due 16/10/17. Rated the 6 themes identiifed in plan as either A/B - complete/embedded/impact seen.	**On track**					
71 CQC sept 16 ref RN043 43.4		EXTERNAL REVIEW: Niche / Grant Thornton Phase 2 review and testing of Mortality & Serious Incident Action plan		**30.11.17**			Carried over from September 2016 CQC Action Plan: 31 Aug 2017 Niche will present report findings to QSC on 19.09.17. Report not yet received and Niche say may struggle to make QSC papers deadline 12.09.17 to send report Sept: Niche presented draft audit opinion on SI and Mortality action to QSC with final report due 16/10/17. Rated the 6 themes identiifed in plan as either A/B - complete/embedded/impact seen.	**On track**					

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	Progress Update	Outcome Measure
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 (11.1b) Attendance registers (11.1c)	Divisional and service level training records to that staff have been trained. (11.1b & 11.1c) Achieve of 90% compliance to clinical audit of physical health needs. (11.1a) Physical health audit to be undertaken in Q3. Audit of SI contributory factors to be undertaken in Q2. (11.1a)	30.11.16	30.06.2017 revised recovery date 31.10.17	Overdue	11.1a Course content reviewed by the ADoNs from AMH and LEaD. Additional options being scoped alongside the 5 day course. Alternatives are physical health specialist subject sessions and e learning. Subject matter inclusive of diabetes and respiratory. 11.1b & c Training records being obtained by L Hartland LEaD. 04.08.16 Input evidence request made for information - meeting was held with ADoNs to discuss e learning and shorter course options October 2016: 5 day physical health course reviewed. The duration of the course does not make it a feasible option for inpatient staff. AMH, Specialised Services & LD Plan - Agreed all qualified nurses and HCSW's working in inpatient services will need to demonstrate competency in the following: - Physical Observations, - Track and Trigger Tool and SBAR(d), - Blood Glucose Monitoring . LEaD practice educators will assess the competency of senior nurses. Nurses achieving level 4 competency will then cascade assessments. LEaD will be introducing 3 skill buttons for the competencies on the training accounts of all staff in the target group on 25/10/16. Staff will be required to e-verify via the LEaD system when they have achieved each competency. All verifications will require manager authorisation. Target is for 80% of staff to be deemed competent in Track and Trigger and SBAR(d) by end of December 2016. Training/education is available via face to face or electronic delivery to support staff to acquire the knowledge and skills in physical health assessment and monitoring. LH meeting Kathy Jackson, Head of Nursing Inpatients (OPMH) 25/10/16. KJ is aware of this action. LH will present plan (as per action 11 above) to the ward managers at the meeting and arrange roll out of assessments for senior nurses. 11/10/16 A summary recovery plan was submitted by Steve Coopey for all actions: - 11.1a Discussions held with divisional leads to agree actions and attendance at physical health steering group commenced. Carole Adcock completed the review of 5 day physical health course. Divisional leads to agree actions following review, share work drafted on education pathway for registered staff and to confirm use of core physical health training workbook which supports competency assessment in practice. - 11.1b To agree which staff require core + additional training a nd confirm % targets trained in physical observations for mental health inpatients by 31.12.16 - 11.1c Louise to provide on-going attendance data on request or in line with agreed targets 17.10.16 11.a The risk related to physical health training in the MH inpatient units has been added to the divisional risk register (for MH) following discussion at AMH MOM in October 2016. Risk no.1100 - AMH - management of physical health care of service users. Risk states that currently the 5 day course is not attended and is being replaced with other training options. 20.10.16 11.1a Specialised Services have devised a project called improving access to physical health for the forensic patient; course developed - trainee advanced nurse practitioner masters pathway. 03.11.16 Further update re OPMH physical health course (CUSP) rolled out. 05.01.17 Update on 11.1d - Physical health assessment and monitoring policy now updated and circulated to the Resuscitation Committee for comments due back by 06.01.17. Task and finish group to be formed once the policy is agreed. A physical health strategy for AMH has also been drafted to ensure staff recognise and respond to patients' physical health needs, and work with service users in the community and look to reduce the incidence of premature mortality. Further update to be received from physical health task and finish group which will convene on	Evidence required: Course attendance records - site / service percentage (11.1b & 11.1c) - Saved 20feb17 data - T&T 87%, Phys obs 84%, Blood Gluc 81% March 2017 agreed that target training figure should be 90% trained. Results of the physical health audit of AMH sites (11.1a) 11.1a. physical health clinical audit report - MH (nov16). 11.1a nov16 audit results 93% - Helen Alger - full physical health review completed within 7 days of admission Audit of SI reports proving a reduction in physical health contributory factors (11.1a) Review of the published Physical Assessment and Monitoring Policy and Procedure for Mental Health and Learning Disability Services which includes a reference to diabetic monitoring (11.1d) AMH Physical Health Strategy (11.1d) Nov16 draft already saved. 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
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	Overdue	March 2017 : 16.1a Compliance to 48 hour reporting onto StEIS: 36% (Jul-16), 19% (Aug), 42% (Sep), 59% (Oct), 75% (Nov), 44% (Dec), 65% (Jan-17) 71% (Feb) 16.1b Compliance to 48 hour panels being held within 48 hours: 55% (Jul-16), 36% (Aug), 46% (Sep), 64% (Oct), 77% (INov) 67% (Dec) 78% (Jan) 71% (Feb-17) Levels of compliance with the mortality panels being held within 48 hours is monitored through Tableau on a daily basis and this is actively discussed at the MF. The compliance to the requirement to report onto StEIS within 48 hours is monitored on a monthly basis and whilst improvement has been seen in the pressure ulcers, compliance to other serious incidents has deteriorated. It is recommended that this action remains red until indicators have reached the required trajectory. Further discussed at QIP Delivery Group the need for divisions to telephone the central SI team at end of 48 hour panel so can put any SI onto STEIS within deadline. Need to continue to monitor. A recovery date for this action has been set for June 2017. 27.04.17 16.1a Compliance to 48 hour reporting onto StEIS: 36% (Jul-16), 19% (Aug), 42% (Sep), 59% (Oct), 75% (Nov), 44% (Dec), 65% (Jan-17) 71% (Feb) 36% (Mar) 16.1b Compliance to 48 hour panels being held within 48 hours: 55% (Jul-16), 36% (Aug), 46% (Sep), 64% (Oct), 77% (INov) 67% (Dec) 78% (Jan) 71% (Feb-17) 82% (Mar) 48 hour panel guidance for ISD been amended to highlight that panel needs to call central SI team if decided that incident is SI. Performance discussed at QIPDG on 25.04.17 with ISD flowcharts/guidance shared for MH division to use if helpful. 5.5.17 Chased for status - Kay and Divisional leads / Requested summary recovery plan - Liz Taylor 8/5/17. We have not breached this in children and Families and are within compliance for reporting - updated divisional leads AMH was Mary Kloer - now David Kingdon, ISD Was Peter Hockey now Rachel Anderson. 25/5/17 evidence review panel - target not met. A change in process has occurred with SI team attending/linking into 48 hour divisional panels to get immediate update re decision making re whether incident is SI. 5/7/17. Target not met. May 17 - 75%(12/16), June 17 - 83%(10/12) 31.7.17 evidence review panel - 16.1a discussed different interpretation of SI Framework with this action using the date the incident is reported as the date for recording onto StEIS whereas commissioners /other trusts use the date the decision is made that an incident is an SI. These differences been discussed at QOC but no agreement to change. New national SI framework may make this reporting clearer - framework delayed. Niche will complete their second phase assurance and present report to QSC Sept and Board Oct so their feedback will guide completion of this action. Recovery plan to be completed and to continue to monitor until Oct 2017. 16.1b complete. 14.8.17 Target not met - 73% (11/14) SI reported onto StEIS within 48 hours. 29.8.17 evidence review panel - target not met in July (73%). Agreed to add another line to SI KPI dashboard which will report on numbers of SIs uploaded to StEIS within 48 hours of incident	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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UIN	Carolan Theme	Recommendation	Trust Actions	Process Input (measures)	Responsible Lead	Essential Partners	Executive Accountability	Process Completion Date	Process Status	Recovery date	Progress Update (Process)	Expected Outcome	Measuring Success Date (Outcome Completion)	Outcome Status	Outcome Measure	Evidence in folders (Process)	Evidence in folders (Outcome)
1.1a	Recognising that family involvement begins with the very first patient contact, and that it is critical to delivering effective healthcare services	1.1 Working with service users, patients, families and staff to identify, develop and implement best practice on engaging with families who have relatives who are accessing services provided by the Trust	1.1a The Trust will work with patients, service users and families to develop and implement best practice on engagement	1.1a Establishment of a Task and Finish Group for the Family Involvement Action Plan and the family first involvement group 1.1a Contacting and engaging with service users, families and staff to establish a network of stakeholders interested in working with the Trust 1.1 Identifying best practice of involvement and engagement of families	Chris Woodfine, Head of Patient Engagement and Experience	~~Carla Roadnight, Area Head of Nursing and AHPs~~ Liz James, Area Head of Nursing and AHPs ~~Pam Sorensen, Engagement Advisor~~	Sara Courtney, Chief Nurse	30/04/2017	Completed-unvalidated		A Family first involvement group was formed in January and continues to meet on a monthly basis. There was a learning network in AMH Southampton to engage staff and hear their ideas. The Triangle of Care has been identified as a collection of best practice that will address issues expressed by families. April 2017 Experience, Involvement and Partnership Strategy developed with patient involvement - with comms dept for final version to be formatted. Implementation plan for strategy in place. Best practice guidance developed and circulated to staff. Task and finish group amended terms of reference so they can continue involvement with this plan. Family First Group continues to meet. Complaints working group had final meeting in April with a planned feedback in 6 m to show improvements made. May 2017 bi-monthly Task and finish group monitors plan. June 2017 action plan is now on SHFT website. Bi-monthly Task and finish group continues to monitor plan. Family First Group also monitors plan. Activities involving families and carers added to website. 31.7.17 SC requested LS Chair of the Task and Finish Group validated this action as complete. plan emailed to LS for validation. Oct 17 BC has emailed LS to validate the completion of this action.	Divisional champions and accountable leads will work with service users, patients and families to agree a set of principles to support a culture that truly values user involvement in physical and mental health teams.	30/04/2017	Completed-unvalidated	A plan that will be developed to ensure that there is a focus on culture which truly recognises the importance of family involvement from the outset.	1.1 Task and Finish Group ToR 1.2 Task and Finish Group Minutes/agendas 1.3 Family First Involvement Group ToR 1.4 Family First Minutes/agendas 10.02.17;06.03.17;31.03.17 1.5 Learning network event AMH 1.6 Best Practice for involvement and engagement of families. 1.7 Task and Finish Group amended ToR 1.8 Story Telling Toolkit (for staff) 1.9 Best practice guidance 2.0 Complaints Working Group T of R 2.1 Complaints working group minutes 06.12.16;07.02.17;14.03.17 2.2 QIPDG meeting agenda and papers for 20thjune - action log item 215 gives link to strategy on website 2.3 website address for strategy: http://www.southernhealth.nhs.uk/get-involved/help-us-to-improve/experience-involvement-and-partnership-strategy/	1.1 Experience, Involvement and Partnership Strategy draft v7.1 2017/18 1.2 Strategy Implementation Plan 2017/18 1.3 Family Experience in Engagement agenda/minutes 25052017 1.4 Family , involvement and partnership strategy- final version
1.1b	Recognising that family involvement begins with the very first patient contact, and that it is critical to delivering effective healthcare services	1.1 Working with service users, patients, families and staff to identify, develop and implement best practice on engaging with families who have relatives who are accessing services provided by the Trust	1.1b To put in place the enabling strategies to support the successful implementation of the Triangle of Care standards	To launch enabling strategies: 1.1b Carer involvement in developing and co-producing plans and actions as described in actions 1.1 1.1b Creating a communications plan 1.1b Refine/adapt HR processes to support alignment of family involvement to clinical practice e.g. job descriptions, objectives, appraisals, clinical supervision and pre and post qualification training	Chris Woodfine, Head of Patient Experience and Engagement Emma McKinney, Head of Communications Graeme Armitage, Interim Head of HR	Sarah Cole, Family Therapist Specialised Services	Sara Courtney, Chief Nurse	30/09/2017	Completed-unvalidated		April 2017 Experience, Involvement and Partnership self assessment for clinical services to complete presented at April PT Exp workstream meeting. May 2017 Quality Account priorities include objectives on care planning - use same evidence. CW meeting JR in comms on 7.6.17 to develop communication plan. CW meeting with F & G CCG to explore carers event with PHT and CCG. 'Sharing information' workshop on 24.5.17 with service users/carers/families/staff - reviewed leaflet for sharing information and made recommendations for changes. Relationship with 3rd sector organisations eg 'Carers together', 'Carers in Southampton'. Divisions have some mechanisms in place to talk with carers. June 2017 CW met with JR who is drafting a communications plan to launch enabling strategies. Planning for refinement of HR processes started. Aug 2017 1.1b communications plan completed re wider engagement. Some services have set up carer groups eg Petersfield AMH. Sept/Oct 17 - posters for our family involvement charters and staff committement charters are in design and being refined ready for distribution in November 17. A new set of Intranet pages focusing on Patient Experience and best practice were also launched during September 17.	In the identification of best practice methodologies, there are a set of enabling strategies that need to be delivered.	30/04/2018	On track	Co-produced plans which are coherent	1.1 Experience, Involvement and Partnership self assessment April 2017 1.2 examples of above 1.3 Sharing Information workshop agenda and materials 24.5.17 1.3 Sharing Information workshop facilitator notes 24.5.17 1.4 communications plan	1.1b Email from responable lead
1.1c	Recognising that family involvement begins with the very first patient contact, and that it is critical to delivering effective healthcare services	1.1 Working with service users, patients, families and staff to identify, develop and implement best practice on engaging with families who have relatives who are accessing services provided by the Trust	1.1c Phase 1: Ensure carers are identified at the first contact or as soon as possible thereafter	1.1c Co-produce a carer's charter/statement of principle that aligns with HCC development of a carers strategy 1.1c Develop guidance and training for staff to enable high levels of care planning skill within staff groups, including the importance of involvement of families and service users	~~Pam Sorensen, Engagement Advisor(now left)~~ Records Keeping and Care Planning work stream ~~(Paula Hull)~~ 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	30/06/2017	Completed-unvalidated		Guiding principled being drafted (March 2017) following joint work with 'Carers Together'. Draft to be shared more broadly for comment etc. On track to meet June 2017 date. April 2017 Carers Charter in draft format attached. May 2017 Training programme for staff in care planning reviewed with revised programme in development; guidance for staff on expected record keeping standards in development. Clinical audits for holistic assessment and care planning will be repeated this year. Clinical reference cards with top tips on record keeping being printed for clinical staff. Patient Exp workstream to draft principles for patients/engagement in general to complement the guiding principles for carers. Aim to have core principles for any involvement whether patient/carer etc. SJ, Head of Essential Training, reviewing the training portfolio to see how family involvement currently reflected in training and then to look at how to weave principles of family involvement in all relevant training. June 2017 Carers Charter agreed with families at different groups/workshops. Positive feedback received. Will wait until 'Principles for involving patients/service users' is finalised and then will launch both formally.'Principles are in draft and will test with patient groups in June/July for feedback and aim to launch in September and to present at Quality Conference in October. SJ has reviewed the training currently provided by LEaD with regard to inclusion of information on patient/family involvement. Need to agree approach to be used re training eg does all training have as a minimum 1 slide on patient/family involvement.	Staff understand what is expected of them with regards to family involvement; Equally, families understand what to expect from our services	30/04/2018	On track	Staff understand what is expected of them with regards to family involvement; Equally, families understand what to expect from our services	1.1c Carers Charter draft v3 1.2 Families First minutes 31.03.17 1.3 Record keeping and care planning minutes 1.4 QIPDG minutes section 6.6 23052017 1.5 QIPDG minutes 27.6.17 1.6 Information sharing workshop with families May 2017	1.1 Experience, Involvement and Partnership self assessment April 2017 1.2 examples of above
1.1d	Recognising that family involvement begins with the very first patient contact, and that it is critical to delivering effective healthcare services	1.1 Working with service users, patients, families and staff to identify, develop and implement best practice on engaging with families who have relatives who are accessing services provided by the Trust	1.1d Phase2: Ensure staff are carer aware and trained in carer engagement strategies	1.1d Run staff and carer events and forums to encourage development of practice.	Heads of Nursing and AHPs		Sara Courtney, Chief Nurse	30/04/2018	On track		May 2017 Quality Conference Oct 2017 will have family/carer involvement. June 2017 Family involvement activities are in place for some services but not yet consistent across whole Trust. For example: Southfield - identify carers as part of the initial assessment; are raising carer awareness at team meetings; implementing carer care plans. Bluebird - implementing carer care plans. Patient engagement and involvement workstream discusses carers. Families presented to the SI workshop in April 2017. Sept: FLO presented her role at medical conference and to attend AMH learning network event in Dec 2017. Carer groups across the trust have been mapped. Oct: CW attended carer group at Melbury Lodge and discussed carer principles with them. Carer groups in place across some services - mapping exercise needs updating. Family stories (clips) presented at Quality Conference	Divisional champions and accountable leads will work with service users, patients and families to encourage development of practice	30/04/2018	On track	Divisional champions and accountable leads will work with service users, patients and families to encourage development of practice	1.1 Quality Conference agenda and presentations. 1.2 Patient Engagement and Experience Workstream **minutes.** 1.3 SI Workshop 25.4.17	
1.1e	Recognising that family involvement begins with the very first patient contact, and that it is critical to delivering effective healthcare services	1.1 Working with service users, patients, families and staff to identify, develop and implement best practice on engaging with families who have relatives who are accessing services provided by the Trust	1.1e Phase 3: Ensure that the Trust strategy on engagement is linked to the staff engagement strategy	1.1e Develop policy and practice protocols on confidentiality and information sharing (covered under action 2.5)					On track					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	1.1 Working with service users, patients, families and staff to identify, develop and implement best practice on engaging with families who have relatives who are accessing services provided by the Trust	1.1f Phase 4:Ensure families/carers have an introduction to the service and staff, with a relevant range of information across the care pathway	1.1f Co-produce an information leaflet for family with service and care co-ordinator contact information	~~Carla Roadnight, Area Head of Nursing and AHP~~ Liz James, Head of Nursing and AHPs AMH Kathy Jackson, Head of Nursing - Inpatients OPMH	Carer groups	Sara Courtney, Chief Nurse	30/08/2017	Overdue	31/12/2017	May 2017 CW to speak to MF who has developed leaflet for her team and discuss whether can be replicated across AMH. June 2017 CW to follow up with MF re progress with leaflet. Aug 2017 At Task & Finish Group agreed to start developing carer info pack on inpatient wards.LJ to lead for AMH; KJ for OPMH. Some inpatient services have carer packs in place eg Bluebird, Southfield which will be shared across services as examples in place. Need to agree a recovery date. Sept: Family First group have reviewed carer packs already in place and given feedback. Melbury Lodge Carers group are reviewing the current carers pack as needs updating - this will be shared as a template for other services as a guide. ISD carer packs = no/little progress;AMH= making progress;OPMH need to update current packs in place;LD = Willow ward has patient info pack but not one for carers - JJ is drafting a pack; SS = need to check carer packs in all sites and up to date.	Families know who to contact if they have any questions	28/02/2018	On track	Families know who to contact if they have any questions	1. Southfield carer pack 2. Willow care pack 3. Bluebird carer pack	Email from CW - Feedback on carers packs
1.1g	Recognising that family involvement begins with the very first patient contact, and that it is critical to delivering effective healthcare services	1.1 Working with service users, patients, families and staff to identify, develop and implement best practice on engaging with families who have relatives who are accessing services provided by the Trust	1.1g Phase 5: Develop a range of carer support services or covering all the key points on the care pathway	1.1g Map out the key points of the care pathway 1.1g measures to be developed in later phase	tbc	tbc	tbc	tbc			tbc	Carers needs are assessed and support provided	tbc		Increased levels satisfaction on patient experience survey question and AMH carer survey		
1.1h	Recognising that family involvement begins with the very first patient contact, and that it is critical to delivering effective healthcare services	1.1 Working with service users, patients, families and staff to identify, develop and implement best practice on engaging with families who have relatives who are accessing services provided by the Trust	1.1h Phase 6: Develop defined posts responsible for carers	1.1g Map out the key points of the care pathway 1.1g measures to be developed in later phase	tbc	tbc	tbc	tbc			tbc	Within services there is a local lead/champion	tbc		Within services there is a local lead/champion		
2.1a	Improving the way the Trust communicates and engages with families	2.1 Ensuring that policy, guidance and procedure related to investigations recognises and supports the iterative process of family engagement	The Trust will improve the way communication and engagement is undertaken with families ensuring that there is a recognition of the process of family engagement within the policies and guidance in relation to investigations by: 2.1a Conducting a review of the policies and procedures related to SIRI and complaint investigations to ensure that they are informed by the same principles of engagement with families	2.1a Undertake a review of all policies and procedures relating to SIRI and complaint investigations with input from front-line clinical staff 2.1a Update policies and procedures pertaining to SIRI and complaint investigations which include the elements of engagement with families as principles.	Helen Ludford, Associate Director of Quality Governance Paula Hull, Divisional Director of Nursing & AHP (ISD)	Complaints Working Group Family First Involvement Group Mortality Forum	Sara Courtney, Chief Nurse	31/07/2017	Completed-unvalidated	31/10/2017	January 2017 The SIRI policy and procedure has been reviewed with input from the Family First Involvement Group. Version control tables in policy/procedures show their input. March 2017 Complaints working group reviewed the complaints policy. The policy is to be reviewed by July 2017. May 2017 The SI policy will be reviewed again once national guidance issued. Complaints policy review underway. June 2017 SI Procedures have had minor amendments made following feedback from external assurance audit of SI and Mortality action plan. Waiting for national SI guidelines to be published and will then amend policy as required. Complaints policy and procedures is being revised currently and will be circulated widely for comments. July 2017 draft complaints policy and procedures - extended the deadline for comments. Feedback received from wide range which is being considered/included. Aug 2017 completion of complaints policy extended to end Oct 17 in order to encompass feedback on draft and discuss/agree changes to processes. Sept 2017 revised policy redrafted and circulated for comments. Oct 2017 final draft of complaints policy and procedures approved at caring group and published on website. NB National SI framework - still waiting for revised guidence to be published	All Trust policies and procedures relating to investigations are aligned to ensure that communication with families is meaningful.	30/09/2017	Completed-unvalidated	Involvement of families' in the review of the SIRI policy and procedure and complaints policy, as identified by the reviewers/contributors within the policies.	1.1 Family First Involvement meeting minutes (Jan 2017). 1.2 Complaints working group minutes (Feb 2017).	1.1 Policy for Managing Incidents and Serious Incidents 1.2 Procedure for the Reporting and Management of Serious Incidents 1.3 revised complaints policy and procedure

UIN	Carolan Theme	Recommendation	Trust Actions	Process Input (measures)	Responsible Lead	Essential Partners	Executive Accountability	Process Completion Date	Process Status	Recovery date	Progress Update (Process)	Expected Outcome	Measuring Success Date (Outcome Completion)	Outcome Status	Outcome Measure	Evidence in folders (Process)	Evidence in folders (Outcome)
2.1b	Improving the way the Trust communicates and engages with families	2.1 Ensuring that policy, guidance and procedure related to investigations recognises and supports the iterative process of family engagement	The Trust will improve the way communication and engagement is undertaken with families ensuring that there is a recognition of the process of family engagement within the policies and guidance in relation to investigations by: 2.1b Incorporating the principles of engagement with families to the admissions and discharge policy (including inclusion in crisis contingency care plan).	2.1b Update admissions and discharge policy to include the principles of family engagement (care planning, family communication and liaison)	~~John Stagg, Associate Director of Nursing & AHP (Learning Disabilities)~~ Julia Lake ADON BU2 (Sarah olley) MCP		Sara Courtney, Chief Nurse	30/09/2017	Overdue		June 2017 JS to review policy. Aug 2017 ADT policy out for review currently - CW to add family engagement principles. Sept 2017 family first meting postponed until October when will review policy. Oct 2017 Admissions and discharge policy overdue against review schedule. Disscussions underway as to setting up a task and finish group. Recovery date for process and outcome is required. Oct 17 familys first group looked at policy on .10.10.2017 with CW feeding back suggestions to JL . 31.10.17 QUIPDG meeting- SO is now the lead for the admissions and discharge policy . task and finish group may be established. recovery date to be added.	All Trust policies and procedures relating to investigations are aligned to ensure that communication with families is meaningful.	30/10/2017	Overdue	Involvement of families' in the review of Admissions discharge and transfer policy as identified by the reviewers/contributors within the policy.		
2.2a	Improving the way the Trust communicates and engages with families	2.2 Recognising that Duty of Candour is not the same as family engagement and ensuring that policy, guidance and procedure reflects this	2.2a Development of a Trust strategy for involving patients, families and the public with specific reference to families	2.2a Develop a Trust strategy on Experience, Involvement and Partnership	Chris Woodfine, Head of Patient Engagement and Experience	~~Pam Sorensen, Engagement Advisor~~	Sara Courtney, Chief Nurse	30/04/2017	Complete		March 2017 The Caring group received the final draft of the strategy and is due to be submitted to the QSC at the end of March for final sign-off. April 2017 slight amendment made to strategy and ready for launch. Implementation plan in place. May 2017 Strategy with comms team for final design prior to circulation. June 2017 Strategy launched via 'message from Julie Dawes to all staff' and is on website. 31.07.17 SC validated this action is 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.	30/04/2018	On track	Compliance with the standards outlined in the overarching Trust strategy.	1.1 Experience, Involvement and Partnership Strategy draft v7.1 2017/18 1.2 Strategy Implementation Plan 2017/18 1.3 QIPDG meeting agenda and papers for 20thjune - action log item 215 gives link to strategy on website 1.4 website address for strategy: http://www.southernhealth.nhs.uk/get-involved/help-us-to-improve/experience-involvement-and-partnership-strategy/ 1.5 Message from Julie Dawes re launch of strategy.	1.1 Experience, Involvement and Partnership Strategy - final version
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 workstream.~~ John Stagg now chair of Record Keeping workstream (added Oct 2017)	Record Keeping and Care Planning Workstream	Sara Courtney, Chief Nurse	31/10/2017	Completed-unvalidated		April 2017 An example of this is within the Children and families business unit who have developed a new template called 'My Plan' which will require a collaborative approach to care planning with parents. May 2017 CW meeting with PH in early July to discuss family involvement in care planning. Aug 2017 Audit of family involvement in care plans/risk assessments/crisis plans completed in OPMH; AMH audit data collection in Sept with report in Oct. LD audit to be completed in future. Holistic assessment and record keeping audit (ISD) which includes involvement of families is in final draft with data collection in Sept and report in Oct. Sept 2017 Holistic tools on Rio have been reviewed, while some have space to record family involvement others do not - discussed at RKCP meeting 18.9.17. and agreed that AU would review	Better clinical outcomes and patient experience as well as reduced spend	31/01/2018	On track	Staff are directly involving families in care-planning.	1.1 Family Involvement Audit report OPMH RKCP minutes Audit results.	
2.2c	Improving the way the Trust communicates and engages with families	2.2 Recognising that Duty of Candour is not the same as family engagement and ensuring that policy, guidance and procedure reflects this	2.2c Trust to ensure that staff and services are aware that Duty of Candour is about being honest when things have gone wrong (training of the duty of candour through providing an e-learning training package)	2.2c Develop an e-learning package (short session of 45 minutes) on "Being Open and Duty of Candour to ensure staff and services are aware of being honest when things have gone wrong 2.2c Duty of Candour module in the Investigating Officer training workshop 2.2c Masterclass on sharing findings of investigations	Helen Ludford, Associate Director of Quality Governance Elaine Ridley, Family Liaison Officer	Vicki Tinkler, Project Manager (LeAD) Tom Williams, Ulysses System Developer Nick Fennemore, Head of Chaplaincy, Spiritual & Pastoral Care	Sara Courtney, Chief Nurse	30/06/2017	Complete		10/04/17 Bulletin article launching e learning module for duty of candour. April 2017 duty of candour session in the Investigating Officer training has been up dated and is now given by the Family Liaison Officer. May 2017 Masterclass 'sharing investigation reports' developed by FLO and chaplain with two provisional dates set for training - 3.7.17 and 17.7.17. June 2017 pocket guides as reminders to staff re Duty of Candour have been designed with 6000 being printed for distribution across clinical services. 31.07.17 SC validated this action is 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	31/03/2018	On track	Compliance with Duty of Candour as monitored through the SI and mortality KPI dashboard and audit of records	1.1 Bulletin article 1.2 E-learning programme 1.3 IO programme	2.2c SI KPI dashboard 2.2cDuty of Candour internal audit 2.2c sharing reports masterclass slides
2.2d	Improving the way the Trust communicates and engages with families	2.2 Recognising that Duty of Candour is not the same as family engagement and ensuring that policy, guidance and procedure reflects this	2.2d Review policy for Duty of Candour and ensure that it sits under the overarching position statement and ensure that this is interlinked to the complaints policy and the serious incident policy and procedure	2.2d Review the Being Open policy incorporating the legal Duty of Candour 2.2d Review the SI policy and procedure 2.2d Review the complaints policy 2.2d Review the safeguarding policy 2.2d Ensure all the above policies align.	Sarah Pearson, Head of Legal and Insurance Services, Chris Woodfine, Head of Patient Engagement and Experience Caz Maclean, Associate Director of Safeguarding	Complaints Working Group Patient Safety Group Family First Involvement Group	Sara Courtney, Chief Nurse	30/09/2017	Completed-unvalidated	31/10/2017	January 2017 The SI policy and procedure has been reviewed with input from the Family First Involvement Group . February 2017 The complaints working group reviewed the policy. March 2017 DoC Policy agreed through policy ratification group on17/03/17, uploaded to intranet 21/03/17, for sign of via Caring Group on 13/04/17. The documents that have been uploaded state that they are to go to Caring group in April but it was agreed that as changes largely minor it could be uploaded in the meantime. May 2017 Complaints policy under review. Safeguarding adult policy reviewed Feb 2017 and Safeguarding children policy reviewed . Aug 2017 completion of complaints policy extended to end Oct 17 in order to encompass feedback on draft and discuss/agree changes to processes. June 2017 Complaints policy and procedures being reviewed and will be circulated widely for comment prior to approval. Complaints working group had already fedback comments on policy. CW to review Safeguarding Policy in context of Duty of Candour. Family First Group are happy to review	Staff are aware of the difference between Duty of Candour and family engagement and there is a culture that fosters staff being open with families which also supports a "No Blame" culture	31/12/2017	On track	Staff are competent in applying the Duty of Candour readily and where appropriate; and there is a clear understanding amongst staff in the difference between family engagement/involvement and duty of candour	1.1 Family First Involvement meeting minutes (Jan 2017). 1.2 Complaints working group minutes (Feb 2017). 1.3 Duty of Candour pocket cards 1.4 QIPDG minutes re LEaD review of training	add policies
2.3a	Improving the way the Trust communicates and engages with families	2.3 Ensuring that steps taken to engaging families in investigations, and the results of those steps are recorded in the investigation report	2.3a The SIRI procedure should state that steps are to be taken to engage families and this should be documented	2.3a Review the SIRI procedure and add statement regarding the engagement of families'	Helen Ludford, Associate Director of Quality Governance	Family First Involvement Group	Sara Courtney, Chief Nurse	31/05/2017	Complete		Jan 2017 The SI policy and procedure have been reviewed - section 4.5 in procedure details the involvement of patients/ families/loved ones. Policy is to be reviewed again July 2017 following publication of new national SI Framework. 31.07.17 SC validated this action is complete.	Staff are consistently documenting the involvement of families during/following an investigation	30/11/2017	Completed-unvalidated	Investigation and reports demonstrate involvement of families where families wish to be involved.	2.3a Policy for Managing Incidents and Serious Incidents 2.3a Procedure for the Reporting and Management of Serious Incidents 2.3a Email confirming schedule of development of e-learning.	2.3a SIs where family involvemnt in Terms of reference. 2.3aCommissioing manager e-learning development schedule
2.3b	Improving the way the Trust communicates and engages with families	2.3 Ensuring that steps taken to engaging families in investigations, and the results of those steps are recorded in the investigation report	2.3b Consistent use of the CCG Quality checklist at the 48 Hour Panel and Corporate Panel as a reference guide	2.3b Add the use of the CCG Quality 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	31/07/2017	Complete		Jan 2017 SI policy and procedures reviewed. Appendix 11 contains the commissioner checklist. Use of this is at corporate panel is in section 9.2 of procedure. SI policy /procedure to be reviewed July 2017 following publication of new national SI Framework. June 2017 SI procedures amended to include reference to use of CCQ Quality checklist/questionnaires. 31.07.17 SC validated this action as complete. NB: revised natioanl SI Framework delayed.	Staff are consistently documenting the involvement of families during/following an investigation	30/11/2017	Completed-unvalidated	All checklists demonstrate that families have been invited to contribute to the terms of reference	2.3b Procedure for the Reporting and Management of Serious Incidents. 2.3b Email confirming schedule of development of e-learning.	2.3b Commissioing manager e-learning development schedule
2.3c	Improving the way the Trust communicates and engages with families	2.3 Ensuring that steps taken to engaging families in investigations, and the results of those steps are recorded in the investigation report	2.3c Review and modify the structure of the Ulysses to include specific headings to record any notes/detail on the steps taken to engage with families	2.3c Add consistent headings within Ulysses SIRI reports in family engagement	Helen Ludford, Associate Director of Quality Governance	Tom Williams, Ulysses System Developer	Sara Courtney, Chief Nurse	30/06/2017	Complete		May 2017 BC discussed possible changes to headings with TW. June 2017 Electronic Root Cause Analysis form on Ulysses has section for 'Involvement and support of the Injured Party'. The divisional and corporate panels check that family involvement is offered. Monthly audit completed re Duty of Candour. 31.07.17 SC validated this action is complete.	Staff are prompted to document the involvement of families during an investigation	31/08/2017	Completed-unvalidated	The Ulysses systems contains a section to document on the steps taken to engage with families	Procedure for the Reporting and Management of Serious Incidents. D of C 12 month report	1. screen shot of usslyses system
2.3d	Improving the way the Trust communicates and engages with families	2.3 Ensuring that steps taken to engaging families in investigations, and the results of those steps are recorded in the investigation report	2.3d Add family engagement and its recording to SIRI training workshop	2.3d Add family engagement and its recording to SIRI training workshop	Helen Ludford, Associate Director of Quality Governance	n/a	Sara Courtney, Chief Nurse	31/05/2017	Complete		April 2017 Investigating Officer training has information and video on involvement of families, loved ones and patients. Training also has specific session on Duty of Candour. Feedback forms form training very positive with staff feeling better and knowledgeable about carrying out investigations. 31.07.17 SC validated this action is complete.	Investigating Officers are trained on steps taken to engage families and how to record onto Ulysses	31/12/2017	Completed-unvalidated	Investigating Officers feel confident on engaging families in investigations	2.3d Investigating Officers 2 day training presentation. 2.3dInvestigating Officers training - Duty of Candour presentation. 2.3dEmail confirming schedule of development of e-learning.	2.3d Feedback forms Oct 2016 2.3d Feedback forms April 2017 2.3d Feedback forms May 2017 2.3d How to share information training materials. 2.3dcourse attandance for 1.4 2.3d Review of IO role report 2.3d Commissioing manager e-learning
2.4a	Improving the way the Trust communicates and engages with families	2.4 Co-producing with families a leaflet that can be sent to all families following a death that explains how investigations are conducted, how the families can get involved, and signposts families to appropriate support and advice	Families have said that written information is important, but that it should not be sent to families, but should be handed to them, following a discussion with the IO. 2.4a The Family Liaison officer will develop with families a leaflet that will be given by the IO as an aide memoire to their conversation with the family detailing the investigation process and signposting and support; this will form part of	2.4a Co-produce leaflet for families on the investigation process and support.	Elaine Ridley, Family Liaison Officer Helen Ludford, Associate Director of Quality Governance	Family First Involvement Group Chris Woodfine, Head of Engagement and Experience Investigating Officers	Sara Courtney, Chief Nurse	31/03/2017	Complete		March 2017 Leaflets have been developed with input from family workshops and the Family First Involvement Group and planned for publication by 31 March 2017. April 2017 leaflets printed - given to IOs on Investigating Officer training days. 31.07.17 SC validated this action is complete.	Families feel involved in the investigation as they wish to be.	31/12/2017	On track	Families understand how investigations will be conducted, how they can get involved and be signposted to appropriate support and advice	1.1 Leaflet for families on serious incident investigations.	1.1 Family Liaison Officer report
2.4b	Improving the way the Trust communicates and engages with families	2.4 Co-producing with families a leaflet that can be sent to all families following a death that explains how investigations are conducted, how the families can get involved, and signposts families to appropriate support and advice	2.4b Seek regular feedback from families regarding their experience of the investigation process	2.4b Undertake a quarterly survey of families' experience of the investigation process	Elaine Ridley, Family Liaison Officer Helen Ludford, Associate Director of Quality Governance	Family First Involvement Group Chris Woodfine, Head of Engagement and Experience Investigating Officers	Sara Courtney, Chief Nurse	31/12/2017	On track		March 2017 The Family Liaison Officer sent 15 questionnaires to families involved in investigations of deaths of loved ones. % questionnaires returned by date of report to Caring Group in March. Feedback positive re contact with IO and support given, however families say reports not easy to understand and unclear on what actions being taken by Trust. To repeat survey on quarterly basis. May 2017 ER completing quarterly surveys with families. June 2017 ER identifies all families where it is appropriate to send a survey. Has recently sent 4 surveys to families covering Jan - March 2017 period - has had 1 returned so far. This survey has positive feedback. ER will be discussing with family groups how best to gain feedback as a survey may not always be appropriate/best method of gaining feedback. Aug 2017 Survey of families on quarterly basis continues - however recognition that there are wider ways to	Families feel involved in the investigation as they wish to be.	30/04/2018	On track	Families report positive feedback in their involvement and support offered	1.1 Questionnaire appendix 1 Family Engagement FLO report 07/03/17 Caring Group. 1.2 FLO report June Caring Group. 1.3 Family First minutes	1.1 Family Engagement FLO report 07/03/17 Caring Group 1.2 FLO report June Caring Group 1.3 Patient surveys

UIN	Carolan Theme	Recommendation	Trust Actions	Process Input (measures)	Responsible Lead	Essential Partners	Executive Accountability	Process Completion Date	Process Status	Recovery date	Progress Update (Process)	Expected Outcome	Measuring Success Date (Outcome Completion)	Outcome Status	Outcome Measure	Evidence in folders (Process)	Evidence in folders (Outcome)
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 tDK Change Control Board oversee a range of training and guidance to ensure that Next of Kin data is completed in all care records	2.5a Amend the Next of Kin section on Rio to ensure that this field is made mandatory 2.5a Embed review of training and guidance for Next of Kin data within the Change Control Board Terms of Reference 2.5a Devise a Trust procedure on what staff should do if there is no Next of Kin data included	~~Paula Hull, Divisional Director of Nursing & AHP (ISD)~~ John Stagg, chair of Record Keeping and Care Planning workstream	Change Control Board Technology Transformation Team Sara Courtney, Chief Nurse	Paula Anderson, Director of Finance	31/10/2017	Completed-unvalidated		May 2017 Performance on meeting next of kin recording has been added to Tableau and is monitored closely by divisions. Inconsistent performance with some teams very high % of next of kin details recorded while other teams have low %. Section 8.3 of openRio Standard Operating Procedure and section 8.2 of SyStmOne Standard Operating Procedure has instructions to staff on recording next of kin data. These are to be updated with clarification regarding recording information where there is no known next of kin or the patient declines to give next of kin details. June 2017 Next of Kin figures are included in reports on Tableau so teams able to check performance. Aug 2017 N of K data reviewed weekly by Trust Executive Group - on 22 Aug compliance for N of K recorded for total caseloads was ISD 80.8%; OPMH 85.1%; MH 74%; LD 84.5%. Target is 80% patients have N of K recorded. Sept 2017 on 14 Sept Nof K for total case loads was recorded ISD 85% OPMH 85% MH 76%. LD 84%. CW attended RKCP meeting- agreed NOK recording on RIO was fit for purpose and NOK page on RIO amended. Oct 17 Julie Dawes weekly message on 30th Oct expressed a positive example of the importance of recording NOK.	A strengthened process for Next of Kin recording is standardised across the Trust with staff understanding that this is a crucial aspect of clinical record-keeping and care planning.	31/10/2017	Completed-unvalidated	Next of kin recording is in place consistently across the Trust	1.1 OpenRio/SystmOne Standard Operating procedures re Next of kin	1.1 Rio standard operating procedure re NOK 1.2 Tableau report NOK 18.8.2017 1.3 Message from Chief Exec
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	31/10/2017	Completed-unvalidated		May 2017 Performance on meeting next of kin recording has been added to Tableau and is monitored closely by divisions. Inconsistent performance with some teams very high % of next of kin details recorded while other teams have low %. Not yet meeting 80% target set by Trust across all divisions. June 2017 N of Kin figures are improving - some services eg specialised services need to cleanse caseloads on RiO. Aug 2017 on 22 Aug compliance for N of K recorded for total caseloads was ISD 80.8%; OPMH 85.1%; MH 74%; LD 84.5%. Target is 80% patients have N of K recorded. Compliance figures for patients seen in last week/month are higher. Sept 2017 on 14 Sept Nof K for total case loads was recorded ISD 85% OPMH 85% MH 76%. LD 84%. CW attended RKCP group -the consent to share form on RIO was being reviewed OCT 17, Exec flash report on 30.10.17 for NOK/ other relationships total caseload was recorded ISD 83.5%, OPMH 86%, MH 76.2% and LD 85% Oct 17 the trusts expectations of 80% complience rate with recording N O K data is happening across the board apart from MH although this is improving and will continue to be monitored by the CQC action plan.	A strengthened process for Next of Kin monitoring is in place across the Trust	31/10/2017	Completed-unvalidated	A metric is developed on Tableau for monitoring next of kin data	1.1 screenshots of tableau	
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 Deliver a families workshop to understand their perspective on barriers to engage 2.5c Understanding the staff perspective on blocks to information sharing 2.5c Workshops involving family, service users and staff to develop guidance	Chris Woodfine, Head of Engagement and Experience	Lesley Barrington, Head of Information Governance MH division Sarah Cole, Family Therapist Specialised Services		31/10/2017	Completed-unvalidated		A family workshop was delivered in January and February 2017 which were highlighted that information sharing was a primary issue The IG training resources now include the consensus statement on information sharing and suicide prevention. May 2017 'Confidentiality' workshop for staff in development. 24.5.17 Sharing Information workshop. Information governance team to rewrite information sharing leaflet based on feedback and reflecting what used by other trusts. June 2017 draft of revised Information Sharing leaflet will be shared with Family First Group in July. Aug 2017 draft information sharing leaflet sent for comments - to be returned by end Aug. Sept 17 information sharing leaflet finalised and circulated .	Staff are competent in managing confidentiality and information sharing with families	31/03/2018	On track	RiO records show the judgements staff have made on information sharing when working with families and service users	1.1 Sharing Information workshop agenda/materials 24.5.17	
2.6a	Improving the way the Trust communicates and engages with families	2.6a Keeping families fully informed of the progress of the investigation and making this an explicit part of the Investigating Officer's role	2.6a Provide better training for Commissioning Managers as practice	2.6a Scoping of improved training for Commissioning Managers on the SIRI procedure which should be standardised across the Trust 2.6a Ensure roll out of improved training for Commissioning Managers 2.6a Undertake an audit of the findings om implementing improved training of Commissioning Mangers	Elaine Ridley, Family Liaison Officer Helen Ludford, Associate Director of Quality Governance		Sara Courtney, Chief Nurse	31/12/2017	On track		Jan 2017 Role of the IO and CM included within the revised SIRI procedure. Investigating officer and commissioning manager role descriptions reviewed and updated version added to the SIRI policy. May 2017 SI policy/procedures to be reviewed once new national SI Framework. More CM training planned. June 2017 Review of IO role includes feedback on the role of commissioning manager - this review is currently being written up. Aug 2017 Revie wof IO roles found that IO and CM roles were not always clear and boundaries were blurred. Oct 17 Further IO traing dates set for November 17. IO and CM roles are discussed. Recent CM training was cancelled due to low uptake. E-learning traing for CM will be developed by 31.03.18.	There is clarity on the roles for the Investigating Officer, Commissioning Manager and Family Liaison Officer and that these roles have an appreciation of the importance of keeping families involved on the progress of the investigation	31/12/2017	On track	Robust and clear descriptors and expectations of Trust staff roles who are involved in the investigation process	1.1 Policy for Managing Incidents and Serious Incidents 1.2 Procedure for the Reporting and Management of Serious Incidents 1.3 Review of IO role	1.1 IO report
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	31/07/2017	Completed-unvalidated		Jan 2017 Investigating officer (IO) and commissioning manager (CM) role descriptions reviewed and updated versions added to the SIRI policy. May 2017 Serious Incident Policy will be reviewed once national Serious Incident framework is published- to include job description of FLO. June 2017 Policy has job descriptions of IO and CM included. SI training includes information on all 3 roles. FLO presents session on duty of candour. July 2017 Policy (10.7) has reference to FLO and Procedure (4.5)	There is clarity on the roles for the Investigating Officer, Commissioning Manager and Family Liaison Officer and that these roles have an appreciation of the importance of keeping families involved on the progress of the investigation	31/12/2017	On track	Robust and clear descriptors and expectations of Trust staff roles who are involved in the investigation process Review of FLO role underway	1.1 Policy for Managing Incidents and Serious Incidents 1.2 Procedure for the Reporting and Management of Serious Incidents 1.3 Review of Io role	1.1 IO report
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 FLO to attend governance and business meetings across divisions to raise awareness of her role and follow up after 6 months 2.7a Investigating Officer makes contact with the FLO via the IMA panel	Elaine Ridley, Family Liaison Officer	Investigating Officers	Sara Courtney, Chief Nurse	31/12/2017	On track		May 2017 FLO is regularly attending the Caring Group and makes contact with Investigating Officers and attends panels. FLO has attended some governance meetings in services and will continue to go out to teams.FLO is receiving referrals from IO. Sept 2017 thematic review of FLO role initiated in quality governance team. June 2017 referral form to FLO is sent to the appropriate team by central SI team when notifying them re a SI. FLO reports summarise the number of families working with. Review of IO role - results currently being written up. Aug 2017 FLO attending divisional meetings and complaints team meetings to discuss role and support offered.	FLO post is embedded within the Trust	30/06/2017	Complete	FLO receives referrals from Investigating Officers in a timely manner. 31.07.17 SC validated action as complete.	Caring group minutes LC IO review FLO reports SI Policy and Procedures divisional meetings minutes customer experience team minutes where FlO attended	FLO reports
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 Family Liaison Officer to identify the key resources that families may need access to 2.7b FLO to develop a resource bank of community resources	Elaine Ridley, Family Liaison Officer	Third sector networks (external)	Sara Courtney, Chief Nurse	31/12/2017	On track		June 2017 FLO has links with suicide prevention support groups and signposts families to as appropriate. FLO met with police FLO representatives from Cornwall to discuss adapting training currently offered to police FLO for use across NHS with contact to be made with NHSE re launch of training nationally. Sept 2017 FLO has a number of resources in place and tailors resources/information shared to the individual family. Thematic review of FLO post is underway.	Families receive information for support according to their needs	30/06/2018	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		1.1 Information leaflet for families 1.2 example of FLO referral
2.8	Improving the way the Trust communicates and engages with families	2.8 Providing a central telephone number and email address for families so that they can contact the investigating team and not be reliant upon Investigating Officers who may have changed role or changed organisation	The Trust accepts the principle that families need to contact someone who is informed. 2.8a Commissioning Managers to create a communications plans with families at the outset and ensure that there is a proactive mechanism for advising families upon change of IO	2.8a Communication plans to be created including contact details of CM and IO Also covered under action 2.4a and 4.6a	Commissioning Managers	Investigating Officers	Sara Courtney, Chief Nurse	31/10/2017	On track		June 2017 leaflet for families regarding investiagtions has space to add in IO and FLO's name and contact details. Aug 2017 Review of IO role found role of commissioning manager/IO not always clear. Sept 2017 IO report shows that training is running for IO and CM, the resposnity of role to be reliterated back to divisions	Staff provide the right contact details to the families and that there are clear processes of handover when a staff member changes their role	31/12/2017		All investigations to have in place a communication plan with families		
3.1	Increasing the competency of staff to engage with families	3.1 Co-producing with families training for staff on engaging with families	3.1a Conduct a review of training for staff on the importance of engaging with families in investigations with input from the Family First Involvement Group.	3.1a Conduct a review of training for staff on the importance of engaging with families in investigations with input from the Family First Involvement Group. 3.1a Conduct a training needs analysis with IOs and CMs 3.1a Review of the training programme	Helen Ludford, Associate Director of Quality Governance	Chris Woodfine, Head of Engagement and Experience	Sara Courtney, Chief Nurse	31/10/2017	Complete unvalidated		May 2017 SJ, Head of Essential Training, reviewing the training portfolio to see how family involvement currently reflected in training and then to look at how to weave principles of family involvement in all relevant training. June 2017 initial results of overview of training /family involvement discussed at QIPDG 27.6.17. CW to invite SJ to Families First Group August meeting to help inform next steps. Sept 17 Thematic review of IO role included feed back on training. any recommendations will be included in ext IO training. Oct 17 SJ attended familys first group and agreed to add standard priniciples of involving familys.	Training for Investigating Officers and CMs are co-produced with families	31/12/2017		Training for Investigating Officers and CMs are co-produced with families		
3.2	Increasing the competency of staff to engage with families	3.2 Involving families in the delivery of training to staff, which can be achieved through co-delivery of the training, or through video or written case studies/testimonies.	3.2a The training content includes personal stories, videos, case studies/testimonies	3.2a Scope improved training programme including training content 3.2a The training content includes personal stories, videos, case studies/testimonies 3.2a Include and implement competency documents to assess fitness to practice and testing communication skills of staff training as well as best practice models	Elaine Ridley, Family Liaison Officer	Chris Woodfine, Head of Engagement and Experience Learning Education and Development (LEaD)	Sara Courtney, Chief Nurse	31/12/2017	On track		May 2017 CW to link with SC training lead who is undertaking a review of competencies staff require for care planning, risk assessment. June 2017 initial results of overview of training /family involvement discussed at QIPDG 27.6.17. CW to invite SJ to Families First Group July meeting to help inform next steps. Oct 2017 SJ from LEaD to attend Families First group in October to discuss training needs re patient experience/engagement. 'Telling your story' workshop to take place in Nov - an AMH family member has signed up already. Family Nurse Partnership also has a young person who is happy to tell their story.	Training resources includes personal accounts of families	31/12/2017	On track	Training resources includes personal accounts of families		
3.3	Increasing the competency of staff to engage with families	3.3 Increasing the amount of training on working with families offered to Investigating Officers as part of their core training	Training for Investigating Officers and also crucially for Commissioning Managers will align within the context of the Trust position statement on engaging with families following death of a service user 3.3a Deliver the training programme as defined by action 3.2	3.3a Training to be made available online or a folder resource 3.3a Ensure roll out of training programme through LEaD	Helen Ludford, Associate Director of Quality Governance	Learning, Education and Development (LEaD)	Sara Courtney, Chief Nurse	31/03/2018	On track		June 2017 FLO/Chaplain have developed training for IOs on how to share reports with families. IO training is revised prior to each delivery to ensure any recent updates/changes to procedures are delivered. Review of IO role has included feedback on training - review currently being written up. Aug 2017 draft report on review of IO role circulated for final approval.Findings will be used to amend IO training as needed. Sept 2017 Report on review of IO role presented to TEC for discussion - report well received. IO training already has information on working with families.	Staff have a detailed resource on training for their roles as Commissioning Manager and Investigating Officer	30/06/2018	On track	Undertake an audit on implementation of improved training for Commissioning Managers and IOs		

UIN	Carolan Theme	Recommendation	Trust Actions	Process Input (measures)	Responsible Lead	Essential Partners	Executive Accountability	Process Completion Date	Process Status	Recovery date	Progress Update (Process)	Expected Outcome	Measuring Success Date (Outcome Completion)	Outcome Status	Outcome Measure	Evidence in folders (Process)	Evidence in folders (Outcome)
3.4	Increasing the competency of staff to engage with families	3.4 Developing person specifications for the Investigating Officer role that includes the competencies needed for successfully engaging with families	Training for Investigating Officers and also crucially for Commissioning Managers will align within the context of the Trust position statement on engaging with families following death of a service user 3.4a Review the role description and person specification for the CM and IO role and develop specific competencies	3.4a Undertake a review job descriptions of the IO, CM and FLO 3.4a Ensure clarity of roles and responsibilities 3.4a Include competencies needed for successful engagement with families	Helen Ludford, Associate Director of Quality Governance	Associate Directors of Nursing & AHPs (all divisions)	Sara Courtney, Chief Nurse	31/07/2017	Completed-unvalidated	08/09/2017	May 2017 job descriptions reviewed. June 2017 Review of IO role - will make recommendations as to any further changes required in job descriptions. IO and CM job descriptions are included in SI Policy. 31.7.17 draft IO review report being finalised. Aug 2017 draft report on review of IO role circulated for final approval.Findings will be used to amend IO training as needed. 31.08.17 Final report to be presented to TEC on 13.09.17 for approval.	IOs and CMs are clear about their roles and meet the person specification	31/07/2017	On track – action required amending as original action did not produce desired outcome.	Robust and clear descriptors and expectations of Trust staff roles who are involved in the investigation process		1.1 Report IO role
3.5	Increasing the competency of staff to engage with families	3.5 Providing clarity about the role of lead Investigating Officers in supporting Investigating Officers with the role	As covered in action 3.4. In addition: 3.5a To review the capacity of the central investigation team	3.5a To review the capacity of the central investigation team 3.5 Produce a business case following the review as appropriate	Helen Ludford, Associate Director of Quality Governance	SIRI team	Sara Courtney, Chief Nurse	30/06/2017	Completed-unvalidated	30/09/2017	May 2017 project to review investigating officer role underway - will look at capacity;training and feedback on the role. June 2017 Review currently being up - business case will need to be made based on results. Aug 2017 draft report on review of IO role circulated for final approval.Business case to be made based on findings. 31.08.17 Final report to be presented to TEC on 13.09.17 for discussion. Oct 2017 Report well received at TEC - did not agree to centrally fund additional lead IO posts as recommended but that divisions need to make a business case to increase IO capacity if they wished to do so. HL to meet with ADONS for MH and LD to look at business planning for 2018 with regards tI IO model.	There is clarity on the roles for the Investigating Officer, Commissioning Manager and Family Liaison Officer and that these roles have an appreciation of the importance of keeping families involved on the progress of the investigation	31/10/2017	On track – action required amending as original action did not produce desired outcome.	Robust and clear descriptors and expectations of Trust staff roles who are involved in the investigation process	1.1 Investigating Officer Review terms of reference	
3.6	Increasing the competency of staff to engage with families	3.6 Providing peer support opportunities and administrative help for Investigating Officers	3.6a To assess the IOs need for supervision and support and devise a programme	3.6a Undertake an anonymised questionnaire survey and quantitative analysis of current lead Investigating Officers to ascertain their experience of role so far, and clarify what resources they may require 3.6a Commission Psychologists to review roles and conduct an analysis and feedback 3.6a Develop a peer support network of lead Investigating Officers 3.6a Scope a programme of psychological supervision for divisional investigating Officers	Helen Ludford, Associate Director of Quality Governance Hazel Nicholls, Clinical Director, Primary Care & IAPT	Lead IOs Divisional IOs	Sara Courtney, Chief Nurse	31/10/2017	Completed-unvalidated		June 2017 review of IO role underway with results being written up currently. Monthly Lead IO supervision meeting in place. Oct 2017 Report on review of IO role presented to TEC in Sept and well received. Lead IOs receive monthly supervision with HL. 3.6a part 2 superseeded by IO report. Lead IO and CM to support IO should be clarified at 48 hour panel. Need to scope programme of psychological support for divisional IOs- Indivdual staff members can access psychological support as required (H.L)	Staff have a strong network of support and information sharing to enable their role competencies	31/12/2017	On track	Staff have a strong network of support and information sharing to enable their role competencies	1.1 Report IO role	1.1 Lead IO supervision minutes
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					Completed-unvalidated					On track – action required amending as original action did not produce desired outcome.			
4.2	Improving the quality of reports	4.2 Giving families access to findings of any investigation including interim findings.	4.2a Establish a protocol on sharing interim findings with families whilst maintaining factual accuracy and adhering to timescales	4.2a Establish a protocol on sharing interim findings with families whilst maintaining factual accuracy and adhering to timescales	Helen Ludford, Associate Director of Quality Governance	Elaine Ridley, Family Liaison Officer Families with experience of an investigation	Sara Courtney, Chief Nurse	30/09/2017	Overdue		June 2017 discussed at Family First Group and agreed that it is not always appropriate to share interim/un - redacted reports eg if police are involved. Agreed that it is best practice to share an interim report byt will need to consider on a case by case basis. Sharing of interim draft reports is included in IO training and in the Sharing Reports training. Need to include this requirement in the SI Policy and Procedures. Sept 2017 need to consider sharing of draft reports on case by case basis. More dates for training on 'sharing reports' circulated.	Reports are accurate and sensitive to the feelings of the families	31/12/2017		Reports are accurate and sensitive to the feelings of the families	1.1 IO training 1.2 Sharing Reports training SI Policy and procedure	
4.3	Improving the quality of reports	4.3 Giving families the opportunity to respond/comment on the findings and recommendations outlined in the final report and be assured that this will be considered as part of the quality assurance and closure process undertaken by the commissioners	4.3a Ensure that families are given the opportunity to comment on the findings and that this is a clear step in protocol	4.3a Ensure that families are given the opportunity to comment on the findings and that this is a clear step in protocol	Helen Ludford, Associate Director of Quality Governance	Investigating Officers	Sara Courtney, Chief Nurse	31/12/2017	On track		June 2017 discussed at Family First Group and agreed that it is not always appropriate to share interim/un - redacted reports eg if police are involved. Agreed that it is best practice to share an interim report byt will need to consider on a case by case basis. Sharing of interim draft reports is included in IO training and in the Sharing Reports training. Need to include this requirement in the SI Policy and Procedures.	Reports are accurate and sensitive to the feelings of the families	31/03/2018	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	4.4a Revise SIRI procedure to include the updated action plan to be shared with families subject to families agreement	As covered in action 2.1a and 2.3a. In addition: 4.4a Action planning with families to be monitored at the WAGs and MOMs 4.4a Revise the SIRI procedure to include that the IO should establish with families on an individual basis whether they would like to see the updated action plan	Helen Ludford, Associate Director of Quality Governance	Complaints Working Group Family First Involvement Group Mortality Forum	Sara Courtney, Chief Nurse	31/12/2017	On track		June 2017 progress with SI action plans being completed is on tableau and monitored at Quality Improvement and Planning Delivery Group. Need to amend SI Policy and Procedure to capture this action.	Families are informed where they wish to be of progress made on agreed actions	31/12/2017		Families are informed where they wish to be of progress made on agreed actions		
4.5	Improving the quality of reports	4.5 Writing the report in plain English, avoiding jargon, or provide comprehensive glossary of terms and a list of abbreviations	4.5a Ensure that the reports are written in plain English, avoiding jargon, or provide comprehensive glossary of terms and a list of abbreviations	4.5a A new revised checklist to be incorporated into the Area and Trust Corporate Panels to including the criteria that all reports must be written in plain English 4.5a Each divisional SIR panels and corporate SIRI panel will have a lay member representative 4.5a Provision of a checklist for Ulysses, to ensure that the author includes a glossary 4.5a Develop training or resources for staff on report writing	Helen Ludford, Associate Director of Quality Governance	Associate Director of Nursing & AHPs (all divisions) Investigating Officers Tom Williams, Ulysses System	Sara Courtney, Chief Nurse	31/12/2017	On track		May 2017 quality of serious incident reports is being reviewed. Workshop on best practice in June 2017. June 2017 Corporate panel feeding back when reports are not clear. Aug 2017 CCG postive feedback re quality of SI reports.Increase over time in the number of SIs which are approved first time at Commissioner SI panel reflects increasing quality. Oct 2017 Niche draft auidt report of SI and Moratlity action plan recognises improvements made in trust in SI investigations although still further improvements to be made. Childrens services and LD services have lay member on panels.	All reports are clear and easy to understand for families	30/06/2018		All reports are clear and easy to understand for families Childrens and LD already have lay membes on panel, AMH mortality have a lay person about to start	1.1 North Hants CCG email re quality of SI	
4.6	Improving the quality of reports	4.6 When families do not feel able to engage with the investigation immediately following the death of their loved one, ensuring that they have the opportunity to raise questions and concerns and input into the review at a time of their choosing	4.6a Ensure adherence to timescales of the 60 day limit whilst also ensuring that staff are aware that they should open the investigation at any stage/allow an opportunity for discussion with the families	As covered in action 2.8a. In addition: 4.6a Communications plan to include detail/note of family preference for timely contact 4.6a Ensuring that SIRI procedure details clear arrangement for point of contact following closure of an investigation	Investigating Officer		Sara Courtney, Chief Nurse	31/12/2017	On track		June 2017 100% of SIs were meeting 60 day deadline for uploading of quality SI report approved by commissioners onto StEIS. There has been agreement to extend a small number beyond the 60 deadline at family's request when further time to review the report has been requested. Aug 2017 94% 15/16 SI uploaded within 60 day target - first time in 12 months that there has been a breach - had achieved 100% since June 2016.	Families are able to be involved at a time that is suitable to them	31/03/2018		Families are able to be involved at a time that is suitable to them		
4.7	Improving the quality of reports	4.7 Considering how the resulting improvements in services following changes recommended by investigations can be measured	4.7a Develop mechanisms for feedback from families to enable Trust to measure changes in involvement of families in investigations	4.7a Generate qualitative data from surveys and interviews with families to evidence families' involvement 4.7a Evidence of families attending the Improvement Panel to observe the improvements made as a result of the recommendations from the investigations 4.7a Inviting families to visit the service to illustrate the changes 4.7a Consider a review to be repeated in 2 years time to ascertain embedding of improvements	Elaine Ridley, Family Liaison Officer Helen Ludford, Associate Director of Quality Governance Associate Director of Nursing & AHPs (all divisions)	SIRI team	Sara Courtney, Chief Nurse	31/03/2018	On track		May 2017 FLO is sending questionnaires to families for feedback. Results are included in reports to Caring Group. June 2017 FLO completing quarterly survey of families and is also exploring how best to gain feedback from families as survey not always most appropriate method. A family member is going to attend an Evidence for Improvement panel soon. Aug 2017 Quarterly surveys of families continues - with discussions ongoing about how to request feedback as surveys not always most appropriate method. Family memebr to attend evidence of improvement panel in late 2017. Sept 2017, 1 family member to attend Evidence of improvement panel 29/9/17. MH offered family to visit site, however the family declined. FLO will feed back to staff ,actions i.e carparking and signage to Melbury lodge. FLO to then go back to families.	Families are assured that the improvement within the services are embedding following the actions developed from the recommendations of the investigation have been completed	31/06/2018		Survey responses are positive and attendance levels of families at improvement panels	FLO reports Evidence of improvement panels Southfield carers work	

process	
Overdue	3
At Risk of Slippage	0
On Track	14
Blanks	2
Completed-unvalidated	15
Complete	7
Sub Total*	41
Duplicate	0
Absolute total	41

outcome	
Overdue	1
At Risk of Slippage	0
On Track	21
Blanks	10
Completed-unvalidated	8
Complete	1
Sub Total*	41
Duplicate	0
Absolute total	41

NHS
Southern Health
NHS Foundation Trust

Building confidence

6,000 STAFF

Improving care today, planning for the future

Includes a summary of our annual report 2016/17

SERVING A POPULATION OF 1.3million

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.**

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

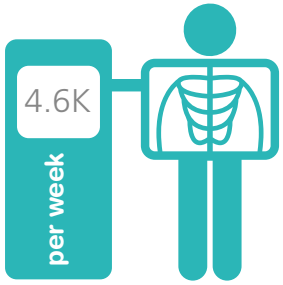
X **240,000** INDIVIDUAL PEOPLE CARED FOR EACH YEAR

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

£300 million FUNDING

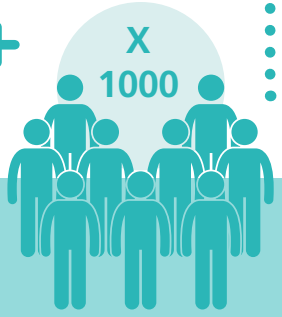
6,000 STAFF

4,600 OUTPATIENT APPOINTMENTS EACH WEEK



SERVING A POPULATION OF **1.3million**

9,000 + PUBLIC MEMBERS



PATIENTS RECEIVED CARE IN OUR HOSPITAL BEDS FOR A TOTAL OF **247,000 days in 2016/17**

1.5million CONTACTS WITH PEOPLE IN THE COMMUNITY EACH YEAR

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.

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.

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

SPOTLIGHT:

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.

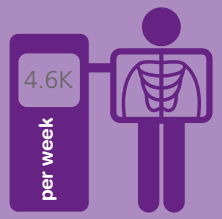
"I just can't thank the team enough. We feel so supported and the care we have received has been first class, we have felt involved right from the start and really feel they genuinely care about my father. Meeting Ally and Abby and her team, it's so evident that for them it's not a job, it's a passion."

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:

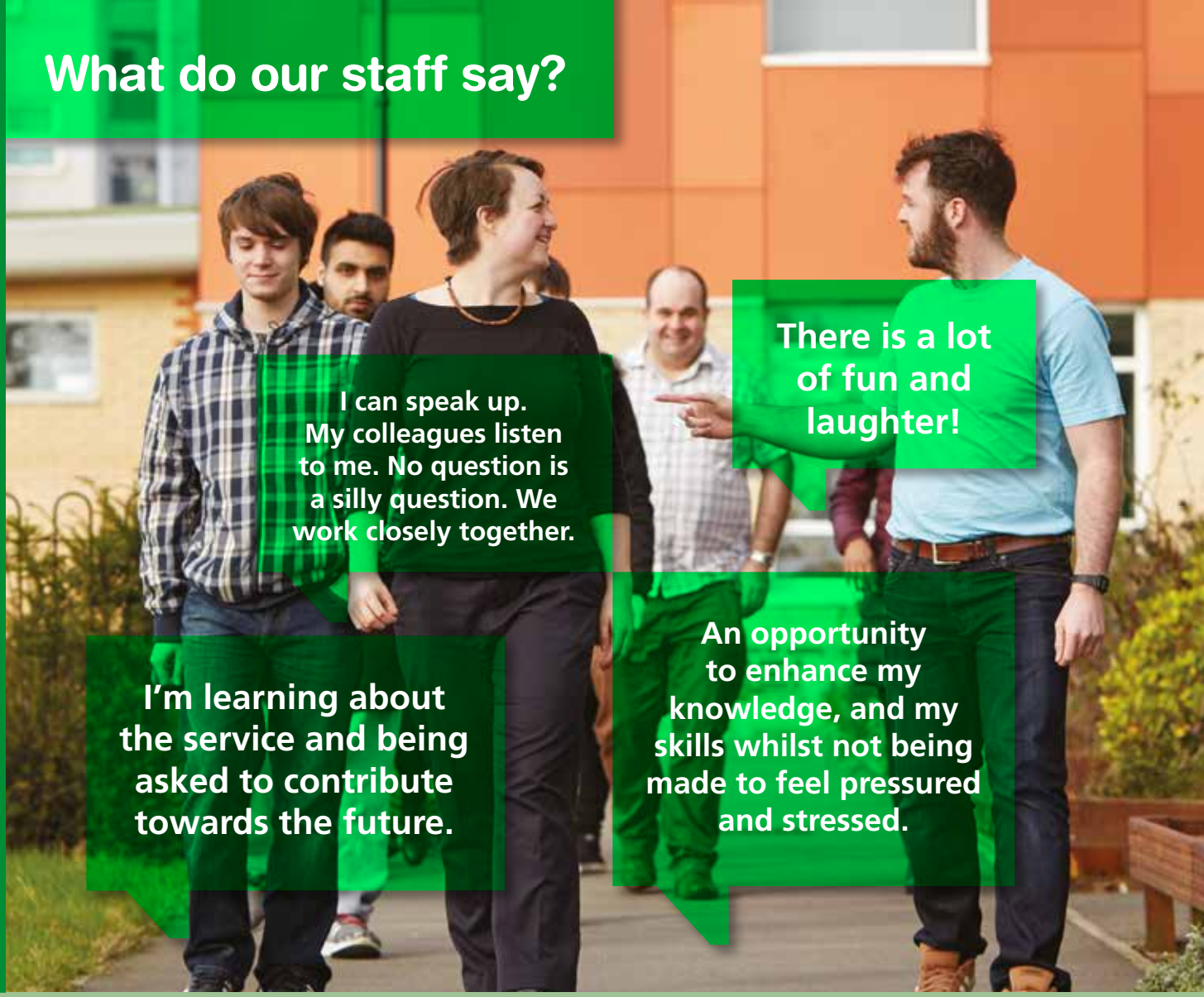
Fantastic feedback for our Older People's Mental Health Team in Havant

"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?



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

£300 million FUNDING

Money

Making the best use of resources and balancing our books

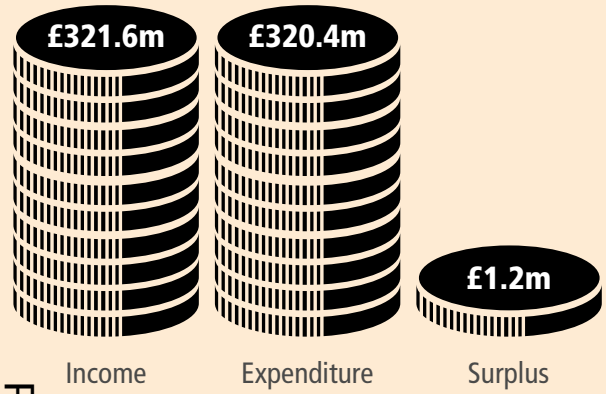
This has been a difficult year for NHS finances, with around half of all Trusts spending more money than they received, to a total deficit of around £800million nationally. In order to balance our books, locally, we made savings of about £10million. We also benefited from extra funding which had been 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.

Some of the big challenges facing our finances include:

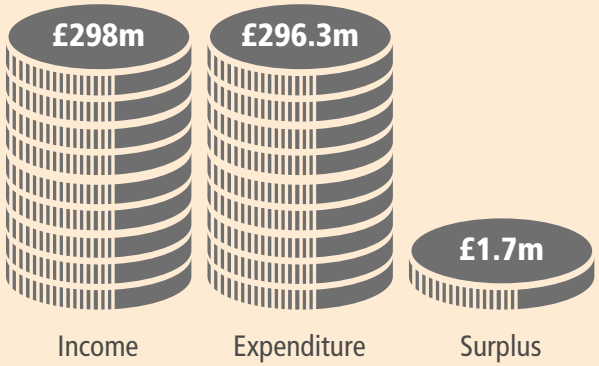
- The amount we spend on agency staff, including locum doctors and nurses, due to difficulties recruiting and retaining permanent staff.
- The cost of placing mental health patients in beds provided by other organisations, because we are unable to discharge patients from our own beds to the community 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%	✗	

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

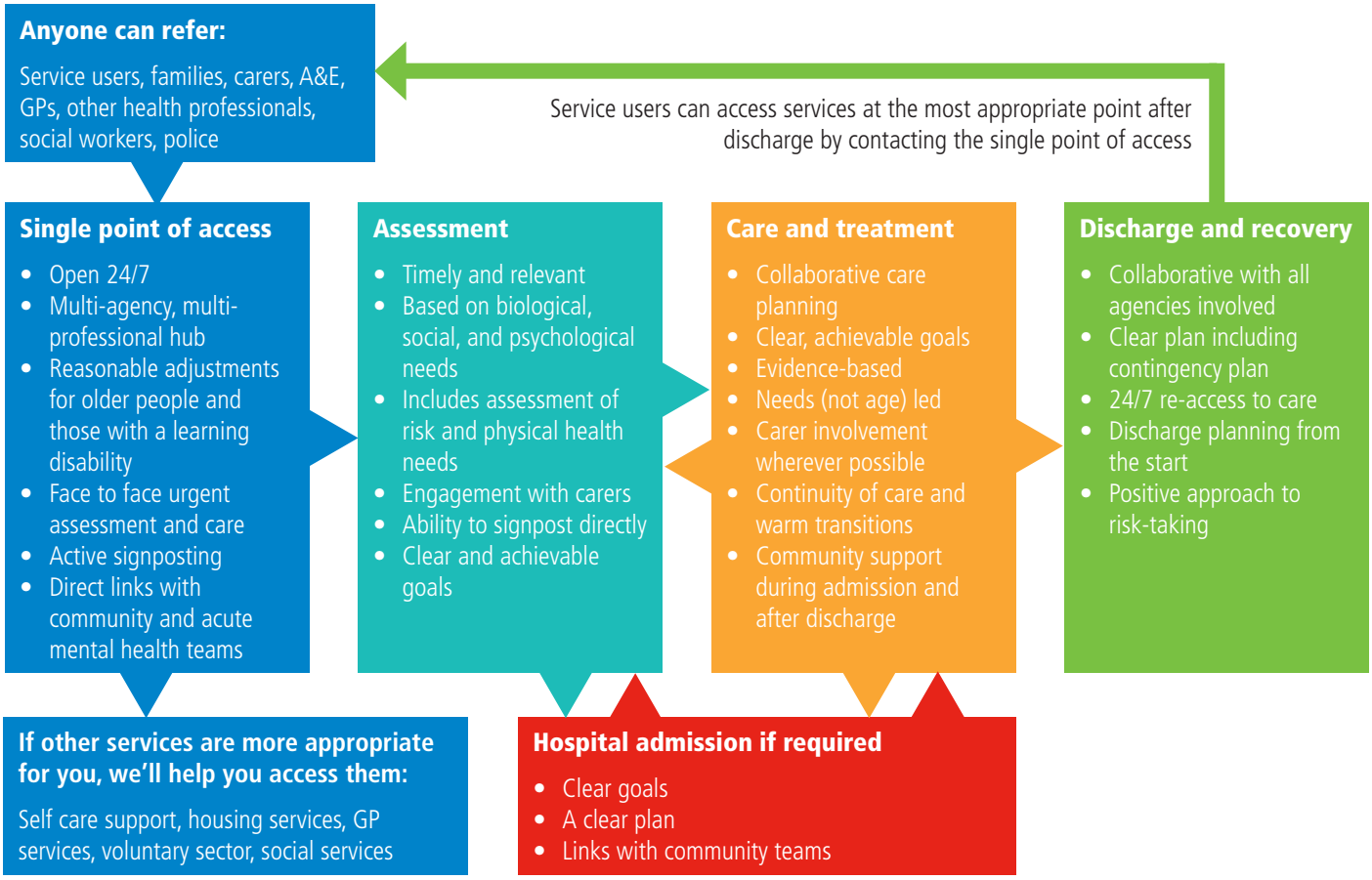
CS45892 – NHS Creative – August 2017

Clinical Services Strategy

Mental health and learning disabilities

NHS
Southern Health
NHS Foundation Trust

Service pathway



Service design principles

- To provide high quality, safe, person-centred and holistic services which improve the health, wellbeing and independence of the people we serve
- To deliver needs-led services, which are timely, proactive and easy to access, 24/7
- Having the right people doing the right job, taking ownership and pride in good communication
- A recovery-focused approach, with a positive attitude to strengths, resilience and risk taking, and which is adaptable to change
- Continuity across boundaries and transitions, removing the barriers

Learn more:
www.southernhealth.nhs.uk/futureservices

Service priorities

- We will actively involve, engage and include service users, families and carers in service delivery and design
- We will improve access to services via a single point of access for all requests accompanied by a culture of supporting requests for help and providing needs-led pathways
- We will transform the urgent care pathway to deliver responsive, reliable, high quality care 24/7 including developing alternatives to admission
- We will improve outcomes for those who use our services the delivery of needs-led, evidence based pathways reduce variation whilst linking into local delivery systems of care
- We will deliver consistent, purposeful, needs-led inpatient care across the trust when it is needed
- We will develop our tertiary (specialist mental health) services to provide care across a complete pathway with pathways that are consistent across the trust
- We will increase access to italk and work with the system to explore primary care based mental health services to keep people well

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HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Adult Social Care Select Committee
Date:	21 November 2017
Title:	Adult Safeguarding Update
Report From:	Director of Adults' Health and Care

Contact name: Jo Lappin, Head of Safeguarding, Quality and Governance

Tel: 01962 847971 **Email:** Jo.Lappin@hants.gov.uk

1. Executive summary

1.1 The purpose of this report is to provide the Health and Adult Social Care Select Committee with an annual update on Adult Safeguarding. This update (as well as completed integral appendices A and B) is provided within the attached Cabinet report (appendix 1).

Recommendations

2.1 That the Health and Adult Social Care Select Committee:

a) Note the content of this report.
b) Receives a further update on Adult Safeguarding in 12 months' time.

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HAMPSHIRE COUNTY COUNCIL

Decision Report

Decision Maker:	Cabinet
Date:	15 September 2017
Title:	Adult Safeguarding
Report From:	Director of Adults' Health and Care

Contact name: Jo Lappin, Head of Safeguarding, Quality & Governance

Tel: 01962 847971 **Email:** Jo.lappin@hants.gov.uk

1. Executive summary

1.1. Adult safeguarding is a core duty of Hampshire County Council. The term adult safeguarding is a term used to describe a broad range of activities and responsibilities to protect adults vulnerable to a range of behaviours which could directly impact upon their welfare and wellbeing. This report provides an overview of developments and actions undertaken by Adults' Health and Care, the County Council and a range of partners in protecting the wellbeing of vulnerable adults in Hampshire.

1.2. Notable issues include the lead role Hampshire Safeguarding Adults Board (HSAB) has in leading the Inter Authority Working Group across the wider Hampshire and Isle of Wight area, the development of responses to increasing awareness to adult safeguarding and the new systems and processes implemented to help mitigate this and the continuing pressures brought about in supporting people with limited or no capacity to manage key decisions relating to finance, accommodation and other key areas of their lives. Particular risk has been identified previously with regard to this area, Deprivation of Liberty Safeguards (DoLS), and this issue is detailed in this report. There are numerous positive elements of the adult safeguarding function that are identified including Hampshire County Council's work with partners, such as the continued development of the Multi-Agency Safeguarding Hub (MASH), responses to emerging forms of abuse and increased activity through traded opportunities in the Client Affairs Service (CAS).

1.3. Therefore, this report provides Cabinet with a detailed insight into the activities undertaken to keep vulnerable adults across Hampshire safe and to identify priorities over the coming year.

2. Context

2.1. Prior to the introduction of the Care Act 2014 Adults' Health and Care operated an effective system to deal with adult safeguarding concerns in a

responsive and consistent way of following allegations of abuse or neglect. However, the introduction of statutory responsibilities for local authorities, Police and the NHS brought about by the Care Act 2014 has brought a change of emphasis and an enhanced focus on prevention and early intervention. The new safeguarding duties and responsibilities cover a wide range of activities and actions taken by a large number of individuals and organisations responsible for preventing, detecting, reporting and responding to the abuse of adults at risk. In a sense, the Care Act 2014 has therefore broadened the scope of adult safeguarding to include all activity designed to prevent harm from occurring, alongside our responsive duties following allegations of abuse or neglect.

2.2. For Adults' Health and Care much of the activity has continued to focus on embedding and implementing the changes brought about by the Care Act 2014 as well as maintaining high levels of operational performance in this area. This has included refocusing internal resources to ensure prevention and early interventions are given equal priority.

3. Hampshire Safeguarding Adults Board (HSAB)

3.1. Hampshire has an established Safeguarding Adults Board, the membership of which includes all multi-agency partners. A wide range of activities have been undertaken to ensure local arrangements are fit for purpose and are compatible with the new statutory requirements.

3.2. The policy framework for adult safeguarding is shared between the four local authority areas in Hampshire and the Isle of Wight and Hampshire Safeguarding Adults Board continues to lead the policy development work on behalf of the other 3 Pan Hampshire local authorities. The policy, guidance and toolkit have recently been revised to produce a second edition post Care Act 2104. They have now been ratified by the 4 Boards and have been published. These documents are supported by a suite of Hampshire Adults' Health and Care internal guidance and a comprehensive training strategy to support practice.

3.3. The Business Plan agreed in the spring of 2017 has the following Board objectives:

- Engaging local communities to ensure wide awareness of adult abuse and neglect and its impact
- Prevention and early intervention – promoting well being and safety and acting before harm occurs
- Well equipped workforce across all sectors
- Safeguarding services improved and shaped by the views of service users, carers and other stakeholders
- Clear effective governance processes are in place within and across organisations
- Learning from experience – mechanisms to gain learning from serious cases and promote service and practice improvement.

3.4. The Hampshire Safeguarding Adults Board Chair has recently taken over the chairing of the Inter Authority Working Group which aims to have strategic oversight and co-ordination of the safeguarding agenda across the Pan Hampshire area. A discussion paper is in development with proposals to improve the co-ordination. It is hoped the proposals will be welcomed by many agencies such as Hampshire Constabulary and Hampshire Fire & Rescue Service who work across the area. It is recognised that for some organisations the obligation to a high number of separate safeguarding boards and sub groups is challenging and may not be sustainable.

4. PREVENT

4.1. The Counter Terrorism and Security Act 2015 created a statutory duty to have due regard to the need to prevent people being drawn into terrorism. This duty applies to all public bodies (local authorities, police, NHS, schools, further and higher education providers, probation, prisons and youth offending services). The duty also applies to private providers supplying public functions for example, in the education sector. Previously, the lead responsibility for PREVENT lay with the police, however, local authorities now have the lead as PREVENT interventions are focused in the 'pre criminal space'.

4.2. Hampshire has a well established PREVENT Partnership Board whose role is to provide a consistent and co-ordinated response across Hampshire and the Isle of Wight to the ideological challenge of terrorism. This is achieved through oversight of PREVENT activities across the area and ensuring PREVENT is addressed, as appropriate, in strategic plans and strategies.

4.3. The Hampshire PREVENT Partnership Board brings together agencies who provide services across Hampshire to share guidance, strategic work and improve co-ordination, however, in terms of governance the three neighbouring local authorities have their own delivery arrangements.

4.4. The Board has agreed a PREVENT Strategy and Action Plan which is monitored by the Board.

4.5 A Home Office led peer review of the County Council's arrangements for PREVENT took place in July 2017. This involved the engagement and participation of a wide range of stakeholders and partners.

4.6 The final report detailing the outcomes of the review is awaited. However, feedback provided at the conclusion of the review identified a number of strengths identified in our local arrangements, including:

- the leadership of the PREVENT Board and PREVENT agenda locally;
- a strong desire to learn and improve local operational practice across agencies; and

- a well developed self assessment, action plan and documented arrangements to support the operational delivery of PREVENT responsibilities.

4.7 The self assessment and review process also identified areas for improvement which are being implemented. These include amendments to some aspects of the overall governance architecture and broadening the officers involved in leading PREVENT, beyond a small number of safeguarding and specialist professionals. There is also an undertaking to work with the South East Counter-Terrorism Unit (SECTU) to further develop and publicise the risk profile of Hampshire into a more dynamic tool and to ensure it is understood more widely across partner organisations.

5. Activity

5.1. Over the last few years Adults' Health and Care have continued to make improvements to the capture and reporting of safeguarding information, as a result of these changes it may not always be possible to directly compare activity between years. The Care Act 2014 has also redefined how safeguarding is defined and recorded.

5.2. The vast majority of safeguarding concerns are now directed to the Adult Multi-Agency Safeguarding Hub (MASH) where staff review them in relation to the action required, consider multi-agency information sharing and proportionality. This enables the services to ensure that concerns that require a different response, for example a review of the care arrangements, are dealt with by the social work teams and not through safeguarding arrangements.

5.3. The nature of concerns reported to Adults' Health and Care are often on a continuum of poor quality care through to extremely serious abuse carried out where police investigation is required. Information gathering is required before a decision can be reached to establish if abuse or neglect has taken place.

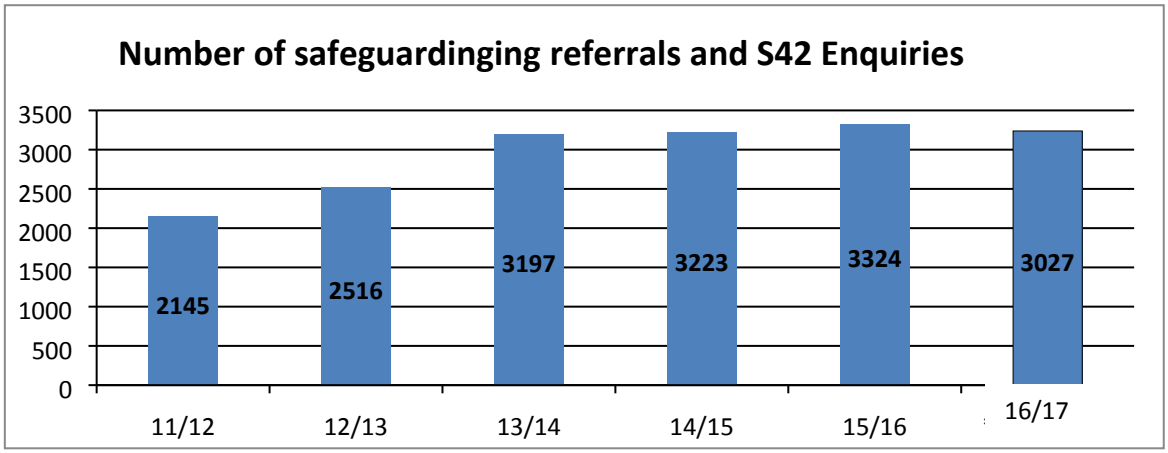
5.4. MASH screen all safeguarding concerns for cases which are not allocated to a community team or keyworker, and advise on appropriate action. During 2016 MASH received circa 16,000 concerns. Of these, in the region of 2,200 were forwarded to community teams as they involved individuals already known and a further 3,600 were forwarded for follow on action.

5.5. The familiar phrase 'safeguarding is everyone's business' is very important in the new landscape and the work that is necessary so that the public and partners understand the parameters of the local authority co-ordination role and the proactive role that all agencies and services are obligated to take to prevent harm occurring to adults at risk. Work is being undertaken to address the volumes of concerns that are forwarded that do not amount to s42 enquiry.

5.6. Information is only forwarded to community teams where either follow on action is required by them, or the information needs to be shared to assist

the local team to build a picture about a service/individual in their area. Despite the increase in concerns coming through the service the number of new S42 enquiries being opened does demonstrate that the role of MASH is having a positive impact on the workload of the community teams who would otherwise be undertaking much more of the screening function. Additionally the quality of the information that is passed to the community teams by the MASH team assists with robust decision-making and the quick identification of actions.

5.7. An overview of annual referral numbers is shown below:



The figure above demonstrates the number of s42 enquiries opened (and in pre Care Act 2014 language referrals).

6. Recent Achievements

6.1. The Quality Outcomes and Contract Monitoring (QOCM) framework is an integral part of all Safeguarding, Quality and Governance activity within the Adults' Health & Care department. The framework allows practitioners to monitor and respond to concerns in provider settings and is a key part of the departments' prevention agenda.

6.2. One of the main aims of this framework is prevent quality issues in a provider service from escalating to a situation where abuse or significant harm has taken place.

6.3. The framework also aims to:

- Support good decision making so that quality concerns are only addressed under the adult safeguarding policy when necessary
- Ensure appropriate systems, processes and procedures are in place to allow teams to record information about the services we commission from
- Enable all staff to use this guidance and the tools within it to provide a proactive proportionate response to quality concerns.

6.4. The framework has recently been updated to strengthen the monitoring aspects and is currently being rolled out across Adults' Health and Care.

6.5. The Client Affairs Service (CAS) operates to manage the property and financial affairs for people who lack the mental capacity to do this for themselves. People supported by the team have no family willing or deemed suitable to do this on their behalf. The CAS works with people who are subject to appointeeship and deputyship. An appointee is responsible for managing a person's benefits if the person has a low level of financial assets and is in receipt of benefits with no other sources of income.

6.6. If a person's financial affairs are more complicated (for example, if they have additional sources of income, investments or significant savings) then deputyship is used to manage all financial affairs including savings, pensions, all sources of income and assets such as property and valuables.

6.7. This is a growing area for the County Council as the contract to provide the service for Southampton City Council has recently been extended to include appointeeship and deputyship. This 'sold' service is developing further due to recent agreements with Guernsey for a limited number of clients and there are discussions with the Clinical Commissioning Groups (CCGs) following the service taking on one client as a one off arrangement. It is possible a service level agreement will be considered for further CCG work.

6.8. At the most recent inspection of the Client Affairs Service the Office of the Public Guardian referred to the Hampshire Service as being a 'Beacon site' for other local authorities and an extremely positive inspection report was received.

6.9. The Service Manager for the DoLS and Client Affairs service is a member of the national Association of Public Authority Deputies (APAD). In the capacity of this role she has been leading on a national development to accredit the Client Affairs Case Officer Role. There is broad based support for accreditation from regional scoping of approx. 20 local authorities and support received for this development from the Care Quality Commission (CQC) National Mental Capacity Act Lead. The training will be piloted in Hampshire and will be accredited by City and Guilds.

6.10. An opportunity has arisen to extend the Board support provided to the Hampshire Safeguarding Adults Board and the PREVENT Board to the Health and Wellbeing Board. It is hoped this will be a positive development and an opportunity to provide consistent support across Strategic Boards, thus enhancing the alignment of the Boards.

7. Key Priorities

7.1. Given that the number of safeguarding concerns continue to rise, one of the key priorities is to manage the demand as effectively as possible and address the opportunity for closer joint working system wide. This includes joining up responses between Children's Services and Adults' Health and Care regarding common areas.

7.2. In the light of the new operating model within Adults' Health and Care and the subsequent restructure it is hoped through the introduction of the Contact Assessment Resolution Team (CART) this will allow MASH to offer an enhanced service, which will include responding to contacts which fall

under the prevention and quality agendas, and to allow the MASH to keep hold of cases for longer so that they are able to resolve more and therefore send less through to the community teams.

7.3. Work is continuing to help improve the quality of Police and Ambulance Service alerts and positive progress has been made, working alongside Southampton, Portsmouth and Isle of Wight local authorities. There is a new reporting process (PPN1) supported by a training roll out involving Adults' Health & Care staff which is hoped will reduce the volume of inappropriate referrals received.

7.4. The Children's MASH and the Adults' MASH operate from the same floor of the same building and the respective Service Managers continue to work together to join up systems wherever possible – e.g. shared referral process for PREVENT referrals.

7.5. Whilst it is recognised that there are different legal frameworks there is a significant opportunity to bring together the work of the teams where it would be valuable to do so and consider integrating processes where this would be beneficial to families.

7.6. The multi-agency MASH Governance Board has recently been reviewed to improve its effectiveness and accountability. This will, now cover both child and adult responsibilities for the three statutory partners.

7.7 As mentioned earlier in this report there is an increased focus on prevention and early intervention. A key aim in this regard has been to integrate safeguarding and the prevention and intervention agenda across the continuum of the procurement of services through to delivery.

7.8 Work streams include:

- The development of the Quality Outcomes Contract Monitoring (QOCM) framework. This informs the departmental risk log and there is now a county level reporting system. This different approach now allows for strategic oversight and early warning, intervention and support for providers.
- As a preventative approach additional quality checks for new providers before they are given business or added to the AIS system is now in place. This aims to ensure that a baseline of information is known about a service before the department commissions packages of care.
- Closer working with the social care regulator, the CQC and NHS colleagues to share information and agree consistent approaches to address poor quality care. The intention is to focus this approach to ensure that we have a robust approach to the management of quality in the sector to ensure we have pro-active embedded quality monitoring structures rather than just a quality improvement approach, largely based on a reactive risk based approach.

7.9 There have been some areas of development in the emerging areas of modern day slavery/human trafficking, serious organised crime and sexual exploitation including multi-agency partnership working.

- Modern day slavery
  - Modern Slavery guidance with a flow chart for Adults' Health and Care developed
- Adult sexual exploitation
  - Adult sexual exploitation strategy and practice guidance developed
  - A short term pilot to test the draft adult sexual exploitation screening tool
  - Training options for staff are being considered to improve understanding and response
- Serious organised crime
  - A Serious and Organised Crime (SOC) Partnership Plan has recently been created by partners working together with Police to effectively deal with serious organised crime.

7.10 The local authority responsibility in respect of Modern Day Slavery/Human Trafficking derives from section 52 of the Modern Slavery Act 2015. The local authority is known as a 'first responder' and has a role in respect of the initial intervention and signposting. Adults' Health & Care have worked alongside the Police, Borders Agency, Salvation Army and the Medaille Trust to develop operational guidance which is now in place, with all referrals being managed via the Multi Agency Safeguarding Hub (MASH).

7.11 Victims of trafficking may not identify themselves as victims. They may appear extremely closed, distrusting and reluctant to communicate. Traffickers and exploiters often develop complex strategies to keep their victims dependent on them, making it especially difficult for victims to escape or disclose details, even if protection and support are offered. Modern Slavery training has therefore been the focus of recent safeguarding update training for the social work workforce to ensure a greater awareness of how to identify victims and the required response.

7.12 For this reason the scale of the crime is unknown. There have been no confirmed incidents in Hampshire since the new duties though there are reported incidents nationally and in neighbouring authorities. National examples include an increased prevalence amongst agricultural workers.

8. Risk Issues

Deprivation of Liberty Safeguards (DoLS)

8.1 The Local Authority acts as the 'supervisory body' under the Mental Capacity Act 2005 for Deprivation of Liberty Safeguards (DoLS). DoLS is the legal framework applied when someone has care and support needs which mean their liberty is deprived in order to keep them safe. Care homes and hospitals ('managing authority') must make an application to the local authority if they

believe someone in their care, who lacks mental capacity, is deprived of their liberty as a result of care arrangements in place. These arrangements are necessary to ensure that no-one is deprived of their liberty without independent scrutiny.

8.2 The result of a Supreme Court judgement in March 2014 has had a considerable impact on resources as a result of the widening of the criteria in terms of who is eligible for a DoLS. This situation has been an issue of risk for the Council over the past three years and has been and continues to be subject to significant management oversight.

8.3 As a result of the judgement, Adults' Health and Care has seen a significant increase in the number of DoLS applications received and there are approximately 4,000 people awaiting assessment.

8.4 The available budget in the DoLS service has been increased for 17/18, removing the financial risk. However, this means that the service must come in on budget whilst continuing to appropriately manage risks.

8.5 Productivity has however, increased with the central team of assessors doubling their throughput since January of last year. However, it is important to recognise that for those individuals for whom the DoLS legislation applies regular review and further authorisation are required.

8.6 For people living in community settings requiring complex support packages there should also be due consideration as to whether the care and support arrangements amount to a deprivation of liberty. In these circumstances applications are made to the Court of Protection. Scoping has identified that there are a greater number of service users who may be deprived of their liberty than applications to the court. Further scoping work is being reviewed by the Care Governance Board and proposals for centralised management being considered.

8.7 All practice should evidence a Making Safeguarding Personal approach to ensure the wishes and views of individuals are reflected in all decisions. Systems changes have been developed to enable recording of decision making but recent audit activity demonstrates a low compliance rate with the new recording standards. The HSAB has a Making Safeguarding Personal project underway to embed the approach across all agencies.

9. Finance

9.1 Adult safeguarding is core work for every team and is embedded in all service provision as a core duty of the department. It is therefore impossible to provide a total cost for carrying out safeguarding work within the Department.

9.2 The HSAB budget is made up of agency contributions as follows - Adult Services 63%, Clinical Commissioning Groups (CCGs) 26% and the Police 11%. The total budget in 2017/18 is £126,384.

9.3 The Prevent duties attracted a £10k one-off payment for local authorities which were used for set up costs and the ongoing specific Prevent budget of £15k will be met by Adults' Health and Care, Children's Services and the Office of the Police Crime Commissioner (OPCC) in equal measure.

9.4 The DoLS budget has been increased to £1.3million in order to manage the demand and the service will successfully operate within this budget.

10. Future Direction

10.1 The main focus of the work over the coming months will be to:

- Ensure the approach of Making Safeguarding Personal is universally adopted
- Deliver the Hampshire Safeguarding Adult Board Business Plan
- Continue to support the development of PREVENT, building on the initial feedback received from the Home Office led peer review, and to take account of the final recommendations when received.
- Continue to work with the NHS and CQC regarding quality improvement
- Continue to work to embed safeguarding into the commissioning and procurement of the department
- Risks in respect of the DoLS service and the demand management around the MASH continue to require attention and close management
- Work will be taken forward to ensure the role of Public Health is integrated and covered in any developments

11. Recommendations

11.1. That Cabinet endorses the direction of travel regarding the future focus of work, as outlined in Section10 – Future Direction, above.

11.2 That Cabinet note the activity and progress within the Adult Safeguarding, Quality and Governance arena.

11.3 That Cabinet note the continued pressure and increasing demands being made upon our statutory duty to safeguard and keep vulnerable adults safe.

11.4 That Cabinet note the role of the Hampshire Safeguarding Adults Board in leading the development of policy across the 3 Pan Hampshire Adult Safeguarding Boards and to note the lead role being taken to chair the Inter-Authority Working Group.

11.5 That Cabinet receive a further update on adult safeguarding in 12 months time.

CORPORATE OR LEGAL INFORMATION:

Links to the Strategic Plan

Hampshire maintains strong and sustainable economic growth and prosperity:	no
People in Hampshire live safe, healthy and independent lives:	yes
People in Hampshire enjoy a rich and diverse environment:	no
People in Hampshire enjoy being part of strong, inclusive communities:	yes

Other Significant Links

Direct links to specific legislation or Government Directives	
Title Care Act	Date 2014

Section 100 D - Local Government Act 1972 - background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

Document	Location
None	

IMPACT ASSESSMENTS:

1. Equality Duty

1.1 The County Council has a duty under Section 149 of the Equality Act 2010 ('the Act') to have due regard in the exercise of its functions to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited under the Act;
- Advance equality of opportunity between persons who share a relevant protected characteristic (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, gender and sexual orientation) and those who do not share it;
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Due regard in this context involves having due regard in particular to:

a) The need to remove or minimise disadvantages suffered by persons sharing a relevant characteristic connected to that characteristic;

b) Take steps to meet the needs of persons sharing a relevant protected characteristic different from the needs of persons who do not share it;

c) Encourage persons sharing a relevant protected characteristic to participate in public life or in any other activity which participation by such persons is disproportionally low.

1.2. **Equalities Impact Assessment:**

The multi-agency policy, guidance and toolkit has its own equality impact assessment. The local authority approach to safeguarding is applicable across all communities.

2. Impact on Crime and Disorder:

2.1. Adults' Health & Care work alongside Hampshire Constabulary and key criminal justice agencies to support those who are at risk of, or suffering, abuse in order that they received access to justice in the event of criminal activity.

3. Climate Change:

3.1. How does what is being proposed impact on our carbon footprint / energy consumption*?*

No impact has been identified

3.2. How does what is being proposed consider the need to adapt to climate change, and be resilient to its longer term impacts?

No impact has been identified

HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Adult Social Care Select (Overview and Scrutiny) Committee (HASC)
Date of meeting:	21 November 2017
Report Title:	Work Programme
Report From:	Director of Transformation and Governance

Contact name: Members Services

Tel: (01962) 847336 **Email:** members.services@hants.gov.uk

1. Purpose of Report

1.1 To consider the Committee's forthcoming work programme.

2. Recommendation

That Members consider and approve the work programme.

WORK PROGRAMME – HEALTH AND ADULT SOCIAL CARE SELECT OVERVIEW & SCRUTINY COMMITTEE: 2017/18

Topic	Issue	Link to Health and Wellbeing Strategy	Lead organisation	Status	21 November 2017	17 January 2018	20 March 2018
Proposals to Vary Health Services in Hampshire - *to consider proposals from the NHS or providers of health services to vary health services provided to people living in the area of the Committee, and to subsequently monitor such variations. This includes those items determined to be a 'substantial' change in service.*							
Andover Hospital Minor Injuries Unit	Temporary variation of opening hours due to staff absence and vacancies	Living Well Healthier Communities	Hampshire Hospitals NHS FT	Updates on temporary variation last heard in June 2017 (via electronic briefing) Update: once temporary hours have been lifted	Further update TBC **(E)**		
Dorset Clinical Services review **(SC)**	Dorset CCG are leading a Clinical Services review across the County which is likely to impact on the population of Hampshire crossing the border to access services.	Starting Well Living Well Ageing Well Healthier Communities	Dorset CCG / West Hampshire CCG	First Joint HOSC meeting held July 2015, CCG delayed consultation until 2016. Last meeting August 2017 to consider consultation outcomes. Decision made by CCG in line with Option B 20	Verbal update to be received once next meeting has been held. **(M)**		

Topic	Issue	Link to Health and Wellbeing Strategy	Lead organisation	Status	21 November 2017	17 January 2018	20 March 2018
				September, which HASC supports.			
North and Mid Hampshire clinical services review **(SC)**	Management of change and emerging pattern of services across sites	Starting Well Living Well Ageing Well Healthier Communities	HHFT / West Hants CCG / North Hants CCG / NHS England	Monitoring proposals for future of hospital services in north and mid Hampshire since Jan 14. Latest update indicated whole system review to report in Jan 17 as part of STP. Status: to next appear once options are available.		To be considered **(M)**	
Move of the Kite Unit	Move of neuropsychiatric inpatient unit from St James Hospital, Portsmouth, to Western Community, Southampton	Living Well Ageing Well	Solent NHS Trust	Considered March 2017 and support provided by Committee. Monitoring update received Summer 17. Next update early 2018			Update on move of unit **(E)**
West Surrey Stroke Services	Review of stroke services	Living Well	NE and SE Hampshire	To be considered once the consultation	Progress prior to		

Topic	Issue	Link to Health and Wellbeing Strategy	Lead organisation	Status	21 November 2017	17 January 2018	20 March 2018
		Ageing Well	CCGs	has closed Heard at June 2017 mtg, where Committee supported proposals	implementation to be heard **(M)**		
Issues relating to the planning, provision and/or operation of health services – *to receive information on issues that may impact upon how health services are planned, provided or operated in the area of the Committee.*							
Care Quality Commission inspections of NHS Trusts serving the population of Hampshire	To hear the final reports of the CQC, and any recommended actions for monitoring.	Starting Well Living Well Ageing Well Healthier Communities	Care Quality Commission	To await notification on inspection and contribute as necessary.	PHT re-inspection action plan **(M)** Southern Health re-inspection **(M)**		
Divestment of Community Health services	To consider the transition of community health services from Southern Health to a new provider in Hampshire	Starting Well Living Well Ageing Well Healthier	Hampshire CCGs	Following the decision taken by the SHFT Board, to monitor the transition of community health services to a new provider			

Topic	Issue	Link to Health and Wellbeing Strategy	Lead organisation	Status	21 November 2017	17 January 2018	20 March 2018
		Communities		Initial overview to be confirmed			
Sustainability and Transformation Plans: one for Hampshire & IOW, other for Frimley	To subject to ongoing scrutiny the strategic plans covering the Hampshire area	Starting Well Living Well Ageing Well Healthier Communities	STPs	H&IOW initially considered Jan 17 and monitored July 17, Frimley March 17 STP working group to undertake detailed scrutiny – updates to be considered through this			Next STP updates to be received to formal meeting
Transforming Care Partnership	To consider the implementation of the TCP locally	Living Well	SHIP 8 CCGs	Considered Plan and proposals for Cypress ward Jan 17, to receive quarterly information updates	Quarterly update to be received **(E)**		
Overview / Pre-Decision Scrutiny – *to consider items due for decision by the relevant Executive Member, and scrutiny topics for further consideration on the work programme*							
Budget	To consider the revenue and capital	Starting Well Living Well	HCC Adults' Health and Care	Considered annually in advance of Council in February		To be considered	

Topic	Issue	Link to Health and Wellbeing Strategy	Lead organisation	Status	21 November 2017	17 January 2018	20 March 2018
	programme budgets for the Adults' Health and Care dept	Ageing Well Healthier Communities	(Adult Services and Public Health)	Transformation to 2019 proposals to be considered September		**(M)**	
Scrutiny Review - *to scrutinise priority areas agreed by the Committee.*							
STP scrutiny	To form a working group reviewing the STPs for Hampshire	Starting Well Living Well Ageing Well Healthier Communities	STP leads All NHS organisations	ToR agreed September 2017	Verbal updates to be received when appropriate		
Real-time Scrutiny - *to scrutinise light-touch items agreed by the Committee, through working groups or items at formal meetings.*							
Adult Safeguarding	Regular performance monitoring of adult safeguarding in Hampshire	Living Well Healthier Communities	Hampshire County Council Adult Services	For an annual update to come before the Committee.	Update due **(M)**		

Topic	Issue	Link to Health and Wellbeing Strategy	Lead organisation	Status	21 November 2017	17 January 2018	20 March 2018
Public Health	To undertake pre-decision scrutiny and policy review of areas relating to the Public Health portfolio.	Starting Well Living Well Ageing Well Healthier Communities	HCC Public Health	Substance misuse transformation to be considered (deferred TBC)			

Key

(E) Written update to be received electronically by the HASC.
(M) Verbal / written update to be heard at a formal meeting of the HASC.
(SC) Agreed to be a substantial change by the HASC.

CORPORATE OR LEGAL INFORMATION:

Links to the Strategic Plan

Hampshire maintains strong and sustainable economic growth and prosperity:	No
People in Hampshire live safe, healthy and independent lives:	Yes
People in Hampshire enjoy a rich and diverse environment:	No
People in Hampshire enjoy being part of strong, inclusive communities:	Yes

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IMPACT ASSESSMENTS:

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Due regard in this context involves having due regard in particular to:

a) The need to remove or minimise disadvantages suffered by persons sharing a relevant characteristic connected to that characteristic;

b) Take steps to meet the needs of persons sharing a relevant protected characteristic different from the needs of persons who do not share it;

c) Encourage persons sharing a relevant protected characteristic to participate in public life or in any other activity which participation by such persons is disproportionally low.

1.2. **Equalities Impact Assessment:** This is a document monitoring the work programme of the HASC and therefore it does not therefore make any proposals which will impact on groups with protected characteristics.

2. Impact on Crime and Disorder:

2.1 This is a forward plan of topics under consideration by the Committee, therefore this section is not applicable to this report. The Committee will request appropriate impact assessments to be undertaken should this be relevant for any topic that the Committee is reviewing.

3. Climate Change:

3.1 How does what is being proposed impact on our carbon footprint / energy consumption?

This is a forward plan of topics under consideration by the Committee, therefore this section is not applicable to this report. The Committee will consider climate change when approaching topics that impact upon our carbon footprint / energy consumption.

3.2 How does what is being proposed consider the need to adapt to climate change, and be resilient to its longer term impacts?

This is a forward plan of topics under consideration by the Committee, therefore this section is not applicable to this report. The Committee will consider climate change when approaching topics that impact upon our carbon footprint / energy consumption.

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Hampshire County Council: Health and Adult Social Care Select (Overview and Scrutiny) Committee (HASC)

Glossary of Commonly used abbreviations / acronyms across Health and Social Care

Please note this is not exhaustive and is revised on a regular basis.

AAA	Abdominal Aortic Aneurysm
A&E	Accident and Emergency or Emergency Department (ED)
AMH	Adult Mental Health
AOT	Assertive Outreach Team
AWMH	Andover War Memorial Hospital
AS	Adult Services
BCF	Better Care Fund
BNHH	Basingstoke and North Hampshire Hospital (part of HHFT)
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CHC	Continuing Healthcare
CPN	Community Psychiatric Nurse
CQC	Care Quality Commission
CX	Chief Executive
DGH	District General Hospital
DH	Department of Health
DTC	Delayed Transfer of Care
ED	Emergency Department / A&E
ENP	Emergency Nurse Practitioner
F&G	Fareham and Gosport
FHFT	Frimley Health NHS Foundation Trust
FT	Foundation Trust
GP	General Practitioner
G&W	Guildford and Waverley
HASC	Health and Adult Social Care (Select Committee)
HCC	Hampshire County Council
HES	Hospital Episode Statistics
HHFT	Hampshire Hospitals NHS Foundation Trust
HOSC	Health Overview and Scrutiny Committee
HWB	Health & Wellbeing Board
IAPT	Improving Access to Psychological Therapies
ICU	Intensive Care Unit
ICT	Integrated Care Team
IRP	Independent Reconfiguration Panel
JHWS	Joint Health and Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
Local HW	Local HealthWatch
MHA	Mental Health Act
MIU	Minor Injuries Unit
NED	Non-executive Director
NEH&F	North East Hampshire and Farnham
NHS	National Health Service
NHSE	NHS England

NHSI	NHS Improvement
NHSP	NHS Property Services
NICE	National Institute for Clinical Excellence
NSF	National Service Framework
OAT	Out of Area Treatment
OBC	Outline Business Case
OBD	Occupied Bed Days
OOH	Out of Hours
OP	Out-patients
OPMH	Older People's Mental Health (services)
PFI	Private Finance Initiative
PHT	Portsmouth Hospitals Trust
QAH	Queen Alexandra Hospital, Cosham
RHCH	Royal Hampshire County Hospital (part of HHFT)
RTT	Referral to Treatment Time (performance indicator)
S&BP FT	Surrey and Borders Partnership NHS Foundation Trust
SCAS	South Central Ambulance NHS Foundation Trust (Service)
SECAMB	South East Coast Ambulance NHS Foundation Trust
SEH	South Eastern Hampshire
SEN	Special Educational Need
SGH	Southampton General Hospital
SHIP	Southampton, Hampshire, Isle of Wight and Portsmouth
STP	Sustainability and Transformation Plan
UHS FT	University Hospital Southampton NHS Foundation Trust
WCH	Western Community Hospital
WiC	Walk in Centre