Public Document Pack

Health Overview and Scrutiny Panel

Thursday, 30th June, 2016
at 6.00 pm

PLEASE NOTE TIME OF MEETING

Conference Room 3 and 4 - Civic Centre

This meeting is open to the public

Members

Councillor Bogle (Chair)
Councillor P Baillie
Councillor Houghton
Councillor Mintoff
Councillor Noon
Councillor Savage
Councillor White

Contacts

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PUBLIC INFORMATION

Role of Health Overview Scrutiny Panel (Terms of Reference)

The Health Overview and Scrutiny Panel will have six scheduled meetings per year with additional meetings organised as required.

- To discharge all responsibilities of the Council for health overview and scrutiny, whether as a statutory duty or through the exercise of a power, including subject to formal guidance being issued from the Department of health, the referral of issues to the Secretary of State.
- To undertake the scrutiny of Social Care issues in the City unless they are forward plan items. In such circumstances members of the Health Overview and Scrutiny Panel will be invited to the relevant Overview and Scrutiny Management Committee meeting where they are discussed.
- To develop and agree the annual health and social care scrutiny work programme.
- To scrutinise the development and implementation of the Joint Strategic Needs Assessment and Health and Wellbeing Strategy developed by the Health and Wellbeing Board.
- To respond to proposals and consultations from NHS bodies in respect of substantial variations in service provision and any other major health consultation exercises.
- Liaise with the Southampton LINk and its successor body "Healthwatch" and to respond to any matters brought to the attention of overview and scrutiny by the Southampton LINk and its successor body "Healthwatch"
- Provide a vehicle for the City Council's Overview and Scrutiny Management Committee to refer recommendations arising from panel enquiries relating to the City's health, care and well-being to Southampton's LINk and its successor body "Healthwatch" for further monitoring.
- To consider Councillor Calls for Action for health and social care matters.
- To provide the membership of any joint committee established to respond to formal consultations by an NHS body on an issue which impacts the residents of more than one overview and scrutiny committee area.

Mobile Telephones: - Please switch your mobile telephones to silent whilst in the meeting.

Use of Social Media: - The Council supports the video or audio recording of meetings open to the public, for either live or subsequent broadcast. However, if, in the Chair's opinion, a person filming or recording a meeting or taking photographs is interrupting proceedings or causing a disturbance, under the Council's Standing Orders the person can be ordered to stop their activity, or to leave the meeting. By entering the meeting room you are consenting to being recorded and to the use of those images and recordings for broadcasting and or/training purposes. The meeting may be recorded by the press or members of the public.
Any person or organisation filming, recording or broadcasting any meeting of the Council is responsible for any claims or other liability resulting from them doing so.
Details of the Council's Guidance on the recording of meetings is available on the Council's website.

Public Representations

At the discretion of the Chair, members of the public may address the meeting on any report included on the agenda in which they have a relevant interest. Any member of the public wishing to address the meeting should advise the Democratic Support Officer (DSO) whose contact details are on the front sheet of the agenda.

Smoking policy – the Council operates a no-smoking policy in all civic buildings.

COUNCIL'S PRIORITIES:

- Jobs for local people
- Prevention and early intervention
- Protecting vulnerable people
- Affordable housing
- Services for all
- City pride
- A sustainable Council

CONDUCT OF MEETING

The general role and terms of reference for the Overview and Scrutiny Management Committee, together with those for all Scrutiny Panels, are set out in Part 2 (Article 6) of the Council's Constitution, and their particular roles are set out in Part 4 (Overview and Scrutiny Procedure Rules of the Constitution.

Business to be discussed
Only those items listed on the attached agenda may be considered at this meeting.

Rules of Procedure
The meeting is governed by the Council Procedure Rules as set out in Part 4 of the Constitution.

Quorum
The minimum number of appointed Members required to be in attendance to hold the meeting is 3.

DISCLOSURE OF INTERESTS

Members are required to disclose, in accordance with the Members' Code of Conduct, ***both*** the existence ***and*** nature of any "Disclosable Pecuniary Interest" or "Other Interest" they may have in relation to matters for consideration on this Agenda.

DISCLOSABLE PECUNIARY INTERESTS

A Member must regard himself or herself as having a Disclosable Pecuniary Interest in any matter that they or their spouse, partner, a person they are living with as husband or wife, or a person with whom they are living as if they were a civil partner in relation to:

(i) Any employment, office, trade, profession or vocation carried on for profit or gain.

(ii) Sponsorship:

Any payment or provision of any other financial benefit (other than from Southampton City Council) made or provided within the relevant period in respect of any expense incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.

(iii) Any contract which is made between you / your spouse etc (or a body in which the you / your spouse etc has a beneficial interest) and Southampton City Council under which goods or services are to be provided or works are to be executed, and which has not been fully discharged.

(iv) Any beneficial interest in land which is within the area of Southampton.

(v) Any license (held alone or jointly with others) to occupy land in the area of Southampton for a month or longer.

(vi) Any tenancy where (to your knowledge) the landlord is Southampton City Council and the tenant is a body in which you / your spouse etc has a beneficial interests.

(vii) Any beneficial interest in securities of a body where that body (to your knowledge) has a place of business or land in the area of Southampton, and either:

a) the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body, or
b) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you / your spouse etc has a beneficial interest that exceeds one hundredth of the total issued share capital of that class.

Other Interests

A Member must regard himself or herself as having an, 'Other Interest' in any membership of, or occupation of a position of general control or management in:

Any body to which they have been appointed or nominated by Southampton City Council
Any public authority or body exercising functions of a public nature

Any body directed to charitable purposes

Any body whose principal purpose includes the influence of public opinion or policy

Principles of Decision Making

All decisions of the Council will be made in accordance with the following principles:-

- proportionality (i.e. the action must be proportionate to the desired outcome);
- due consultation and the taking of professional advice from officers;
- respect for human rights;
- a presumption in favour of openness, accountability and transparency;
- setting out what options have been considered;
- setting out reasons for the decision; and
- clarity of aims and desired outcomes.

In exercising discretion, the decision maker must:

- understand the law that regulates the decision making power and gives effect to it. The decision-maker must direct itself properly in law;
- take into account all relevant matters (those matters which the law requires the authority as a matter of legal obligation to take into account);
- leave out of account irrelevant considerations;
- act for a proper purpose, exercising its powers for the public good;
- not reach a decision which no authority acting reasonably could reach, (also known as the "rationality" or "taking leave of your senses" principle);
- comply with the rule that local government finance is to be conducted on an annual basis. Save to the extent authorised by Parliament, 'live now, pay later' and forward funding are unlawful; and
- act with procedural propriety in accordance with the rules of fairness.

Dates of Meetings: Municipal Year 2016/2017

2016	2017
30 June	23 February
25 August	27 April
27 October	
22 December	

AGENDA

Agendas and papers are now available via the City Council's website

1 APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)

To note any changes in membership of the Panel made in accordance with Council Procedure Rule 4.3.

2 ELECTION OF VICE-CHAIR

To elect the Vice Chair for the Municipal Year 2016/2017.

3 DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS

In accordance with the Localism Act 2011, and the Council's Code of Conduct, Members to disclose any personal or pecuniary interests in any matter included on the agenda for this meeting.

NOTE: Members are reminded that, where applicable, they must complete the appropriate form recording details of any such interests and hand it to the Democratic Support Officer.

4 DECLARATIONS OF SCRUTINY INTEREST

Members are invited to declare any prior participation in any decision taken by a Committee, Sub-Committee, or Panel of the Council on the agenda and being scrutinised at this meeting.

5 DECLARATION OF PARTY POLITICAL WHIP

Members are invited to declare the application of any party political whip on any matter on the agenda and being scrutinised at this meeting.

6 STATEMENT FROM THE CHAIR

7 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)
(Pages 1 - 4)

To approve and sign as a correct record the minutes of the meeting held on 28th April 2016 and to deal with any matters arising, attached.

8 UPDATE ON PROGRESS - INDEPENDENT REVIEW OF DEATHS OF PEOPLE WITH A LEARNING DISABILITY OR MENTAL HEALTH PROBLEM IN CONTACT WITH SOUTHERN HEALTH NHS FOUNDATION TRUST APRIL 2011 TO MARCH 2015
(Pages 5 - 24)

Report of the Chairman of Southern Health NHS Foundation Trust providing the Panel with the requested update on Southern Health's progress implementing the improvement plan and feedback from regulators.

9 UPDATE ON 'GETTING THE BALANCE RIGHT IN COMMUNITY-BASED HEALTH SERVICES'
(Pages 25 - 48)

Report of the Director of System Delivery providing the Panel with an assessment of the impact of the closure of the Bitterne Walk-In Service.

10 SOUTHAMPTON, HAMPSHIRE, ISLE OF WIGHT AND PORTSMOUTH HEALTH OVERVIEW AND SCRUTINY PANELS: ARRANGEMENTS FOR ASSESSING SUBSTANTIAL CHANGE IN NHS PROVISION (REVISED JUNE 2016)
(Pages 49 - 64)

Report of the Service Director, Legal and Governance, recommending that the Panel agrees the revised arrangements for assessing substantial change in NHS provision.

Wednesday, 22 June 2016 SERVICE DIRECTOR, LEGAL AND GOVERNANCE

SOUTHAMPTON CITY COUNCIL
HEALTH OVERVIEW AND SCRUTINY PANEL

MINUTES OF THE MEETING HELD ON 28 APRIL 2016

Present: Councillors Bogle (Chair), Furnell, Noon, Parnell and White (Vice-Chair)

Apologies: Councillors Houghton and Tucker

35. **DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS**

The Panel noted that Councillor Bogle declared an interest in items relating to the University Hospital Trust and remained in the meeting. It was explained that her employer had been involved with projects listed within the Trust's draft quality account.

36. **MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)**

RESOLVED: that the minutes for the Panel meeting on 24th March 2016 be approved and signed as a correct record.

37. **SOUTHAMPTON PROVIDER QUALITY ACCOUNTS 2015/16**

The Panel considered the report of the Service Director, Legal and Governance introducing the 2015/16 draft Quality Accounts for NHS providers operating within Southampton.

UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST (UHS)

Gail Byrne, Director of Nursing and Organisational Development at UHS and Jane Hayward, Director of Transformation and Improvement UHS were present and with the consent of the Chair addressed the meeting.

The Trust outlined its performance against 2015/16 targets and reasons for choosing the priorities for the forthcoming year. Clarification was given to the Panel on the initiatives outlined in the introduction to the Quality Account relating to the new 7 day service standards and staff health and wellbeing. The Panel requested that it be provided with the priorities and targets for 2016/17 that are referenced in Appendix C.

The Panel welcomed the improvements identified in the draft Quality Account and noted that there was still work to do to improve performance in a number of areas, notably within the Emergency Department.

CARE UK

Penny Daniels, Hospital Director at Southampton NHS Treatment Centre and Minor Injuries Unit and Rachel Broadly, Medical Director at Southampton NHS Treatment Centre were present and with the consent of the Chair addressed the meeting.

The Panel noted that the Care Quality Commission had assessed the Minor Injuries Unit (MIU) overall as "Good" in 2015 and that they had been rated "outstanding" for caring.

The Panel were provided with highlights of the draft Quality Account, detailing the performance against the priorities set out in 2015-2016 and the reasons for choosing the priorities for the forthcoming year. The Panel raised questions relating to the aftercare service offered and were pleased to see the introduction of a Dementia Screening Tool in pre-op planning.

In addition the Panel questioned whether the closure of the Bitterne Walk in Centre had caused an increase in the number of people attending the MIU. In response it was noted that the number of people attending the MIU had increased in the past 6 months, this was placed within the context of an increase nationally in the demand for urgent care.

SOLENT NHS TRUST

Ellen McNicholas, Deputy Director of Nursing Solent NHS Trust and Alex Whitfield, Chief Operating Officer Solent NHS Trust outlined the draft of the Trusts 2015-2016 Quality Account to the Panel. It was noted that the draft presented to the Panel for consideration was at a very early stage of preparation. It was noted that the CQC were to inspect the Trust in June 2016. In addition the Panel received an update on the financial position of the Trust.

SOUTHERN HEALTH NHS FOUNDATION TRUST

Dr Lesley Stevens, Medical Director and Professor David Kingdon, Clinical Services Director for Adult Mental Health in Southampton for Southern Health NHS Foundation Trust presented the draft Quality Account to the Panel. It was noted that the Trust had not achieved a number of the priorities set out in the previous years Quality Account. The Panel noted that there had been an improvement in some of the priorities for services within the City of Southampton but, that across the Trust as a whole there continued to be concerns. It was noted that the Trust continued to be under a great deal of scrutiny both nationally and regionally and that measures put in place in the early part of 2016 had not yet had sufficient time to bed in properly.

John Richards - Chief Officer NHS Southampton City Clinical Commissioning Group (CCG) was also present and was asked by the Chair to provide the CCG’s evaluation of the Quality Accounts.

RESOLVED that the Panel;

(i) Noted the draft 2015/16 Quality Accounts from the University Hospital Southampton NHS Foundation Trust, Care UK, Solent NHS Trust and Southern Health NHS Foundation Trust.
(ii) Agreed that a response to each Quality Account would be developed, following consultation with the Chair, for inclusion within the final reports;
(iii) Requested that it be provided with the priorities and targets for 2016/17 that are referenced in Appendix C of the University Hospital Southampton NHS Foundation Trust Quality Account.

38. UPDATE ON PROGRESS - INDEPENDENT REVIEW OF DEATHS OF PEOPLE WITH A LEARNING DISABILITY OR MENTAL HEALTH PROBLEM IN CONTACT WITH SOUTHERN HEALTH NHS FOUNDATION TRUST APRIL 2011 TO MARCH 2015

The Panel considered the report providing the Panel with the requested update on Southern Health's progress implementing the improvement plan and feedback from regulators.

Dr Lesley Stevens, Medical Director and Professor Kingdon from Southern Health NHS Foundation Trust, John Richards - Chief Officer NHS Southampton City Clinical Commissioning Group (CCG), Councillor Pope and Denise Wyatt (resident) were in attendance and with the consent of the Chair addressed the meeting.

The Chair noted that the Care Quality Commission (CQC) had given advance notice of the publication of their report into Southern Health. It also was noted that the Chair of the Foundation Trust had tendered their resignation shortly after the advance notice of the CQC report had been circulated.

The Chair stated that at the time of the meeting the details of the CQC report had been embargoed from general publication. However, the Chair advised that the Panel had been circulated the accompanying press release to the report, which whilst similarly embargoed from release did highlight a number of concerns. The CQC report found that:

- The Trust had not put in place robust governance arrangements to investigate incidents, including deaths;
- Effective arrangements had not been put in place to identify, record or respond to concerns about patient safety raised by patients, their carers, staff or by the CQC;
- Inspectors had serious concerns about the safety of patients with mental health problems and learning disabilities in some of the locations inspected; and
- Overall, the Trust's governance arrangements did not facilitate effective, proactive, timely management of risk. Where action was taken by the Trust to mitigate risk, this was delayed and mainly done in response to concerns raised by the CQC.

It was noted that NHS Improvement had appointed an Improvement Director to the Trust.

Councillor Pope addressed the meeting and presented a motion to the Panel seeking its endorsement. The Panel considered the motion and agreed that matters raised were extremely serious and of concern to the Panel. It was noted that the Panel had not had the opportunity to examine the CQC report therefore Panel Members declined to endorse the tabled motion.

The Panel acknowledged that urgent action was required to resolve the issues identified by the CQC and stated that this item would be referred to the first meeting of the next municipal year and that every effort should be made to ensure that appropriate officers from the Trust and the regulator, NHS Improvement, be present.

RESOLVED that the matter return to the Panel's first meeting of the municipal year and that every effort be taken to ensure that the appropriate and relevant officers from the trust and regulator are in attendance.

39. **MONITORING SCRUTINY RECOMMENDATIONS TO THE EXECUTIVE**

The Panel noted the report of the Service Director, Legal and Governance detailing the actions of the Executive and monitoring progress of the recommendations of the Panel.

DECISION-MAKER:	HEALTH OVERVIEW AND SCRUTINY PANEL
SUBJECT:	UPDATE ON PROGRESS - INDEPENDENT REVIEW OF DEATHS OF PEOPLE WITH A LEARNING DISABILITY OR MENTAL HEALTH PROBLEM IN CONTACT WITH SOUTHERN HEALTH NHS FOUNDATION TRUST APRIL 2011 TO MARCH 2015
DATE OF DECISION:	30 JUNE 2016
REPORT OF:	CHAIRMAN – SOUTHERN HEALTH NHS FOUNDATION TRUST

CONTACT DETAILS

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STATEMENT OF CONFIDENTIALITY

None

BRIEF SUMMARY

NHS England commissioned Mazars to conduct an investigation of the deaths of all patients of Southern Health who had been in receipt of mental health or learning disability services since 2011 following the avoidable death of Connor Sparrowhawk in Oxfordshire. Connor was a patient in the care of Southern Health NHS Foundation Trust.

The Mazars report was published on NHS England's website on 17 December 2015 and highlights a number of actions for the Trust, commissioners and regulators.

At the 1 February 2016 meeting of the Health Overview and Scrutiny Panel (HOSP) the Panel considered the Mazars report with invited representatives and recommended that Southern Health, at an appropriate meeting, updates the Panel on progress implementing the improvement plan and feedback from regulators.

Appended to this report is a briefing paper and updated action plan informing the Panel of the progress made following publication of the Mazars report, and the recent developments with regards to NHS Improvement and the Care Quality Commission.

The Panel are requested to consider the appendices and discuss the key issues with the invited representatives from Southern Health NHS Foundation Trust.

RECOMMENDATIONS:

	(i)	That the Panel considers the attached briefing paper and updated action plan and discusses the issues with the invited representatives from Southern Health NHS Foundation Trust.

REASONS FOR REPORT RECOMMENDATIONS

1.	To enable the Panel to effectively scrutinise the issues impacting on health services in Southampton raised by the Mazars report and the subsequent Care Quality Commission inspection report.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2.	None.

DETAIL (Including consultation carried out)	
3.	Following consideration of the Mazars report at the 1 February 2016 meeting of the HOSP the Panel made a number of recommendations for Southern Health and commissioners.
4.	The Panel recognised the need to regularly review the issues raised in this report until the Panel are assured that progress is being made. The Panel therefore made the following recommendation: *'That, following discussion with the Chair, Southern Health NHS Foundation Trust updates the Panel on progress implementing the improvement plan and feedback from regulators, at an appropriate meeting of the HOSP.'*
5.	Attached as Appendix 1 is a briefing paper from Southern Health NHS Foundation Trust. Attached as Appendix 2 is the Mortality and Serious Incident Management report. Attached as Appendix 3 is the CQC Action Plan. The Panel are requested to consider the briefing paper and associated plans, and discuss the key issues with the invited representatives.
RESOURCE IMPLICATIONS	
Capital/Revenue	
6.	N/A
Property/Other	
7.	N/A
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
8.	N/A
Other Legal Implications:	
9.	None
POLICY FRAMEWORK IMPLICATIONS	
10.	N/A

<table>
<tr><td colspan="2">KEY DECISION</td><td colspan="2">N/A</td></tr>
<tr><td colspan="2">WARDS/COMMUNITIES AFFECTED:</td><td colspan="2"></td></tr>
<tr><td colspan="4" align="center"><u>SUPPORTING DOCUMENTATION</u></td></tr>
<tr><td colspan="4">Appendices</td></tr>
<tr><td>1.</td><td colspan="3">Briefing Paper - Update on progress made by Southern Health NHS Foundation Trust since publication of the Mazars report, and the Care Quality Commission inspection report</td></tr>
<tr><td>2.</td><td colspan="3">Mortality and Serious Incident Management Report</td></tr>
<tr><td>3.</td><td colspan="3">CQC Action Plan</td></tr>
<tr><td colspan="4">Documents In Members’ Rooms</td></tr>
<tr><td>1.</td><td colspan="3">None</td></tr>
<tr><td colspan="4">Equality Impact Assessment</td></tr>
<tr><td colspan="3">Do the implications/subject of the report require an Equality and Safety Impact Assessments (ESIA) to be carried out.</td><td>No</td></tr>
<tr><td colspan="4">Privacy Impact Assessment</td></tr>
<tr><td colspan="3">Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.</td><td>No</td></tr>
<tr><td colspan="4">Other Background Documents
Equality Impact Assessment and Other Background documents available for inspection at:</td></tr>
<tr><td colspan="2">Title of Background Paper(s)</td><td colspan="2">Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)</td></tr>
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Southern Health NHS
NHS Foundation Trust

Update on progress made by Southern Health NHS Foundation Trust since publication of the Mazars report, and the Care Quality Commission inspection report

1.1 This report aims to update Southampton Health Overview and Scrutiny Panel members regarding progress made against Southern Health's improvement plans following publication of the Mazars report in December 2015, and the subsequent Care Quality Commission inspection report in April 2016.

1.2 The independent Mazars review found that the Trust's processes for reporting and investigating deaths of people with learning disabilities and mental health needs could have been better. We fully accept this and apologise unreservedly that families were not always involved as much as they could have been. We accept the report's recommendations.

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

1.4 Since the independent report was published we have made extensive changes to the way we record and investigate deaths of any patient who uses services provided by Southern Health. On 1 December 2015, a new Trust-wide system for reporting and investigating deaths came into force to increase monitoring and scrutiny, share learning with staff and improve the quality of reports and investigations. This system is continuously being reviewed by the Board and significant progress has been made in a number of areas:

- Deaths are reported under specific categories, reviewed by a senior manager (initial management assessment) and decision made at a 48 hour panel as to whether an investigation is required and at what level; no investigation, local investigation (internal reporting) or serious incident investigation (external reporting). Since the introduction of the new mortality reporting process in December 2015 (and as of 3 June 2016) there have been 442 deaths, with the 48 hour panel and Initial Management Assessment completed in 100% of cases.
- Every family has been offered the opportunity to be involved in an investigation into the death of their loved one wherever possible.
- All clinical staff have been informed of the requirement for them to adhere to the new system for reporting patient deaths. Compliance with the new system is closely monitored and scrutinised by a member of the Executive team.

1.5 The Care Quality Commission (CQC) undertook a follow-up inspection of Southern Health services in January, focusing on improvements within mental health and learning disability services, in particular acute mental health

inpatient wards, units for people with learning disabilities, crisis/community mental health teams and child and adolescent inpatient and secure services.

1.6 The CQC published a warning notice on 6 April 2016 which highlights further improvements that need to be made to our governance arrangements in respect of findings from the 2014 inspection. We have been very clear and open that we have a lot of work to do to fully address recent concerns raised about the Trust.

1.7 The full CQC inspection report was published at the end of April 2016, which highlighted some areas of good practice and improvement, but a number of areas of serious concern.

1.8 We take the CQC's concerns very seriously and have been very clear and open that we have a lot of work to do to fully address the concerns raised. Good progress has been made, and we are pleased that the CQC report pointed to a significant amount of progress made in a number of our units. However, we accept that the CQC feels that in some areas we have not acted swiftly enough. We acknowledge that there is more work to be done to improve services and are moving at pace to achieve this.

1.9 Some of the action taken in response to the CQC report has included the following:

- The Trust is reviewing the current Risk Management Strategy, and is developing a Quality Improvement Strategy. This will ensure that actions taken in response to concerns raised by patients, families, staff, or external reviews and reports are fully embedded across the organisation.
- A Ligature Project Manager has been appointed, each ward has Ligature Plan which shows where any remaining ligature points are and how to risk assess them, and the Trust's ligature policy and procedure has been revised.
- A series of environmental improvements have been made to a number of sites including Antelope House, Melbury Lodge, Evenlode and The Ridgeway Centre.
- Improvements in the way staff supervision is carried out, recorded and monitored across Adult Mental Health teams, improving the support and leadership available.

1.10 The health sector regulator, NHS Improvement, announced in January 2016 that it had decided to take action against Southern Health, utilising its powers under section 106 of the Health and Social Care Act 2012. NHS Improvement is providing expert support to improve the way the Trust reports and investigates deaths. Southern Health has agreed with NHS Improvement to take a number of steps to show how the Trust is improving. These are:

- Implement the recommendations of the Mazars report through a comprehensive action plan

- Get assurance from independent experts on the action plan
- Work with an Improvement Director appointed by NHS Improvement.

1.11 In addition to the above, on 3 May 2016 Julie Dawes joined Southern Health as Director of Nursing and Quality. Julie's role has a focus on quality; reviewing and strengthening existing quality structures and arrangements, as well as providing strong professional leadership for nursing and Allied Health Professionals. Julie is also leading on delivery of the improvements following the CQC inspection, and working closely with staff to maintain high levels of patient care.

1.12 On 5 May 2016 NHS Improvement appointed Tim Smart as Interim Chair of Southern Health. As Chair, Tim is working closely with Alan Yates (who was appointed as Improvement Director earlier this year) and our Board to support us in continuing to make the improvements needed to address the CQC's concerns.

1.13 Tim is currently undertaking a review of the work carried out across the Trust in response to the Mazars and CQC reports, and of the current governance arrangements. At the end of June he intends to be able to deliver a plan for any further action based on his review findings.

1.14 Southern Health fully accepts the need to continue to make changes. We will continue to work closely with the Improvement Director, our regulators and commissioners to make the improvements required. The Trust's focus continues to be on ensuring that everyone who relies on the services we provide receives the best possible care.

ENDS

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Southern Health NHS
NHS Foundation Trust

Death / Mortality and Serious Incident Reporting, Management and Assurance

1. Purpose and Background

1.1. On the 11 January 2016 NHS Improvement (formally Monitor) confirmed that members of their Provider Regulation Executive had approved the undertakings submitted by the Trust. These undertakings are in addition to those accepted by NHS Improvement in April 2014. The Trust is expected to take action to comply with these Enforcement Undertakings. On 19 January 2016 NHS Improvement published the undertakings that have been agreed with the Trust in response to the Mazars report.

1.2. This paper provides evidence and assurance that the undertakings the Trust has agreed with NHS Improvement are delivered.

1.3. Oversight of the delivery of the improvement action plan is being undertaken by the Serious Incident Oversight and Assurance Committee (SIOAC) which meets on a fortnightly basis and reports to the Board.

1.4. As of 1 April 2016 the NHS Improvement Director, Alan Yates, has commenced in post and is working with the Executive Team to apply scrutiny, challenge and seek assurance as to the delivery of the improvement plan.

1.5. An expert reviewer, Niche Consultancy and Grant Thornton, have assessed the action plan and have provided feedback to the Trust on 17 May 2016. A rewrite of the action plan is now taking place.

1.6. Mortality and serious incident management are key indicators of the Trusts safety and effectiveness. This paper provides an update for the Trust Board on serious incident management and mortality reporting since 1 December 2015 when a new process was commenced as a result of the review into deaths.

1.7. The Trust is committed to identifying, reporting and investigating deaths and serious incidents, ensuring that learning is shared across the organisation and actions taken to reduce the risk of recurrence. The Trust seeks, where at all possible, to prevent the occurrence of serious incidents by taking a proactive approach to the reporting and management of risk, to ensure safe care is provided to patients, through the promotion of a positive reporting and investigation culture.

2. Death / Mortality

2.1. Death / mortality reporting has been in place as from the 1 December 2015 following the guidance of the Trust-wide document *Procedure for the reporting and investigating of deaths* SH NCP75 issued December 2015. Data collection is via the Ulysses Safeguard risk management system on an electronic platform.

2.2. Deaths are reported under categories stipulated within the procedure, reviewed by a senior manager (initial management assessment) and decision made at a 48 hour panel as to whether an investigation is required and at what level; no investigation, local investigation (internal reporting) or serious incident investigation (external reporting[1]).

2.3. Compliance with the new procedure has been monitored using an auditable extraction from the Ulysses database. Compliance to the dataset has been available to all of the divisions on a daily basis and has featured as an element of the Quality Governance Flash report which is produced for the organisation every Monday.

2.4. The data extraction produced on the 8 June 2016 showed an overall Trust-wide compliance of 100% to the process. This meets the improvement target on the action plan. Performance is being monitored and discussed at the Mortality Working Group (MGW).

2.5. The compliance results as of 8 June 2016 are;

Mortality data													Number of deaths 459
Division	No of deaths reported from 1st Dec 15	IMA completed?	48 hour panels completed	% 48 hour panels completed	Trend for the last 4 weeks : % Panels completed in 48 hours and (no of reported deaths)								
					09/05/2016		16/05/2016		23/05/2016		30/05/2016		Trend
Childrens	20	20	20	100%		(0)		(0)	100%	(2)		(0)	▲
East ISD	139	139	139	100%	100%	(7)	100%	(2)	100%	(3)	75%	(4)	▼
Learning Disabilities	40	40	40	100%	100%	(1)		(0)	100%	(2)		(0)	▲
Mental Health	79	77	78	99%	100%	(3)	100%	(2)	100%	(2)	33%	(3)	▼
North East ICS	10	10	10	100%		(0)	100%	(1)		(0)		(0)	▶
Southampton & West ISD	163	163	161	99%	67%	(9)	83%	(6)	75%	(4)	25%	(4)	▼
TQ Twentyone	3	3	3	100%		(0)		(0)		(0)		(0)	▶
Trust Wide	459	457	456	99.3%	85%	(20)	91%	(11)	92%	(13)	45%	(11)	▼

2.6. Analysis and quality assurance of the data provides to following information.

2.6.1. Compliance detail;

- 456 out of the 459 reported deaths have been reviewed as of 8 June 2015; 99.3% compliance
- Compliance to the review taking place within 48 hrs dropped in May to 84% therefore the Trust has not met the target of 95%. This will be discussed at the June Mortality Working Group (MWG) directly with the panel Chairs.
- In May 12 (22%) of the 55 deaths reviewed in May were reported as Serious Incidents.

Compliance to the 48 hour panels on a monthly basis							
Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
12%	54%	68%	93%	88% (53/60)	84% (59/70)		

2.6.2. Quality Assurance;

2.6.2.1. An audit of a random 20% sample of the Ulysses held records of the mortality panels and decision making occurs every month.

2.6.2.2. The overarching audit question for the establishment of the results was: Ensure there is evidence of the rationale of the decision making process of whether to conduct an investigation into a death and this is clearly recorded.

[1] Serious Incidents are those which meet the requirement of reporting to the Strategic Executive Information System (StEIS) as guided by the national Serious Incident Framework 2015.

2.6.2.3. The audit tool was changed in April following review of the first four months audit. It is now more specific regarding the review of the IMA and the 48 hour panel decision. An additional question about the Duty of Candour evidence has also been added.

2.6.2.4. The target set for the monitoring of the mortality process was that 60% of death reports would be correct without central moderation and there would be a robust audit trail of the decisions to investigate a death.

2.6.2.5. The overall results were:

December	January	February	March	April
94%	100%	100%	75%	83%

2.7. The results have been shared with the Mortality Working Group (MWG) at the May meeting and moving forwards a wider group of senior clinicians will be undertaking the audit.

2.8. A further deep dive audit of 10 cases specific to a location noted as having poor compliance was undertaken by the Associate Medical Director – Patient Safety. The results have been discussed with the Senior Management Team which shows marked variety between the information provided by the locality teams. This will repeated in three months' time. The Learning Disability division has been found to produce robust IMAs and 48 hour panel records.

2.9. Following review of the first four months audit data the audit tool has been adjusted to be more specific regarding the review of the IMA and the 48 hour panel decision. An additional question about the Duty of Candour evidence has also been added. A further review of the tool will take place at the end of the next quarter.

2.10. All activity is being reported to Quality Improvement and Development Forum and the Serious Incident Oversight and Assurance Committee.

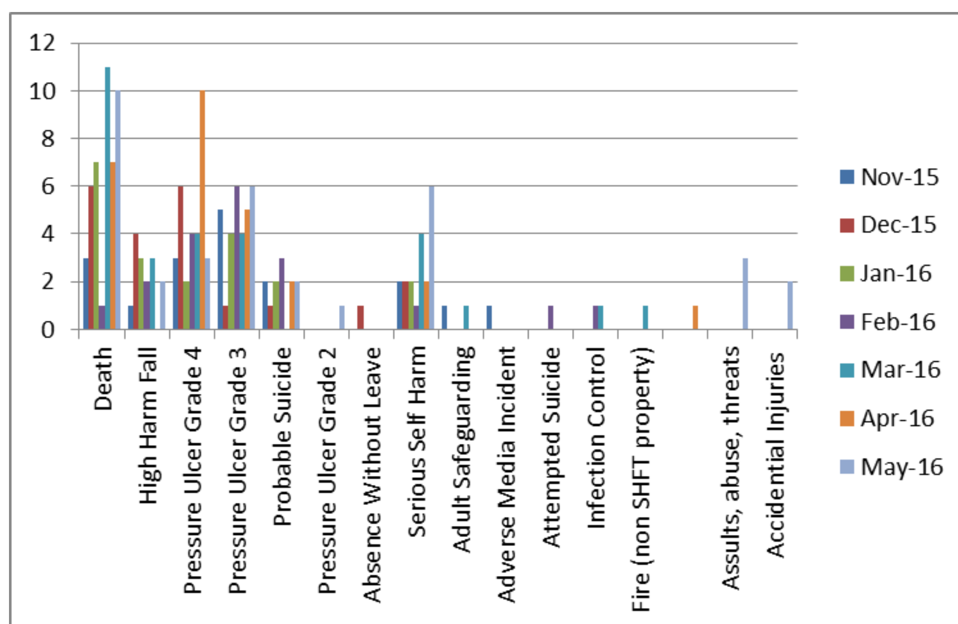
3. Serious Incidents

3.1. There were 27 Serious Incidents reported during March. This is a slight decrease on the previous month but remains within normal statistical control (SPC).

Division	No. of SI's reported in May 2016 (April 2016 in brackets)	Type of Incident
ICS North East	0 (4)	
East ISD	3 (9)	1 death 1 high harm fall 1 grade 4 pressure ulcer
West ISD	12 (4)	2 deaths 1 high harm fall 1 grade 2 pressure ulcer 6 grade 3 pressure ulcers 2 grade 4 pressure ulcers
Mental Health (includes Specialised	19 (9)	2 probable suicides 6 deaths

Services)		6 serious self-harm 3 assaults (to staff/patients/ visitor/public) 2 accident or injury
Learning Disabilities	1(1)	1 death
TQtwentyone	0(0)	
Children and Families Division	0(0)	
Corporate	0(0)	
Total	35(27)	

3.2. The 35 Serious Incidents can be broken down into the following categories;



3.3. All serious incidents must be reported, investigated, approved by corporate panel and submitted through the StEIS system within 60 working days as stipulated in the national framework document.

3.4. The position 8 June 2016 showed 66 open Serious Incident investigations underway in the Trust, 5 have been officially paused due to Safeguarding Serious Case Reviews (SCR) or police investigations taking place.

3.5. From a position of the Trust having a backlog of investigation reports past the required submission deadline. All current reports remain within 60 working days.

Number of reports overdue for submission:

February 2016	March 2016	April 2016	May 2016	June 2016
39	39	35	24	0

4. Present Status – 08.06.16

4.1. There are no investigation reports overdue on the 60 day submission to StEIS criteria.

4.2. The June trajectory report is predicting:

4.2.1. 94% compliance to the 60 day uplift to StEIS requirement for June supported by 21 out of the 24 expected reports booked to panel dates

4.2.2. 42% has already been achieved through early submission to StEIS

4.2.3. 6% / 3 reports (North) East ISD do not have confirmed panel dates

StEIS number	Incident number	Division	Due date	Dates in Red are panel dates booked but not yet concluded Dates in Black are concluded panel dates		
2016/6705	93876	East ISD	03/06/2016	01/06/2016	Yes	
2016/6699	93754/93780	North East ISD	03/06/2016	27/05/2016	Yes	
2016/7630	92642	Mental Health	13/06/2016	27/05/2016	Yes	
2016/7768	93177	Southampton & West ISD (PU)	14/06/2016	08/06/2016	Yes	Downgrade requested on 19/05/16 further request made to commissioners 1/6/2016, and 8/6
2016/7766	92296	North East ISD (PU)	14/06/2016	DATES AWAITED	Yes	Booked on Divisional Panel on 11/03/2016 to be reviewed by new Matron
2016/7765	93575	Southampton & West ISD (PU)	14/06/2016	07/06/2016	Yes	Approved on 7/6/2016 Awaiting Action Plan
2016/7769	94095	North East ISD	14/06/2016	08/06/2016	Yes	Virtual panel 08/06/2016
2016/7770	93443	Mental Health	14/06/2016	20/05/2016	Yes	
2016/7763	94298	Mental Health	14/06/2016	10/06/2016	Yes	Booked on Corporate 10/06/2016
2016/7749	93269	Specialised Services	14/06/2016	10/06/2016	Yes	Booked on Corporate 10/06/2016
2016/7826	94167	Childrens	15/06/2016	24/05/2016	Yes	
2016/7963	94601	Childrens	16/06/2016	24/05/2016	Yes	
2016/8084	94154	OPMH	16/06/2016	08/06/2016	Yes	Virtual panel 08/06/2016
2016/8090	93836	Mental Health	16/06/2016	23/05/2016	Yes	
2016/8094	91188	Mental Health	16/06/2016	10/06/2016	Yes	Booked on Corporate 10/06/2016
2016/8158	94349	North East ISD (PU)	17/06/2016	DATES AWAITED	Yes	
2016/8613	93327	Mental Health	22/06/2016	07/06/2016	Yes	
2016/8623	93404	Mental Health	22/06/2016	07/06/2016	Yes	
2016/5511	92333	East ISD	22/06/2016	17/06/2016	Yes	4 week extn (from 25/5/16) agreed by Julia Barton. Booked to corp panel 17/06/16
2016/8949	85568	Mental Health	24/06/2016	22/04/2016	Yes	
2016/8941	94855	Mental Health	24/06/2016	10/06/2016	Yes	Booked on Corporate 10/06/2016
2016/9152	94472	North East ISD (PU)	28/06/2016	DATES AWAITED	Yes	
2016/9159	94615	Southampton & West ISD (PU)	28/06/2016	13/06/2016	Yes	Booked on Divisional MAP panel on 13/06/2016
2016/9165	94815	Southampton & West ISD (PU)	28/06/2016	23/06/2016	Yes	Divisional Panel 23/06/2016

4.3. Moving forwards:

4.3.1. 21 reports are due in July, 20 have panel dates

4.3.2. 40 reports are due in August, all have panel dates

5. Lessons Learned

5.1. Common themes resulting from the serious incident panels in May:

5.1.1. The Did Not Attend / Did Not Engage policy used in Mental Health and Older Persons Mental Health to be reviewed as could be viewed as inflexible and not meeting the needs of our service users. Task and finish group established to review the policy especially considering escalation of concerns following sudden and unexpected disengaging.

5.1.2. Lack of up-to-date risk assessments, care plans or risk factors which is captured solely in the RiO progress note is a contributory factor in a very high percentage of investigation reports. Thematic review has now been commissioned.

5.1.3. Lack of accurate next of kin information being kept within the clinical record. This makes contact difficult for the investigating officers and hampers the timely involvement of families in investigations.

5.1.4. Several cases where the investigation is completed but lacks information related to physical health provided by primary care. Engagement within the investigation process across service providers is not consistent. These have been reported to CCG Quality Managers for follow up within primary care.

5.2. One Trust-wide alert was published warning all staff of the dangers related to oxygen cylinders being managed in an upright position in people's homes. The correct position is side lying. A serious incident resulting in illness leading to death had occurred due to

a cylinder falling on an elderly patients foot which lead to the development of gangrene.

5.3. Improvement action plans resulting from major and catastrophic SI's are being scheduled to an Improvement Monitoring Panel where completion will be checked by the Executive Director level Chair. The first panel is scheduled to take place on 20th June 2016 and five improvement action plans are due to be heard.

6. Risks

6.1. There was a high level of activity of divisional and corporate panels during May to clear the backlog of serious incident investigation reports and there is a risk of slippage if the activity is not sustained during June. Twice weekly trajectory monitoring calls are in place as an early warning system to prevent this.

Improvement Plan for: CQC Warning Notice

Southern Health NHS Foundation Trust

Version No:
Final V1.0
Progress last updated: 08/06/2016 - TM

Date:
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Approved by:
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Ref No	Requirement Notice?	CQC KEY QUESTION	Core Service	Location	Theme	CQC actions required	Regulation breached	How the regulation was not being met	Outcome or Improvement the action will deliver once completed	Who is accountable for ensuring the action is completed? Name & Job Title	Action/s to be taken	How will completion of the action be evidenced (Evidence and method of review)	Who is responsible for completing the action Name & Job Title	Date action must be completed dd/mm/yyyy	Month	Action Progress Blue=Complete Green= Begun/On Track Amber= Risk of slippage Red=Overdue	Progress - to include position statement, risks, obstacles, action taken etc.	How will you evidence that the completion of the actions has led to the intended outcome	Intended Outcome Achieved Blue=Complete Green= Begun/On Track Amber= Risk of slippage Red=Overdue
1	Enforcement Action	WELL-LED	Provider / Trust	Board	Risk Management	Key risks and actions to mitigate risks were not driving the senior management team or the board agenda	Regulation 17 HSCA (RA) Regulations 2014 Good governance This is a breach of Regulation 17 (2) (a) (b)Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)	Key risks and actions to mitigate risks were not driving the senior management team or the board agenda	Board clearly sighted on and assured about the management of key risks and the delivery of the quality improvement agenda with clear sight of the mortality improvement plan and CQC improvement plans	Julie Dawes Director of Nursing	1.1 Central Quality Governance team to be restructured to deliver a Business Partner model (replicated from HR and Finance model) to strengthen the links and accountability lines between the central governance team and divisional quality structures.	New business partner model will be in place and posts will be appointed into (submission of documents)	Helen Ludford Associate Director of Quality Governance	31/08/2016	August	Green	May: New structure redesigned and proposal sent to Finance for final costings. Organisational Change HR Consultation with the central team underway. 2 - 4 week consultation required	Tracking examples of risks being identified and escalated Review of Board and sub-committee agendas at year end against top organisational risks	
									Clear Ward to Board visibility of reporting and accountability	Julie Dawes Director of Nursing	1.2 Review of Ward to Board reporting on quality performance (Board and its sub-committees)	2016/17 reporting schedule will be agreed at Trust Board (submission of documents)	Paul Streat MCP Development Director	30/06/2016	June	Green	May: Draft 2016/17 schedule developed awaiting NED and Executive approval before publication		
									Clear accountability demarkation for the quality agenda between Executive portfolios and shared responsibility for delivery between three clinical Executives to ensure accountability for delivery of quality improvement plan.	Katrina Percy Chief Executive	1.3 Executive Quality Portfolios to be revised and strengthened with the three Clinical Executives forming a 'Quality Team'	Executive portfolio changes will be published and communicated both internally and externally (submission of documents)	Julie Dawes Director of Nursing Chris Gordon Director for Improvement & Safety	30/06/2016	June	Green	May: Changes to portfolios agreed with Executives and NEDs in May 2016. New Director of Nursing commenced in post 03/05/16. Specific responsibilities to be agreed where portfolios overlap.		
									Strengthening of Professional leadership and Quality Governance focus within the Mental Health and Learning Disability Division	Julie Dawes Director of Nursing	1.4 Establishment of and appointment to new role - Deputy Director of Nursing and Quality,Mental Health and Learning Disabilities Division - to provide senior professional and governance leadership. Interim appointment to be made whilst the substantive appointment is recruited to	Interim and then substantive appointments made and individuals in post	Mark Morgan Divisional Director Mental Health and Learning Disabilities	Interim appointment 31/05/2016 Substantive appointment 30/11/2016	November	Green	May: Post agreed at Trust Executive Group. Interim appointment made (Debra Moore) to provide professional leadership pending recruitment of a substantive individual		
									Clear Ward to Board visibility of quality performance	Katrina Percy Chief Executive	1.5 New Divisional Quality Performance Reporting framework to be launched and embedded across the organisation to ensure Ward to Board quality performance reporting and escalation of concerns, including 'hotspot' reporting	Ward to Board audit trail of quality performance reporting (submisison of documents)	Julie Dawes Director of Nursing	31/07/2016	July	Green	May: Team level 'hotspot' Tableau reporting directly to Trust Executive Group from April 2016.		
									Improved risk management across the organisation	Julie Dawes Director of Nursing	1.6 Risk Management Policy to be reviewed (including Risk Appetite Statement)	Revised Policy will be published (submission of documents)	Helen Ludford Associate Director of Quality Governance	31/08/2016	August	Green	May: New Director of Nursing reviewing the Risk Policy and Risk Appetite Statement with the Risk Manager		
2	Enforcement Action	SAFE	Provider / Trust	Trust wide	Environment	The trust must make significant improvement to the safety and quality of healthcare provided by ensuring governance arrangements are effective in identifying and prioritising risks to patient safety arising from the physical environment including ligature risks, falls from height and risks from patients absconding	Regulation 17 HSCA (RA) Regulations 2014 Good governance This is a breach of Regulation 17 (2) (a) (b)Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)	The trust did not have effective governance arrangements that identified, prioritised and mitigated risks to patient safety, for example, ligature risks, fall from heights and risks from patients absconding	Capital planning process appropriately prioritising bids on the basis of clinical risk	Paula Anderson Chief Finance Officer Julie Dawes Director of Nursing	2.1 The Trust will review and redesign the Trust Infrastructure Group (TIG) decision making framework to ensure Quality Impact Assessment and Risk mitigation is a core element of prioritisation of capital bids. Capital bid applications will need to include a Quality Impact Assessment and Risk Score and all new bids will require a quality impact assessment in year.	Quality impact and risk mitigation will be in place at local unit level for all works (submission of documents)	Paul Johnson Head of Estate Services	30/06/2016	June	Green	May: New capital planning process in place. Clinical panel to review 'rejected' capital bids for 16/17 to ensure appropriate mitigation in place	Site visits consistently show evidence of staff aware of ligature risks associated with their units and of measures in place to mitigate risk.	
									Exception reporting to Trust Executive Group on a monthly basis to allow for early escalation of delays in enrivonmental improvement programme	Paula Anderson Chief Finance Officer	2.2 New process to be designed and fully implemented to ensure delays to any estates work linked to patient safety are escalated to both TIG and Trust Executive Group. This will include a monthly 'capital status report' to the Trust Executive group	Monthly exception reporting to TEG will be in place (submission of documents)	Paul Johnson Head of Estate Services	31/05/2016	May	Blue	May: Head of Estates Services provided a monthly exception report to Trust Executive Group in May and this is now a monthly standing item on the TEG agenda.		
									Strategic Capital plans will be in place improving the prioritisation, risk assessment and risk management of environmental risks at the frontline	Paula Anderson Chief Finance Officer	2.3 Develop a strategic 3 year capital programme to ensure appropriate short/medium/long term planning	Longer term strategic plans for Capital planning will be in place	Paul Johnson Head of Estate Services	31/03/2017	Mar-17	Green			
									Improved interface between estates and clinical services	Paula Anderson Chief Finance Officer	2.4 Each MH/LD/OPMH inpatient unit will have its own site-specific environmental and estate work plan. This will be held on a central sharepoint location in order that frontline staff can view the plan at any time. Capital prioritisation decisions will be formally shared in a set reporting framework with frontline clinical teams following every TIG meeting.	Environmental improvement plans will be in place. These will include estate works timescales (as appropriate). (review of sharepoint files)	Paul Johnson Head of Estates Services	30/06/2016	June	Green	May: Site-specigic work plans being developed to include actions arising from ligature risk assessments, site visits, staff feedback etc		
									Clear, visible plans will be in place on each unit	Paula Anderson Chief Finance Officer	2.5 Estates team to produce and install standardised displays of capital plans for each site	Clear plans will be displayed (site visits)	Paul Johnson Head of Estates Services	31/07/2016	July	Green	May: Examples of unit plans were shared at CQC delivery group on 06/05/2016		
									More robust risk identification and risk mitigation will be in place	Mark Morgan Divisional Director Mental Health and Learning Disabilities Division	2.6 The previous Task and Finish ligature group terms of reference and purpose will be reviewed and a new Trust Ligature Management Group will be formed. Membership will be reviewed and strengthened with increased clinical membership, including the appointment of a senior clinical co-chair with estates. The ToR will include the following elements:- - Act as an expert decision making group in relation to ligature decisions - Prioritise capital expenditure for ligatures against the capital control total agreed by the Trust executive - Ensure that there are processes in place to deliver the ligature management programme to include risk assessment and identification, operational mitigation and financial allocation - Develop a new risk assessment tool which will help the clinical teams to assess comprehensively - Ensure that the Trust is fully compliant with accepted standards & guidance from external agencies (eg.NICE) - Monitor and audit identified ligature works across the Trust - Monitor the uptake of E-Learning Training and Assessment on Ligature Risk Care - Monitor the quality and completion of Ligature Risk Assessments across the Trust - Ensure that appropriate management information is available for reporting - Continually identify areas for improvement	Minutes of Ligature Management Group Reports to Quality Improvement and Development Forum (QID) (submission of documents)	Paul Johnson Head of Estates Services Nicky Bennett Associate Director of Nursing - Forensic Services	28/02/2016	February	Blue	May: Terms of Reference amended, new clinical co-chair in place, new meeting agenda commenced, new risk assessment template developed - programme of support for teams to complete this in place. All units have been visited by Ligature project manager - posters in place on units.		
									Improved understanding of risk assessment and more consistent risk scoring at the frontline and more robust risk mitigation plans will be in place	Mark Morgan Divisional Director Mental Health and Learning Disabilities Division	2.7 The Trust ligature risk assessment tool will be redesigned away from using 'the Manchester Tool', to using industry agreed risk assessment methodology (5x5)	New risk assessment tool (submission of documents)	Paul Johnson Head of Estates Services Nicky Bennett Associate Director of Nursing - Forensic Services	30/04/2016	April	Blue	May: New assessment tool developed and launched in March/April.		
									Triangulation of risk assessment will ensure all risks, mitigations and controls are in place	Mark Morgan Divisional Director Mental Health and Learning Disabilities Division	2.8 An annual ligature risk assessment programme will be rolled out to include the newly appointed Project lead, estates lead and clinical lead for the area undertaking a joint risk assessment to ensure continuity, quality and a collective agreement as to the risks, mitigations and controls in place. This will report into the Trust ligature management group	All MH/LD/OPMH inpatient units will have a ligature risk assessment completed on the new paperwork that is accurate and of a high quality (submission of documents)	Paul Johnson Head of Estates Services Nicky Bennett Associate Director of Nursing - Forensic Services	30/06/2016	June	Green	May: 2016/17 annual programme being reported this month		
									Clear policy change and consistent implementation	Mark Morgan Divisional Director Mental Health and Learning Disabilities Division	2.9 The Ligature Management Policy will be updated to ensure the new risk assessment process is clearly documented	New Ligature management policy (submission of documents)	Paul Johnson Head of Estates Services Nicky Bennett Associate Director of Nursing - Forensic Services	30/06/2016	June	Green	May: Policy updated - due to be submitted to QID 03/06/2016 for ratification		
									Named lead will coordinate all elements of Ligature Risk assessment and mitigation	Mark Morgan Divisional Director Mental Health and Learning Disabilities Division	2.10 Appoint a dedicated full time Trust clinical ligature project manager	New manager in post	Nicky Bennett Associate Director of Nursing - Forensic Services	01/03/2016	March	Blue	May: Project manager commenced in role		
									All security risks will be clear to frontline teams and all will have management and mitigation plans in place	Paula Anderson Chief Finance Officer	2.11 Improve the robustness of the Site-specific security management reviews. All new reviews will go back over recommendations from previous years' reports to identify what actions, if any, have not been addressed and what management controls are in place to manage any identified risks	All security risks will be clearly identified, assessed and mitigated	Paul Johnson Head of Estates Services	30/08/2016	August	Green			
									Guttering will minimise the risk of patients accessing the roof	Mark Morgan Divisional Director Mental Health and Learning Disabilities	2.12 Install anti-climb guttering at Melbury Lodge to reduce the risk of service users accessing the roof and garden fencing. During the undertaking of the works, security will be enhanced in the garden area, staffing levels will be increased, risk assessments and admission criteria will be reviewed.	Guttering will be in place. Number of service users successfully accessing the roof will reduce (site visits)	Paul Johnson Head of Estates Services	11/05/2016	May	Blue	May: Installation completed mid May.		
3	Trust wide Must Do	SAFE	Provider / Trust	Trust wide	Environment	The trust must make significant improvement to the safety and quality of healthcare provided by ensuring governance arrangements: are effective in recording and implementing interim and long-term control measures to mitigate risks to patient safety arising from the physical environment including ligature risks, falls from height and risks from patients absconding.	n/a	n/a			See actions in 2 above							Clearly auditable evidence of identification and mitigation of risk and of appropriate escalation	
									Identification of themes and trends will be more robust	Julie Dawes Director of Nursing	3.1 The Trust approach to thematic review will be more systematic and robust. This will allow for more meaningful opportunities for staff to idenitfy trends and take appropriate action to implement control measures. Peer review schedule for 2016/17 will include thematic peer reviews over several sites.	Annual Thematic Review schedule will be in place and delivered (submission of documents)	Helen Ludford Associate Director of Quality Governance	30/06/2016	June	Green			
									QID will receive assurance of team-level mitigation of risks associated with the environment.	Julie Dawes Director of Nursing	3.2 The Quality, Improvement and Development Forum (QID) will receive assurance reports regarding the mitigation of risks associated with the environment. This will allow for exception reporting to the Quality & Safety Committee.	QID papers and minutes (submission of documents)	Deputy Directors of Nursing: Sara Courtney Paula Hull Debra Moore	31/07/2016	July	Green			
									Teams will have greater ability to review their own performance and understand how this is linked to their objectives including those around patient safety.	Paul Streat MCP director	3.3 Existing team dashboards will be further enhanced to align them to the Trut's approach to team-level objective setting via the navigational maps.	All teams will have team performance dashboards in place and Trust Board will have visibility of every teams performance (submission of documents)	Simon Beaumont Head of Information Sara Courtney Deputy Director of Nursing and Quality	31/03/2017	Mar-17	Green	May: Information team presenting team level performance to Trust Executive Group on a weekly basis from April 2016. Programme in place to roll out the planned improvements over the financial year.		
									Early intervention to provide support to struggling teams will mitigate the risk of significant deterioration in performance including that linked to the management of environmental risks	Julie Dawes Director of Nursing Sandra Grant Director of Workforce	3.4 A systematic approach to providing 'intensive support' to frontline teams highlighted as having a reduced level/quality of delivery performance will be developed and rolled out across the Trust throughout 2016 . This will include a review of Practice Development roles and capacity	Trust wide team performance will be supported with a systematic approach to 'intensive support' programmes (submission of documents)	Sara Courtney Deputy Director of Nursing and Quality	31/12/2016	December	Green	May: Organisational Development leads presented current programmes of support and a proposed 'intensive support' package to Trust Executive group in April 2016		
									Having a single, team level Improvement plan will enable teams to more accurately monitor and deliver required improvement actions including those linked to environmental risks	Julie Dawes Director of Nursing Chris Gordon COO, Director of Patient Safety	3.5 Team Quality Improvement plans will be in place for every team across the Organisation by the end 2016 These will encompass all elements of the Navigation Maps, will include core measures as well as tailored measures to the specific team objectives	Every team will have its own team level Improvement plan linked to its team Navigation Map, incorporating all improvement actions (submission of documents)	Sara Courtney Deputy Director of Nursing and Quality	31/12/2016	December	Green	May: Many teams within Learning Disabilities, Mental Health, Childrens and the ISDs have already initiated the creation of a single Improvement plan as a result of their Nav Map exercise. These are not standardised at present		
4	Enforcement Action	SAFE	Provider / Trust	Trust wide	Investigations & learning	The trust must make significant improvement to the safety and quality of healthcare provided by ensuring governance arrangements: are effective at delivering robust incident investigation to ensure opportunities for future risk reduction are identified and acted upon.	Regulation 17 HSCA (RA) Regulations 2014 Good governance This is a breach of Regulation 17 (2) (a) (b)Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)	The trust did not have effective governance arrangements to deliver robust incident investigation	New death reporting processes will be embedded across the organisation	Chris Gordon COO, Director of Patient Safety	The Trust will deliver the Mortality and SIRI action plan in full and to time.	Monitored through separate SIRI and Mortality Action Plan						Internal audit of investigation process to be added to audit schedule for Q4	
									Inpatient deaths in AMH/LD will be investigated in a consistent fashion	Chris Gordon COO, Director of Patient Safety	4.1 Amend Mortality reporting process to ensure all Learning Disability and Adult Mental Health inpatient deaths are reported as SIRIs and undergo full Root Cause Analyisis investigation	Updated policies and procedures Ulysses data (submission of documents)	Helen Ludford Associate Director of Quality Governance	30/06/2016	June	Green	May: All MH/LD inpatient deaths being reported as SIRIs. Procedure for Reporting and investigating deaths is in the process of being updated to reflect this change.		
									Ensure high quality of investigation and all opportunities for Organisational Learning are identified and actioned regardless of whether a SIRI or not	Chris Gordon COO, Director of Patient Safety	4.2 All Root Cause Analysis Investigations that are not SIRIs (excluding pressure ulcers) will go through the same processes as SIRIs, (this may include a thematic review where appropriate), including corporate panel sign off	Updated policies and procedures Ulysses data (submission of documents)	Helen Ludford Associate Director of Quality Governance	30/06/2016	June	Green	May: New process in place which ensures all RCAs go through corporate panel SIRI and incident policies being updated to reflect this change		
									Mitigate risks inherent in IMA stage of process	Chris Gordon COO, Director of Patient Safety	4.3 IMA audit tool will be amended to ensure it includes adequate checks against RIO	IMA audits undertaken and feedback provided to staff (submission of documents)	Helen Ludford Associate Director of Quality Governance	31/05/2016	May	Blue	May: IMA audit tool amended to include cross check with Patient Notes. Audits taking place on a monthly basis.		
									Improved experience for family members/carers involved in investigations into deaths	Lesley Stevens Medical Director	4.4 The Trust will commission an external review of the experiences of family members in the investigation process to provide recommendations on how this can be improved. Action will be taken based on review findings and recommendations	Review will be completed and clear improvement recommendations will be identified and implemented (submission of documents)	External Reviewer Helen Ludford Associate Director of Quality Governance	30/09/2016	September	Green	May: Review commissioned and investigator appointed. Work underway to contact families and set up interviews		
									A dedicated lead for Patient Experience will ensure maximum focus, coordination and improvement will be delivered across all services	Lesley Stevens Medical Director	4.5 The Trust will appoint a Trust Patient Experience Lead	Postholder will be in place with clear job description and clear objectives	Lesley Stevens Medical Director	30/06/2016	June	Green	May: post holder recruited and commenced in role. Final details of objectives being agreed.		
									Improve the culture of organisational learning from serious incidents	Chris Gordon COO, Director of Patient Safety	4.6 CAS system to be used to disseminate learning from SIRIs where corporate panel has grade these as level 4 or 5	Alert system will be in use and same day dissemination of learning from corporate panels will be evidenced (submission of documents)	Helen Ludford Associate Director of Quality Governance	30/05/2016	May	Blue	May: Internal alert procedure already in place via the CAS module on Ulysses. Template for sharing learning from corporate panels via this system has been developed and agreed.		
										Julie Dawes Director of Nursing	4.7 The Oranisational learning strategy will be reviewed and updated	New strategy (submission of documents)	Helen Ludford Associate Director of Quality Governance	30/08/2016	August	Green			

										Chris Gordon COO, Director of Patient Safety	4.8 Where corporate panels grade incidents as 4 or 5, a follow-up panel structure will be put in place to gain assurance re competion of action plans.	Panel minutes (submission of documents)	Helen Ludford Associate Director of Quality Governance	30/08/2016	August	Green			
										Chris Gordon COO, Director of Patient Safety	4.9 All SIRI investigation reports to include as standard a TOR which requires the investigator to determine whether any similar incidents have taken place within the team/unit in the preceeding 12 months and what action was taken as a result of these. This will allow for improved identification of themes and lead to improved actions to address the root causes. - 48hr panel chairs to be advised of new requirement - Commissioning manager training will include reference to this requirement	Investigation reports (submission of documents)	Helen Ludford Associate Director of Quality Governance	30/08/2016	August	Green			
										Sandra Grant Director of Workforce	4.10 The Trust will upskill frontline staff in quality improvement methodologies using the existing Team Viral programme to support this	Course content and Attendance logs (submission of documents)	John Monahan Organisational Development	31/03/2017	Mar-17	Green			
5	**Trust wide Must Do**	**RESPONSIVE**	Provider / Trust	Trust wide	Supporting staff	The trust must make significant improvement to the safety and quality of healthcare provided by ensuring governance arrangements: identify, record and effectively action concerns about patient safety raised by staff.	n/a	n/a	Improved medical leadership throughout the Organisation with standardised Role Descriptors and clear accountabilities and objectives	Lesley Stevens Medical Director	5.1 Medical Director will review Associate Medical Director appointments and Roles and clarify the role of the Clinical Director with Divisional Directors to ensure consistency	Standardised Role desciptors and job plans will be in place (submission of documents)	Divisional Directors	31/07/2016	July	Green	May: Review commenced		
									Improved senior leadership visibility at the frontline (including Executives and NEDs) and increased focus on Patient Safety	Julie Dawes Director of Nursing	5.2 A structured leadership visibility programme will be introduced to inlcude executive safety walkabouts, 'Back to the Floor' programme etc.	Programme to be in place and frontline teams to report increased visibility of senior leaders (submission of documents)	Helen Ludford Associate Director of Quality Governance	31/07/2016	July	Green			
									A more engaged workforce who feel supported to raise concerns and are confident they will be dealt with appropriately	Sandra Grant Director of Workforce	5.3 Undertake a review of the Trust's staff engagement strategy	Review report (submission of documents)	Amanda Smith Deputy Director of Workforce Emma McKinney Associate Director of communications	30/09/2016	September	Green			
									Staff clear as to the escalation processes that are in place to raise concerns about patient safety	Sandra Grant Director of Workforce	5.4 A review of staff feedback mechanisms will be undertaken to determine whether there are sufficient processes in place for staff to escalate matters beyond their line manager when these fall below the threshold that would require whistleblowing procedures to be followed. This will include a review of the methods through which feedback is collated and used when this is received at events such as staff briefings, staff survey etc. Promotion of exisiting/new mechanisms to be communicated to staff	Review report and communications (submission of documents)	Amanda Smith Deputy Director of Workforce Emma McKinney Associate Director of communications	31/10/2016	October	Green			
6	**Trust wide Must Do**	**SAFE**	Provider / Trust	Trust wide	Supporting staff	The trust must make significant improvement to the safety and quality of healthcare provided by ensuring governance arrangements: identify, record and effectively action concerns raised by staff about their competence to carry out their roles.	n/a	n/a			See action in 5 above								
									Improve staff engagement in the annual Training Needs Analysis process	Sandra Grant Director of Workforce	6.1 Ensure frontline staff are fully engaged in the Trust's Training Needs Analysis process by reviewing current practice and identifying ways in which this can be improved. Consideration will be given to the hosting of open days by the LEaD department and a communications drive during the months when the TNA process is undertaken.	Staff engagement activities around TNA (submission of documents)	Bobby Moth Associate Director of Leadership, Education and Development	31/10/2016	October	Green			
									Appraisal and revalidation process will be used to assess any skills and competency gaps and staff will be supported to address these.	Sandra Grant Director of Workforce	6.2 Conduct a staff survey to include a question that evaluates whether staff feel that their appraisal and/or revalidation process has adequately addressed their training needs	Survey results (submission of documents)	Amanda Smith Deputy Director of Workforce	30/09/2016	September	Green			
									Standardised approach to supervision to support staff and provide a structured 'space' for concerns around competencies to be raised	Julie Dawes Director of Nursing	6.3 A review of the current supervision policy and procedures to be undertaken to ensure they are fit for purpose and updated as necessary. This will include scoping the possibility of an electronic solution linked to the LEaD system to optimise supervision record keeping	Staff supervision records will be in place and staff will report supervision has taken place and has been effective	Paula Hull Deputy Director of Nursing and Quality	30/09/2016	September	Green			

Appendix 1 Improvement Plan for: CQC Inspection Recommendations - January 2016

Southern Health NHS Foundation Trust

Version No: FINAL V1.0
Progress last updated: 08/06/2016 - TM

Date: *27/05/2016*

Approved by:
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	Requirement Notice?	CQC KEY QUESTION	Core Service	Location	Theme	CQC actions required	Regulation breached	How the regulation was not being met	Outcome or Improvement the action will deliver once completed	Who is accountable for ensuring the action is completed?	Action/s to be taken	How will completion of the action be evidenced (Evidence and method of review)	Who is responsible for completing the action	Date action must be completed dd/mm/yyyy	Month last action will be completed	Action Progress Blue=Complete Green= Begun/On Track Amber= Risk of slippage Red=Overdue	Progress update on individual actions	How will you evidence that the completion of the actions has led to the intended outcome	Intended Outcome Achieved Blue=Complete Green= Begun/On Track Amber= Risk of slippage Red=Overdue
WARNING NOTICE ACTIONS 1-6 ARE PRESENTED ON A SEPARATE TAB																			
7	**Requirement Notice**	**SAFE**	Community-based mental health services for adults of working age.	Southampton AMH community teams	Risk assessments & care planning (including capacity & consent)	The trust must ensure that staff undertake risk assessments for all patients that use the service and that patients' care plans include the risks that have been identified and the actions required to manage these.	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment This is a breach of regulation 12(2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)	There was not consistent use of risk assessment processes. Crisis plans were not used consistently.	100% of risk assessments will be completed. Decreased numbers of patient safety incidents where failures in risk management were a contributory or causative factor.	Mark Morgan, Director of Operations (Mental Health, Learning Disabilities & Social Care)	7.1 Interim action: Update AMHT/CMHT SOP to limit the places on RiO where risk information is entered. (Risk Assessment module and the latest consultant letter only)	Revised SOP Communications to staff about revised SOP/minutes of team meeting discussions (Submission of documents)	Liz Durrant, Area Manager – Southampton AMH	30/06/2016	June	Green		Increased numbers of patients have a 'My Safety Plan' in place (trajectory to be determined by t&f group and evidenced by RiO report or manual audit) Increased compliance with new training programme (trajectory to be determined by t&f group and evidenced by LEaD reports) Thematic reviews of AMH incidents will be carried out on a 6 monthly basis and will expect to see a reduction in the number of incidents where failings in risk management were a causative or contributory factor.	
											7.2 Task & Finish Group to: - review the functionality of the existing RiO risk assessment tool and determine the improvements required - determine how the new 'My Safety Plan' (collaborative safety care plan) and crisis plans reflect the risk information and are incorporated onto RiO - carry out a gap analysis of the risk assessment and risk care planning training currently available and determine the improvements required - establish trajectory of compliance for My Safety Plans being in place and new risk management training being undertaken	Report from Task and Finish group (Submission of document)	Liz Durrant, Area Manager – Southampton AMH	30/09/2016	September	Green			
											7.3 Make the necessary changes to the risk module on RiO in association with Servelec to reflect the recommendations of the task and finish group	Updated risk assessment module on RiO (Submission of document)	Tony Goodwin, Senior Systems Manager	TBC at end Sept 16 (dependant on extent of changes recommended by T&F group)	TBC	Green			
											7.4 Devise a risk management training package and establish a programme to roll this out in 2017 that reflects the recommendations of the task and finish group	New training materials and schedule for roll out (Submission of documents)	Louise Hartland, Governance, Quality and Compliance Manager LEaD	31/12/2016	December	Green			
8	**Requirement Notice**	**SAFE**	Community-based mental health services for adults of working age.	Southampton AMH community teams	Risk assessments & care planning (including capacity & consent)	The trust must ensure that staff follow a consistent procedure for following up on patients who do not attend their appointments, especially those identified as posing a high risk of harm to themselves and/or to others.	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment This is a breach of regulation 12(2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)	There was no clear process for following up on patients who did not attend their appointments, even when a person was identified as high risk of harm to themselves and/or others.	A robust system and consistent procedure is in place applied 100% of the time. Decreased numbers of patient safety incidents where poor management of DNA episodes was a contributory or causative factor.	Mark Morgan, Director of Operations (Mental Health, Learning Disabilities & Social Care)	8.1 Interim action: All multi-disciplinary team meetings to include discussion of patients who DNA as a standard agenda item.	Communications to staff/minutes of team meeting discussion MDT agendas (Submission of documents)	AMH Area Managers: Liz Durrant Karen Guy Graham Webb	31/05/2016	May	blue	May 16 This is now a standing item on all MDT agendas	Corporate panels will monitor on an ongoing basis whether DNA management continues to be a contributory or causative factor in incidents Biannual audit of DNA management until practice is embedded	
											8.2 Administration of MDT meetings to be changed in order that discussions about patients who DNA and the plans that are agreed as a result are entered onto the individual patient's RiO record rather than in the MDT minutes	Audit of individual patient records who DNA as identified through Tableau report (Submission of documents)	AMH Area Managers: Liz Durrant Karen Guy Graham Webb	31/07/2016	July	Green			
											8.3 Revise the CMHT and AMHT Standard Operating Procedure to reflect the requirement for teams to discuss people who DNA at the MDT meetings	Revised SOP within AMHT and CMHT Communication of SOP amendments to team/discussion of SOP amendments at team meetings (Submission of documents)	Karen Guy. Area Manager- CMHT / Liz Durrant, Area Manager- AMHT	30/06/2016	June	Green	May16 AMHT SOPhas been updated. CMHT SOP is in progress		
											8.4 Complete the review of the current Clinical Disengagement Policy and make any necessary improvements to it. The review process will include a Soton Learning network event which will discuss learning from previous incidents associated with clinical disengagement.	Revised (Version 6) SH CP 97 "Clinical Disengagement / Patients who DNA" policy available on Trust website- (Submission of documents)	Area Heads of Nursing: Carol Adcock Nicky Duffin Liz James	30/09/2016	September	Green			
											8.5 Launch revised Clinical Disengagement policy including headlining it at AMH Learning Network event	Communications to staff and agenda of learning network event (Submission of documents)	Area Heads of Nursing: Carol Adcock Nicky Duffin Liz James	31/10/2016	October	Green			
9	**Requirement Notice**	**SAFE**	Child and adolescent mental health wards.	Bluebird House	Restrictive practice	The trust must ensure that it follows the Mental Health Act Code of Practice (chapter 26, paragraph 26.128). This requires that the responsible clinician or duty doctor (or equivalent) undertakes the first medical review of a young person in seclusion within one hour of the commencement of seclusion, if the seclusion was authorised by an approved clinician who is not a doctor or the professional in charge of the ward.	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment This is a breach of Regulation 12 (2) (a) (b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)	In Bluebird House medical staff were not able to attend young people's medical reviews, within one hour of the commencement of seclusion, as they had other commitments.	Trust will have a model of on-call cover that is able to meet the requirements of the MHA Code of Practice whilst being cost-effective and sustainable.	Dr Lesley Stevens, Medical Director	9.1 Interim action: Put plans in place to ensure Consultant Psychiatrist on-call or senior registrar on-call undertake the initial medical review for new episodes of seclusion out of hours if on-call trainee doctor is unavailable and that any breaches are reported on Ulysses as an incident.	Communications to staff Minutes of Trust SAFER group meetings Review of Ulysses incidents (Submission of documents)	Dr Mayura Deshpande, Clinical Service Director (SS) Mary Kloer, Clinical Director (AMH) Jennifer Dolman, Clinical Director (LD)	31/05/2016	May	blue	May 16 Consultant psychiatrists, senior registrars on on-call rota and senior nurses made aware of expectation.	Periodic audit of seclusion medical review until practice is embedded	
											9.2 Carry out a review of all episodes of seclusion in AMH, specialised services and LD from Dec 2015 - April 2016 to determine how many episodes of seclusion were not reviewed within the first hour by the on-call doctors out of hours and thereby establish scale of the problem.	Review report (Submission of documents)	Dr Mayura Deshpande, Clinical Service Director (SS) Mary Kloer, Clinical Director (AMH) John Stagg,Associate Director of Nursing (LD)	31/07/2016	July	Green			
											9.3 Use results of audit to feed into Trust-wide review of junior medical on-call	Trust-wide review report (Submission of documents)	Dr Mayura Deshpande, Clinical Service Director	31/08/2016	August	Green			
10	**Requirement Notice**	**SAFE**	Acute wards for adults of working age and psychiatric intensive care units	All wards	Environmental & equipment	The trust must ensure that premises and equipment are safe. The provider must identify and prioritise action required to address environmental risks on the wards, such as management of ligature points.	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment This was a breach of Regulation 12 (2) (b) (d) (g) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)	There has been insufficient action taken to identify and prioritise action required to address environmental ligatures on the wards.	A clear understanding by frontline staff of the ligature, environmental and equipment related risks on each inpatient unit and robust systems and processes for prioritising and managing these.	Mark Morgan, Director of Operations (Mental Health, Learning Disabilities & Social Care)	See Action 2 (warning notice tab) for Trust-wide actions which will include AMH services							Staff understanding of ligature management process evident on peer reviews/site visits and up to date unit-based environmental work plans in place Ongoing monitoring of incidents linked to ligature points or environment	
											10.1 Develop a clear process for identifying and prioritising environmental risks across AMH services that includes the process for escalation and governance responsibilities.	Environmental Process document for AMH Minutes of AMH Environmental Meetings (Submission of documents)	Nina Davies, Transformation Business Partner- Mental Health	31/05/2016	May	Blue	May 16 Process in place across the division. AMH minutes available.		
11	**Requirement Notice**	**SAFE**	Acute wards for adults of working age and psychiatric intensive care units	Kingsley Ward, Melbury Lodge	Environmental & equipment	The trust must ensure it takes sufficient action to manage the safety of patients at Kingsley ward, Melbury Lodge, including ensuring staff can clearly observe patients to mitigate environmental risks	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment This was a breach of Regulation 12 (2) (b) (d) (g) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) Regulation 17 HSCA (RA) Regulations 2014 Good governance This is a breach of regulation 17(1)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)	Insufficient action had been taken and to manage the safety of patients at Kingsley ward. Staff could not clearly observe patients and patients could access the roof and climb out of the wards garden. The trust had not ensured security arrangements were in place to keep patients safe whilst receiving care, including, restrictive protection required in relation to the Mental Health Act 1983. Patients detained under the Mental Health Act 1983 have absconded from Kingsley ward via the fence and the roof. The most recent abscond was 21 February 2016.	No incidents linked to AWOLS/falls from Melbury Lodge. Reduction in the number of incidents linked to observations on the unit	Mark Morgan, Director of Operations (Mental Health, Learning Disabilities & Social Care)	See action 2 (warning notice tab) in relation to Trust-wide improvements in ligature/estates management and action 2.12 specifically in relation to the Melbury roof								
											11.1 Domed mirrors to be installed on Kingsley Ward, Melbury Lodge to improve the sight lines	Domed mirrors in situ (site visit)	Paul Johnson, Head of Estate Services	31/05/2016	May	Blue	May16 Dome mirrors Installed on 16.5.16	Peer reviews and site visits Regular review of incidents linked to the environment at Melbury Lodge to identify any emerging or unresolved issues. Evidence of action taken in response to patient safety incidents related to the environment	
12	**Requirement Notice**	**SAFE**	Acute wards for adults of working age and psychiatric intensive care units	Kingsley Ward, Melbury Lodge	Environmental & equipment	The trust must ensure that it protects patients' privacy and dignity in a safe way on Kingsley ward.	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect This is a breach of Regulation 10(2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)	The trust had not ensured that patients' privacy and dignity is protected in a safe way on Kingsley ward.	Improved privacy and dignity for patients on Kingsley Ward whilst still allowing safe observations	Mark Morgan, Director of Operations (Mental Health, Learning Disabilities & Social Care)	12.1 Vistamatic windows to be installed on all 25 bedroom doors, Resource Room and Family Room	New doors installed (site visit)	Paul Johnson, Head of Estate Services	30/04/2016	April	Blue	May16 Vistamatic doors installed in April 2016	Review of patient feedback from Melbury ward to ensure continued patient satisfaction around privacy and dignity	
13	**Requirement Notice**	**SAFE**	Acute wards for adults of working age and psychiatric intensive care units	Hamtun PICU, Antelope House	Environmental & equipment	The trust must ensure that the works on the seclusion room on Hamtun psychiatric intensive care unit are completed so that the room is fit for purpose.	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment This was a breach of Regulation 12 (2) (b) (d) (g) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)	The seclusion room on Hamtun psychiatric intensive care unit is not fit for purpose.	Fit for purpose seclusion room on Hampton ward that complies with MHA Code of Practice Standards	Mark Morgan, Director of Operations (Mental Health, Learning Disabilities & Social Care)	13.1 Amend Hamtun seclusion room plans taking into account MHA Code of Practice and additional suggestions made by CQC	Revised seclusion room plans/drawings (submission of documents)	Paul Johnson, Head of Estate Services	31/05/2016	May	Blue	May16 A number of different design options have been provided to the Trust and these have been considered by the clinical team resulting in a preferred design option being agreed.	n/a - evidence of individual actions will provide the necessary assurance	
											13.2 PFI partners to provide costings for new design and issue tender	Costings and tender paperwork (submission of documents)		30/06/2016	June	Green	May16 An intrusive survey is being carried out on 01.06.16 following the design option chosen by the clinical team. Following this, the construction team will provide costs and timescales for the clinical team to sign off on 10th June.		

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No.	Requirement Notice?	CQC KEY QUESTION	Core Service	Location	Theme	CQC actions required	Regulation breached	How the regulation was not being met	Outcome or Improvement the action will deliver once completed	Who is accountable for ensuring the action is completed?	Action/s to be taken	How will completion of the action be evidenced (Evidence and method of review)	Who is responsible for completing the action	Date action must be completed dd/mm/yyyy	Month last action will be completed	Action Progress Blue=Complete Green= Begun/On Track Amber= Risk of slippage Red=Overdue	Progress update on individual actions	How will you evidence that the completion of the actions has led to the intended outcome	Intended Outcome Achieved Blue=Complete Green= Begun/On Track Amber= Risk of slippage Red=Overdue
											13.3 External contractor to carry out building works of new seclusion room	Building works completed on new seclusion room (site visit)		TBC after 30/06 (dependant on costings and tender process)	TBC	Green	May16 Options arising from the survey/costing stage will dictate the programme length. Building control will be required prior to commencing work (up to 4 week timeframe). It has been agreed with the contractors (Bellrock) that during this time materials will be ordered to allow commencement of building work immediately following building control sign off.		
											13.4 Interim action: Screen to be used as an interim measure, when the seclusion room is in use, to protect privacy and dignity of patients	ward manager spot checks	Liz Durrant, Area Manager – Southampton AMH	15/04/2016	April	Blue	May16 Screen being used for each seclusion episode		
14	Requirement Notice	SAFE	Acute wards for adults of working age and psychiatric intensive care units	Elmleigh & Melbury Lodge	Environmental & equipment	The trust must ensure that staff at Elmleigh and Kingsley ward at Melbury Lodge check and record medicine fridge temperatures to ensure medicines are stored at the correct temperature.	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment This was a breach of Regulation 12 (2) (b) (d) (g) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)	Staff did not always check and record medicine fridge temperatures at Elmleigh and on Kingsley ward at Melbury Lodge to ensure medicines were stored at the correct temperature.	Appropriate management of medication fridges	Dr Lesley Stevens, Medical Director	14.1 Medicines Management team to re-issue advice re action to be taken if outside of safe range.	communications from Meds management team (submission of documents)	Ewan Maule, Interim Chief Pharmacist	31/05/2016	May	Blue	May16 Communication regarding the requirements and escalation process sent out to staff from the Medicines Management Team	Site visits and peer reviews consistently find evidence of fridge temperatures being managed appropriately	
											14.2 Fridge temperature monitoring template to be reviewed and re-issued so as to assure standardisation across the trust	New template (submission of documents)	Vanessa Lawrence, Pharmacy Lead	30/06/2016	June	Green			
											14.3 Survey of the maximum temperatures reached in all inpatient dispensing rooms where medicines are stored to be carried out and solutions to be sought to ensure temperatures remain within the recommended limits (e.g. air conditioning installation)	Completed survey results and plans for remedial works (submission of documents)	Paul Johnson, Head of Estate Services Vanessa Lawrence, Pharmacy Lead	30/06/2016	June	Green			
15	Requirement Notice	SAFE	Wards for people with learning disabilities and autism	Evenlode	Environmental & equipment	The trust must ensure that environmental risks are addressed at Evenlode and that appropriate measures are implemented to effectively mitigate the risks to patients using the service.	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment This was a breach of Regulation 12 (2) (d) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)	The environmental risks at Evenlode must be addressed. Until the necessary changes are made to make the environment as safe as possible, appropriate measures must be implemented immediately to mitigate effectively the risks to people using the service.	A safe environment will be provided for patients at Evenlode with remedial estates works completed as appropriate and residual risks managed through clinical risk management processes.	Mark Morgan, Director of Operations (Mental Health, Learning Disabilities & Social Care)	See action 2 (warning notice tab) regarding Trust-wide improvements in ligature/estates management which will apply to Evenlode								
											15.1 Introduce immediate safeguards to ensure patient safety - shortening of cables - review of ligature risk assessments - review and update patient risk plans - increase night time observations	(Site visits) Evidence was also reviewed by CQC at repeat visit in February 2016.	Linda Kent, Ward Manager	30/03/2016	March	Blue	May16 All actions taken following initial CQC visit and evidence provided to CQC during repeat visit in February 2016	Peer reviews and site visits Regular review of incidents linked to the environment at Evenlode to identify any emerging or unresolved issues. Evidence of action taken in response to patient safety incidents related to the environment	
											15.2 Engage and consult effectively with the patient group around further changes being made to reduce the risk from ligature points.	Minutes from patient engagement meetings,1-1 discussions documented in care notes (submission of documents)		31/05/2016	May	Blue	May16 Patients have been involved and consulted with regarding the planned bedroom refurbishment works.		
											15.3 Schedule of bedroom works to be completed by external contractors	Bedroom works completed (site visits)	Paul Johnson, Head of Estate Services	30/07/2016	July	Green	May16 Programme of refurbishment of bedrooms underway. New doors ordered with integrated hinges and vistamatic panels. Integrated door alarm to be fitted.		
											15.4 Once structural bedroom works are completed, install new ligature-free beds and wardrobes.	New furniture in place (site visits)		31/07/2016	July	Green	May16 Wardrobes and beds ordered and awaiting completion of bedrooms for installation.		
16	Requirement Notice	SAFE	Wards for people with learning disabilities and autism	The Ridgeway Centre	Environmental & equipment	The trust must take action to address the remaining environmental risks at the Ridgeway Centre.	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment This was a breach of Regulation 12 (2) (d) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)	Known environmental risks at the Ridgeway Centre had not been addressed.	A safe environment will be provided for patients at The Ridgeway Centre with remedial estates works completed as appropriate and residual risks managed through clinical risk management processes.	Mark Morgan, Director of Operations (Mental Health, Learning Disabilities & Social Care)	See action 2 (warning notice tab) in relation to Trust-wide improvements in ligature/estates management which will apply to The Ridgeway Centre							Peer reviews and site visits Regular review of incidents linked to the environment at Evenlode to identify any emerging or unresolved issues. Evidence of action taken in response to patient safety incidents related to the environment	
											16.1 Address outstanding ligature points in garden as highlighted by CQC	remedial works carried out (site visit)	Paul Johnson, Head of Estate Services	31/05/2016	May	Blue	May16 Work to remove residual ligature risks identified in garden have been undertaken		
17	Requirement Notice	SAFE	Wards for people with learning disabilities and autism	Evenlode	Environmental & equipment	The trust must ensure that the clinic room at Evenlode is fit for purpose and contains all appropriate essential equipment for resuscitation.	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment This was a breach of Regulation 12 (2) (d) Health and Social Care Act 2008 (Regulated Activities)	The clinic room at Evenlode must be made fit for purpose and contain all appropriate essential equipment for resuscitation.	Safe fit for purpose clinic room facility	Mark Morgan, Director of Operations (Mental Health, Learning Disabilities & Social Care)	17.1 Identify gaps in essential resuscitation equipment and purchase any necessary additional equipment	equipment in place (site visit)	Linda Kent, Ward Manager	31/05/2016	May	Blue	May16 Resus bag now equipped as per policy.	Site visits and peer reviews consistently find clinic room fit for purpose	
											17.2 Remove staff lockers currently within clinic room	no unnecessary items in clinic room (site visit)		31/05/2016	May	Blue	May16 Lockers removed from clinic room		
											17.3 Purchase clinic room treatment chair	equipment in place (site visit)		30/06/2016	June	Green	May16 Treatment chair ordered.		
18	Requirement Notice	SAFE	Wards for people with learning disabilities and autism	Evenlode	Supporting staff	The trust must ensure that staff at Evenlode receive appropriate and up to date specialist training to be able to carry out their jobs as safely and effectively as possible.	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment This was a breach of Regulation 12 (2) (d) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)	The training, learning and development needs of staff had not been identified and actions taken to meet any gaps.	Staff feel properly trained to carry out their roles and supported in accessing this.	Mark Morgan, Director of Operations (Mental Health, Learning Disabilities & Social Care)	18.1 Review all staff training records to ensure compliance with statutory and mandatory training and seek staff views as to additional training they feel is required.	Training Records and 1:1/appraisal paperwork (site visit)	Linda Kent, Ward Manager	30/06/2016	June	Green	May16 Staff have had 2x away days where they identified some training needs over and above stat and man training. Stat and Man compliance is being monitored on a rolling basis through divisional performance meetings Additional training needs analysis to be undertaken.	Report that provides assurance that staff have accessed all the training that they and their line manager agreed was required following individual training needs analysis	
											18.2 Liaise with LEaD to establish how best to meet identified training needs on an ongoing basis and ensure all staff are booked onto required courses.			30/06/2016	June	Green	May16 External specialist training in forensic risk assessment and general update in forensic practice has been organised.		
19	MUST	SAFE	Wards for people with learning disabilities and autism	Trust wide	Supporting staff	The trust must ensure that its 'Protocol for the Safe Bathing and showering of People with Epilepsy' is embedded as swiftly as possible and that staff receive appropriate training to ensure understanding and consistency of practice.	n/a	n/a	100% compliance with 'Protocol for the Safe Bathing and showering of People with Epilepsy' for inpatients with epilepsy.	Mark Morgan, Director of Operations (Mental Health, Learning Disabilities & Social Care)	19.1 The protocol will be re-visited with all appropriate staff through discussion in team meetings. Reference to the protocol will be included in local induction checklists.	Staff to sign to evidence reading and understanding of bathing protocol Updated local induction checklists (submission of documents)	Evenlode - Linda Kent, Ward Manager RWC - Paul Munday, Clinical Service Manager	31/05/2016	May	blue	May16 Evenlode - 100% of currently available staff have signed to say have read.. RWC - 100% of staff currently available to work have received and signed for in respect of receiving the protocol.	Bathing care plan audits Staff awareness demonstrated at peer review/site visits	
											19.2 Posters to be created and placed in each room with a bath	Posters visible in each bathroom (site visits)	Evenlode - Linda Kent, Ward Manager RWC - Paul Munday, Clinical Service Manager	31/05/2016	May	blue	Local induction checklist for LD inpatient services has been amended to add reference to Bathing protocol Posters created and in place		
20	Requirement Notice	SAFE	Wards for people with learning disabilities and autism	Evenlode & The Ridgeway Centre	Investigations & learning	The trust must ensure that learning takes place following serious incidents.	Regulation 17 HSCA (RA) Regulations 2014 Good governance This is a breach of Regulation 17(2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)	The trust had not analysed and responded to information gathered from internal reviews to take action to address issues where they were raised, or used information to make improvements and demonstrated they have been made. The trust had not monitored progress against plans	Learning is shared. Actions and recommendations have been considered and, where appropriate, applied not only within the team but across the service, the division or the entire Trust.	Julie Dawes, Director of Nursing & AHPs	See action 3 (warning notice tab) re plans for team-based improvement plans that will apply across the organisation and action 4 (warning notice tab) re sharing learning across the Trust.								
											20.1 Add standing agenda item regarding learning from incidents to local quality and governance meetings.	Agendas and minutes of local quality and governance meetings (submission of documents)	Evenlode - Linda Kent, Ward Manager RWC - Paul Munday, Clinical Service Manager	30/06/2016	June	Green	May16 Local Quality Governance meetings (monthly) now include a standing agenda item "Learning from Experience"	Site visits and peer reviews consistently find that staff are able to describe learning from incidents across the Trust	
21	Requirement Notice	EFFECTIVE	Wards for people with learning disabilities and autism	Evenlode & The Ridgeway Centre	Supporting staff	The trust must ensure that staff at the Ridgeway Centre and Evenlode receive consistent and regular supervision and senior management oversight.	Regulation 18 HSCA (RA) Regulations 2014 Staffing This is a breach of Regulation 18(2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)	Staff did not receive appropriate on-going supervision in their role.	100% of available staff have received supervision in the last 6 weeks.	Julie Dawes, Director of Nursing & AHPs	See action 5 (warning notice tab) for Trust-wide actions in relation to the supervision process.								
											21.1 Roll out a programme of regular supervision in Evenlode and the Ridgeway Centre ensuring that by end June 2016, all clinical staff have had a clinical supervision session and there is a clear schedule for future supervision in place.	Supervision records (submission of documents)	Evenlode - Linda Kent, Ward Manager RWC - Paul Munday, Clinical Service Manager	30/06/2016	June	Green	May16 Evenlode - Dates booked for staff to receive supervision in May. Supervision data to be collated weekly RWC - Supervision database available.	Site visits and peer reviews consistently find that supervision records on staff files show 4-6 weekly supervision sessions	
22	Requirement Notice	RESPONSIVE	Wards for people with learning disabilities and autism	Evenlode & The Ridgeway Centre	Environmental & equipment	The trust must make the necessary improvements to the environment at both services in order to protect people's dignity and privacy at all times.	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect This is a breach of Regulation 10(2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)	The provider must make the necessary improvements to the environment at both services in order to protect people's dignity and privacy at all times.	Privacy and dignity will be maintained.	Mark Morgan, Director of Operations (Mental Health, Learning Disabilities & Social Care)	22.1 Install curtains in patient bedroom (RWC)	Environmental modifications in place (Site visits)	Paul Munday, Clinical Service Manager	31/05/2016	May	Blue	May16 Curtains purchased and fitted in relevant bedroom.	Site visits, peer reviews and patient feedback consistently report privacy and dignity being managed appropriately at the two sites	
											22.2 Seek options (from various specialist resources / national standards) for door observation panels that do not compromise privacy and dignity (Evenlode)		Linda Kent, Ward Manager	30/06/2016	June	Green	May16 Doors with integrated hinges and Vistamatic viewing panels have been identified as part of programme of works. Doors will be fitted with integrated alarms. Estates negotiating alarm fitting with manufacturer		
23	SHOULD	RESPONSIVE	Provider / Trust	Trust wide	Investigations & learning	The trust should review its policies relating to complaints to ensure they reflect current legislation, best practice, role and responsibilities and the management of local concerns. It should continue to improve the way it responds to complaints and ensure robust, consistent systems for sharing and learning from complaints across the trust.	n/a	n/a	Up to date policy and procedure which reflect best practice and National Guidance and lead to an improved complaints process reflected by feedback from complainants and staff.	Helen Ludford - Associate Director Quality Governance	23.1 Undertake a thematic peer review of the complete complaints management process involving staff and complainants to review the process in practice and make recommendations for improvements	Thematic peer review report with recommendations and SMART action plan which will be presented to QID (submission of documents)	Tracey McKenzie - Head of Compliance	30/06/2016	June	Green	May16 Working group established, thematic review TOR agreed, review in progress and on target for draft report to be written by mid June.	Improved feedback from all staff involved in complaints process/response sign off and feedback from complainants	
											23.2 Review complaint policy and procedure to ensure that they are aligned with national best practice guidance and incorporate recommendations from the thematic peer review	Revised policy and procedure available for staff on website & communicated via weekly bulletin and incorporated into relevant training (submission of documents)	Cathy Lakin - Complaints Manager	31/07/2016	July	Green	May16 Initial review of policy against national guidance completed. Further review to take place following peer review		
24	SHOULD	RESPONSIVE	Provider / Trust	Trust wide	Investigations & learning	The trust should continue to develop its complaints reports to the board to contain more detailed analysis and explanation so the board is provided with more robust information for assurance.	n/a	n/a	More informative Board sub-committee reports to present themes and assure Board that learning from complaints is being implemented	Helen Ludford - Associate Director Quality Governance	24.1 Enhance the reports submitted to Quality & Safety Committee and the Exec Board Report to include: - evidence of specific learning and service improvement as a result of complaints - case trend analysis related to areas, services and staff groups - evaluation of quality of complaint response letters (6 monthly)	Revised reports to QSC & Board (submission of documents)	Cathy Lakin - Complaints Manager	30/06/2016	June	Green		Positive feedback from Board members that they are assured through reports they receive that service improvements are taking place as a result of complaints	
25	SHOULD	EFFECTIVE	Community-based mental health services for adults of working age	Southampton AMH community teams	Supporting staff	The trust should ensure that staff in all teams receive regular supervision and that this is used to support implementation of the improvement	n/a	n/a	100% of available staff have received supervision in the last 6 weeks.	Kate Brooker, Associate Director- MH	See action 6 (warning notice tab) re Trust-wide plans relating to the supervision process								

	Requirement Notice?	CQC KEY QUESTION	Core Service	Location	Theme	CQC actions required	Regulation breached	How the regulation was not being met	Outcome or Improvement the action will deliver once completed	Who is accountable for ensuring the action is completed?	Action/s to be taken	How will completion of the action be evidenced (Evidence and method of review)	Who is responsible for completing the action	Date action must be completed dd/mm/yyyy	Month last action will be completed	Action Progress Blue=Complete Green= Begun/On Track Amber= Risk of slippage Red=Overdue	Progress update on individual actions	How will you evidence that the completion of the actions has led to the intended outcome	Intended Outcome Achieved Blue=Complete Green= Begun/On Track Amber= Risk of slippage Red=Overdue
			age.			plan. Supervision should include a review of caseloads and monitoring of care records.					25.1 Supervision templates developed by LD and Specialised services to be reviewed and the most appropriate one circulated for interim use within AMH	Communication of template to staff/minutes of team meeting discussions (submission of documents)	AMH Area Managers: Liz Durrant Karen Guy Graham Webb	31/05/2016	May	blue	May16 Interim template has been circulated to teams	Site visits and peer reviews consistently find that staff feel supported and have clinical supervision in place	
											25.2 AMH specific clinical supervision template to be designed	Standardised template in use across all AMH teams (site visits)		30/06/2016	June	Green			
											25.3 All Soton community staff to have had first supervision session and planned schedule of supervision sessions in place	Monthly supervision date reports reviewed by area managers monthly and submitted quarterly to AMH Performance and Assurance Board, evidenced in minutes (submission of documents)		31/07/2016	July	Green			
26	SHOULD		Child and adolescent mental health wards.	Bluebird House	Involving patients	The trust should ensure that there are suitable arrangements in place to ensure that all young people are involved in all aspects of planning their care and treatment in Bluebird House	n/a	n/a	Increased young persons' engagement in their care planning	Nicki Brown, Associate Director, Specialised Services	26.1 Consultant psychiatrists and ward managers to ensure that all patients have advanced statements	Audits of patient records (submission of documents)	Dr Mayura Deshpande, Clinical Service Director, Bluebird House	30/06/2016	June	Green	May16 Communication sent to consultants by clinical services director outlining expectations	Consistent evidence at site visits, peer review and through patient feedback of involvement in care planning.	
											26.2 Template of CPA meeting to be changed to ensure wishes of young people are formally captured	New template (submission of documents)	Karen Dixon, Modern Matron	31/05/2016	May	Blue	May16 New template in use		
											26.3 Additional staff to be trained in graphic facilitation so as to roll it out to all CPA meetings to help improve patients' understanding and involvement in treatment planning	Training records for graphic facilitation and CPA minutes (submission of documents)		31/12/2016	December	Green			
27	SHOULD		Child and adolescent mental health wards.	Bluebird House	Restrictive practice	The trust should ensure that where rapid tranquilisation is used by intramuscular injection, young people in Bluebird House have their physical health observations monitored on the format within their care files.	n/a	n/a	Improved aftercare for patients receiving intramuscular rapid tranquilisation medication.	Nicky Bennett, Clinical Service Manager	27.1 Remind all clinical staff of the risks associated with using Rapid Tranquilisation intramuscular medication and the benefits of the Track and Trigger tool	Communications to staff (submission of documents)	Dr Mayura Deshpande, Clinical Service Director, Bluebird House	31/05/2016	May	blue	May16 Communication has been sent out to staff	Consistent evidence at site visits, peer review and through audit of track and trigger tool being used post administration of rapid tranquilisation IM.	
											27.2 Ensure reference to Track and Trigger Tool is included on local induction checklist for agency staff.	Amended local induction checklist (submission of documents)	Karen Dixon, Modern Matron	30/06/2016	June	Green			
											27.3 Carry out an audit of compliance with the Track and Trigger tool from March-May 2016 to determine scale of compliance issues and allow better targeted future interventions aimed at increasing compliance with its use.	Audit report (submission of documents)		31/07/2016	July	Green			
28	SHOULD		Child and adolescent mental health wards.	Bluebird House	Restrictive practice	The trust should ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely. The provider should ensure that they address the high levels of prone restraint and provide staff at Bluebird House with appropriate restraint training as agreed.		n/a	A clear restraint reduction strategy will be in place and there will be robust Trust systems for monitoring the numbers, positions and durations of restraints with the wishes of patients will be taken into account.	Dr Lesley Stevens, Medical Director	28.1 Develop a Trust position statement that sets out the principles staff should work to with regards to restrictive practice. This will sit above a suite of policy documents and protocols that address restraint, seclusion, rapid tranquillisation and relational security.	Position statement (submission of documents)	Dr Mayura Deshpande, Clinical Service Director, Bluebird House & Chair of Safer Forum Debra Moore, Deputy Director of Nursing - MH/LD	31/07/2016	July	Green		Monitoring of restraint by Safer Forum will show restraint techniques being used in accordance with Trust position statement and policy. Duration of restraint will be closely monitored with outlying trends investigated	
											28.2 Review the restrictive interventions policy, in line with the position statement and address any identified gaps	Revised restrictive interventions policy (submission of documents)				Green			
											28.3 Review the training programme, in line with the new restrictive interventions policy, and produce a paper with recommendations for future training	Recommendations paper presented to TEG Minutes of TEG discussion (submission of documents)				Green			
											28.4 Implement the changes to the training programme and roll-out to relevant staff groups	Revised training materials and roll-out schedule (submission of documents)	Simon Johnson, Head of Essential Training Delivery	TBC following outcome of recommendations paper	TBC	Green			
											28.5 Ulysses to be updated and staff to record the duration of each type of restraint as part of the incident reporting processes. Statistics from these incidents will be reviewed as part of the services governance arrangements and issues will be escalated via the SAFER forum.	Through regular reports to the Trust Quality Improvement and Development Forum. Monthly review via local governance and Monthly review at Safer forum (submission of documents)	Tom Williams, Risk Manager & Ulysses System Developer Dr Mayura Deshpande, Clinical Service Director, Bluebird House & Chair of Safer Forum	31/07/2016	July	Green			
29	SHOULD		Child and adolescent mental health wards.	Bluebird House	Risk assessments & care planning (including capacity & consent)	The trust should ensure that suitable arrangements are in place to obtain the consent of patients in relation to the care and treatment provided in Moss and Steward wards in Bluebird House.	n/a	n/a	All clinicians who undertake therapeutic activities with patients will record the patients' consent in their electronic patient record.	Nicki Brown, Associate Director, Specialised Services	29.1 Staff to be trained in assessing and recording of capacity and consent as part of their local induction (open to all staff).	Training records held by the Modern Matron Audit of records (submission of documents)	Karen Dixon, Modern Matron Dr Mayura Deshpande, Clinical Service Director, Bluebird House	31/07/2016	July	Green		Consistent evidence at site visits and peer reviews and through documentation audit of capacity to consent to treatment being recorded appropriately.	
30	SHOULD		Child and adolescent mental health wards.	Bluebird House	Restrictive practice	The trust should ensure that staff in Bluebird House always record the length of seclusion and the time when seclusion has ended.	n/a	n/a	All episodes of seclusion will be carried out in accordance with the Mental Health Act 1983 Code of Practice and Trust policy	Nicki Brown, Associate Director, Specialised Services	30.1 Design seclusion flow chart	New flow-chart (submission of documents)	Dr Mayura Deshpande, Clinical Service Director Karen Dixon, Modern Matron	30/06/2016	June	Green		Seclusion paperwork consistently found to be compliant with MHA Code of practice on audit or peer review/site visit spot checks	
											30.2 Review Trust seclusion documentation to ensure it is as simple as it can be for staff to complete.	Revised seclusion documentation (submission of documents)		30/06/2016	June	Green			
											30.3 Carry out a scoping exercise to look at the possibility of moving seclusion paperwork to RiO	Feasibility paper (submission of documents)		31/12/2016	December	Green			
31	SHOULD		Child and adolescent mental health wards.	Bluebird House	Restrictive practice	The trust should ensure that staff in Bluebird House continue to monitor the use of prone restraint and there is senior oversight of this.	n/a	n/a	All episodes of restraint recorded as per Trust policy	Dr Lesley Stevens, Medical Director	See action 28 above.								
32	SHOULD		Child and adolescent mental health wards.	Bluebird House	Environmental & equipment	The trust should ensure that a medical emergency bag is available on all wards at Bluebird House. We noted the wards were spread out and it would take staff in the region of five minutes to go to Hill ward where the bag was kept, potentially putting young people at risk.	n/a	n/a	Medical emergency bags are available for use on each ward	Nicky Bennett, Clinical Service Manager	32.1 New emergency bags to be ordered and placed on each ward.	Emergency bags in situ on each ward (site visit)	Karen Dixon, Modern Matron	10/06/2016	June	Green	May16 New bags have been ordered and are due for delivery beginning June	n/a - evidence of individual actions will provide the necessary assurance	
33	SHOULD	EFFECTIVE	Acute wards for adults of working age and psychiatric intensive care units	All wards	Risk assessments & care planning (including capacity & consent)	The trust should ensure that it clearly documents the decision-making behind judgements of a patient's capacity to make a decision.	n/a	n/a	The inpatient's mental capacity to consent will have been recorded and staff will be able to see and monitor any changes.	Kate Brooker, Associate Director- MH	33.1 The Ward round proforma which is copied to each patient's RiO record will be amended and standardised for all inpatient units to include the following: - Does the person have the capacity to consent to treatment? Y/N, Why? - Are there any other decisions that require capacity testing? Y/N/ Who will test/ When? This is to be discussed and documented in all MDT meetings and the additional prompts around the capacity to consent will be contained within the MDT pro forma.	Compliance to be monitored as part of recordkeeping audits (submission of documents)	AMH Area Managers: Liz Durrant Karen Guy Graham Webb	30/06/2016	June	Green	May16 The pilot to be implemented within the AMH Wards by end of May, with embedding and evaluation period during June 2016.	Consistent evidence at site visits and peer reviews and through documentation audit of capacity to consent to treatment being recorded appropriately.	
34	SHOULD	CARING	Acute wards for adults of working age and psychiatric intensive care units	All wards	Involving patients	The trust should ensure it clearly documents when patients have been involved in the development of their care plan.	n/a	n/a	The care plans will be completed in a person centred way with person's view recorded	Kate Brooker, Associate Director- MH	34.1 Supervision template to be amended to include requirement for care plans to be reviewed. This will allow documentation around patient involvement to be picked up and discussed on an individual basis with staff.	Documentation audits Patient experience surveys (submission of documents)	Area Heads of Nursing: Carol Adcock Nicky Duffin Liz James	31/07/2016	July	Green		Documentation audits and spot checks at peer review and site visits consistently show evidence of patient involvement in developing care plans.	
35	SHOULD	SAFE	Wards for people with learning disabilities and autism	Evenlode & The Ridgeway Centre	Supporting staff	The trust should make every effort to ensure there are enough qualified nursing staff recruited to fully staff both services.	n/a	n/a	Full nursing establishment in place in order to provide safe services	Simon Tarrant	35.1 Ensure staff establishment is met with Trust recruitment processes being followed.	Budget and staffing in post reflect WTE. Recruitment drive in place to deliver any shortfall. (submission of documents)	Evenlode - Linda Kent, Ward Manager RWC - Paul Munday, Clinical Service Manager	31/05/2016	May	blue	May16 Evenlode - All posts filled, no current need for recruitment. RWC - as all staff are at risk pending divestment of service from SHFT, recruitment will not go ahead. Safe services will be maintained through a balance of number of admissions, use of NHS P staff (incl agency) together with consideration of remaining numbers of substantive staff. This will be reviewed on a weekly basis.	Ongoing monitoring of staffing levels and review of patient safety incidents to ensure there are no themes or trends that emerge relating to staffing levels.	
36	SHOULD	CARING	Wards for people with learning disabilities and autism	Evenlode & The Ridgeway Centre	Involving patients	The trust should ensure it engages and consults effectively with patients whenever significant changes are to be made that will affect them or will impact on the service they receive.	n/a	n/a	Patients are informed and consulted when any changes within the service are planned	Donna Schell, Strategic Change Lead	36.1 Establish programme of patient meetings that include planned changes within service.	Patient Community Meeting Agenda (submission of documents)	Evenlode - Linda Kent, Ward Manager	30/06/2016	June	Green		Patient satisfaction with level of information being provided about service change as evidenced at patient meetings and through monitoring of complaints and other feedback.	
											36.2 Extra-ordinary Meetings to be held if changes need to be made rapidly.	Minutes of Meetings with Patients (submission of documents)	RWC - Paul Munday, Clinical Service Manager	30/06/2016	June	Green			
											36.3 Meetings minuted and copies of minutes available for patients to access.	Minutes of Meetings with Patients (submission of documents)		30/06/2016	June	Green			
37	SHOULD	CARING	Wards for people with learning disabilities and autism	Evenlode & The Ridgeway Centre	Involving patients	The trust should consult with patients and review the activities provided for them at both services, to make sure that the activities provided meet people's needs and are in line with their wishes.	n/a	n/a	Patients have range of activities that meets their needs and wishes.	Simon Tarrant, Forensic Service Manager	37.1 OT to consult with Patient group to discuss and understand their needs and preferences	Revised activity programme and evidence of patient engagement (submission of documents)	Catherine Loadman / Michelle Dale	30/06/2016	June	Green		Patient satisfaction with activities on offer as evidenced through site visits/peer review and from monitoring of complaints and other feedback.	
											37.2 OT to develop activity programme that meets people's needs and wishes and is linked to their goal setting to promote discharge			30/06/2016	June	Green			
38	SHOULD	WELL-LED	Wards for people with learning disabilities and autism	Evenlode	Supporting staff	The trust should consult openly with the staff at Evenlode about the long-term future of the service. The trust should take steps to improve staff morale, to ensure all staff at the service feel fully supported and are able to share in the trust's vision and values.	n/a	n/a	Staff kept informed of the future of Evenlode.	Donna Schell, Strategic Change Lead	38.1 Ensure regular communications to the team either by letter, email or face to face to keep them up to date with future plans regarding the Evenlode service.	Evidence of regular communication / meetings with the Team	Simon Tarrant, Forensic Services Manager	30/06/2016	June	Green	May16 Updates provided to team at Away Days (April)	Staff satisfaction with level of information being provided to them as evidenced through site visits/peer review and from monitoring of complaints and other feedback from staff.	

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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		UPDATE ON "GETTING THE BALANCE RIGHT IN COMMUNITY-BASED HEALTH SERVICES"		
DATE OF DECISION:		30 JUNE 2016		
REPORT OF:		DIRECTOR OF SYSTEM DELIVERY - NHS SOUTHAMPTON CITY CLINICAL COMMISSIONING GROUP		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Dawn Buck**	**Tel:**	**023 80296932**
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STATEMENT OF CONFIDENTIALITY		
None		
BRIEF SUMMARY		
This report provides a review of both quantitative and qualitative data on the impact of closing the service and an update on progress on the actions that were agreed by the Southampton City CCG Governing Body and Health Overview and Scrutiny Panel (HOSP).		
RECOMMENDATIONS: That the Panel:		
	(i)	Note the progress on decommissioning of the Bitterne Walk in Service (BWIS) and consider the information presented at the meeting and following discussions comment on the report.
	(ii)	Note that the recommendations around the closure of the service, that were the responsibility of the CCG to enact, have been completed.
REASONS FOR REPORT RECOMMENDATIONS		
1.	The Health Overview and Scrutiny Panel has requested regular updates on the impact and implementation of the closure of the Walk-In Service.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
2.	Not applicable.	
DETAIL (Including consultation carried out)		
	Overview	
3.	Following a public consultation in the summer 2015, the CCG, on 31st October 2015, decommissioned the Walk-in Service at Bitterne Health Centre (BWIS), provided by Solent NHS Trust. Funding for the service has remained with Solent and transferred to the community nursing service line, as set out in the case for change	
4.	As part of the decision making of the Governing Body, the following actions were identified: • Develop a clear plan with the GP Federation and other primary care	

	providers to improve GP access. This will also inform the primary care strategy. • Increase public awareness on urgent and emergency care services as a priority • Develop and implement a detailed communication plan • Develop and implement reporting mechanisms to review both quantitative and qualitative impacts of closing the service.
5.	Subsequent to the decision by the Governing Body, Southampton City Health Overview and Scrutiny Panel (HOSP) accepted the decision and made the following monitoring recommendations: • Circulate the draft Urgent and Emergency Communication Plan to the Panel for comment. This action is complete. • Circulate response times and key performance information relating to the NHS 111 and GP out of hours services to the Panel. This action is complete. • Consider the proposal for a community hub on the east side of Southampton at a future meeting of the Panel, if the scheme progresses. This action lies with Southampton City Council. • Provide data reports for the Panel to scrutinise the impact and implementation of the closure of the BWIS at each HOSP meeting until the Panel informs the CCG that the information is no longer required. This action is in progress. All the above recommendations have been enacted by the CCG where it is their responsibility so to do.
	Communications and Engagement
6.	Communications and engagement has continued throughout the last six months with particular emphasis on supporting local people to manage common winter and spring conditions such as coughs, colds and hay fever. Messaging included top tips to treat symptoms along with the promotion of the relevant services. Information was disseminated via: • social media (Twitter and Facebook): we sent around 155 messages on Twitter over this period with each message being seen on average 646 times, we posted 44 times on Facebook and these posts reached around 26,760 people • press releases, including articles regarding pharmacies and online access to GP appointment booking and repeat prescription ordering were covered by the Daily Echo • ongoing radio advertising aimed at 15-40 year olds over the winter period directing people to their local pharmacy and NHS 111 • Solent NHS Trust and Southern Health NHS Foundation Trust, who have provided all their front line staff with a supply of NHS 111 wallet cards to hand out during patient consultations • posters advertising NHS 111, pharmacies and online services were distributed to practices, pharmacies, libraries, schools and nurseries throughout the city • BBC Radio Solent's Big Cuppa event at the Guildhall to reduce isolation • public engagement events at community centres, children's centres and Sikh and Hindu temples • community groups such as Black Heritage and Priory Road Luncheon

	Club. The urgent and emergency communications plan continues to form part of the CCG's business as usual.
7.	A separate communications plan has been developed to improve access to GPs. This is intended to provide a firm platform for the delivery of the overarching strategy for primary care which is part of Better Care Southampton plan. The communications plan will be supported by both the CCG and NHS England and will involve practices advertising their services on their websites, in their newsletters, via social media and on a face to face basis. In conjunction with this the CCG has: • provided practices with a comprehensive communications and marketing support including an upcoming social media workshop. • disseminated messages throughout our wide ranging network of schools, nurseries, major employers, community and voluntary groups via a variety of channels. • worked with local media to promote the benefits of online access. • attended local community events to encourage people to register for online appointment booking. Baseline data has been recorded on a per practice basis and we will measure ongoing progress.
	Monitoring the Impact
8.	The qualitative impact is monitored through the CCGs normal monitoring mechanism. We have used a range of methods to enable people to give us feedback about their personal experiences of health services since the closure of the Bitterne walk-in service. The methods we have used are as follows: • Patient Experience/Complaints Service • Two roadshows/market stands in Bitterne precinct • Website, social media and mailbox • Surveys • Service user forums such as: Patients' Forum, Equality Reference Group, Communications and Engagement Group, Consult and Challenge • Group interviews with: Thornhill Health & Wellbeing Network (THAWN) Together Reducing Isolation Project (TRIP) SO18 Big Local Health & Wellbeing sub committee Sure Start East Lunch club, St.Denys Southampton Women's Forum • Health watch • The media.
	Qualitative feedback received

<table>
<tr><td>9.</td><td>• Patient Experience/Complaints Service - We have not received any complaints about the closure of the service. We have received two enquiries through the patient experience service asking about the availability of the monitoring data.
• Email - We have received one email from a patient in Eastleigh who had gone to the walk-in service and did not know it had closed and was concerned. This patient was referred to West Hampshire CCG as she was a registered patient in Eastleigh.
• Roadshows - A total of 149 face to face contacts were made during two roadshows in Bitterne precinct. Patient experience leaflets were distributed to everyone to provide the opportunity to share a personal experience. No-one said that they had been personally affected by the closure but there were three comments about the service:
    o “instead of closing down BWIS, more should be opened instead to take the pressure of A&E”
    o “now that BWIS is closed there is nothing on this side of the city”
    o “You used to be seen quite quickly at the BWIS”
Some people were not aware of GP practice extended hours and 12 people had not heard of NHS 111
• Group interviews - All participants said that there had been no immediate effect on them or their family by not having access to the BWIS. Two participants had used the MIU for incidences for which they would have previously gone to the walk-in service.
• Service user forums - All our service user forums provide opportunities for people to share patient experiences of local health services. Apart from individual service users we also have representatives of voluntary and community groups who are active in their local community. No-one has reported a negative effect following the closure with one group representative and health watch representative commenting:
“We have heard of no negative incidents since the closure of Bitterne Walk in Centre, the people we have spoken to have said that they have either been telephoning 111, or use the Minor Injury Unit at the Royal South Hants hospital. We have just had a couple of people say that they miss the centre being there, but that is all.”
• Health watch - Health watch has not reported any individual complaints to us. They have however enquired about the six month monitoring data – a copy of which will be made available to them.
• Social media and media - Since November 2015 we have received one enquiry via twitter and one from a local journalist, both enquiries asking for information about the monitoring report.</td></tr>
<tr><td></td><td>Qualitative Surveys</td></tr>
<tr><td>10.</td><td>In early 2016 we carried out a survey to understand local people’s experience of booking an appointment at their GP practice:
• Availability of appointments. When asked if patients had witnessed any improvements in the waiting time for a GP appointment over the last six months 39% of people said it had stayed the same, whilst 57% of people thought it had deteriorated. Further investigation of this issue with GP practices revealed that an average of 6300</td></tr>
</table>

appointments were missed every month. Making use of these missed appointments would reduce the waiting times for other patients. The CCG therefore launched a promotional campaign, in collaboration with the Daily Echo, to encourage local people to cancel their unwanted appointments. The evaluation of this campaign will be available at the end of July 2016.

- **Online Access**. The survey results went on to detail how 64% of respondents had registered for online appointment booking with a further 14% believing that online registration would help them to access their GP.
- Overall, in terms of access, people were happy with the range of options available for appointment booking making suggestions to improve the current situation which included adding more appointments to the online system and allowing family members to have linked accounts. They were however still disappointed at how long they needed to wait to access GP services.
- The results of the surveys will also inform the commissioning arrangements for extended access to primary care. We intend to continue working closely with practices over the coming months to ensure that patients are aware of the available appointments and how to access them, making use of online systems where appropriate.
- In addition to this work we also undertook a survey to understand people's knowledge of urgent care services in the city and asked respondents what services they would use in a variety of situations.
- We undertook this survey during November and December 2015 and repeated it in June 2016. The initial survey received 57 responses and the second 465.
- The biggest shift in attitude over the six month period were the actions people would take if they became unwell and needed help straight away. When asked who they would contact first in 2015 44% of people said either A&E or 999. In June 2016 this figure had fallen to 9%.
- In 2015 44% of people said that their GP would be their first port of call if they became unwell however in June this number had increased to just over 75%.
- It was however disappointing to see that self-care and pharmacy received little recognition as viable options when people become unwell.
- When moving on to discuss what people would do if they experienced a minor injury, in June 42% said they would visit the Minor Injury Unit (MIU) at the Royal South Hants Hospital, this had fallen from 53% in 2015.
- A further 20% noted that they would visit a walk in centre; this could potentially refer to the MIU, as some people mentioned the 'walk in centre at the Royal South Hants'. Conversely, it could infer a lack of knowledge of the closure of the walk-in service at Bitterne.
- We also asked people where they would go if they or a family member was experiencing a mental health crisis. Whilst 60% said GP, 14% said they didn't know what they would do, with only 9% of respondents mentioning NHS 111 in relation to a mental health crisis. This demonstrates that more work is needed to promote the mental health support available in the city.

	• We proceeded to prompt respondents as to their awareness of the various urgent health services in the city and were encouraged to see that in June 2016 everyone responding had either heard of or used their GP practice, local pharmacy or A&E. There was however, little recognition of the minor ailments service which offers free medicines for a range of minor health issues, to anyone who receives free prescriptions. • Only half of respondents had heard of community mental health services, supporting the evidence in the previous question that more work is needed in this arena. • Finally, when asked if they had any comments around the provision of urgent health care in Southampton, 250 people responded in the June survey. Of these comments, approximately 10% related to the closure of walk-in services such as Bitterne and Shirley as well as requests for more walk-in services. This tied in with around 20% of the comments which referred to a lack of GP access in the city. These comments detailed both long waits for appointments as well as a perceived lack of evening and weekend surgeries. • People also commented that more information was needed as to the availability of services with 8% of people particularly referencing a lack of mental health support or understanding of how to access it.
	Quantitative Impact
11.	The BWIS closure impact monitoring data pack for June (based mainly on April data) can be found at Appendix 1. This data pack is refreshed monthly and forms part of the CCG routine performance monitoring. The data at 6 months post-closure shows: • There has been no significant negative impact on other urgent care services. • There has been no significant variance/demonstrable change in the behaviour of East locality patients where not anticipated. • The MIU has seen the biggest increase in activity from East locality patients. This was expected (actively promoted as an alternative, along with pharmacies and 111), planned for and managed. • A seasonal trend of activity increase in all services with patients from all areas, with demand particularly high in March 2016 (this winter's flu season came later and with a higher rate of flu-like illness than in previous years). • While numbers of patients accessing urgent care services increased over winter (across the board) the % proportion of those from the East locality has not increased significantly with the exception of the MIU (expected). • The majority of Southampton patients (>900 per month) previously attending the BWIS have not attended MIU or ED since the BWIS has closed.
	Community Nursing Service
12.	The community nursing service received additional investment in 2014/15 in recognition of significant workload pressures which has been sustained through the BWIS funding bringing the establishment up to 101.5 WTE. The investment made into the service has provided a 6.2% increase in direct visits to patients and carers between 2014/15 and 2015/16 (and a 33.8%

increase in overall service user contacts, including non face to face contacts). During 2014/15, 116,677 contacts were recorded; this increased to 156,137 contacts during 2015/16. Some of these contacts can also be attributed to a change in workforce configuration, but the increased investment has boosted the capacity of the service as it faces increasing demand due to an ageing population with increased complexity of need.

13. The data for the community nursing service is also monitored monthly. The profile of alert status for the community nurses is shown below. This reporting is incorporated into the data pack at Appendix 1 and illustrates that there has been a significant reduction since November 2015 in the occurrences when the service is on black alert (i.e. service failing as a result of insufficient capacity to meet demand). There has been a corresponding slight increase in the occurrences when the service is at green status. It should be noted however that the service continues to be frequently on red (under severe pressure) and amber (under moderate pressure) alert, partly as a result of increasing numbers and complexity amongst the city's older people population and partly owing to difficulties in recruitment.

	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
Black	15%	70%	63%	70%	68%	20%		0%	5%	5%	5%	5%
Red	34%	6.0%	23%	2%	9%	14%		26%	43%	55%	38%	45%
Amber	26%	2%	2%	2%	4%	8%		42%	43%	20%	57%	4%
Green	9%	0%	0%	1%	3%	5%		5%	9%	15%	0%	10%
Data not available	16%	22%	12%	25%	16%	53%		27%	0%	5%	0%	0%

14. Commissioners are continuing to work with the provider to closely monitor performance and promote the development of resilient sustainable working practices, embedding best practice such as that set out in the NHSE Framework for Commissioning Community Nursing. A new vision for Community Nursing in the city has been developed within the context of the city's Better Care programme, based around the 6 local primary care clusters, which has had strong engagement from Solent NHS Trust, other NHS Trust providers, the City Council, Primary Care, voluntary sector and local people and a project group has been set up to implement this in 2016/17. This work is covering a range of aspects such as effective workload management, embedding approaches to self-care and person centred commissioning, workforce planning to meet current and future needs, leadership and governance, driving up quality and use of technology.

15. Members are asked to consider the information presented at the meeting and following discussions comment on the report.

RESOURCE IMPLICATIONS

Capital/Revenue

16. None.

Property/Other

17. None.

LEGAL IMPLICATIONS		
Statutory power to undertake proposals in the report:		
18.	The duty for local authorities to undertake health scrutiny is set out in National Health Service Act 2006. The duty to undertake overview and scrutiny is set out in Part 1A Section 9 of the Local Government Act 2000.	
Other Legal Implications:		
19.	None	
POLICY FRAMEWORK IMPLICATIONS		
20.	None	
KEY DECISION	No	
WARDS/COMMUNITIES AFFECTED:	None directly as a result of this report	

SUPPORTING DOCUMENTATION

Appendices		
1.	Bitterne Walk-in Service (BWIS) closure impact monitoring Data available at June 2016	
Documents In Members' Rooms		
1.	None	
Equality Impact Assessment		
Do the implications/subject of the report require an Equality and Safety Impact Assessments (ESIA) to be carried out.		Yes
Privacy Impact Assessment		
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.		No
Other Background Documents **Equality Impact Assessment and Other Background documents available for inspection at:**		
Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)	
1.	None	

Bitterne Walk-in Service (BWIS) closure impact monitoring
Data available at June 2016

(April 2016 data, 6 months post closure)

Contents

June update report for monitoring of SCCCG and East GP registered patients' activity within the urgent care system (data mainly from April 2016 – 6 months post closure)

- Slide 2 – summary at June
- Slide 3 - reporting time line
- Slide 4 - utilisation of Pharmacy First Minor Ailments scheme
- Slide 5 - GP patient access and experience
- Slide 6 - referrals to GP hubs (Southampton Primary Care Ltd, SPCL)
- Slide 7 - calls to 111 (South Central Ambulance Service, SCAS)
- Slide 8 - 111 patient experience
- Slide 9 - calls to GP Out of Hours (OOH, Partnering Health Ltd, PHL)
- Slide 10 - OOH patient experience
- Slide 11 – paediatric activity and utilisation of Children's Outreach Assessment and Support Team (COAST, Solent NHS Trust)
- Slide 12 - attendances to Minor Injuries Unit (MIU, Care UK)
- Slide 13 - MIU patient experience
- Slide 14 - attendances to Emergency Department (ED, University Hospital Southampton)
- Slide 15 – BWIS user activity at MIU and ED before and after closure
- Slide 16 – Community Nursing capacity (Solent NHS Trust)

BWIS closure impact monitoring – summary at 10/06/2016

Service/activity	Measure (East locality)	Anticipated impact	Post BWIS closure												Comments on East locality activity post BWIS closure
			Against baseline - East locality						Month on month trend - East locality						
			Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	
Pharmacy First	Number of patients using service	Increase	▼ (orange)	▲ (green)	▲ (green)	▲ (green)	▲ (green)	▲ (green)	▼ (orange)	▲ (green)	▲ (green)	▼ (orange)	▲ (green)	▼ (orange)	Positive uptake, particularly in March
SPCL hub utilisation	Number of referrals	Increase	▲ (green)	▲ (green)	▲ (green)	▲ (green)	▲ (green)	Data n/a	▲ (green)	▲ (green)	▼ (orange)	▲ (green)	▼ (orange)	Data n/a	Positive uptake, reporting ceased in March
111 calls	% proportion of calls	Slight increase	▲ (orange)	▲ (orange)	▲ (orange)	▲ (orange)	▶ (green)	▼ (green)	▲ (orange)	▶ (green)	▲ (orange)	▼ (green)	▼ (green)	▼ (green)	No significant impact to service; 1% increase in % proportion of calls out of all Southampton calls
OOH calls	% proportion of calls	Slight increase	▶ (green)	▲ (orange)	▲ (red)	▲ (orange)	▶ (green)	▲ (orange)	▶ (green)	▲ (orange)	▲ (red)	▼ (green)	▼ (green)	▲ (orange)	No significant impact to service; 1% increase in % proportion of calls out of all Southampton calls
COAST utilisation	Number of referrals	Slight increase	▲ (green)	▲ (green)	▼ (orange)	▶ (green)	▼ (orange)	▼ (orange)	▲ (green)	▼ (orange)	▼ (orange)	▲ (green)	▼ (orange)	▲ (green)	No significant change in referral numbers, no significant impact on ED or short stay admissions
MIU attendances	% proportion of attendances	Increase	▲ (orange)	▲ (orange)	▲ (orange)	▲ (orange)	▲ (orange)	▲ (orange)	▲ (orange)	▲ (orange)	▲ (orange)	▼ (green)	▲ (orange)	▲ (orange)	6% increase in % proportion of all Southampton attendances, expected and managed
ED attendances	% proportion of attendances	No change	▶ (green)	▶ (green)	▲ (orange)	▲ (orange)	▶ (green)	▶ (green)	▶ (green)	▶ (green)	▲ (orange)	▲ (orange)	▼ (green)	▶ (green)	No significant impact to service: 1% increase in % proportion of all Southampton attendances
Community nursing capacity	Number of reported level blacks	Reduction	▼ (green)	▼ (green)	▼ (green)	▼ (green)	▼ (green)	▼ (green)	▼ (green)	▶ (green)	▼ (green)	▲ (orange)	▶ (green)	▶ (green)	Reduction in level black status, staffing WTE sustained, increase in contacts

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June report mainly April 16 data – sixth month post closure, with some data available for May

No significant negative impact to other urgent care services to highlight

- MIU has seen the biggest increase in activity from East locality patients – expected, planned for and managed
- No significant variance/demonstrable change in behaviour for East locality patients where not anticipated
- Note that Pharmacies, 111 and MIU have been and still are actively promoted as alternative services to BWIS
- Note that data is not weighted and that East GP registered population is greater that other localities (35% , vs 33% Central and 32% West*)*

Impact monitoring and reporting timeline

Month	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	*Jul 16*	*Aug 16*	*Sept 16*	*Oct 16*
Report	Baseline	1	2	3	4	5	6	7	8	*9*	*10*	*11*	*12*
CPT	28th	11th	2nd	6th	3rd closed	n/a	n/a	n/a	n/a	*n/a*	*n/a*	*n/a*	*n/a*
SMT BTM	29th	12th	3rd	7th	4th 29th	31st	28th	26th	23rd	*28th*	*25th*	*22nd*	*27th*
CEG		18th	9th	13th	10th	16th	13th	11th	15th	*20th*	*17th*	*21st*	*12th*
GB (*public)		25th *		27th *	24th	23rd *	27th	25th *	29th	*27th **	*31st*	*28th **	*26th*
HOSP		26th		28th		24th	28th		30th		*25th*		*27th*
Check points	Baseline					1st impact review (3m data)			2nd / final impact review (6m data to GB)				*3rd/final impact review (10m data)*
Notes	All baseline data to be received by 30/10	First reports received and reporting format approved	Reports timely and working	Follow up GP survey	Reporting becomes business as usual as part of CCG finance and activity and performance report for 16/17 (as agreed by GB and HOSP)				Confirm if report needs to continue BI to run deep dive into MIU & ED activity by BWIS users before and after	*Follow up GP survey*			*Confirm if report needs to continue*
NB:	Data will be mainly M5 (Aug)	Data will be mainly M6 (Sept)	Data will be mainly M7 (Oct)	Data will be mainly M8 (Nov)	Data will be mainly M9 (Dec)	Data will be mainly 10 (Jan)	Data will be mainly M11 (Feb)	Data will be mainly M12 (Mar)	Data will be mainly M1 (Apr)	*Data will be mainly M2 (May)*	*Data will be mainly M3 (June)*	*Data will be mainly M4 (July)*	*Data will be mainly M5 (Aug)*

BWIS closure impact monitoring – data at June 2016 (to May)

Pharmacy First minor ailments scheme utilisation

GP registered practice	Average weekly activity			% of total utilisation		
	East	West	Central	East	West	Central
Baseline	4	4	7	28%	24%	48%
Nov-15	3	2	12	15%	14%	71%
Dec-15	7	3	7	45%	15%	40%
Jan-16	9	5	15	30%	17%	53%
Feb-16	6	4	13	26%	16%	58%
Mar-16	18	6	14	48%	14%	38%
Apr-16	7	4	14	27%	17%	56%
May-16	8	3	9	38%	14%	47%

Pharmacy accessed	Average weekly activity			% of total utilisation		
	East	West	Central	East	West	Central
Baseline	3	3	9	22%	17%	61%
Nov-15	2	2	12	12%	14%	74%
Dec-15	7	2	8	42%	12%	46%
Jan-16	8	4	17	28%	14%	59%
Feb-16	5	3	15	22%	12%	66%
Mar-16	18	5	15	46%	14%	40%
Apr-16	6	4	15	24%	16%	59%
May-16	6	3	11	31%	14%	55%

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Would otherwise have attended	Weekly feedback			
	GP	WIC	ED	Other
Baseline	85%	4%	0%	11%
Nov-15	91%	3%	0%	6%
Dec-15	89%	6%	0%	5%
Jan-16	97%	0%	1%	2%
Feb-16	94%	2%	2%	2%
Mar-16	88%	5%	0%	7%
Apr-16	90%	4%	0%	6%
May-16	79%	5%	4%	12%

- Utilisation of the scheme has been gradually increasing over time, peaking in March
- The scheme is aimed at patients who are eligible for free prescriptions – the majority of patients presenting are <16 years
- There are a range of common minor illness and ailments covered – the majority of patients are presenting with paediatric fever, cough, cold, earache and sore throat
- The majority of East patients using the service are from 3 practices (whose patients were previously high users of the BWIS) – Chessel, Bath Lodge and West End Road
- There are currently 6 pharmacies across the East locality accredited to provide this service, including a 100hr pharmacy and 2 in close proximity to Bitterne Health Centre, which are all being utilised
- We will continue with targeted engagement and take learning from the practices and pharmacies actively promoting this service to further increase usage

BWIS closure impact monitoring – data at June 2016

GP access and patient experience

Question	Survey published	SCCCG	National	East practices at or above national average
Overall, how would you describe your experience of your GP surgery?	July 2015 Jan 2016	84% good 84% good	85% good 85% good	6/10 6/10
Generally, how easy is it to get through to someone at your GP surgery on the phone?	July 2015 Jan 2016	68% easy 69% easy	71% easy 70% easy	5/10 5/10
How helpful do you find the receptionist at your surgery?	July 2015 Jan 2016	87% helpful 88% helpful	87% helpful 87% helpful	7/10 7/10
The last time you wanted to see or speak to a GP or nurse, were you able to get an appointment to see or speak to someone?	July 2015 Jan 2016	84% yes 84% yes	85% yes 85% yes	4/10 5/10
How convenient was the appointment you were able to get?	July 2015 Jan 2016	90% convenient 92% convenient	92% convenient 92% convenient	4/10 3/10
Overall, how would you describe your experience of making an appointment?	July 2015 Jan 2016	72% good 73% good	73% good 73% good	4/10 3/10
How do you feel about how long you normally have to wait to be seen?	July 2015 Jan 2016	51% not too long 52% not too long	58% not too long 58% not too long	2/10 2/10
Did you have confidence and trust in the GP you saw or spoke to?	July 2015 Jan 2016	91% yes 91% yes	92% yes 92% yes	5/10 7/10
Did you have confidence and trust in the nurse you saw or spoke to?	July 2015 Jan 2016	84% yes 83% yes	85% yes 84% yes	8/10 10/10
How satisfied are you with the hours that your GP surgery is open?	July 2015 Jan 2016	76% satisfied 75% satisfied	75% satisfied 75% satisfied	4/10 4/10
Aware of online booking for appointments (used online booking in last 6 months)	July 2015 Jan 2016	28% (6%) 29% (8%)	27% (7%) 29% (7%)	N/A
Aware of online ordering of repeat prescriptions (used online ordering in last 6 months)	July 2015 Jan 2016	25% (8%) 27% (10%)	28% (13%) 30% (10%)	N/A

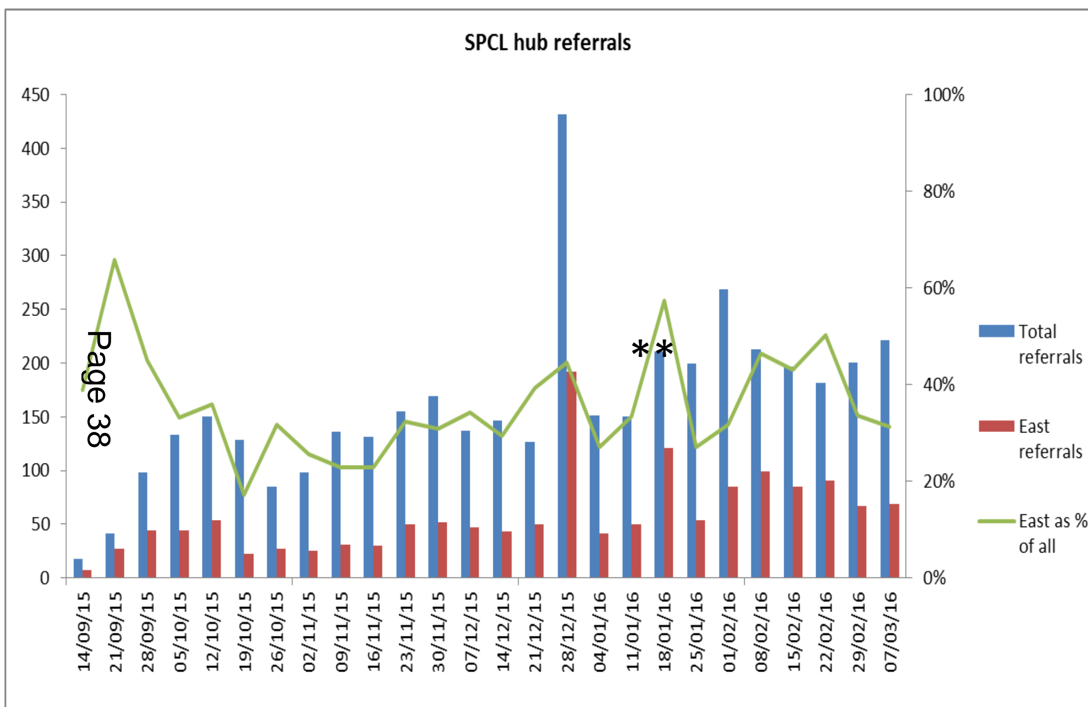
Data source: NHSE GP patient survey - SCCCG slide packs

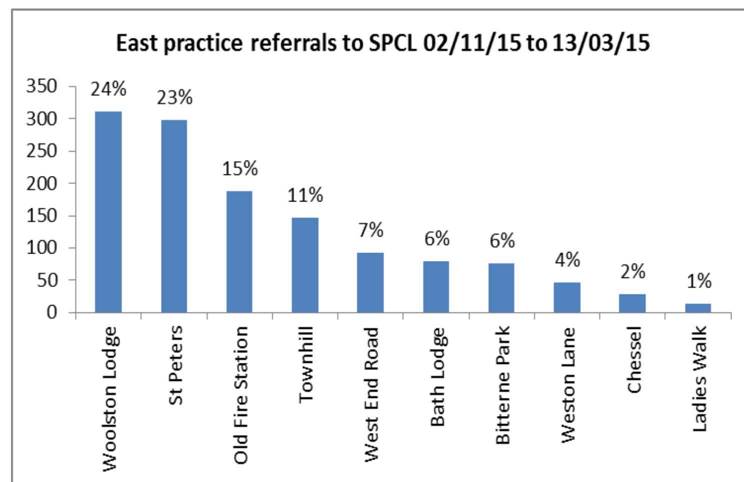
- Baseline July 2015 survey results (for period July – September 2014 and January – March 2015)
- January 2016 survey results (for period January – March and July to September 2015)
- Next survey due July 2016

Note GP feedback and experience is reported in the qualitative impact monitoring

BWIS closure impact monitoring – data at June 2016 (to w/c 07/03/16)

Referrals to Southampton Primary Care Ltd (SPCL) GP hubs





SPCL weekly referrals	Baseline average	Post closure average
All practices	93	185
East practices	32	67
East as % of all	34%	36%

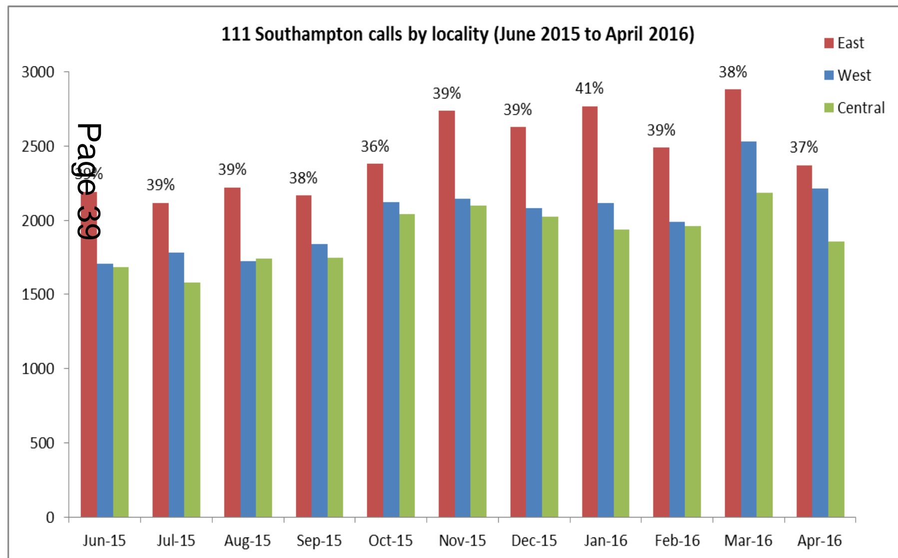
- 3 hubs in city (1 in each locality, East went live first)
- East locality practices averaging 36% of all hub activity since BWIS closure
- ** Hubs went live on 111 DoS from 15th January 2016 and are accepting patients via 111 to support managing demand on OOH service

BWIS closure impact monitoring – data at June 2016 (to April)

Calls to 111

Calls to 111	Baseline average	Post closure average
Southampton as % of all	15%	14%
East as % of Southampton	38%	39%
East as % of all	6%	6%

111 calls	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Total calls answered	37945	38115	40722	38611	43024	46610	50068	49046	44490	52253	42704
Calls answered within 60 seconds (≥95%)	98%	96%	97%	95%	93%	92%	89%	77%	70%	57%	90%
Calls abandoned before answered (<5%)	0.2%	0.4%	0.7%	0.5%	0.8%	0.9%	2%	4%	4%	8%	2%
Southampton patient call volume	5582	5480	5687	5753	6539	6981	6727	6824	6436	7595	6445
Southampton as % of all	15%	14%	14%	15%	15%	15%	13%	14%	14%	15%	15%
East	2193	2117	2221	2167	2379	2737	2626	2767	2488	2881	2370
West	1707	1782	1727	1840	2121	2145	2080	2117	1989	2528	2216
Central	1682	1581	1739	1746	2039	2099	2021	1940	1959	2186	1859



Southampton 111 calls by East practice	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Bath Lodge (registered population 12351)	208	231	259	238	230	280	298	318	241	285	243
Bath Lodge as % of East calls	*9%*	*11%*	*12%*	*11%*	*10%*	*10%*	*11%*	*11%*	*10%*	*10%*	*10%*
Bitterne Park (registered population 8979)	185	148	139	166	157	176	218	205	169	214	152
Bitterne Park as % of East calls	*8%*	*7%*	*6%*	*8%*	*7%*	*6%*	*8%*	*7%*	*7%*	*7%*	*6%*
Chessel (registered population 12758)	331	280	343	320	373	342	318	330	320	361	284
Chessel as % of East calls	*15%*	*13%*	*15%*	*15%*	*16%*	*12%*	*12%*	*12%*	*13%*	*13%*	*12%*
Ladies Walk (registered population 8223)	133	154	138	136	150	165	158	190	154	176	133
Ladies Walk as % of East calls	*6%*	*7%*	*6%*	*6%*	*6%*	*6%*	*6%*	*7%*	*6%*	*6%*	*6%*
Old Fire Station (registered population 8605)	157	138	112	127	150	204	182	220	178	215	150
Old Fire Station as % of East calls	*7%*	*7%*	*5%*	*6%*	*6%*	*7%*	*7%*	*8%*	*7%*	*7%*	*6%*
St Peter's (registered population 5223)	103	98	75	82	98	135	111	104	109	96	112
St Peter's as % of East calls	*5%*	*5%*	*3%*	*4%*	*4%*	*5%*	*4%*	*4%*	*4%*	*3%*	*5%*
Townhill (regisistered population 5465)	109	98	108	90	94	127	104	107	109	115	98
Townhill as % of East calls	*5%*	*5%*	*5%*	*4%*	*4%*	*5%*	*4%*	*4%*	*4%*	*4%*	*4%*
West End Road (registered population 11627)	244	206	231	213	234	287	306	324	255	291	259
West End Road as % of East calls	*11%*	*10%*	*10%*	*10%*	*10%*	*10%*	*12%*	*12%*	*10%*	*10%*	*11%*
Weston Lane (registered population 9369)	193	210	211	213	244	249	250	225	243	286	243
Weston Lane as % of East calls	*9%*	*10%*	*10%*	*10%*	*10%*	*9%*	*10%*	*8%*	*10%*	*10%*	*10%*
Woolston Lodge (registered population 13749)	229	248	271	260	270	317	307	340	289	344	283
Woolston Lodge as % of East calls	*10%*	*12%*	*12%*	*12%*	*11%*	*12%*	*12%*	*12%*	*12%*	*12%*	*12%*
SO18/19 no GP recorded	301	306	334	322	379	455	374	404	421	498	413
SO18/19 no GP recorded as % of East calls	*14%*	*14%*	*15%*	*15%*	*16%*	*17%*	*14%*	*15%*	*17%*	*17%*	*17%*

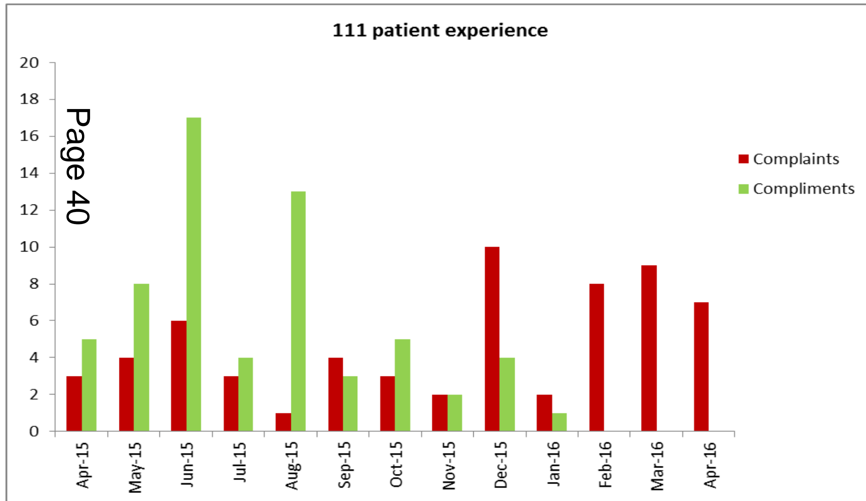
- Calls from Southampton GP registered patients on average represent ~14% of all calls to the local 111 service
- Within the city, East locality patients are consistently the highest user of the service
- Number of calls increased over winter from all areas (expected, seasonal trend)
- The proportion of East patients has remained fairly consistent, averaging 38% of all Southampton call at baseline and 39% since BWIS closure
- % of calls represented by each practice in the East remains fairly consistent

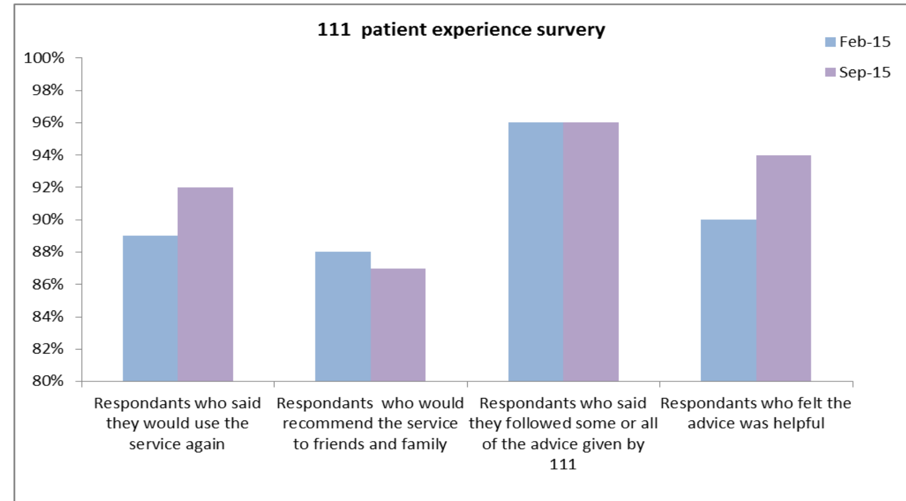
BWIS closure impact monitoring – data at June 2016 (to April)

111 patient experience

111 patient expereince (SHIP)	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Complaints	3	4	6	3	1	4	3	2	10	2	8	9	7
Compliments	5	8	17	4	13	3	5	2	4	1	0	0	0

Patient satisfaction survery (SHIP - contract level)	Feb-15	Sep-15
Respondants who said they would use the service again	89%	92%
Respondants who would recommend the service to friends and family	88%	87%
Respondants who said they followed some or all of the advice given by 111	96%	96%
Respondants who felt the advice was helpful	90%	94%



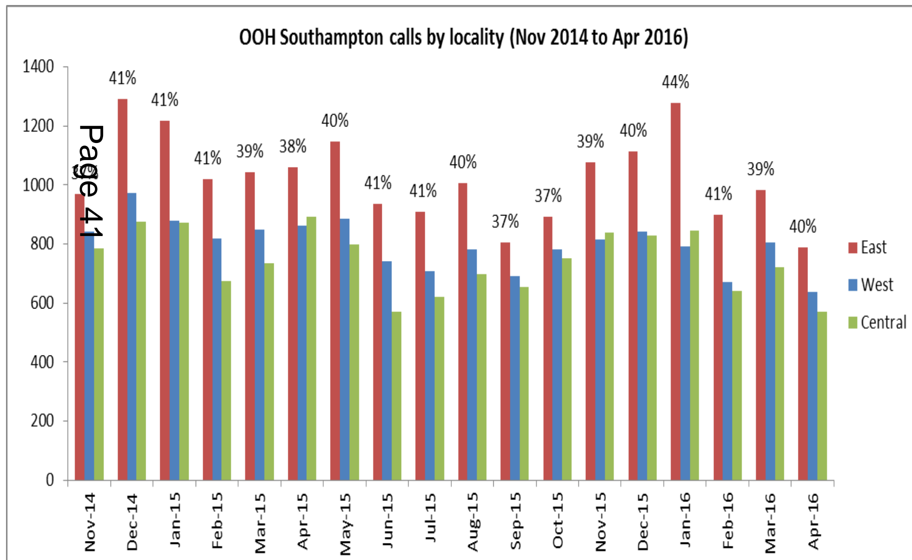


- Patient satisfaction survey shows the majority of patients would recommend the service and use it again, with the majority feeling the advice given was both appropriate and applied – next one expected in Q2 2016/17
- Complaint rate is <0.02%

BWIS closure impact monitoring – data at June 2016 (to April)

Calls to GP Out of Hours service (OOH)

Calls to OOH	Baseline average	Post closure average
Southampton as % of all	17%	16%
East as % of Southampton	39%	40%
East as % of all	6%	6%



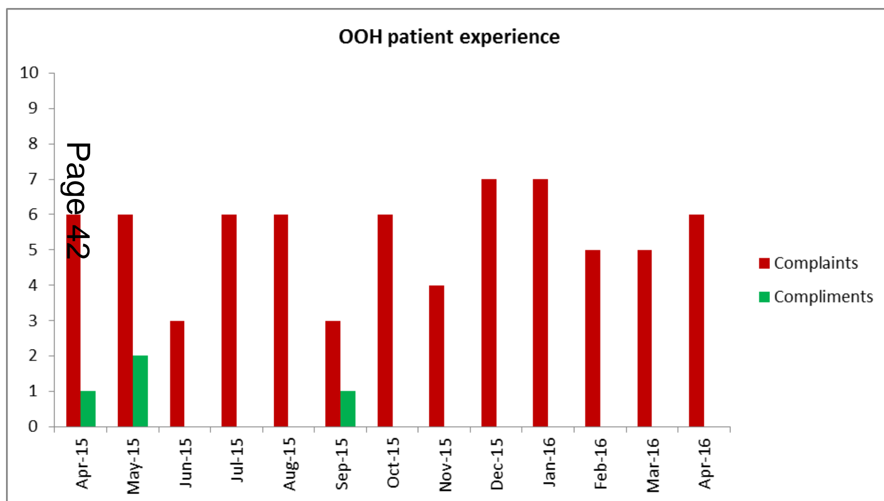
Southampton OOH calls by East practice	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Bath Lodge (registered population 12296)	112	140	126	98	143	149	153	100	121	101
Bath Lodge as % of East calls	*12%*	*14%*	*16%*	*11%*	*13%*	*13%*	*12%*	*11%*	*12%*	*13%*
Bitterne Park (registered population 9021)	55	80	72	65	93	105	136	65	82	46
Bitterne Park as % of East calls	*6%*	*8%*	*9%*	*7%*	*9%*	*9%*	*11%*	*7%*	*8%*	*6%*
Chessel (registered population 12623)	151	188	124	179	164	157	208	148	159	134
Chessel as % of East calls	*17%*	*19%*	*15%*	*20%*	*15%*	*14%*	*16%*	*16%*	*16%*	*17%*
Ladies Walk (registered population 8153)	81	81	63	69	77	76	111	76	80	69
Ladies Walk as % of East calls	*9%*	*8%*	*8%*	*8%*	*7%*	*7%*	*9%*	*8%*	*8%*	*9%*
Old Fire Station (registered population 8641)	66	58	50	65	91	82	101	78	89	54
Old Fire Station as % of East calls	*7%*	*6%*	*6%*	*7%*	*8%*	*7%*	*8%*	*9%*	*9%*	*7%*
St Peter's (registered population 5257)	54	41	30	46	59	44	53	43	35	45
St Peter's as % of East calls	*6%*	*4%*	*4%*	*5%*	*5%*	*4%*	*4%*	*5%*	*4%*	*6%*
Townhill (regisistered population 5483)	32	56	48	44	60	38	54	37	31	33
Townhill as % of East calls	*4%*	*6%*	*6%*	*5%*	*6%*	*3%*	*4%*	*4%*	*3%*	*4%*
West End Road (registered population 11828)	112	100	89	93	126	163	163	102	124	91
West End Road as % of East calls	*12%*	*10%*	*11%*	*10%*	*12%*	*15%*	*13%*	*11%*	*13%*	*12%*
Weston Lane (registered population 9433)	109	118	85	108	123	121	110	118	120	96
Weston Lane as % of East calls	*12%*	*12%*	*11%*	*12%*	*11%*	*11%*	*9%*	*13%*	*12%*	*12%*
Woolston Lodge (registered population 13727)	137	143	117	126	141	177	187	131	140	119
Woolston Lodge as % of East calls	*15%*	*14%*	*15%*	*14%*	*13%*	*16%*	*15%*	*15%*	*14%*	*15%*

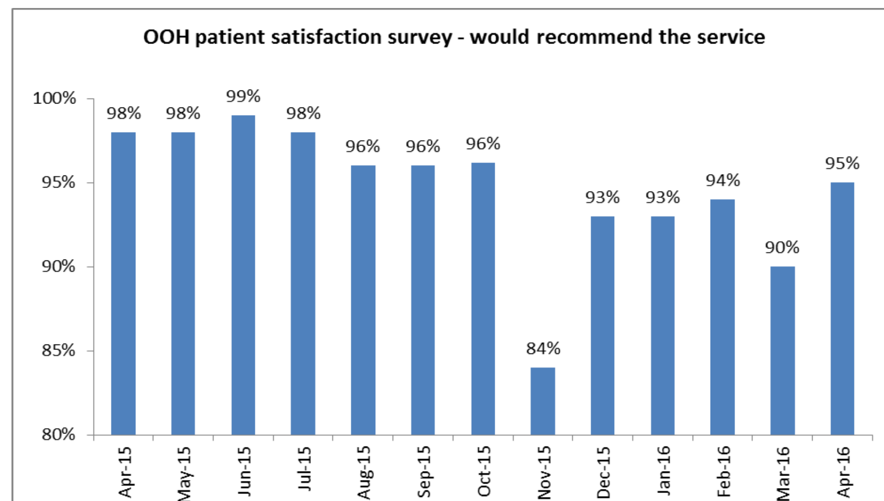
- Calls from Southampton GP registered patients represent ~16% of all calls to the local OOH service
- Within the the city, East locality patients are consistently the highest user of the service
- Numbers increased over winter from all areas (expected, seasonal trend)
- The proportion of East patients has increased slightly, averaging 39% of all Southampton call at baseline and 40% since BWIS closure
- % of calls represented by each practice in the East remains fairly consistent

BWIS closure impact monitoring – data at June 2016 (to April)

OOH patient experience

Patient satisfaction with OOH (SHIP)	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Total patient call volume	16791	17960	13078	13329	15351	12812	14654	15760	17850	17821	13677	16832	13239
% respondents who say they would recommend the service	98%	98%	99%	98%	96%	96%	96%	84%	93%	93%	94%	90%	95%
Complaints	6	6	3	6	6	3	6	4	7	7	5	5	6
Compliments	1	2	0	0	0	1	0	0	0	0	0	0	0

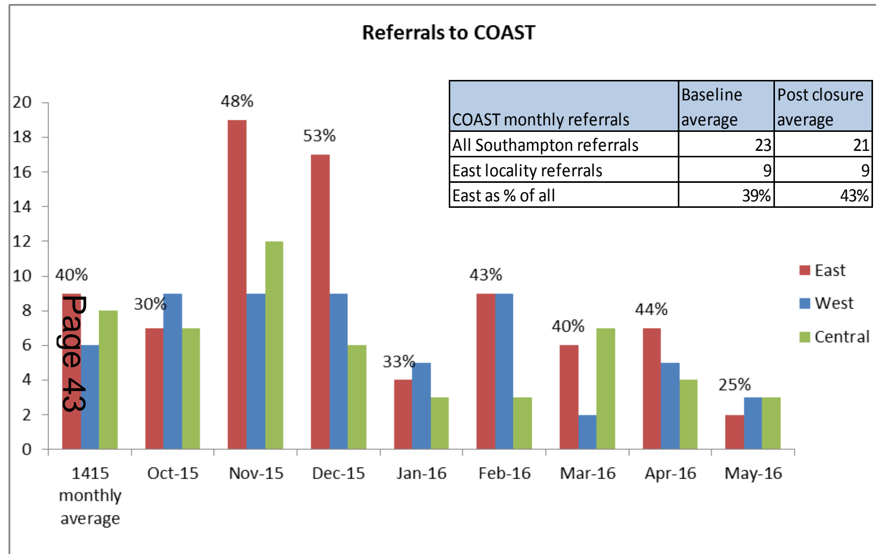




- % of respondents saying they would recommend the service to family and friends has declined slightly over the last 12 months, but with the exception of November is ≥90%
- Complaint rate is <0.05%

BWIS closure impact monitoring – data at June 2016 (to May)

Paediatric patients and utilisation of Childrens Outreach Assessment and Support Team (COAST)



COAST monthly referrals	Baseline average	Post closure average
All Southampton referrals	23	21
East locality referrals	9	9
East as % of all	39%	43%

Main ED: Under 18s

Locality	13/14	14/15	15/16
East	1,713	1,414	1,652
Central	1,087	984	1,006
West	2,094	2,105	2,360
All Southampton	4,894	4,503	5,018
East as a % of all	35%	31%	33%

Data from Nov - Mar

Paed Medicine High Volume Pathway NEL: 0-1 day LOS

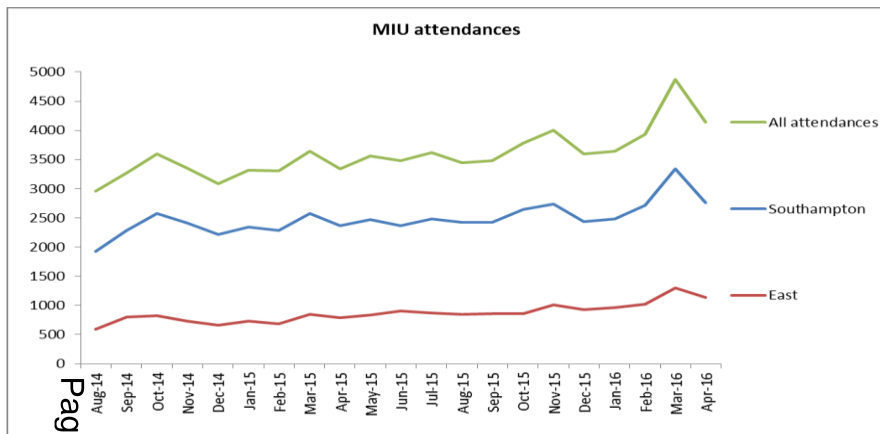
Locality	13/14	14/15	15/16
East	350	375	418
Central	248	255	256
West	339	342	379
All Southampton	937	972	1,053
East as a % of all	37%	39%	40%

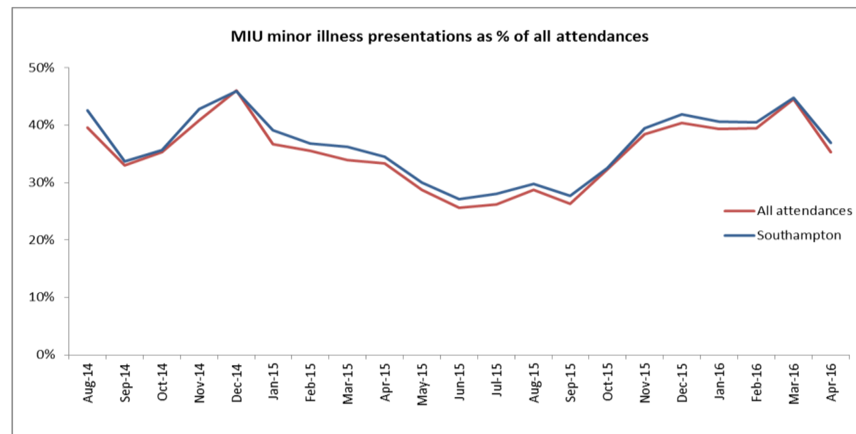
Data from Nov - Apr

- BWIS closure has not impacted on utilisation of COAST by East practices – November and December were higher than usual, with the majority of patients from one practice. Only one East practice has high admission by population rate but they utilise COAST
- BWIS closure has not had a significant impact on paediatric high volume admissions with a length of stay 0-1 days – there has been an increase from across the city, but as a % proportion of all, a slight increase of 1% for East patients in 2015/16 compared to 2014/15
- BWIS closure has not had a significant impact of paediatric attendances to the Emergency Department (ED) – there has been an increase from across the city. As a % proportion of all, a slight increase of 2% for East patients (main increase in age 0-2 years) in 2015/16 compared to 2014/15, however the 2015/16 proportion is lower than 2013/14
- Patient level analysis (see slide 15) shows that from April 2014 to October 2015, the cohort of under 18s who attended BWIS made on average 557 attendances to an 'A&E type department' per month. For the six months following the closure, the same cohort of patients made an average of 248 attendances to an 'A&E type department' per month

BWIS closure impact monitoring – data at June 2016 (to April)

Minor Injury Unit (MIU) attendances





MIU attendances	Baseline average	Post closure average
Southampton as % of all	70%	68%
East as % of Southampton	33%	39%
East as % of all	23%	26%

MIU minor illness presentations	Baseline average	Post closure average
Minor illness - all	33%	40%
Minor illness - Southampton	35%	41%

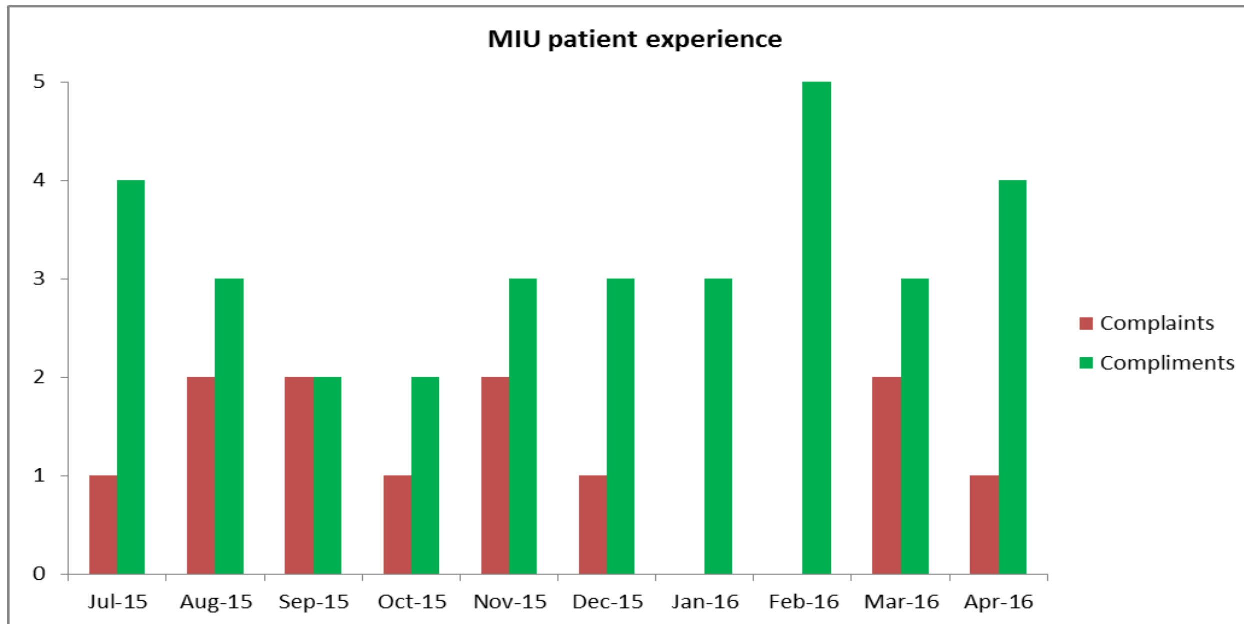
MIU attendances	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
All attendances	2955	3274	3600	3355	3082	3319	3302	3637	3344	3561	3479	3618	3447	3483	3782	3997	3590	3637	3930	4867	4141
Southampton attendances	1923	2280	2578	2415	2221	2347	2285	2575	2366	2467	2367	2485	2419	2420	2644	2734	2434	2484	2710	3336	2761
Southampton as % of all	65%	70%	72%	72%	72%	71%	69%	71%	71%	69%	68%	69%	70%	69%	70%	68%	68%	68%	69%	69%	67%
East locality patients	590	803	823	726	663	730	686	849	788	833	901	866	847	862	856	1012	926	965	1023	1302	1134
East as % of Southampton	31%	35%	32%	30%	30%	31%	30%	33%	33%	34%	38%	35%	35%	36%	32%	37%	38%	39%	38%	39%	41%
East as % of all	20%	25%	23%	22%	22%	22%	21%	23%	24%	23%	26%	24%	25%	25%	23%	25%	26%	27%	26%	27%	27%

- MIU attendances during 15/16 quarter 4, particularly March, were higher than in previous months, and higher compared to same period last year - a trend seen for patients from all areas (although a greater increase for East patients) and reflects trends seen across other urgent care services
- East locality attendances as a % proportion of all Southampton activity post BWIS closure have increased from baseline (expected and manageable)
- East locality patient attendance activity across the day follows the same pattern to rest of the city
- Minor illness presentations are slightly higher for Southampton patients, and the rate increased over winter (seasonal and expected)
- ≥90% of minor illness patients are given 'Choose Well' advice and MIU actively promote Pharmacy First Minor Ailments service

BWIS closure impact monitoring – data at June 2016 (to April)

MIU patient experience

Patient experinece	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Complaints	1	2	2	1	2	1	0	0	2	1
Compliments	4	3	2	2	3	3	3	5	3	4



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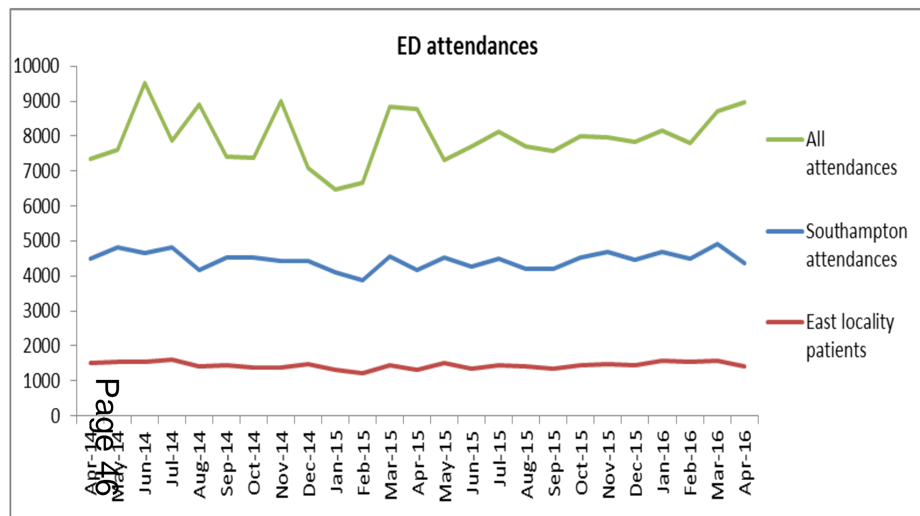
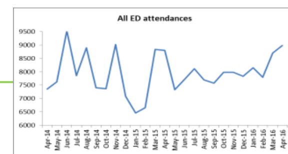
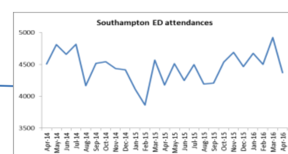
- Friends and Family Test at April 2016 shows 99.3 % of patients would be extremely/very likely to recommend service
- Generally the service is receiving more compliments than complaints

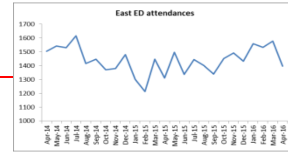
BWIS closure impact monitoring – data at June 2016 (to April)

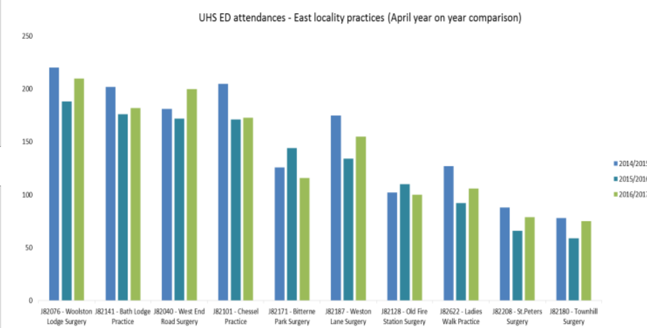
Emergency Department (ED) attendances











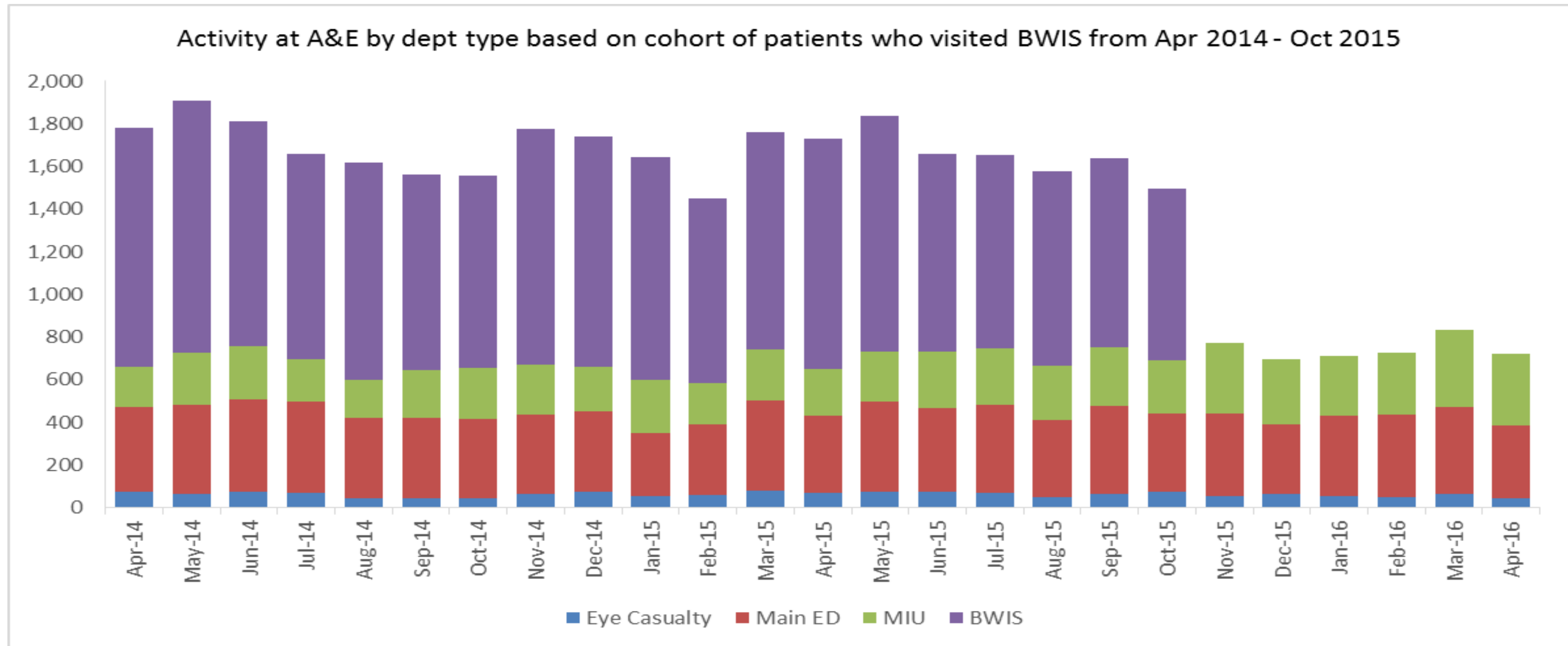
Main ED attendances	Baseline average	Post closure average
Southampton as % of all	57%	56%
East as % of Southampton	32%	33%
East as % of all	18%	18%

ED attendances	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
All attendances	7349	7621	9527	7851	8894	7405	7370	9011	7081	6458	6656	8830	8790	7326	7710	8115	7696	7577	7980	7974	7833	8150	7795	8697	8981
Southampton attendances	4505	4813	4658	4818	4169	4515	4541	4436	4415	4109	3862	4569	4179	4510	4250	4496	4192	4207	4537	4687	4466	4676	4500	4923	4370
Southampton as % of all	61%	63%	49%	61%	47%	61%	62%	49%	62%	64%	58%	52%	48%	62%	55%	55%	54%	56%	57%	59%	57%	57%	58%	57%	49%
East locality patients	1504	1543	1530	1616	1417	1448	1371	1381	1480	1301	1214	1448	1312	1498	1337	1444	1401	1340	1452	1491	1433	1558	1533	1579	1396
East as % of Southampton	33%	32%	33%	34%	34%	32%	30%	31%	34%	32%	31%	32%	31%	33%	31%	32%	33%	32%	32%	32%	32%	33%	34%	32%	32%
East as % of all	20%	20%	16%	21%	16%	20%	19%	15%	21%	20%	18%	16%	15%	20%	17%	18%	18%	18%	18%	19%	18%	19%	20%	18%	16%

- East locality patient ED attendances during 15/16 quarter 4, particularly March, were higher than in previous months, and higher compared to same period last year – this is a trend seen for patients from all areas and reflects trends seen across other urgent care services
- % of East locality attendances as a proportion of all activity and Southampton activity has remained fairly consistent over time. There has been a marginal increase post BWIS closure (1%)
- Activity change year on year for majority of East practices reflects that of other city practices – either less than previous year or <10% increase
- Attendances by time of day for East locality patients mirrors that of the rest of the city

BWIS closure impact monitoring – data at June 2016 (to April)

BWIS patient activity at MIU and ED before and after closure



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- Analysis has been carried out observing 'A&E type activity' (MIU and ED) of Southampton patients that attended the BWIS in the 19 months pre-closure (April 2014 to October 2015) and this same patient cohort's activity in the 6 months following the BWIS closure (November 2015 to April 2016)
- During the pre-closure period, 43% of patients attending the BWIS also attended the MIU and/or ED at least once
- The majority (82%) of Southampton BWIS users were from East locality GP practices. Post BWIS closure there has been a corresponding increase in activity at the MIU that these patients have contributed to, over and above the natural increase in MIU activity. There has been no obvious increases in these patients visiting ED
- The average monthly increase in activity over the last six months at the MIU is 85 patients greater than the pre-closure average. The average activity at the BWIS was 994 Southampton patients per month. Therefore over 900 Southampton patients per month who were attending the BWIS (predominantly East locality patients) have not attended a secondary A&E service (MIU and/or ED) post BWIS closure, implying that they are self-managing their conditions, visiting a pharmacy, seeing their GP or calling 111 for advice

BWIS closure impact monitoring – data at June 2016 (to May)

Community Nursing

	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
Black	15%	70%	63%	70%	68%	20%		0%	5%	5%	5%	5%
Red	34%	6.0%	23%	2%	9%	14%		26%	43%	55%	38%	45%
Amber	26%	2%	2%	2%	4%	8%		42%	43%	20%	57%	4%
Green	9%	0%	0%	1%	3%	5%		5%	9%	15%	0%	10%
Data not available	16%	22%	12%	25%	16%	53%		27%	0%	5%	0%	0%

Black	100% and above	Potential Service Failure
Red	90-99%	Severe Pressure
Amber	80-89%	Moderate Pressure
Green	below 80%	Normal Service

- The above table provides a high level overview of the service capacity status position reported by Solent Community Nursing in Southampton, with no black level reported in January and only one day in February, March, April and May. It should be noted that the reduction in reported level blacks are attributable to a number of factors including a revised escalation framework and change in workforce configuration as well as investment
- The overall Community Nursing funded establishment is currently 101.5 wte and remains unchanged since additional investment in 2014/15 (sustained through redeployed funds from the BWIS closure in 2015/16)
- The investment made into the Community Nursing service has provided a 33.8% increase in visits to patients and carers. Some of these contacts can also be attributed to a change in workforce configuration, but the increased investment has boosted the capacity of the service as it faces increasing demand due to an ageing population with increased complexity of need

DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		SOUTHAMPTON, HAMPSHIRE, ISLE OF WIGHT AND PORTSMOUTH HEALTH OVERVIEW AND SCRUTINY PANELS: ARRANGEMENTS FOR ASSESSING SUBSTANTIAL CHANGE IN NHS PROVISION (REVISED JUNE 2016)		
DATE OF DECISION:		30 JUNE 2016		
REPORT OF:		SERVICE DIRECTOR – LEGAL AND GOVERNANCE		
CONTACT DETAILS				
AUTHOR:	Name:	Mark Pirnie	Tel:	023 8083 3886
	E-mail:	Mark.pirnie@southampton.gov.uk		
Director	Name:	Richard Ivory	Tel:	023 8083 2794
	E-mail:	Richard.ivory@southampton.gov.uk		

STATEMENT OF CONFIDENTIALITY

None

BRIEF SUMMARY

This report seeks the Health Overview and Scrutiny Panel to agree the revised arrangements for assessing significant developments or substantial variations in NHS services across the Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP) local authority areas.

RECOMMENDATIONS:

	(i)	That the Panel agrees the revised arrangements, attached as Appendix 1, for assessing substantial change in NHS provision.

REASONS FOR REPORT RECOMMENDATIONS

1.	To agree a consistent way of working across the SHIP region in relation to health scrutiny arrangements.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2.	None.

DETAIL (Including consultation carried out)

3.	The purpose of this document is to agree the arrangements for assessing significant developments or substantial variations in NHS services across the Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP) areas.
4.	It describes the actions and approach expected of relevant NHS bodies or relevant health services providers and local authorities with health scrutiny functions when proposals that may constitute substantial service change are being developed. It also outlines the principles that will underpin each parties' role and responsibility.
5.	The document is the fourth refresh of the 'Framework for Assessing Substantial Service Change' originally developed with advice from the Independent Reconfiguration Panel (IRP) and updates the guidance relating to the key issues to be addressed by relevant NHS bodies or relevant health service providers when service reconfiguration is being considered. Emphasis

	is placed on the importance of constructive working relationships and clarity about roles by all parties based on mutual respect and recognition that there is a shared benefit to our respective communities from doing so. The updated framework is attached at Appendix 1.
RESOURCE IMPLICATIONS	
<u>Capital/Revenue</u>	
6.	N/A
<u>Property/Other</u>	
7.	N/A
LEGAL IMPLICATIONS	
<u>Statutory power to undertake proposals in the report</u>:	
8.	Section 244 of the NHS Act 2006 places a duty on relevant NHS bodies or relevant health service providers to consult Local Authorities on any proposals for significant development or substantial variation in health services.
<u>Other Legal Implications</u>:	
9.	None
POLICY FRAMEWORK IMPLICATIONS	
10.	N/A
KEY DECISION	No
WARDS/COMMUNITIES AFFECTED:	None

	<u>SUPPORTING DOCUMENTATION</u>	
Appendices		
1.	Southampton, Hampshire, Isle of Wight and Portsmouth Health Overview and Scrutiny Committees: Arrangements for Assessing Substantial Change in NHS provision.	
Documents In Members' Rooms		
1.	None	
Equality Impact Assessment		
Do the implications/subject of the report require an Equality and Safety Impact Assessments (ESIA) to be carried out.		No
Privacy Impact Assessment		
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.		No
Other Background Documents **Equality Impact Assessment and Other Background documents available for inspection at:**		
Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)	
1.	None	

Southampton, Hampshire, Isle of Wight and Portsmouth Health Overview and Scrutiny Committees: Arrangements for Assessing Substantial Change in NHS provision (revised June 2016)

Purpose and Summary

1) The purpose of this document is to agree the arrangements for assessing significant developments or substantial variations in NHS services across the Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP) Local Authority areas.

2) It describes the actions and approach expected of relevant NHS bodies or relevant health service providers and Local Authorities with health scrutiny functions when proposals that may constitute substantial service change are being developed and outlines the principles that will underpin the discharge of each parties' role and responsibilities.

3) The document is the fourth refresh of the 'Framework for Assessing Substantial Service Change' originally developed with advice from the Independent Reconfiguration Panel (IRP)[1] and updates the guidance relating to the key issues to be addressed by relevant NHS bodies or relevant health service providers when service reconfiguration is being considered. Emphasis is placed on the importance of constructive working relationships and clarity about roles by all parties based on mutual respect and recognition that there is a shared benefit to our respective communities from doing so.

4) This framework was amended in 2013 following the publication of 'The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013'[2]. These regulations followed from changes made to local authority health scrutiny in the Health and Social Care Act 2012. Subsequent guidance has been produced by NHS England[3] and the Department of Health[4] on health scrutiny, and this framework has been consequentially updated.

5) The legal duties placed on relevant NHS bodies or relevant health service providers and the role of health scrutiny are included to provide a context to the dialogue that needs to be taking place between relevant NHS bodies or relevant health service providers and the relevant local authority/authorities to establish if a proposal is substantial in nature. In this document, the term 'NHS' and 'NHS bodies' refer to:
   - NHS England
   - Clinical Commissioning Groups
   - NHS Trusts and NHS Foundation Trusts

[1] http://www.irpanel.org.uk/view.asp?id=0
[2] http://www.legislation.gov.uk/uksi/2013/218/contents/made
[3] https://www.england.nhs.uk/wp-content/uploads/2015/10/plan-ass-deliv-serv-chge.pdf
[4] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/324965/Local_authority_health_scrutiny.pdf

6) It is intended that these arrangements will support:
   - Improved communications across all parties.
   - Better co-ordination of engagement and consultation with service users carers and the public.
   - Greater confidence in the planning of service change to secure improved outcomes for health services provided to communities across Southampton, Hampshire, the Isle of Wight and Portsmouth.

7) Section 242 of the NHS Act places a statutory duty on the NHS to engage and involve the public and service users in:
   - Planning the provision of services
   - The development and consideration of proposals to change the provision of those services
   - Decisions affecting the operation of services.

8) This duty applies to changes that affect the way in which a service is delivered as well as the way in which people access the service.

9) Section 244 of the NHS Act 2006 places a statutory duty on relevant NHS bodies or relevant health service providers to consult Local Authorities on any proposals for significant development or substantial variation in health services. NHS organisations will note that this duty is quite distinctive from the routine engagement and discussion that takes place with Local Authorities as partners and key stakeholders.

10) Significant development and substantial variation are not defined in the legislation but guidance published by the Department of Health and Centre for Public Scrutiny on health scrutiny make it clear that the body responsible for the proposal should initiate early dialogue with health scrutineers to determine:
    1. If the health scrutiny committee consider that the change constitutes a significant development or substantial variation in service
    2. The timing and content of the consultation process.

11) Where it is agreed that a set of proposals amount to a substantial change in service, the NHS body or relevant health service provider must draw together and publish timescales which indicate the proposed date by which it is intended that a decision will be made. These timescales must also include the date by which the local authority will provide comments on the proposal, which will include whether the NHS Body has:
    - Engaged and involved stakeholders in relation to changes; and,
    - Evidenced that the changes proposed are in the interest of the population served.

    It is therefore expected that the NHS body or relevant health service provider works closely with health scrutineers to ensure that timetables are reflective of the likely timescales required to provide evidence of the

above considerations, which in turn will enable health scrutiny committees to come to a view on the proposals.

12) The development of the framework has taken into account the additional key tests for service reconfiguration set out in the Government Mandate to NHS England. Where it is agreed that the proposal does constitute a substantial change the response of a health scrutiny committee to the subsequent consultation process will be shaped by the following considerations:
    - Has the development of the proposal been informed by appropriate engagement and involvement of local people and those using the service? This should take account of the relevant equality legislation and be clear about the impact of the proposal on any vulnerable groups.
    - The extent to which commissioners have informed and support the change.
    - The strength of clinical evidence underpinning the proposal and the support of senior clinicians whose services will be affected by the change.
    - How the proposed service change affects choice for patients, particularly with regard to quality and service improvement.

13) NHS organisations and relevant health service providers will also wish to invite feedback and comment from the relevant Local Healthwatch organisation. Local Healthwatch has specific powers, including the ability to refer areas of concern to health scrutineers and Healthwatch England, and also specific responsibilities, including advocacy, complaints, and signposting to information. Health scrutiny committees expect to continue good relationships with patient and public representatives and will continue to expect evidence of their contribution to any proposals for varying health services from the NHS.

14) The framework attached at Appendix One identifies a range of issues that may inform both the discussion about the nature of the change and the response of health scrutiny committees to the consultation process. The intention is that this provides a simple prompt for assessing proposals, explaining the reasons for the change and understanding the impact this will have on those using, or likely to use, the service in question.

15) The framework is not a 'blueprint' that all proposals for changing services from the NHS / relevant health service provider are expected to comply with. The diversity of the health economy across the Southampton, Hampshire, Isle of Wight and Portsmouth area and the complexity of service provision need to be recognised, and each proposal will therefore be considered in the context of the change it will deliver. The framework can only act as a guide: it is not a substitute for an on-going dialogue between the parties concerned. It is designed for use independently by organisations in the early stages of developing a proposal, or to provide

a basis for discussion with health scrutineers regarding the scope and timing of any formal consultation required.

16) Although it remains good practice to follow Cabinet Office guidance in relation to the content and conduct of formal consultation, health scrutiny committees are able to exercise some discretion in the discharge of this duty. Early discussions with the health scrutiny committee whose populations are affected by a proposal are essential if this flexibility is to be used to benefit local people.

17) Any request to reduce the length of formal consultation with a health scrutiny committee will need to be underpinned by robust evidence that the NHS body or relevant health service provider responsible for the proposal has engaged, or intends to engage local people in accordance with Section 242 responsibilities. These require the involvement of service users and other key stakeholders in developing and shaping any proposals for changing services. Good practice guidance summarises the duty to involve patients and the public as being:
    1. Not just when a major change is proposed, but in the on-going planning of services
    2. Not just when considering a proposal, but in the development of that proposal, and
    3. In decisions that may affect the operation of services

18) All proposals shared with health scrutiny committees by the NHS body or relevant health service provider – regardless of whether or not they are considered substantial in nature - should therefore be able to demonstrate an appropriate consideration of Section 242 responsibilities.

19) Individual health scrutiny committees will come to their own view about the nature of change proposed by an NHS body or relevant health service provider. Where a proposal is judged to be substantial and affects service users across local authority boundaries the health scrutiny committees concerned are required to make arrangements to work together to consider the matter.

20) Although each issue will need to be considered on its merits the following information will help shape the views of health scrutiny committees regarding the proposal:
    1. The case of need and evidence base underpinning the change taking account of the health needs of local people and clinical best practice.
    2. The extent to which service users, the public and other key stakeholders, including GP commissioners, have contributed to developing the proposal. Regard must be given to the involvement of ‘hard to reach groups’ where this is appropriate, including the need for any impact assessment for vulnerable groups.
    3. The improvements to be achieved for service users and the additional choice this represents. This will include issues relating to service quality, accessibility and equity.

4. The impact of the proposal on the wider community and other services. This may include issues such as economic impact, transport issues and regeneration as well as other service providers affected.
5. The sustainability of the service(s) affected by proposals, and how this impacts on the wider NHS body or relevant health service provider.

21) This information will enable health scrutiny committees to come to a view about whether the proposal is substantial, and if so, whether the proposal is in the interest of the service users affected.

22) The absence of this information is likely to result in the proposal being referred back to the responsible NHS Body or provider of NHS services for further action.

23) If an NHS body or relevant health service provider consider there is a risk to the safety or welfare of patients or staff then temporary urgent action may be taken without consultation or engagement. In these circumstances the health scrutiny committee affected should be advised immediately and the reasons for this action provided. Any temporary variation to services agreed with the health scrutiny committee, whether urgent or otherwise, should state when the service(s) affected will reopen.

24) If the health scrutiny committee affected by a proposal are not satisfied with the conduct or content of the consultation process, the reasons for not undertaking a consultation (this includes temporary urgent action) or that the proposal is in the interests of the health service in its area then the option exists for the matter to be referred to the Secretary of State. Referrals are not made lightly and should set out:
- Valid and robust evidence to support the health scrutiny committee’s position. This will include evidence that sustainability has been considered as part of the service change.
- Confirmation of the steps taken to secure local resolution of the matter, which may include informal discussions at NHS Commissioning Board Local Area Team level.

Guiding Principles

25) The four health scrutiny committees and panels in Southampton, Hampshire, the Isle of Wight and Portsmouth work closely in order to build effective working relationships and share good practice.

26) Health scrutiny committees will need to be able to respond to requests from the NHS or relevant health service providers to discuss proposals that may be significant developments or substantial variations in services. Generally in coming to a view the key consideration will be the scale of the impact of the change on those actually using the service(s) in question.

27) Early discussions with health scrutiny committees regarding potential for significant service change will assist with timetabling by the NHS and avoid delays in considering a proposal. Specific information about the steps, whether already taken or planned, in response to the legislation and the four tests (outlined in paragraph 12), will support discussions about additional information or action required. NHS organisations should also give thought to the NHS' assurance process, and seek advice as to the level of assurance required from NHS England, who have a lead responsibility in this area.

28) Some service reconfiguration will be controversial and it will be important that health scrutiny committee members are able to put aside personal or political considerations in order to ensure that the scrutiny process is credible and influential. When scrutinising a matter the approach adopted by health scrutiny committees will be:

1. Challenging but not confrontational
2. Politically neutral in the conduct of scrutiny and take account of the total population affected by the proposal
3. Based on evidence and not opinion or anecdote
4. Focused on the improvements to be achieved in delivering services to the population affected
5. Consistent and proportionate to the issue to be addressed

29) It is acknowledged that the scale of organisational change currently being experienced in the NHS coupled with significant financial challenges across the public sector is unprecedented. Consultation with local people and health scrutiny committees may not result in agreement on the way forward and on occasion difficult decisions will need to be made by NHS bodies. In these circumstances it is expected that the responsible NHS body or relevant health service providers will apply a 'test of reasonableness' which balances the strength of evidence and stakeholder support and demonstrates the action taken to address any outstanding issues or concerns raised by stakeholders.

30) If the health scrutiny committee is not satisfied that the implementation of the proposal is in the interests of the health service in its area the option to refer this matter to the Secretary of State remains.

31) All parties will agree how information is to be shared and communicated to the public as part of the conduct of the scrutiny exercise.

Appendix One – Framework for Assessing Change

Key questions to be addressed

Each of the points outlined above have been developed below to provide a checklist of questions that may need to be considered. This is not meant to be exhaustive and may not be relevant to all proposals for changing services

The assessment process suggested requires that the NHS or relevant health service providers responsible for taking the proposal forward co-ordinates consultation and involvement activities with key stakeholders such as service users and carers, Local Healthwatch, NHS organisations, elected representatives, District and Borough Councils, voluntary and community sector groups and other service providers affected by the proposal. The relevant health scrutiny committee(s) also need to be alerted at the formative stages of development of the proposal. The questions posed by the framework will assist in determining if a proposal is likely to be substantial, identify any additional action to be taken to support the case of need and agree the consultation process.

Name of Responsible (lead) NHS or relevant health service provider:

Name of lead CCG:

Brief description of the proposal:

Why is this change being proposed?

Description of Population affected:

Date by which final decision is expected to be taken:

Confirmation of health scrutiny committee contacted:

Name of key stakeholders supporting the Proposal:

Date:

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
Case for Change 1) Is there clarity about the need for change? (e.g. key drivers, changing policy, workforce considerations, gaps in service, service improvement) 2) Has the impact of the change on service users, their carers and the public been assessed? 3) Have local health needs and/or impact assessments been undertaken? 4) Do these take account of : a) Demographic considerations? b) Changes in morbidity or incidence of a particular condition? Or a potential reductions in care needs (e.g due to screening programmes)?		

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
c) Impact on vulnerable people and health equality considerations? d) National outcomes and service specifications? e) National health or social care policies and documents (e.g. five year forward view) f) Local health or social care strategies (e.g. health and wellbeing strategies, joint strategic needs assessments, etc) 5) Has the evidence base supporting the change proposed been defined? Is it clear what the benefits will be to service quality or the patient experience? 6) Do the clinicians affected support the proposal? 7) Is any aspect of the proposal		

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
contested by the clinicians affected? 8) Is the proposal supported by the lead clinical commissioning group? 9) Will the proposal extend choice to the population affected? 10) Have arrangements been made to begin the assurance processes required by the NHS for substantial changes in service? **Impact on Service Users** 11) How many people are likely to be affected by this change? Which areas are the affecting people from? 12) Will there be changes in access to services as a result of the changes proposed? 13) Can these be defined in terms of a) waiting times?		

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
b) transport (public and private)? c) travel time? d) other? (please define) 14) Is any aspect of the proposal contested by people using the service? **Engagement and Involvement** 15) How have key stakeholders been involved in the development of the proposal? 16) Is there demonstrable evidence regarding the involvement of a) Service users, their carers or families? b) Other service providers in the area affected? c) The relevant Local Healthwatch?		

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
d) Staff affected? e) Other interested parties? (please define) 17) Is the proposal supported by key stakeholders? 18) Is there any aspect of the proposal that is contested by the key stakeholders? If so what action has been taken to resolve this? **Options for change** 19) How have service users and key stakeholders informed the options identified to deliver the intended change? 20) Were the risks and benefits of the options assessed when developing the proposal? 21) Have changes in technology or best practice been taken into account?		

Criteria for Assessment	Yes/No/NA	Comments/supporting evidence
22) Has the impact of the proposal on other service providers, including the NHS, local authorities and the voluntary sector, been evaluated? 23) Has the impact on the wider community affected been evaluated (e.g. transport, housing, environment)? 24) Have the workforce implications associated with the proposal been assessed? 25) Have the financial implications of the change been assessed in terms of: a) Capital & Revenue? b) Sustainability? c) Risks? 26) How will the change improve the health and well being of the population affected?		