Public Document Pack

HEALTH OVERVIEW AND SCRUTINY PANEL

Thursday, 27th October, 2016
at 6.00 pm

PLEASE NOTE TIME OF MEETING

Conference Rooms 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

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 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.

3 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.

4 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.

5 STATEMENT FROM THE CHAIR

6 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

(Pages 1 - 2)

To approve and sign as a correct record the minutes of the meeting held on 25th August 2016 and to deal with any matters arising, attached.

7 UPDATE ON PROGRESS - SOUTHERN HEALTH NHS FOUNDATION TRUST

(Pages 3 - 30)

Report of the Interim Chief Executive enabling the Panel to discuss progress being made by Southern Health NHS Foundation Trust.

8 LOCAL SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2015-2016

(Pages 31 - 80)

Report of the Independent Chair of the Local Safeguarding Adults Board introducing the 2015-16 Annual Report.

9 ADULT SOCIAL CARE PERFORMANCE
(Pages 81 - 96)

Report of the Acting Service Director - Adults, Housing and Communities providing the Panel with performance information for Adult Social Care.

Wednesday, 19 October 2016 SERVICE DIRECTOR, LEGAL AND GOVERNANCE

SOUTHAMPTON CITY COUNCIL
HEALTH OVERVIEW AND SCRUTINY PANEL

MINUTES OF THE MEETING HELD ON 25 AUGUST 2016

Present: Councillors Bogle (Chair), P Baillie, Houghton, Mintoff, Noon, Savage and White

6. MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

RESOLVED: that the minutes for the Panel meeting on 30th June 2016 be approved and signed as a correct record.

7. TRANSFORMING PRIMARY MEDICAL CARE IN SOUTHAMPTON - DRAFT STRATEGY

The Panel considered the report of Chair of NHS Southampton Clinical Commissioning Group (CCG) seeking the Panel's consideration and comment on the draft Primary Medical Care Strategy for Southampton

Dr Mark Kelsey - Deputy Chair of the Southampton CCG, John Richards – Chief Executive of the Southampton CCG, Stephanie Ramsey - Director of Quality and Integration, Ali Howett – Primary Care Lead for the Southampton CCG, Dr Chris Budge – GP Bath Lodge Practice, Harry Dymond – Southampton Healthwatch and Claudia Murg – "we make Southampton" were present and, with the consent of the Chair addressed the meeting.

The Deputy Chair of the Southampton CCG outlined aspects of local and national context that set the basis for the strategy. It was explained that the national shortages of GPs was reflected locally. The CCG were trying to make it as attractive as it could to take up practice locally and it was explained that the cluster form of working provided a supportive environment that enabled GPs to specialise.

The Panel noted that whilst the majority of public interaction with the health system was through their GPs, Primary Care only consumed a relatively small percentage of the national NHS budget. In addition it was stated that GP practices were in fact separate businesses that had their own constraints and demands such as staffing costs, IT and the management and ownership of premises.

The Deputy Chair of the CCG set out how the Strategy sought to increase collaboration with pharmacists, social care agencies and within the local health networks in order to improve the quality and quantity of care provided. It was noted that this collaboration would have to include matters like information technology and the sharing of information. Panel Members were concerned that the use of IT should not make it more difficult for the public to access health care or for professionals to provide care. It should be used to enhance the ability of GPs and pharmacists to provide care and advice without undue burden on their time or their budgets.

The Panel discussed the rules regarding merging and closing GP practices and noted the level of control that the local CCG would have, should the practice decide to close or merge.

Panel Members drew attention to the fact that the Draft Strategy did not reference collaboration between GPs and dentists within the City and suggested that future drafts of the strategy explore the potential scope for this collaboration. In addition it was noted that the final version of the strategy could be supported with a number of frequently asked questions and a glossary of terms.

It was explained that Healthwatch Southampton were generally in favour of the Draft Strategy but, sought a greater clarity on the role of the public within the next steps sections of the strategy.

RESOLVED

(i) that the Panel considered the report on the draft Primary Care Strategy and requested that NHS Southampton CCG give consideration to including the following within the Transforming Primary Care in Southampton Strategy:
   a. context to the issue of ownership and payments for GP premises;
   b. detail on the increased demand on GPs over the past 5 years;
   c. reference the potential scope for collaborative working with dentists in Southampton;
   d. reference, within the Next steps section, to the work that is to be undertaken by the CCG communicating the key messages within the strategy to the general public;
   e. include a frequently asked questions section (FAQ) or a Glossary of terms that helps to answer some of the fundamental questions relating to roles, responsibilities and finances within the NHS relevant to primary care.

(ii) That the Panel would consider matters relating to telecare and information technology at a future meeting.

NOTE: Councillor Baillie declared an interest as a local pharmacist but did not withdraw from the meeting.

8. **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 – SOUTHERN HEALTH NHS FOUNDATION TRUST
DATE OF DECISION:	27 OCTOBER 2016
REPORT OF:	CHIEF EXECUTIVE – 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 into 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.

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

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

At the 1 February 2016 meeting of the Health Overview and Scrutiny Panel (HOSP) the Panel considered the Mazars report and recommended that Southern Health, at an appropriate meeting, updates the Panel on progress implementing the improvement plan and feedback from regulators. An initial update was provided on 30 June 2016, during which the Panel also requested an update on the progress following the review into Southern Health by former Interim Chair Tim Smart.

Appended to this report is a briefing paper (Appendix 1) including updates on the Mazars action plan, the CQC action plan, and the recent developments at Southern Health as well as the progress made against the recommendations made by the former Interim Chair. The briefing paper is supported by detailed action plans (Appendices 2, 3 and 4).

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 papers and updated action plans 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 Appendices 3 and 4 are the CQC Action Plan and exceptions report for October 2016.

6. During the HOSP meeting on 30 June 2016, the Panel were updated on the temporary closure of the Psychiatric Intensive Care Unit (PICU) at Antelope House in Southampton. Attached as Appendix 5 is an update on developments with regards to the PICU. The Panel are requested to consider the briefing papers and associated plans, and discuss the key issues with the invited representatives.

RESOURCE IMPLICATIONS

Capital/Revenue

7. N/A

Property/Other

8. N/A

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

9. N/A

Other Legal Implications:

10. None

POLICY FRAMEWORK IMPLICATIONS

11. N/A

KEY DECISION N/A

WARDS/COMMUNITIES AFFECTED: All

SUPPORTING DOCUMENTATION

Appendices

1. 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
2. Mortality and Serious Incident Management Report
3. CQC Action Plan
4. CQC – Summary Exception Report for October 2016

5 Update on Antelope House

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	

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Southern Health NHS Foundation Trust

Southampton City Council
Health Overview and Scrutiny Panel
October 2016

Southern Health NHS Foundation Trust:

Update on progress following the Mazars & CQC reports

Background

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

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

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

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

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

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

Mazars report: actions and progress (Appendix 2)

SIRI process

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

- A new policy for investigating patient deaths has been implemented and this is now reported to commissioners in the weekly governance flash reports.

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

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

Patient and Family Engagement

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

CQC report: actions and progress

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

The most recent National Community Mental Health survey, which is conducted annually amongst patients and staff across the UK, shows that Southern Health has

made significant progress in many areas, including crisis care and support and wellbeing. Our rating of the overall experience is above the national average.

A new project management approach to monitoring and reporting progress against the delivery plans has been set up, enabling the Trust to track progress much more efficiently. Detailed action plans are included as appendices 3 and 4.

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

Estates improvements

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

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

Quality Improvement Strategy

- Southern Health NHS Foundation Trust has begun to implement a one-year Quality Improvement Strategy developed to align quality priorities with the Trust Operational Plan, with the first review commencing in November 2016.
- A new Divisional Quality Performance Reporting framework has been launched to ensure clear ward to Board visibility of quality performance. A Trust-wide Quality & Safety Pack, which reports against the key CQC questions (safe, effective, caring, responsive, well-led), shows Trust quality and safety measures in detail down to Directorate level across the Trust. This is supported by a new quality meeting structure and agenda framework and a senior nurse weekly ‘Back to the floor’ programme.
- Furthermore, a new Business Partner approach is being introduced to the Central Quality Governance Team to strengthen the links and accountability lines between the central team and divisional quality structures, with roles currently being recruited to.

Staff engagement

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

- Our 'Your Voice' facility gives staff the opportunity to contact the executive team with questions, concerns or suggestions (anonymously if desired) and receive a reply within seven days. Responses are made public.
- We have also appointed a Freedom to Speak Up Guardian – an independent role dedicated to supporting the Trust to become a more open and transparent place to work by listening to staff and supporting them to raise concerns. Our aim is to create an open and listening culture where patient and staff views contribute to the running of the organisation.
- A review of staff feedback mechanisms is underway to determine whether there are sufficient processes in place for staff to escalate matters beyond their line manager.
- We have increased 'back to the floor' days by senior managers and are reviewing our supervision policy.
- Our Interim CEO Julie Dawes has put in place a series of dedicated events across the Trust aimed at listening to staff's views and concerns and answering questions.

Leadership

Following the review by former Interim Chair Tim Smart into Southern Health, which confirmed Katrina Percy in post, she stepped down from her position as CEO on 30 August 2016. Katrina was offered a regional strategic advisory role for 12 months; however, following correspondence received from the public, patients and families expressing their concerns both the Trust and NHS Improvement believed it was no longer possible for Katrina Percy to continue in this role. She left the Trust on 7 October.

Interim Chair Tim Smart resigned on 19 September citing personal reasons. We are working with NHS Improvement to appoint a new Interim Chair as soon as possible, who will then lead the recruitment process for the new substantive Chair and CEO. In the meantime, Malcolm Berryman, as Deputy Chair, will ensure that the duties of the Trust Board are carried out.

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

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

The current leadership team at Southern Health:

- Chris Gordon, Chief Operating Officer, and Sandra Grant, Director of People and Communications, are both currently on secondment. Chris is working with NHS Improvement but is still involved in our incident review processes during this period. Sandra is leading on strategic workforce development across the

region as part of the emerging Sustainability and Transformation Plan (STP) for Hampshire and the Isle of Wight.

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

Future work

The severe criticism of the Trust has led it to focus on two priorities. The first has been to significantly improve the services. A great deal of progress has been made and that progress is starting to be recognised by external independent regulatory bodies. However the Trust will make only so much progress by doing better what it has always done. That is why the second priority is so important. As indicated in the outcome of former Interim Chair Tim Smart's review, the Trust needs to establish quickly how services need to change to be more effective for its patients and the public.

To respond to this second priority we are now carrying out a fundamental review of the Trust's "Clinical Strategy", with two purposes. The first is to identify how the services will be best delivered in the future and the second to look at whether the current organisational arrangements need to change to support that clinical strategy.

The current circumstances are causing unnecessary uncertainty and it is important that this clinical strategy work happens quickly so that everyone shares the same expectations of the future and can work towards them. We will set out to both complete the clinical strategy and have clarity about the possible organisational consequences within four months.

We will be looking to clinical leaders in the Trust to develop the strategy, supported by an external expert reference group and working in partnership throughout with people who use services and their families. It will involve a lot of work in a short time and so we have engaged Deloitte LLP to support this work. We are also working with experienced clinicians from Northumberland Tyne & Wear NHSFT, one of the largest Mental Health and Learning Disabilities trusts in England recently rated outstanding by CQC.

Throughout we will work closely with our commissioners and system partners through a steering group, led by the Chairman of the Trust, to ensure partners are fully involved and to encourage support for the strategy by our stakeholders.

The clinical strategy is not an end in itself. Only when implemented will it make a positive difference to people and that implementation will need further clinical, patient, family and stakeholder engagement, planning and effective management.

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Serious Incident and Mortality Improvement Action Plan

Southern Health NHS
NHS Foundation Trust

Version No: 15.6 **Date:** 05/10/16 **Produced by: (Name & Job Title)** Helen Ludford Associate Director of Quality Governance

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

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

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

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

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

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

Mazars Recommendation Theme	Mazars Recommendations	Related Actions	Responsible Lead Central Support Services	Responsible Lead Divisional	Executive Accountability	Input Action Timescale	Action Progress Blue - Complete Green - On Track / Begun	Expected Outcome / Benefit	Progress Update	How will you evidence that the completion of the actions has led to the intended outcome	Timescale for measuring success	Intended Outcome Achieved Blue - Complete Green - On Track / Begun
		18.3a Role description for the Lead Investigator (centralised team) to include the specific role of oversight of communication and involvement of families. Investigation officers training involves a continuous golden thread through out the two day course about involving families: how to involve them, how to communication with them, how to record the communication and how to feedback to report to them. 18.3b There is a responsibility of the Divisional 48 hour panel to discuss Duty of Candour and involvement of families to ensure that there is a contact plan defined. 18.3c Scope the role, create a job description and recruit a Family Liaison Officer to directly liaise with families regarding their involvement in investigations, the questions which they would like addressing and to support the process through an agreed and structured communications plan. This role will predominantly support the families but will also support the 48 hour panels and the investigating officers. (action added 04.08.16 therefore input achievement timescale extended until 31.10.16)	Helen Ludford, Associate Director of Quality Governance (18.3a and 18.3b)	Mandy Slaney, Lead IO AMH Eileen Morton, Lead IO AMH Georgie Townsend, Lead IO Childrens and Families Angela O Brien, Lead IO East ISD Jane Bray, Lead IO West ISD Nic Cicutti, Lead IO LD & TQ21 (18.3a and 18.3b)	Sara Courtney, Acting Chief Nurse (18.3a and 18.3b)	31.10.16	Evidence obtained: Lead Investigator Role Description (18.3a and 18.3b) Recruitment of FLO (18.3c)	That families will be involved, where appropriate and where they want to engage in the investigation process which will support an outcome that the investigations are conduct in an open and transparent way which leads to honesty as to any act or omission in treatment. The FLO will ensure that the families feel supported and that their voices are heard.	External review commissioned. Monitoring through Corporate panel that the DoC requirements have been completed and families where appropriate have been involved in the investigations.	The external review into the quality of the experience of Duty of Candour and the involvement of families in SIRI investigations will provide information which will be reviewed by the Trust. There is an expectation that the Trust has improved in this area however the report will be analysed and improvement actions applied as required. To be completed and reported by 30.09.16. (18.3b) The corporate panel process ensures that the DoC has been achieved where possible for each individual case and this is recorded on the panel checklist. (18.3b)	30.09.16	Evidence required: Report from externally commissioned thematic review.(18.3b) Corporate panel checklist, random selection of 10 records (18.3b) Internal thematic review of Serious Incidents will prove that families have been included in 100% of investigations where appropriate and they wish to be involved (18.3c)
		18.4a Leaflet to be created which explains the Duty of Candour requirements and how families are welcomed to be involved in investigations to service users / patients / staff / next of kin.	Ryan Thomas, Head of Incident Management and Patient Safety (18.4a)	N/A	Sara Courtney, Acting Chief Nurse (18.4a and 18.4b)	31.03.16	Evidence obtained: Duty of Candour Leaflet (18.4a)	The families will be informed of the investigation process both verbally and in writing. A leaflet has been provided to this effect explain what the DoC is and introducing contacts for the investigation. This will assure that families and patients feel better informed and are involved where it is appropriate and they wish to be.	External review commissioned. Leaflet approved through committee for imminent launch in the Trust (at printers). 04.08.16 Leaflet now available to all services	The external review into the quality of the experience of Duty of Candour and the involvement of families in SIRI investigations will provide information which will be reviewed by the Trust. There is an expectation that the Trust has improved in this area however the report will be analysis and improvement actions applied as required. To be completed and reported by 30.09.16 (18.4a) The monthly DoC audit will supply information as to the quality of the recording of DoC related activities on the Ulysses system. (18.4a) Internal thematic review of Serious Incidents will prove that families have been included in 100% of investigations where appropriate and they wish to be involved (18.4a)	30.09.16	Evidence required: Report from externally commissioned thematic review.(18.4a) Monthly report from the validation of the DoC information. (18.4a) Internal thematic review of Serious Incidents will prove that families have been included in 100% of investigations where appropriate and they wish to be involved (18.4a)
		18.5a The Trust will seek to engage lay people, families and service users to oversee the development of documents in relation to Duty of Candour and the investigation processes. This will ensure that the documents - policies, procedures and leaflets are written to easily understood by all parties and process followed.	Emma McKinney, Associate Director of Communications Chris Woodfine, Head of Patient Engagement and Experience (18.5a - joint responsibility)	N/A	Lesley Stevens, Medical Director (18.5a)	31.03.16	Evidence obtained: Role descriptions for lay persons (18.5a)	True lay person involvement in the development of processes to ensure that they engage families in investigations and that contacts are specifically recorded. This support true partnership working.	Role description advertised for the MWG. 21.07.16 Lay person recruited to join the MWG. Healthwatch have agreed to have input into the SIOAC. Outcome will remain overdue until the evidence of this engagement is documented in the minutes. 04.08.16 - Evidence outcome remains red as lay person is yet to attend 3 x MWG but will join the meeting on 02.09.16 following DBS and reference checks 30.08.16 Recovery plan for action 18.5a submitted to SIOAC and action timescale approved for change - reset at 31.11.16 to allow for 3 sets of minutes following the meetings	Evidence of lay involvement in the ratification of policy and procedures through clear documentation of the ratification groups. To be overseen by the patient engagement and experience workstream. (18.5a)	30.11.16	Evidence required: Minutes of SIOAC x 3 (18.5a) Minutes of MWG x 3 (18.5a)
		18.6a Ulysses Safeguard screens to be further developed to map the Duty of Candour and family involvement and to record full compliance with each stage. This information will include why families are not involved. Audit of data capture will be used as an evidence base for assuring family involvement or reviewing cases where it has not been appropriate to facilitate involvement. This will be reported back to the different divisions as a performance check.	Thomas Williams, Ulysses Systems Developer (18.6a)	N/A	Sara Courtney, Acting Chief Nurse (18.6a)	30.06.16	Evidence obtained: Screenshot of DoC capture screens on Ulysses (18.6a) Guide to use (18.6a)	Assurance that families are involved where possible and correct in the investigations and to what level. There feel supported, able to ask questions and that they are receiving honest and open answers.	Monthly validation audit in place but requires review to add additional questions.	Monthly audit to ascertain that the Duty of Candour is being undertaken and there is documentation to support this. (18.6a) The Corporate Panel checklist will ensure that the correct level of engagement where appropriate has taken place and that this is documented on a case by case basis for serious incidents. There is an expectation that the Trust will achieve 100% compliance undertaking DoC requirements as per Regulation 20 CQC and that this is clearly documented. Internal thematic review of Serious Incidents will prove that families have been included in 100% of investigations where appropriate and they wish to be involved (18.6a)	30.09.16	Evidence required: Monthly report from the validation of the DoC information. (18.6a) Corporate panel checklist, random selection of 10 records (18.6a) Internal thematic review of Serious Incidents will prove that families have been included in 100% of investigations where appropriate and they wish to be involved (18.6a)
		18.7a Data from Ulysses Safeguard to be used to report the Duty of Candour and regulation 20 (CQC) compliance to Commissioners via CQRM process. This will include the involvement of families in investigations which is over and above what is required by the regulations.	Ryan Thomas, Head of Incident Management and Patient Safety (18.7a)	N/A	Sara Courtney, Acting Chief Nurse (18.7a)	31.03.16	Evidence obtained: Monthly report from the validation of the DoC information. (18.7a)	Assurance for CCGs that SHFT is fulfilling the Duty of Candour requirement correctly therefore has robust information to support that conversation and the appropriate level of correspondence has been sent to patient and families. The Trust has been open and honest and said sorry for and acts or omissions in its care which has led to patient harm.	Monthly validation audit in place but requires review to add additional questions.	Monthly audit to ascertain that the Duty of Candour is being undertaken and there is documentation to support this. The Corporate Panel checklist will ensure that the correct level of engagement where appropriate has taken place and that this is documented on a case by case basis for serious incidents. There is an expectation that the Trust will achieve 100% compliance undertaking DoC requirements as per Regulation 20 CQC and that this is clearly documented and reported externally to commissioners. (18.7a)	30.09.16	Evidence required: Achievement of 100% on the monthly report from the validation of the DoC information. (18.7a)
		18.8a Commission an external review of the current quality of the experience of the involvement of families in SIRI investigations over a 2 year period. The Review will use a mixture of Appreciative Inquiry and Experience Based Design methodology to understand the experience for staff, families, carers, patients and service users involved in SIRI investigations in the mental health and learning disability directorate. The review will provide recommendations to improve the experience of investigations for families and staff and to achieve an excellence standard of engagement.	Lesley Stevens, Medical Director (18.8a - commissioner) Helen Ludford, Associate Director of Quality Governance (18.8a - data contact)	N/A	Lesley Stevens, Medical Director (18.8a)	31.05.16	Evidence obtained: Commissioning agreement / scoping document. (18.8a)	Independent findings of an external review into family involvement will provide information which supports practice improvements actions that the trust can make going forwards. The enquiry is over a 2 year period and it is anticipated that improvement will be seen during the last 6 months of the investigations reviewed.	External review commissioned and underway	The external review into the quality of the experience of Duty of Candour and the involvement of families in SIRI investigations will provide information which will be reviewed by the Trust. There is an expectation that the Trust has improved in this area however the report will be analysed and improvement actions applied as required. To be completed and reported by 31.10.16 (18.8a)	30.09.16	Evidence required: Report from externally commissioned thematic review.(18.8a)
		18.9a The electronic patient records where possible and at the consent of the patient or service user will contain up to date next of kin contact details and there is an information sharing agreement in place. These should be checked at each appointment. This facilitates the correct contact in the case of an emergency. 18.9b In instances where there is no recorded next of kin detail the investigation should approach other agencies to assist such as the Coroners officer or GP however they have no obligation to share. Please note - in death, there is a legal challenge that patient / service user confidentiality no longer applies in the absence of a sharing agreement however the nature of the death and the information within the investigations should be reviewed for appropriate sharing and the approach should be discussed with the Coroner. Families my still participate in the investigation and be supported to pose their specific questions. New action as of 04.08.16	Paula Hull, Deputy Director of Nursing responsible for record keeping (18.9a) Simon Beaumont, Head of Informatics (18.9a - compliance monitoring)	Sara Courtney, Associate Director of Nursing East ISD Paula Hull, Deputy Director of Nursing ISD's John Stagg, Associate Director of Nursing, LD TQ21 Carol Adcock, Associate Director of Nursing, AMH Nicky Bennet, Associate Director of Nursing, Specialised Services Liz Taylor, Associate Director of Nursing, Childrens and Families	Sara Courtney, Acting Chief Nurse (18.2a)	31.10.16	Evidence required: Record keeping procedure stipulating the responsibility (18.9a) Serious Incident procedure (18.9b)	Where possible up to date next of kin details should be available and a sharing agreement in place. This enables early contact with family members to support involvement in any investigation. Families will feel involved and that they have a voice.	04.08.16 New action to address the lack of next of kin details for some patient / service users.	An informatics report will provide a base of line of recorded next of kin details which can be improved through a targeted unit based communications and monitoring supported by the record keeping group.	31.10.16	Evidence required: Informatics report showing that 80% of patient records have a next of kin listed (18.9a) Serious incident investigation report where next of kin details have been obtained through an alternative means (18.9b)
		18.10 Following the receipt of the external appreciative enquiry into the current quality of the experience of the involvement of families in SIRI investigations over a 2 year period the Trust will: 18.10a Create a task and finish group to review the report in detail and focusing on continuing improvement create an action plan to address the recommendations this will include representative from the cohort of families involved 18.10b Re-review the engagement and duty of candour policies and procedures updating where necessary 18.10c Review the Trust-wide training of family engagement and duty of candour, how this is delivered and to whom in the workforce New action added 28.08.16	Paula Hall, Deputy Director of Nursing Mayura Deshpande, Associate Medical Director - Patient Safety Chris Woodfine, Head of Patient Engagement and Experience Bobby Moth, Associate Director of LEaD Family Liaison Officer	N/A	Lesley Stevens, Medical Director (18.10a & 18.10b) Jane Pound (18.10c)	30.11.16	Evidence required: Minutes of the task and finish group (18.10a) Review of the Trust-wide training re family engagement and duty of candour (18.10c) Reviewed and updated family engagement and duty of candour policy / procedures (18.10b)	That the family members and next of kin are involved, were possible, in the care of their loved ones and are facilitated to be involved in an investigations which arise. They feel communicated with in an honest and transparent manner and information is given in a timely and appropriate manner.	28.09.16 New action added to address the recommendations of the appreciative enquiry	The quantative research undertaken within the first appreciative enquiry will be repeated to evidence improvement. (18.10) The involvement of families and next of kin will continue to be checked and challenged at divisional and corporate panels. (18.10) That staff are able to follow policy and procedures fully understanding the content and application in practice (18.10b and 18.10c)	30.09.17	Evidence required: Internal thematic review report on serous incident investigation reports to be undertaken at 6 monthly intervals will review family involvement (18.10a) Appreciative enquiry to be repeated for cohort April2016 to April 2017 (18.10a, 18.10b and 18.10c)

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

Summary Milestones Plan for CQC Improvement Action Plan

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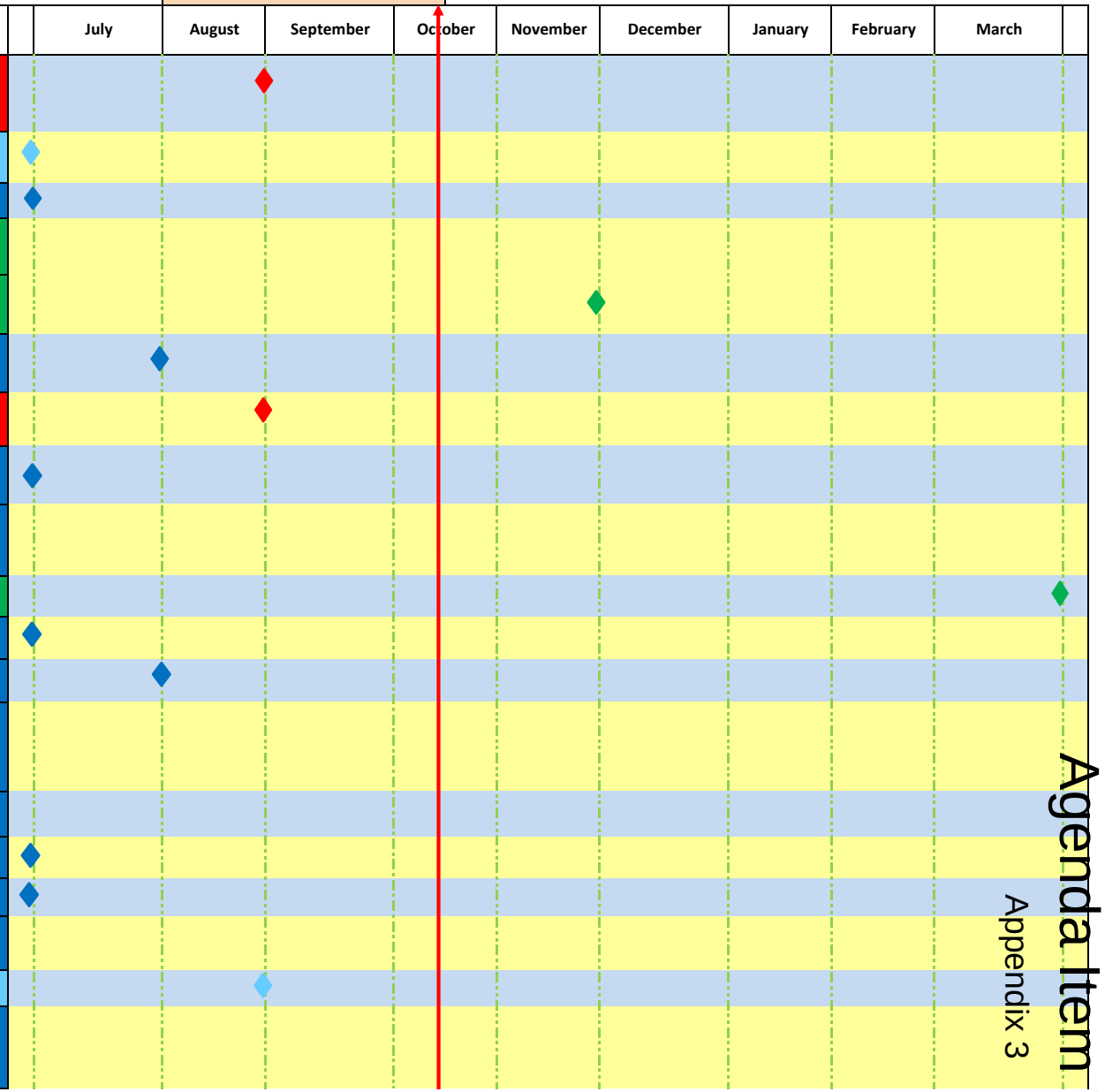
UIN	WARNING NOTICE ACTIONS	Target date	Status
WN001 1.1	Central Quality Governance team to be restructured to deliver a Business Partner model (replicated from HR and Finance model) to strengthen the links and accountability lines between the central governance team and divisional quality structures.	31/08/2016	Not on Track
WN001 1.2	Review of Ward to Board reporting on quality performance (Board and its sub-committees)	30/06/2016	Unvalidated
WN001 1.3	Executive Quality Portfolios to be revised and strengthened with the three Clinical Executives forming a 'Quality Team'	30/06/2016	Complete
WN001 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	31/05/2016	On Track
		30/11/2016	On Track
WN001 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	31/07/2016	Complete
WN001 1.6	Risk Management Policy to be reviewed (including Risk Appetite Statement)	31/08/2016	Not on Track
WN002 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.	30/06/2016	Complete
WN002 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	31/05/2016	Complete
WN002 2.3	Develop a strategic 3 year capital programme to ensure appropriate short/medium/long term planning	31/03/2017	On Track
WN002 2.4	Each MH/LD/OPMH inpatient unit will have its own site-specific environmental and estate work plan.	30/06/2016	Complete
WN002 2.5	Estates team to produce and install standardised displays of capital plans for each site	31/07/2016	Complete
WN002 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.	28/02/2016	Complete
WN002 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)	30/04/2016	Complete
WN002 2.8	An annual ligature risk assessment programme will be rolled out	30/06/2016	Complete
WN002 2.9	The Ligature Management Policy will be updated to ensure the new risk assessment process is clearly documented	30/06/2016	Complete
WN002 2.10	Appoint a dedicated full time Trust clinical ligature project manager	01/03/2016	Complete
WN002 2.11	Improve the robustness of the Site-specific security management reviews.	31/08/2016	Unvalidated
WN002 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.	11/05/2016	Complete



Summary Milestones Plan for CQC Improvement Action Plan

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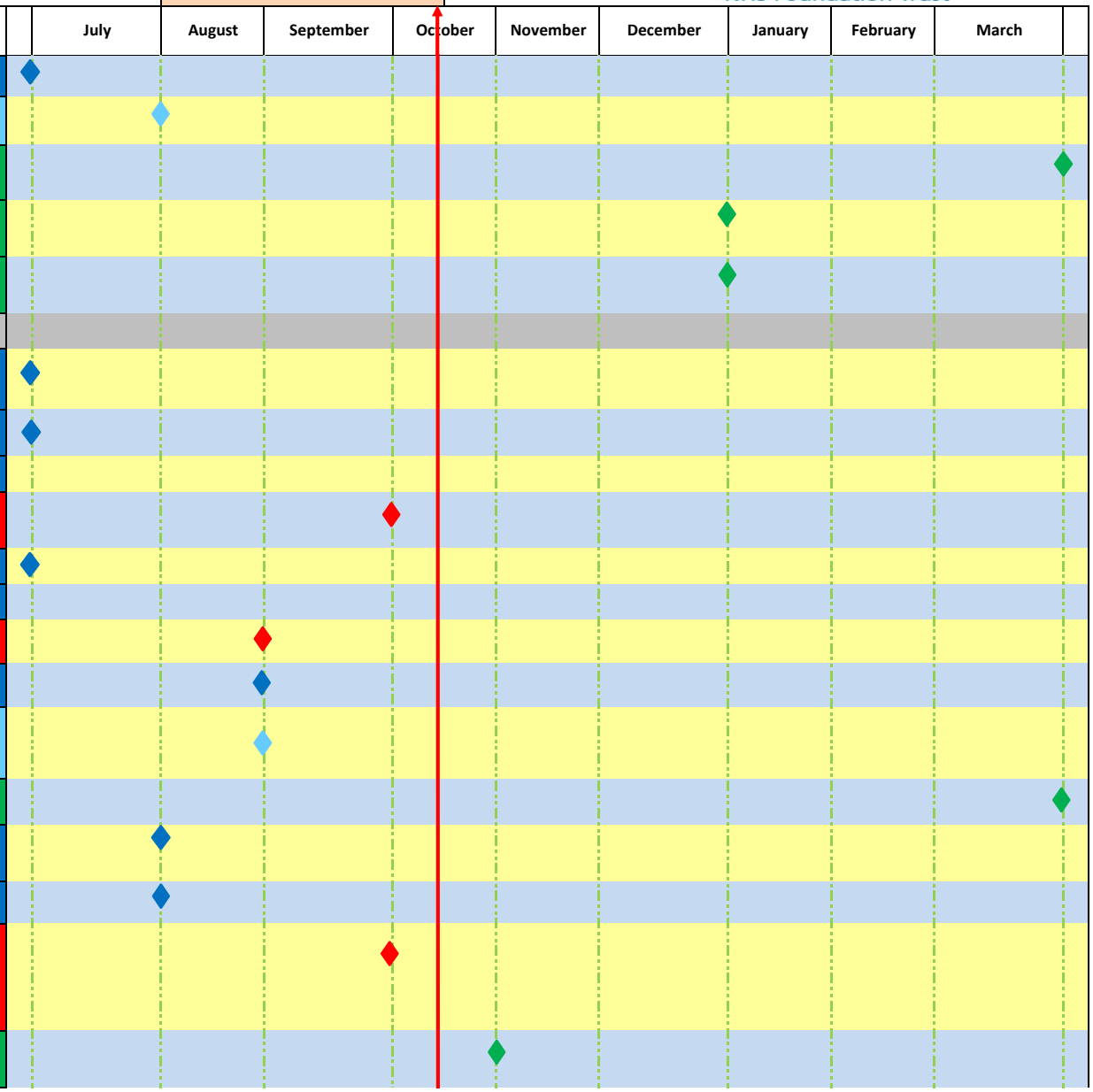
Southern Health NHS Foundation Trust

UIN	WARNING NOTICE ACTIONS	Target date	Status
WN 3.1	3.1 The Trust approach to thematic review will be more systematic and robust.	30/06/2016	Complete
WN 3.2	The Quality, Improvement and Development Forum (QID) will receive assurance reports regarding the mitigation of risks associated with the environment.	31/07/2016	Unvalidated
WN 3.3	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.	31/03/2017	On Track
WN 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	31/12/2016	On Track
WN 3.5	Team Quality Improvement plans will be in place for every team across the Organisation by the end 2016	31/12/2016	On Track
WN 4	The Trust will deliver the Mortality and SIRI action plan in full and to time		
WN 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 Analysis	30/06/2016	Complete
WN 4.2	All Root Cause Analysis Investigations that are not SIRIs (excluding pressure ulcers) will go through the same processes as SIRIs	30/06/2016	Complete
WN 4.3	IMA audit tool will be amended to ensure it includes adequate checks against RiO	31/05/2016	Complete
WN 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.	30/09/2016	Not on Track
WN 4.5	The Trust will appoint a Trust Patient Experience Lead	30/06/2016	Complete
WN 4.6	CAS system to be used to disseminate learning from SIRIs where corporate panel has grade these as level 4 or 5	30/05/2016	Complete
WN 4.7	The Organisational learning strategy will be reviewed and updated	31/08/2016	Not on Track
WN 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.	31/08/2016	Complete
WN 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.	31/08/2016	Unvalidated
WN 4.10	The Trust will upskill frontline staff in quality improvement methodologies using the existing Team Viral programme to support this	31/03/2017	On Track
WN 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	31/07/2016	Complete
WN 5.2	A structured leadership visibility programme will be introduced to inlcude executive safety walkabouts, 'Back to the Floor' programme etc.	31/07/2016	Complete
WN 5.3	Undertake a review of the Trust's staff engagement strategy	30/09/2016	Not on Track
WN 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	31/10/2016	On Track



Summary Milestones Plan for CQC Improvement Action Plan

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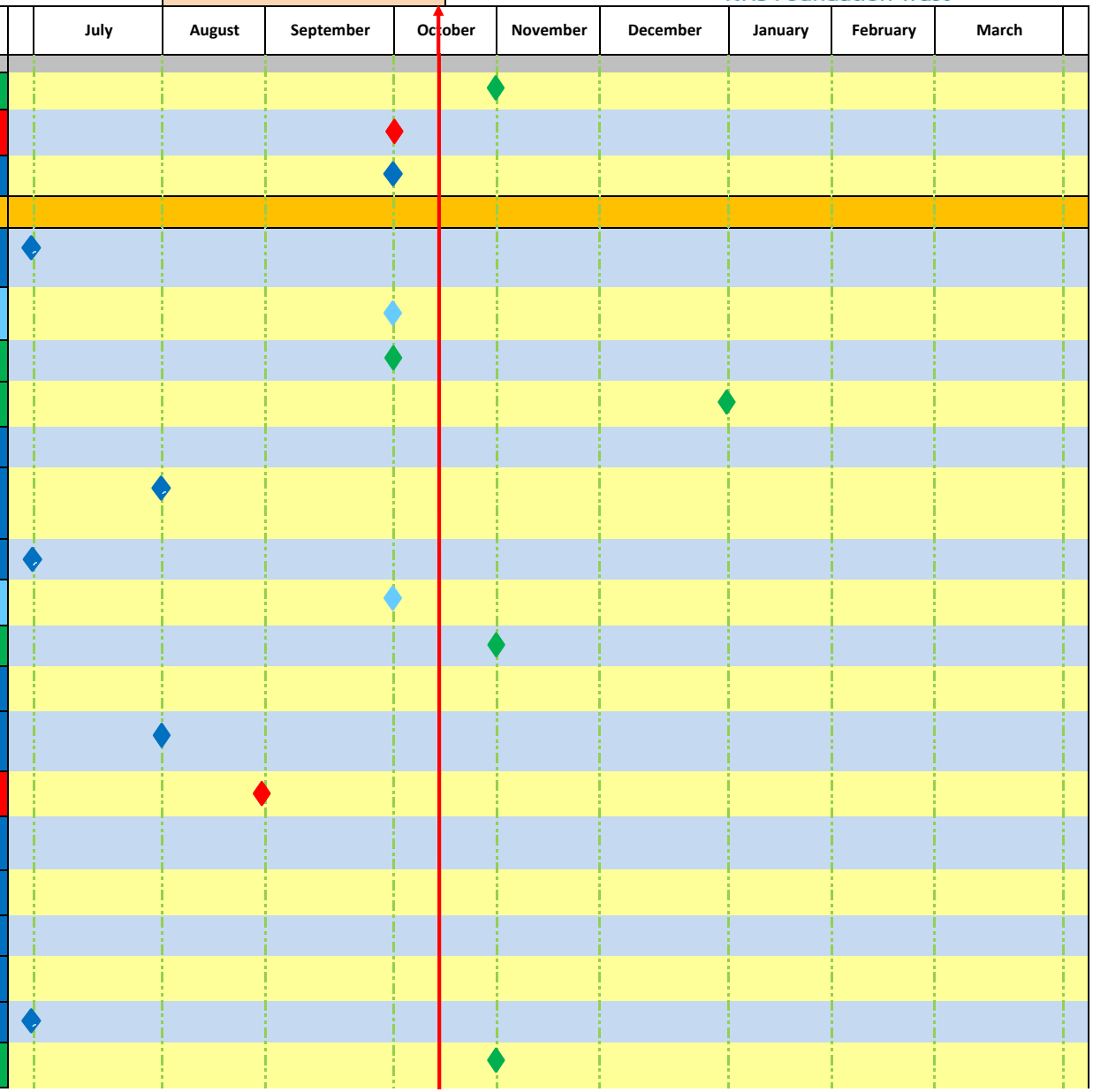
UIN	WARNING NOTICE ACTIONS	Target date	Status
	See action in 5 above		
WN 6.1	Ensure frontline staff are fully engaged in the Trust's Training Needs Analysis process	31/10/2016	On Track
WN 6.2	Conduct a staff survey to include a question that evaluates whether staff feel that their appraisal and/or revalidation process has adequately addressed their training needs	30/09/2016	Not on Track
WN 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.	30/09/2016	Complete
	MUST DO ACTIONS		
MD 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)	30/06/2016	Complete
MD 7.2	Task & Finish Group to: review the functionality of the existing RiO risk assessment tool and determine the improvements required	30/09/2016	Unvalidated
MD 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	30/09/16 (TBC)	On Track
MD 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	31/12/2016	On Track
MD 8.1	Interim action: All multi-disciplinary team meetings to include discussion of patients who DNA as a standard agenda item.	31/05/2016	Complete
MD 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	31/07/2016	Complete
MD 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	30/06/2016	Complete
MD 8.4	Complete the review of the current Clinical Disengagement Policy and make any necessary improvements to it.	30/09/2016	Unvalidated
MD 8.5	Launch revised Clinical Disengagement policy including headlining it at AMH Learning Network event	31/10/2016	On Track
MD 9.1	Interim action: Put plans in place to ensure Consultant Psychiatrist on-call or senior registrar on-call	31/05/2016	Complete
MD 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	31/07/2016	Complete
MD 9.3	Use results of audit to feed into Trust-wide review of junior medical on-call	31/08/2016	Not on track
MD 10.1	Develop a clear process for identifying and prioritising environmental risks across AMH services that includes the process for escalation and governance responsibilities.	31/05/2016	Complete
MD 11.1	Domed mirrors to be installed on Kingsley Ward, Melbury Lodge to improve the sight lines	31/05/2016	Complete
MD 12.1	Vistamatic windows to be installed on all 25 bedroom doors, Resource Room and Family Room	30/04/2016	Complete
MD 13.1	Amend Hamtun seclusion room plans taking into account MHA Code of Practice and additional suggestions made by CQC	31/05/2016	Complete
MD 13.2	PFI partners to provide costings for new design and issue tender	30/06/2016	Complete
MD 13.3	External contractor to carry out building works of new seclusion room (Antelope)	30/10/2016	On Track



Summary Milestones Plan for CQC Improvement Action Plan

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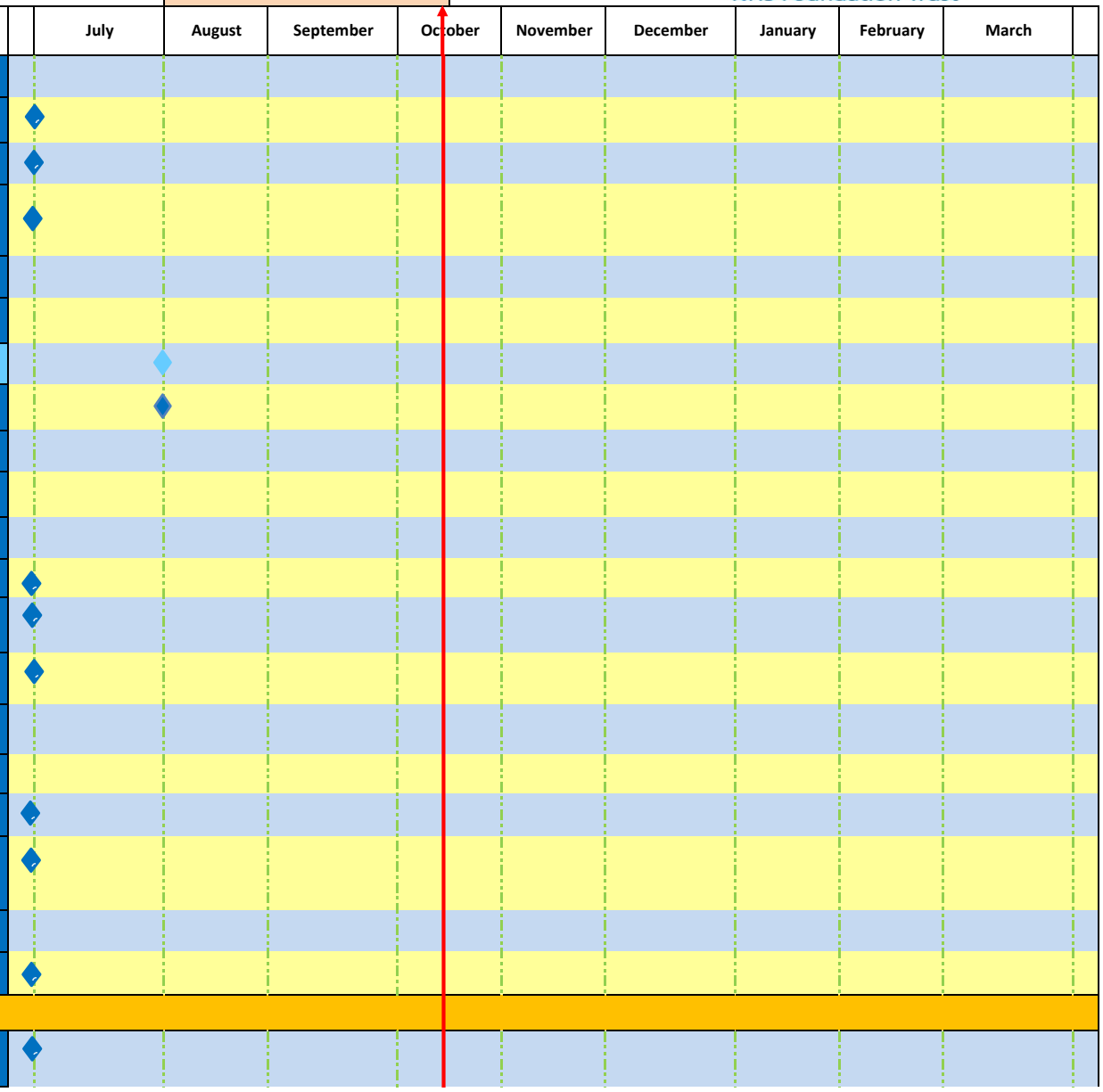
Southern Health NHS Foundation Trust

UIN	WARNING NOTICE ACTIONS	Target date	Status
MD 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	15/04/2016	Complete
MD 14.1	Medicines Management team to re-issue advice re action to be taken if outside of safe range.	31/05/2016	Complete
MD 14.2	Fridge temperature monitoring template to be reviewed and re-issued so as to assure standardisation across the trust	30/06/2016	Complete
MD 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 Action superseded	30/06/2016	Complete
MD 15.1	Introduce immediate safeguards to ensure patient safety	31/03/2016	Complete
MD 15.2	Engage and consult effectively with the patient group around further changes being made to reduce the risk from ligature points.	31/05/2016	Complete
MD 15.3	Schedule of bedroom works to be completed by external contractors	30/07/2016	Unvalidated
MD 15.4	Once structural bedroom works are completed, install new ligature-free beds and wardrobes.	31/07/2016	Complete
MD 16.1	Address outstanding ligature points in garden as highlighted by CQC	30/05/2016	Complete
MD 17.1	Identify gaps in essential resuscitation equipment and purchase any necessary additional equipment	31/05/2016	Complete
MD 17.2	Remove staff lockers currently within clinic room	31/05/2016	Complete
MD 17.3	Purchase clinic room treatment chair	30/06/2016	Complete
MD 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.	30/06/2016	Complete
MD 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	Complete
MD 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.	31/05/2016	Complete
MD 19.2	Posters to be created and placed in each room with a bath	31/05/2016	Complete
MD 20.1	Add standing agenda item regarding learning from incidents to local quality and governance meetings.	30/06/2016	Complete
MD 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.	30/06/2016	Complete
MD 22.1	Install curtains in patient bedroom (RWC)	30/05/2016	Complete
MD 22.2	Seek options (from various specialist resources / national standards) for door observation panels that do not compromise privacy and dignity (Evenlode)	30/06/2016	Complete
	SHOULD DO ACTIONS		
SD 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	30/06/2016	Complete



Summary Milestones Plan for CQC Improvement Action Plan

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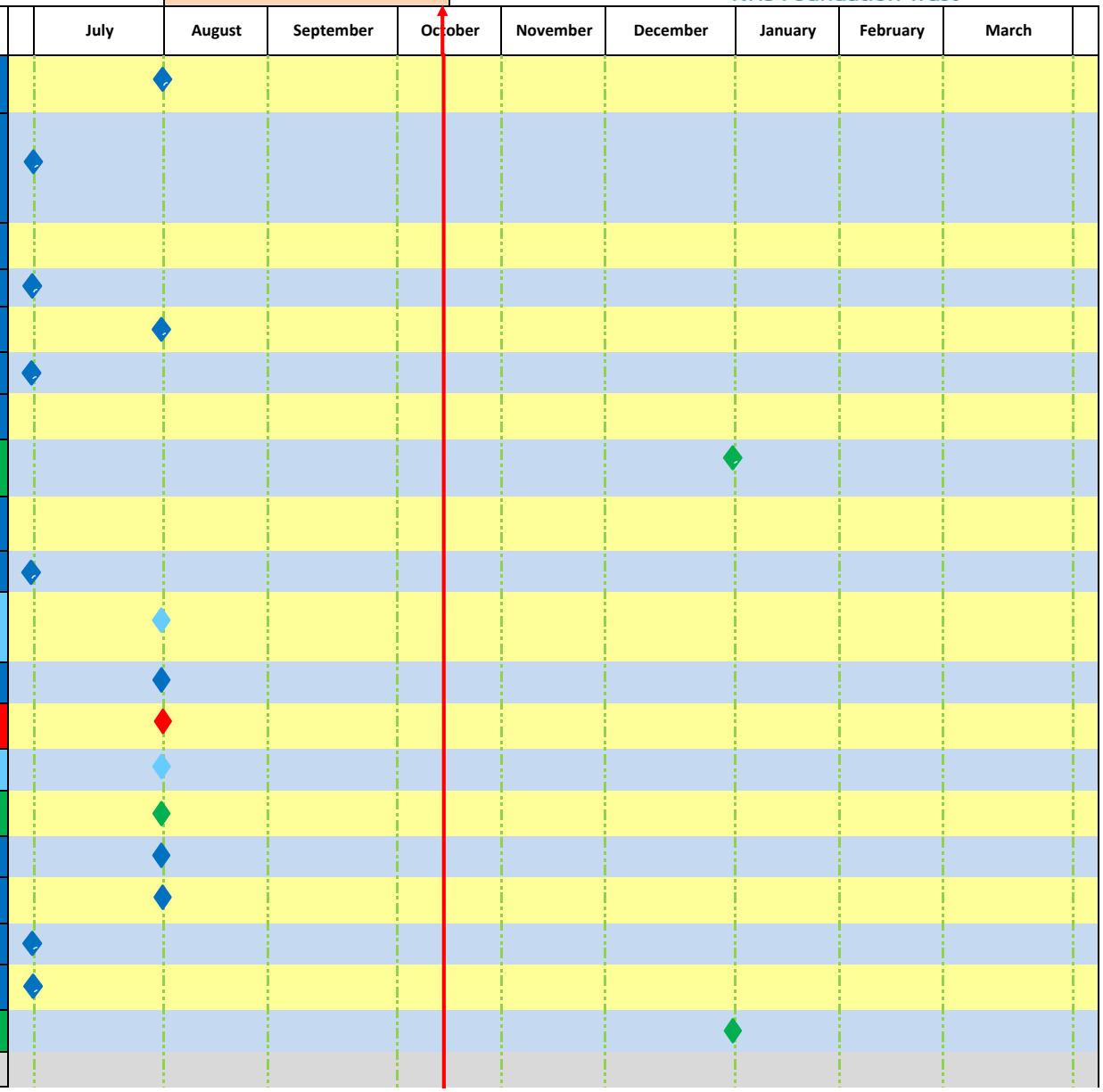
Southern Health NHS
NHS Foundation Trust

UIN	WARNING NOTICE ACTIONS	Target date	Status
SD 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	31/07/2016	Complete
SD 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)	30/06/2016	Complete
SD 25.1	Launch revised Clinical Disengagement policy including headlining it at AMH Learning Network event	31/05/2016	Complete
SD 25.2	AMH specific clinical supervision template to be designed	30/06/2016	Complete
SD 25.3	All Soton community staff to have had first supervision session and planned schedule of supervision sessions in place	31/07/2016	Complete
SD 26.1	Consultant psychiatrists and ward managers to ensure that all patients have advanced statements	30/06/2016	Complete
SD 26.2	Template of CPA meeting to be changed to ensure wishes of young people are formally capture red.	31/05/2016	Complete
SD 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	31/12/2016	On Track
SD 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	31/05/2016	Complete
SD 27.2	Ensure reference to Track and Trigger Tool is included on local induction checklist for agency staff.	30/06/2016	Complete
SD 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.	31/07/2016	Unvalidated
SD 28.1	Develop a Trust position statement that sets out the principles staff should work to with regards to restrictive practice.	31/07/2016	Complete
SD 28.2	Review the restrictive interventions policy, in line with the position statement and address any identified gaps	31/07/2016	Not on Track
SD 28.3	Review the training programme, in line with the new restrictive interventions policy, and produce a paper with recommendations for future training	31/07/2016	Unvalidated
SD 28.4	Implement the changes to the training programme and roll-out to relevant staff groups	31/07/2016 (TBC)	On Track
SD 28.5	Ulysses to be updated and staff to record the duration of each type of restraint as part of the incident reporting processes.	31/07/16	Complete
SD 29.1	Staff to be trained in assessing and recording of capacity and consent as part of their local induction (open to all staff).	31/07/2016	Complete
SD 30.1	Design seclusion flow chart	30/06/2016	Complete
SD 30.2	Review Trust seclusion documentation to ensure it is as simple as it can be for staff to complete.	30/06/2016	Complete
SD 30.3	Carry out a scoping exercise to look at the possibility of moving seclusion paperwork to RiO	31/12/2016	On Track
SD 31	See action 28 above.		

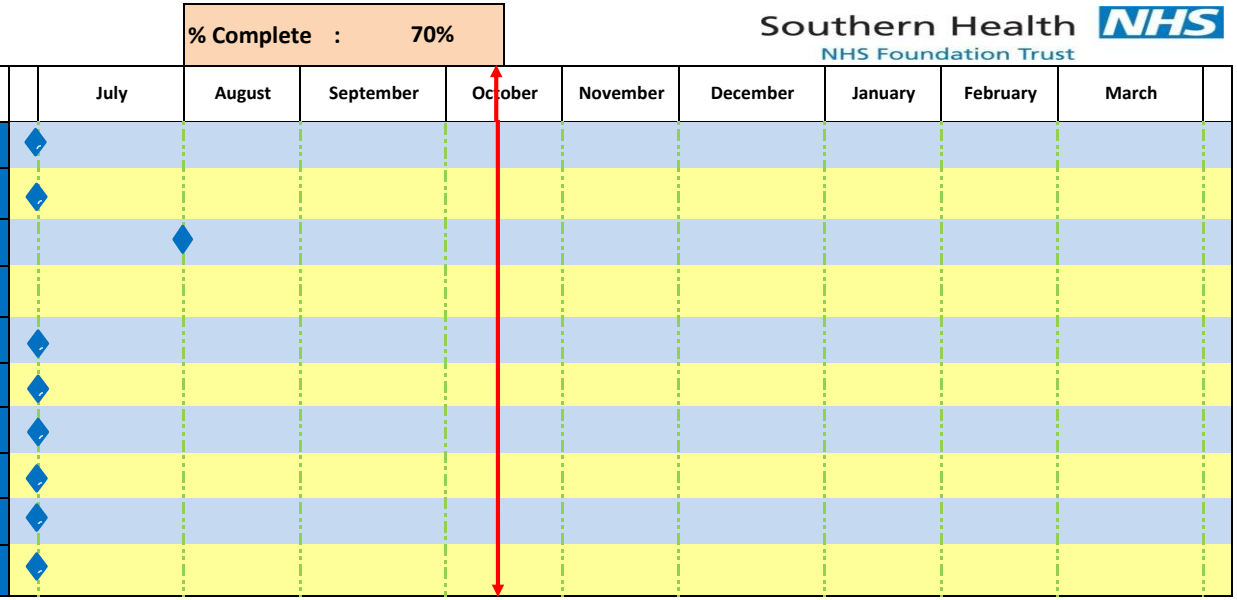


Summary Milestones Plan for CQC Improvement Action Plan

% Complete : 70%

Southern Health NHS
NHS Foundation Trust

UIN	WARNING NOTICE ACTIONS	Target date	Status
SD 32.1	New emergency bags to be ordered and placed on each ward.	10/06/2016	Complete
SD 33.1	The Ward round proforma which is copied to each patient's RiO record will be amended and standardised for all inpatient units	30/06/2016	Complete
SD 34.1	Supervision template to be amended to include requirement for care plans to be reviewed.	31/07/2016	Complete
SD 35.1	Ensure staff establishment is met with Trust recruitment processes being followed.	31/05/2016	Complete
SD 36.1	Establish programme of patient meetings that include planned changes within service.	30/06/2016	Complete
SD 36.2	Extra-ordinary Meetings to be held if changes need to be made rapidly.	30/06/2016	Complete
SD 36.3	Meetings minuted and copies of minutes available for patients to access.	30/06/2016	Complete
SD 37.1	OT to consult with Patient group to discuss and understand their needs and preferences	30/06/2016	Complete
SD 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	Complete
SD 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.	30/06/2016	Complete



Summary Exception Report for: CQC Warning Notices and Must Do Actions October 2016

Southern Health NHS
NHS Foundation Trust

UIN	IMPROVEMENT PLAN ACTIONS	Target date	Status	Responsible	Current Status	Evidence
WN001 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.	31/08/2016	Not on Track	Helen Ludford Associate Director of Quality Governance	October 2016: Two of the three Quality Governance Business Partner roles have been recruited to; one will start in November and the other in December / January following due HR processes. The third post currently has been filled by an interim candidate whilst substantive recruitment continues; further interim arrangements to be in place by 31/10/16, whilst substantive positions to be filled.	IN FOLDER: 1.1 - Governance team Structure as of 1 August 2016 showing vacancies
WN001 1.6	Risk Management Policy to be reviewed (including Risk Appetite Statement)	31/08/2016	Not on Track	Helen Ludford Associate Director of Quality Governance	October 2016: The risk management strategy has been approved. The risk appetite framework was submitted to the Trust Board at the end of September and will be submitted to the Audit, Assurance and Risk Committee (AARC) in October.	IN FOLDER: Risk Management Strategy and Policy (DRAFT out for consultation)
WN 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	30/09/2016	Not on Track	External Reviewer Helen Ludford Associate Director of Quality Governance	May 2016: Review commissioned and investigator appointed. Work underway to contact families and set up interviews September 2016: Review completed and reported presented to senior managers. Results to be used to shape improvements to the process. Mark as Amber until copy of report and outcome of paper are received.	Awaiting a copy of report and action plan
WN 4.7	The Organisational learning strategy will be reviewed and updated	31/08/2016	Not on Track	Helen Ludford Associate Director of Quality Governance	June 2016: Quality Improvement Strategy was approved by Board at the end of June 2016. The Organisational Learning Strategy is now being reviewed by the workstream to align with this. October 2016: Strategy development in progress but delayed due to changing priorities (CQC inspection). To be completed and approved by end of October 2016.	June 2016: Quality Improvement Strategy was approved by Board at the end of June 2016. The Organisational Learning Strategy is now being reviewed by the workstream to align with this. 23/09/16 - strategy development in progress but delayed due to changing priorities (CQC inspection). To be completed and approved by end of October 2016.
WN 5.3	Undertake a review of the Trust's staff engagement strategy	30/09/2016	Not on Track	Amanda Smith Deputy Director of Workforce Emma McKinney Associate Director of communications	October 2016: The Staff Engagement Plan was presented at the last Quality and Safety Committee and it is due to be discussed at the next Trust Executive Group (TEG). The plan has been modified and an update is given regularly at the CQC Delivery Group.	Awaiting copy of staff engagement plan finalised by TEG
WN 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	30/09/16	Not on Track	Amanda Smith Deputy Director of Workforce	September 2016: Survey has been completed and results analysed. Paper to go to Strategic Workforce Committee in October 2016. Mark as Amber until copy of report and outcome of paper are received. October 2016: The survey has been completed and a paper will be submitted to the Strategic Workforce Committee in October. This will detail on the outcomes from the survey and any action to be taken to improve the process. This paper will then be presented to the CQC Delivery Group at the end of October to close off this action.	Awaiting copy of report from John Monahan
MD 9.3	Use results of audit to feed into Trust-wide review of junior medical on-call	31/08/2016	Not on track	Dr Mayura Deshpande, Clinical Service Director	August 2016: Audit results reviewed and non-compliance identified. Shows wider issue related to junior medical on-call which will not be addressed by end of August - action plan to address issued to be presented at CQC delivery group meeting on 30/08/16 October 2016: The audit is complete and one of the actions included undertaking a review of the junior medical on-call rota. Dr Lesley Stevens has asked for a review to be undertaken to put in place a long-term measure for the on-call rota. A short-term mitigation is in place to ensure all episodes of seclusion have an initial medical review within the first hour. Consultant cover is arranged where junior medical staff are unable to undertake this. An administrative post is also being recruited currently to ensure that there is a central point for logging all on-call rotas.	Awaiting record of decision/ copy of the Review

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Southern Health NHS Foundation Trust

Southampton City Council
Health Overview and Scrutiny Panel
October 2016

Southern Health NHS Foundation Trust: Update on Antelope House

Background

During the HOSP meeting on 30 June 2016, the panel was updated on the reasons for the temporary closure of Hamtun ward at Antelope House in Southampton, as well as plans for recruitment and staff retention. Hamtun ward closed in July 2016 and is anticipated to reopen in March 2017, with the majority of patients being cared for at Huntercombe unit in Roehampton in the meantime.

Having successfully recruited to almost all posts in the spring of 2015, Antelope House has struggled to maintain and fill all nursing vacancies, for a number of reasons. The number of substantive nursing staff in post was less than 50% of the overall staffing numbers required for the unit, which made the unit unsafe to run.

The decision was taken to close the ward for a defined period of time in order to ensure safe staffing levels on all other units at Antelope House, and being able to focus resources on developing a sustainable staff recruitment and retention strategy.

There are a number of reasons why Antelope House has struggled to fill and maintain all nursing posts:

- There is a national shortage of nurses and fewer nurses are entering training. This is a short and long term challenge for the whole NHS.
- Improvements are needed to the shape of the workforce in our acute mental health services, so patients are supported by the right staff at the right time.
- A recent redesign of mental health services in Southampton created new opportunities for staff in different teams.
- Antelope House is a very busy hospital supporting some of the most unwell people, so it is a very demanding job. With staff shortages this becomes even more difficult and can affect the wellbeing and resilience of our staff.

Recent activity

Staff retention

As part of our skill mix review we have enhanced our career pathways from band 2 to band 7 posts. We anticipate this will be attractive to both health care support workers and qualified nurses and support retaining staff.

Staff have helped to develop the new staffing model, the job descriptions and the career pathways; and at a recent inspection the CQC commented positively on it and encouraged us to share it more widely. We have started to share the work in Southampton with our other inpatient units so they can begin developing a similar model.

We have been holding staff drop-in sessions at Antelope House, which has assisted with ensuring we fully engage our workforce in future developments ensuring their ideas and initiatives are central to the way forward.

Recruitment

We have undertaken a substantial amount of work in developing our recruitment material to include a focus on the service user experience, with service users describing their experience and how staff have contributed to their recovery, and staff focusing on how satisfying and fulfilling this makes our work.

Based on this, we have created our first film about working at Antelope House and in mental health, which is set to air this month. There are two further films planned – one about people's experience of using our service and the other about our new model and our work with students.

We have started our social media campaign to encourage more people to work at Antelope House and are currently developing more adverts to enable us to launch a new one each month. The adverts include pictures of the team and quotes about working here.

We have also started our new local recruitment panel process (monthly panels aimed at streamlining the process) and have recruited one nurse from Scotland. Based on this we are targeting some adverts in local and regional Scottish papers and developing links with their universities. We have employed a workforce administrator to do much of the administration associated with recruitment with the intention of freeing up nursing time.

Management of the current situation

We have been working to develop our relationship with Huntercombe unit in Roehampton. Our aim is to support good quality of care and treatment as well as the safe and effective transition of patients between our services.

We visit Huntercombe every other week to meet with service users and carers as well as having a presence in the ward review with the team and service user. In addition, we are holding weekly clinical meetings and receive daily updates on patient care. We financially support carers to visit their loved ones and receive regular information about incidents and restrictive practice so we can ensure the quality of care is of a standard we expect.

Contact

We recognise that this situation is not ideal and want to do what is best for our service users, their carers and our staff to improve people's experience when using our services. Should you wish to discuss this situation, your concerns and any ideas you have please contact:

Liz Durrant, Area Manager, Southampton Adult Mental Health Services

Liz.Durrant@southernhealth.nhs.uk

DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		LOCAL SAFEGUARDING ADULTS BOARD (LSAB) ANNUAL REPORT 2015-16		
DATE OF DECISION:		27 OCTOBER 2016		
REPORT OF:		INDEPENDENT CHAIR OF THE LSAB		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Fiona Bateman**		
	E-mail:	**Fiona.bateman@southampton.gov.uk**		

STATEMENT OF CONFIDENTIALITY
None

BRIEF SUMMARY

This report introduces the 2015/16 Local Safeguarding Adults Board's ['LSAB'] annual report.

RECOMMENDATIONS:

That the Panel review the 2015/16 Annual report and note:

(i) The LSAB have concerns regarding the accuracy and availability of safeguarding data reported to the LSAB and NHS Digital in 2015-16.

(ii) Agree any feedback on the achievements in the last year and future priorities for the LSAB as set out in the Strategic plan [Appendix 2].

(iii) Consider and agree if there are any matters arising within the annual report or strategic plan that the Panel would like to receive further information on as part of its future work programme.

REASONS FOR REPORT RECOMMENDATIONS

1. The Health Overview and Scrutiny Panel has requested the LSAB report on the activity of the Board each year.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. Not applicable

DETAIL (Including consultation carried out)

3. Adult protection became a corporate statutory duty on the 01.04.15 and the annual report sets out the work undertaken on policy formation and training by the LSAB to ensure councillors, SCC staff and staff from across the partnership were supported to meet their new duties. The LSAB also scrutinised 9 organisational audit reports, advising partners on areas for improvement to ensure that services are in a position to meet best standards in safeguarding practice.

4. A key function of the Board is to gather data to establish a picture of the prevalence of abuse and neglect in the area. The LSAB has prioritised this in the last 3 years, directing very limited resources so that we now have an analysis working with all our key partners to collect, collate and analyse data we receive. However, SCC remain unable to provide key performance data.

Data reported within the national Safeguarding Adult Collection ['SAC'] is incomplete and though this has been rectified where possible with data available to the LSAB, we do not have a reliable profile of need in the city. Whilst the LSAB understands that resources are constricting across the entire partnership, it isn't correct to require 'back office functions' of quality assurance to compete with frontline responsibilities. Safe, effective recording leads to more informed, better decision making both at an operational and strategic level. The LSAB is seeking support from HOSP that they will support LSAB in securing accurate data in a timely manner.

5. The annual report provides a detailed breakdown of the data we have received. Given difficulties reported above, the LSAB have been advised that this is unlikely to reflect practice and certainly the Safeguarding Adults Team have reported a rise in workloads, with many cases being more complex and unable to be completed within the 12 month period, as such these are not counted within SAC data which was drawn from only 73 cases completed during the year.

6. Key issues to note:

- There is still a huge differential between concerns reported by professional partners e.g. police/ SACS and health staff etc (over 4,000) and those triaged for consideration as a safeguarding enquiry (945). It remains unclear what processes are in place to feedback to those raising concerns what action or support has been offered, increasing the risk that proactive/preventative action isn't provided in a timely manner.
- Previously we have highlighted a high re-referral rate (23%) suggests that issues were not addressed at the earliest opportunity. Unfortunately the SAC no longer reports this data and despite requests that this continue to be reported to the LSAB we do not have these figures for 2015/16.
- Despite introduction of a statutory duty to ensure advocacy support for safeguarding enquiries data there is still an unacceptable high level of 'unknown' or 'not recorded' against this KPI data. However, even with this there is a clear discrepancy between those who lacked capacity and those provided with support from an advocate, family or friend.

7. Embedding 'Making safeguarding personal' principles into practice across the partnership was (and remains) a key priority. There is now a statutory expectation, as set out in the Care Act guidance. In 2015-16 the LSAB provided training on what this would mean, reviewed operational practice and set up a task and finish group to consider how best to implement policy changes and monitor the impact. To date it has been difficult to monitor the impact, so an audit will be commissioned this year. HOSP are asked to note the principles and, through their work, ensure that SCC and partners understand the importance of and measurable benefits of person centred practice to encourage wider commitment.

8. The LSAB has received regular reports on the quality of health and registered social care provision within Southampton. In August 2015 the LSAB were advised standards of care within the sector were improving in response to a more collaborative approach of working with providers to agree robust improvement programmes and firmer monitoring arrangements. For the second year running there has been no reports of any organisational abuse, in addition the numbers of allegations made against social care staff

and in care settings has reduced. CQC reported that their inspection regime had changed and was more challenging, particularly in respect of safeguarding. They confirmed 36% of social care providers in the city were rated good. However, 54% of services inspected required improvement and 5% were inadequate.

9. Partners also reported on activities relating to emerging areas of risk, such as human trafficking (11 cases referred to NRM), FGM and on work done to implement learning from case reviews, e.g. police initiatives to improve communications when adults with care needs go missing.

10. The LSAB actively supported initiates to improve mental wellbeing in Southampton by responding to consultations, seeking assurance on service redesigns and receiving reports on the implementation of action plans. The annual report also details work undertaken in respect of mortality reviews during the period. The report also details findings from case reviews and audits and the training opportunities offered by the LSAB.

RESOURCE IMPLICATIONS

Capital/Revenue

11. None.

Property/Other

12. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

13. 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:

14. The Care Act 2014 requires Southampton City Council establish a LSAB and provides for accountability of the Independent Chair to the Chief Executive of the Local Authority.

POLICY FRAMEWORK IMPLICATIONS

15. None.

KEY DECISION? No

WARDS/COMMUNITIES AFFECTED: All

SUPPORTING DOCUMENTATION

Appendices

1. LSAB Annual Report 2015/16
2. LSAB Strategic Plan 2015/16

Documents In Members' Rooms

1. None

Equality Impact Assessment

Do the implications/subject of the report require an Equality Impact Assessment (EIA) 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	

LSAB
Southampton
Local Safeguarding
Adults Board

Annual Report

2015-2016

Contents

Introduction

This report is produced by Southampton Local Safeguarding Adults Board (LSAB) in accordance with the Care Act 2014 which requires the LSAB to publish an annual report detailing what each member and the LSAB has done collectively during the year to achieve its main objective and implement its strategic plan.

This report provides a summary of safeguarding activity carried out by the partners across the social care, health and criminal justice sectors in Southampton. The report will focus on:

- Adult protection work to investigate and resolve cases where allegations of abuse and neglect were raised in respect of adults at risk in Southampton.
- Work undertaken to raise awareness of safeguarding; the types of risks faced by adults who need care and support in our city.
- Reviewing the impact that the LSAB has had by seeking assurance that work undertaken by providers, regulatory or commissioning bodies to prevent abuse and neglect before any concerns arise or respond to actual or perceived safeguarding risk so that harm is averted.
- Set out the findings of any Safeguarding Adults Reviews and subsequent action taken to implement the recommendations arising from those.

Chair's Foreword

As Chair I welcome the commitment partners have shown to the work of the LSAB throughout the course of the year. When I first started in this role, in 2014, I was fully aware of the significant impact that financial restraints and organisational changes across partner agencies could have on the ability of LSAB to improve practice in this field. Notwithstanding these challenges I was optimistic that partnership working was the best model available to offer effective protection for adults at risk of abuse and neglect. Since this time, the Board and I have witnessed unprecedented change. At times this has felt unrelenting, but throughout it frontline staff and strategic leaders have remained focused on developing and improving services for those in need of care and support. Motivated, I believe, by the importance placed by the community on protecting the most vulnerable members of our society. This was confirmed in a survey by Southampton City Council of residents in 2015, which rated '*people in Southampton are safe and protected from harm*' as the most important outcome out of 14 possible.

Year on year partners have shown a passion for innovation; rising to the challenge of new legal responsibilities and to counter considerable pressure on financial and staffing resources. Many of those initiatives are set out in detail later and I would thoroughly recommend taking time to read through this report. However, I particularly want to draw attention to initiatives this year that raised awareness of new challenges, such as risks posed to those 'wandering with purpose' or from 'honour' based violence, and those that brought heightened awareness of safeguarding responsibilities to GPs and other primary health professionals and to those working with social care providers to raise standards.

In April 2015 the Care Act came into force and with it clear statutory responsibilities for safeguarding. Whilst section 42 of the Care Act defined an 'adult at risk' and set out it was for the local authority to lead enquiries,

the Care and Support Guidance explicitly provided that safeguarding responsibilities must be undertaken in partnership with the individual, their carers and any 'relevant partner' who might be in a position to assist with an enquiry or take action to protect the adult from abuse, neglect or exploitation. It is a very wide duty; requiring carers, professionals and volunteers to protect an adult from harm whilst respecting their wishes and rights to privacy and family life. We must all better understand the standards of lawful enquiry and safe, effective protection planning that the 'making safeguarding personal principles' encompass. A summary of which is included within the report.

The nature of this report means that the focus will be on the exceptional; we do not necessarily report on activities carried out in 2015-16 as part of our usual business. For example, as Chair I have attended many forums to raise the profile of adult safeguarding and the statutory responsibilities owed to adults at risk. The LSAB is also now recognised as a useful body to consult where partners are proposing changes in policy, practice or service delivery that might impact of safeguarding responsibilities. I also want to take this opportunity to comment on the contribution made by many people to the work of the LSAB's sub groups, their commitment enables the LSAB to carry out many of its functions. These functions focus on the need to offer constructive challenge about how local services, (be that statutory, voluntary or community groups) work to provide safe, effective care to adults in need and support for their carers. Equally the quality assurance functions of case review, multi-agency auditing and measuring policy implementation allows the LSAB to better understand if partners are responding in line with adult protection obligations. I would encourage anyone who is interested in this work to get in touch with me or the safeguarding board team as we would welcome involvement, particularly from community groups.

2015-16 has seen many positive improvements, but there is never room for complacency. I understand that it may take time to embed practices that ensure all partner agencies can evidence full compliance with new statutory duties. However, one of the LSAB's key functions does require specific comment within this section. As a multi-agency partnership the Board is perfectly placed and is therefore expected to gather data to establish a picture of the prevalence of abuse and neglect in the area. The main body of this reports sets out just how important this is to the work of the partners and why it is so vital. It is disappointing that, for the third year running, many partners remain unable to provide key performance data and there are still too many gaps in what is recorded. Data reported within the national Safeguarding Adult Collection is incomplete and though this has been rectified where possible with data available to the LSAB, we do not have a reliable profile of need in the city. It is unacceptable for poor recording or reporting to go unchallenged. The LSAB understands that resources are constricting across the entire partnership, but it isn't correct to require 'back office functions' of quality assurance to compete with frontline responsibilities. Safe, effective recording leads to more informed, better decision making both at an operational and strategic level and it is for this reason that the LSAB will continue to push partners to comply in full with this expectation. I recognise some members have only been able to put in place measures this year to improve practice, but the LSAB must start to reap the benefits of these changes quickly if we are to better support partners meet their statutory duties to protect adults effectively.

Finally, I would like to extend my gratitude to members of the public, frontline staff and volunteers who have attended training sessions or taken time privately to develop a better understanding of their role in safeguarding adults from harm. It is so important that professionals working within partner agencies understand the risks and respond effectively when an adult is facing abuse or neglect, but we must also work in partnership with the

public. I would like to therefore take this opportunity to recognise the positive impact of countless volunteers and carers without whom many more adults would experience abuse or neglect. I also want to express heartfelt thanks those who responded to the appeal that "***Safeguarding is everyone's responsibility"*** by raising a concern about an adult at risk. Without such vigilance and courage to report many cases would not have come to light and, I have no doubt, many more people would have experienced abuse and neglect.

Fiona Bateman
Independent Chair of Southampton LSAB

What is meant by ‘Making Safeguarding Personal’?

We know that residents in Southampton place a high value on safe, effective services that work together to keep vulnerable adults safe from abuse and neglect. We also know that for adults who are at risk of, or have suffered abuse or neglect, their families and carers it is important that any safeguarding intervention is focused on the wishes and needs of the ‘adult at risk’ and achieving outcomes that support people to improve or resolve their circumstances.

Making Safeguarding Personal (MSP) is a set of principles which aims to develop safeguarding practice to ensure services are engaging with people about the outcomes they want at the beginning and middle of working with them, and then ascertaining the extent to which those outcomes were realised at the end.

MSP is a national initiative which seeks to achieve:

- a personalised approach that enables safeguarding to be done with, not to, people
- practice that focuses on achieving meaningful improvement to people's circumstances rather than just on ‘investigation' and ‘conclusion'
- an approach that utilises social work skills rather than just ‘putting people through a process'
- an approach that enables practitioners, families, teams and SABs to know what difference has been made.

In 2015-16 our strategic plan recognised the need to ensure these principles were embedded into practice and an action plan was devised to encourage positive change in practice. The SAB held a workshop for professionals from across the partnership and community networks who considered these

principles and the challenges faced in changing practice from a process based approach to a person led, outcome focused one. All those attending fully endorsed the principles and understood the treating people as '*experts in their own lives*' shows respect for the individual and enabled flexible responses that recognise diversity in the City. There is widespread understanding of the significant benefits in working alongside adults at risk and the people that matter to them as this enables them to better understand the risks and find resolution of their circumstance and recovery.

The LSAB has made use of a nationally developed MSP toolkit to ensure these principles shape data collection, audits and our quality assurance framework. Many of the training events hosted by the LSAB had MSP as a theme. The principles have also influenced the 2016-18 Strategic plan where embedding this practice change across the partnership remains a key priority.

There is, however, still much to be achieved before we can evidence a universal shift in practice across the partnership. The LSAB will continue to work with partners, supporting them to implement changes and seeking assurance that they are working alongside clients, their families and carers to identify and respond to safeguarding risks. Key to success will be demonstrating this programme has positively improved the adult at risk's quality of life, wellbeing and safety.

Case Study: Ms P

Ms P is a 38 year old lady with Learning Disabilities & Autism who finds a change of environment very difficult. Previous hospital admissions had proved distressing for her and resulted in delays to a surgical procedure to treat an aggressive carcinoma. Ms P also found it difficult to understand the importance of keeping her wound clean and therefore consequently picked at her dressings post operatively. This resulted in delayed wound healing and increased risk of infection.

Prior to subsequent admissions, staff arranged a 'Best Interest' Meeting to included her consultant, parents, Learning Disability Nurse, carers and LD Liaison Service to ensure that the treatment plan was in her best interest and that all reasonable adjustments considered. A number of adjustments were agreed and communicated in advance to the admitting ward staff, for example, ensuring she was first on the list to reduce waiting, appropriate sedation and support by familiar carers and providing treatment in a side room. Staff were also supported to better understand her behaviours so that they could recognise when she might be anxious. Post operative care was also adapted to better meet her needs safely, wound sprays and barrier creams were available at home straight after the procedure and the liaison team worked with both the CLDN and the local LD Intensive Support Team to produce practical guideline for her carers to follow post operatively.

This cohesive working across the community and with day surgery colleagues ensured Ms P was relaxed and comfortable on arrival to theatre which made treatment straightforward. Carers were available to support when Ms P was in recovery and on return to ward and she was discharged home in a timely way following successful surgery. The Liaison Team kept in touch with the carers and ward during this time. Her carers and treatment team all confirmed that the work undertaken prior to admission ensured a positive experience for Ms P, her carers and treating staff.

How has the prevalence of abuse experienced by adults changed in Southampton in 2015-16?

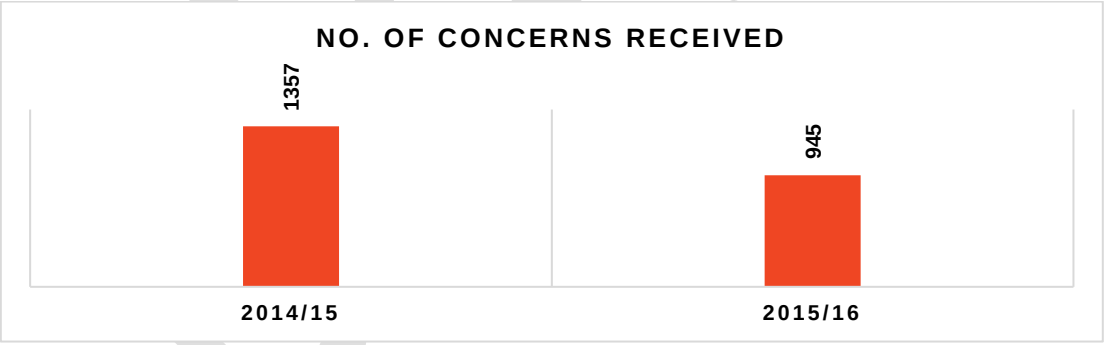
Number of Concerns

The following is the number of concerns received for 2015/16 as reported on the quarterly dataset.

Adult Social Care

Number of concerns received by Adult Social Care has decreased from last year by 30%. This is the number of concerns received after the initial triage. The decrease in the number of concerns received does not represent a fall in the workload; rather this could be as a result of better practice in the recording and capturing of data as well as a change in decision making with regarding to triaging safeguarding concerns. But it is also worth noting that comparative national data, published by NHS Digital (05.10.16 at http://www.content.digital.nhs.uk/catalogue/PUB21917/SAC_%201516_report.pdf) shows a rise in reported concerns. The LSAB will continue to monitor this to ensure that staff are able to effectively respond to concerns of abuse or neglect.

Figure 1. Number of concerns received that have been triaged in 2015/16 compared to those in 2014/15



Partner Providers

The following are the number concerns raised by partner agencies to Adult Social Care.

Figure 2. Number of concerns made to Hampshire Fire and Rescue Services (HFRS), SCC Regulatory Services, Southern Health Foundation Trust (SHFT), Solent NHS and University Hospital Trust (UHS)

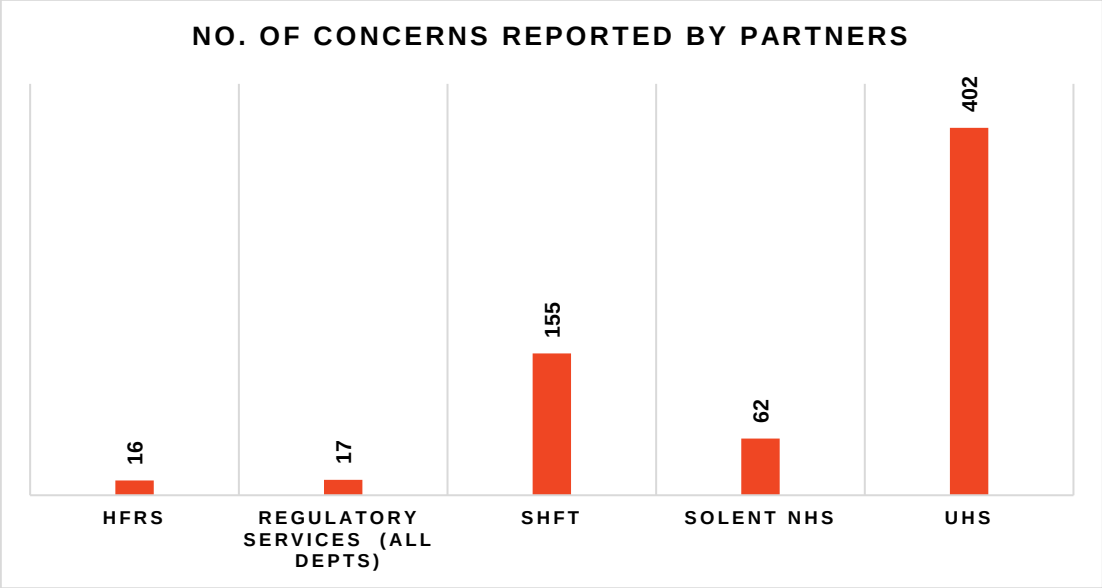
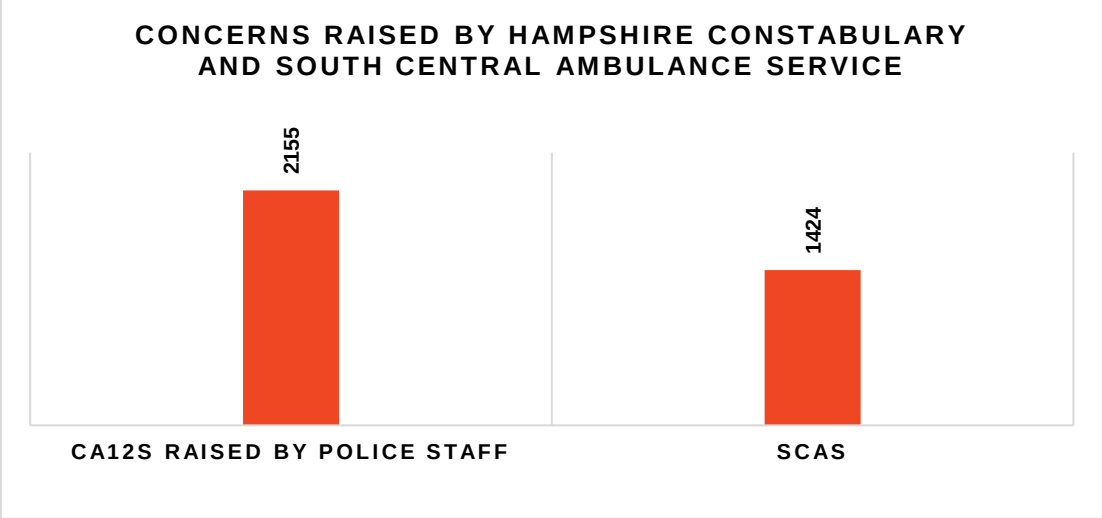


Figure 3. Number of CA12's and Concerns by Hampshire Constabulary and South Central Ambulance Services respectively.

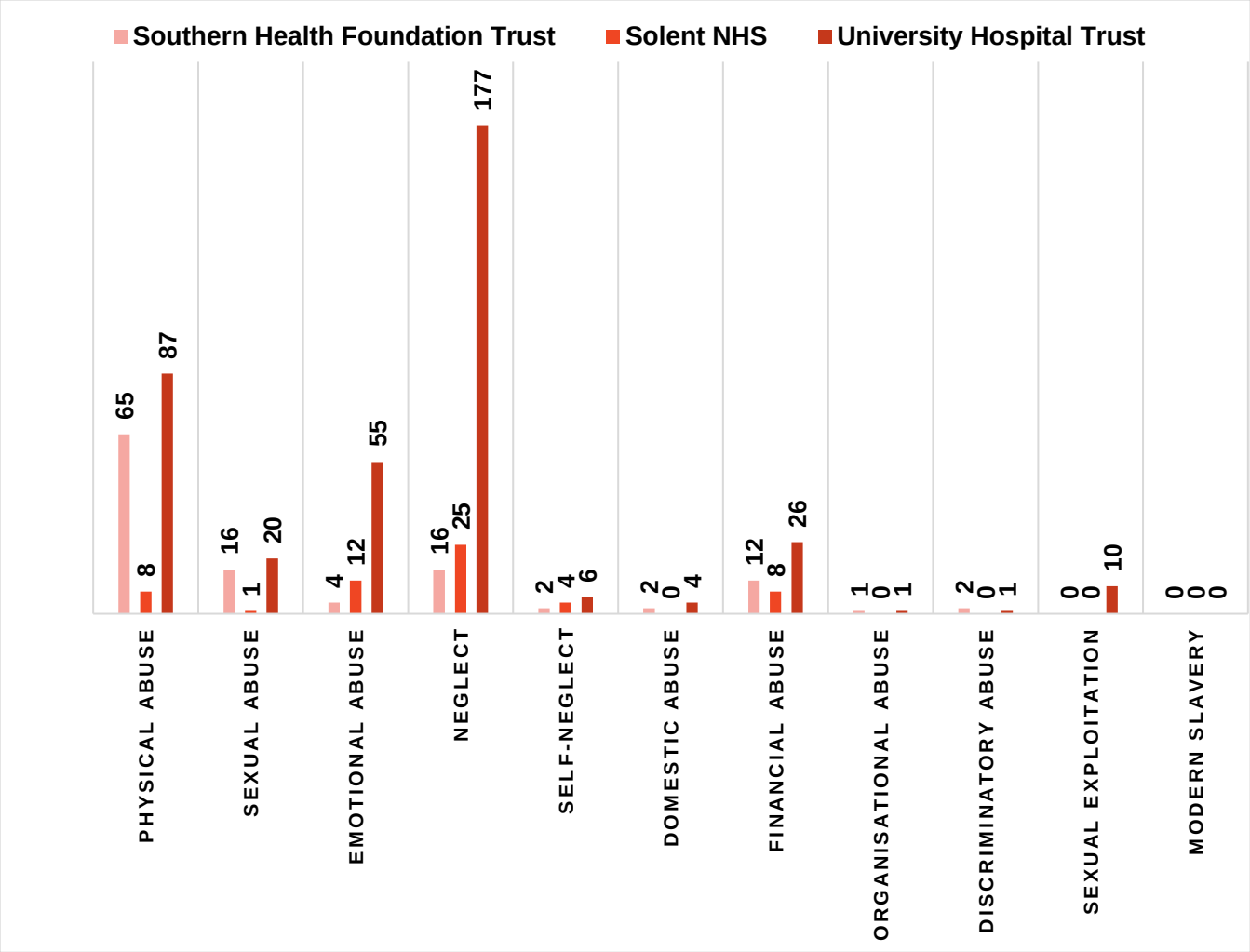


It is important to note that the number of concerns raised by partners will not be equivalent to the number of concerns treated, post triage as s.42 enquiries. In particular not all concerns raised by SCAS or Hampshire Constabulary are necessarily related to safeguarding, so many are initially filtered out. The LSAB are aware that the gap between those concerns that come in to Adult Social Care and those that then go on post triage is very large (3286 concerns). It suggests an over-reliance by partners on the Single Point of Access to make decisions and manage potential lower level safeguarding concerns.

Type of abuse seen by Health Providers and Hampshire Constabulary

The following is a breakdown of the different types of abuse as seen in the concerns raised by the health providers, Southern Health, Solent NHS and University Hospital Trust. The most prevalent types of abuse are neglect, physical and emotional abuse.

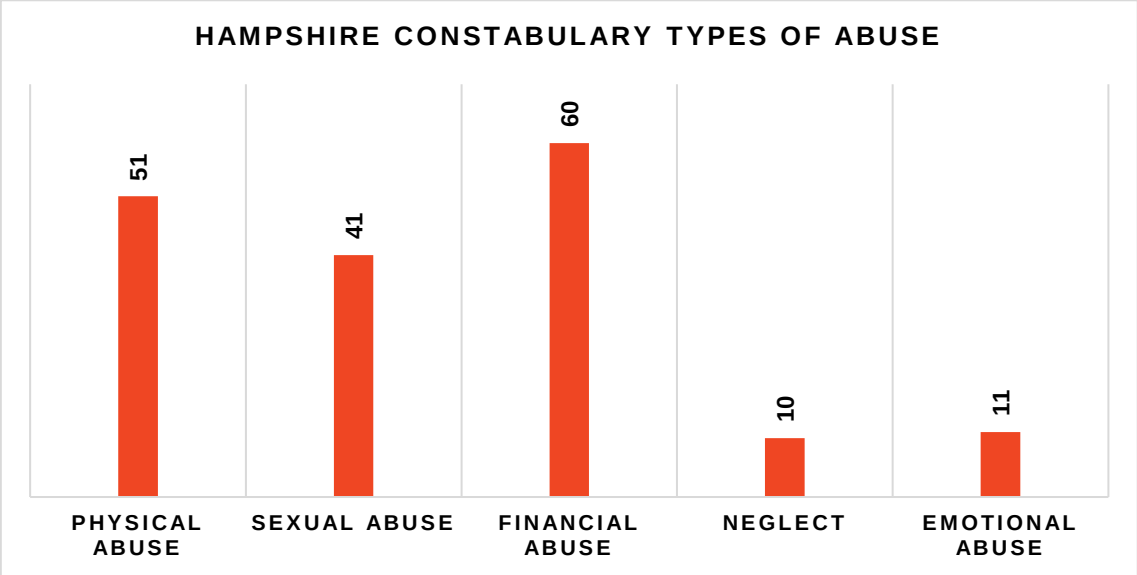
Figure 4. The breakdown of the types of abuse seen by University Hospital Trust, Solent NHS and Southern Health Foundation Trust. These categories of abuse are those categories in the Care Act.



The following is a breakdown in the types of abuse seen in concerned raised by Hampshire Constabulary. The most prevalent type of abuse is financial abuse followed by physical and sexual abuse. Hampshire constabulary report cases of financial abuse in Southampton are consistent with other areas, whilst all allegations are not substantiated the Force believes this demonstrates improved identification of possible abuse and improved cooperation and reporting by providers and services, including SCC's regulatory services, working with adults who are targeted by

fraudsters. It is also an indication of the commitment by the Police to complete robust investigations where financial abuse is alleged.

Figure 5. The categories of abuse seen by Hampshire Constabulary.

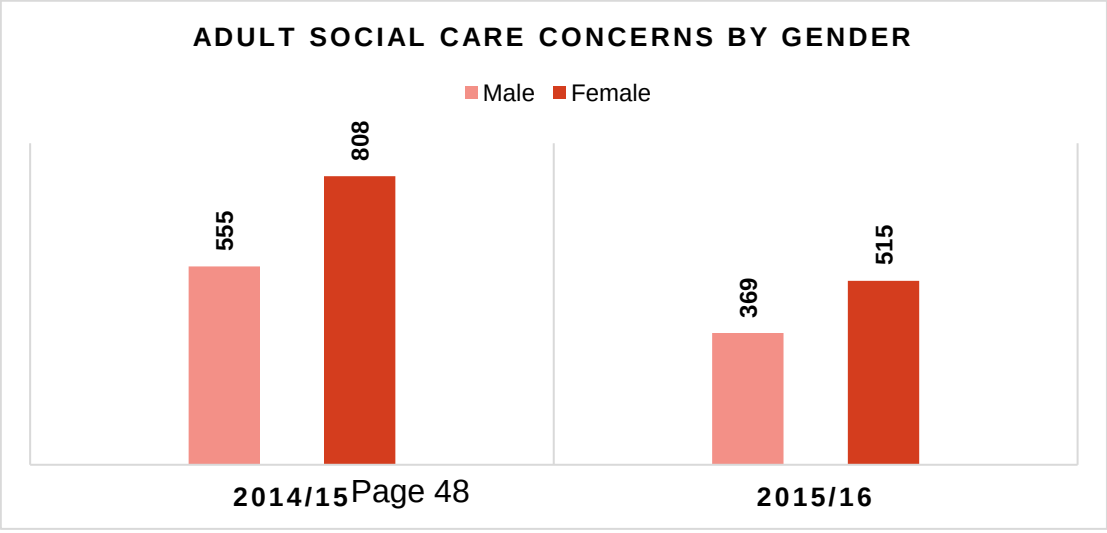


Profile of concerns and Section 42s in Adult Social Care

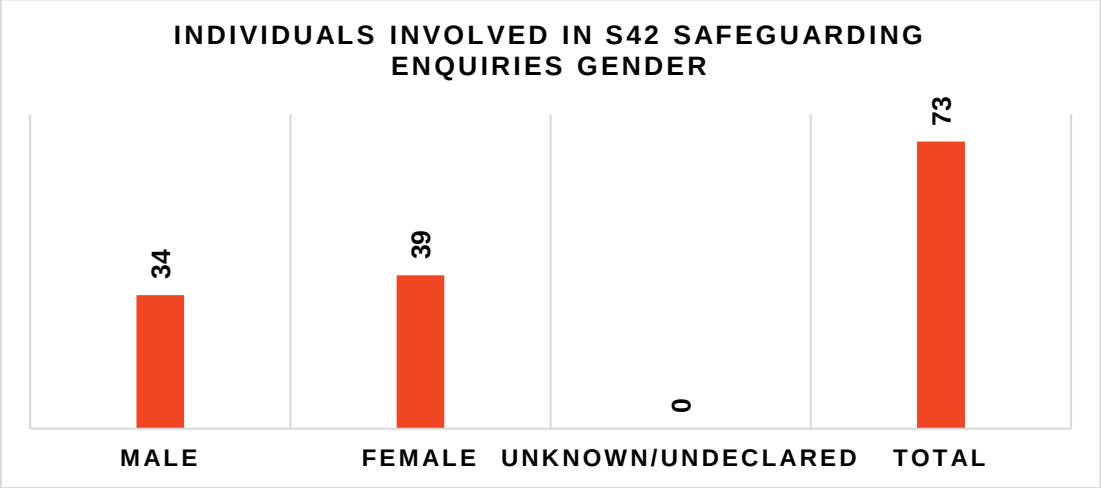
Gender

This year the number of concerns related to women was 30% higher than those concerns related to men. This is in line with the gender breakdown seen last year. This difference is more marked than reported nationally so more needs to be done so that the Board can better understand whether women in Southampton are more at risk or if it may be due to a lack of awareness within the male populations.

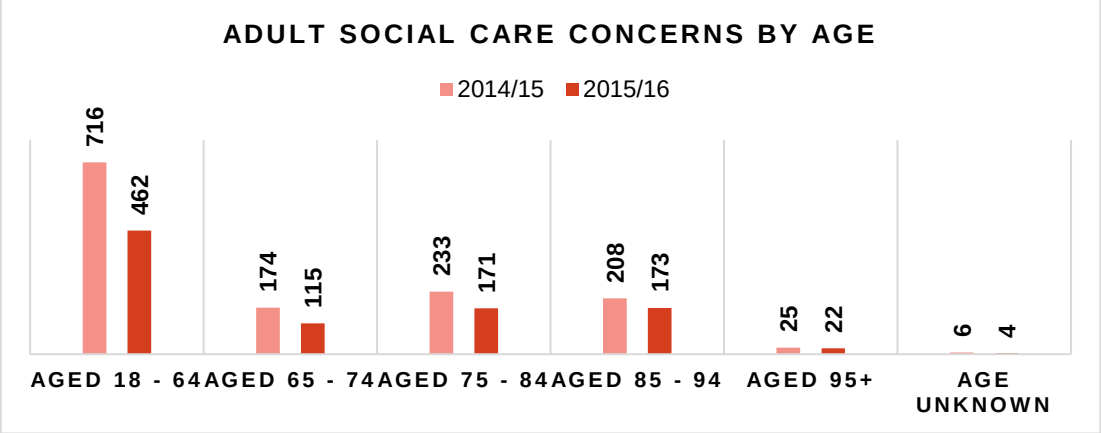
Figure 6. Gender profile of concerns received by Adult Social Care in 2015/16 and 2014/15.



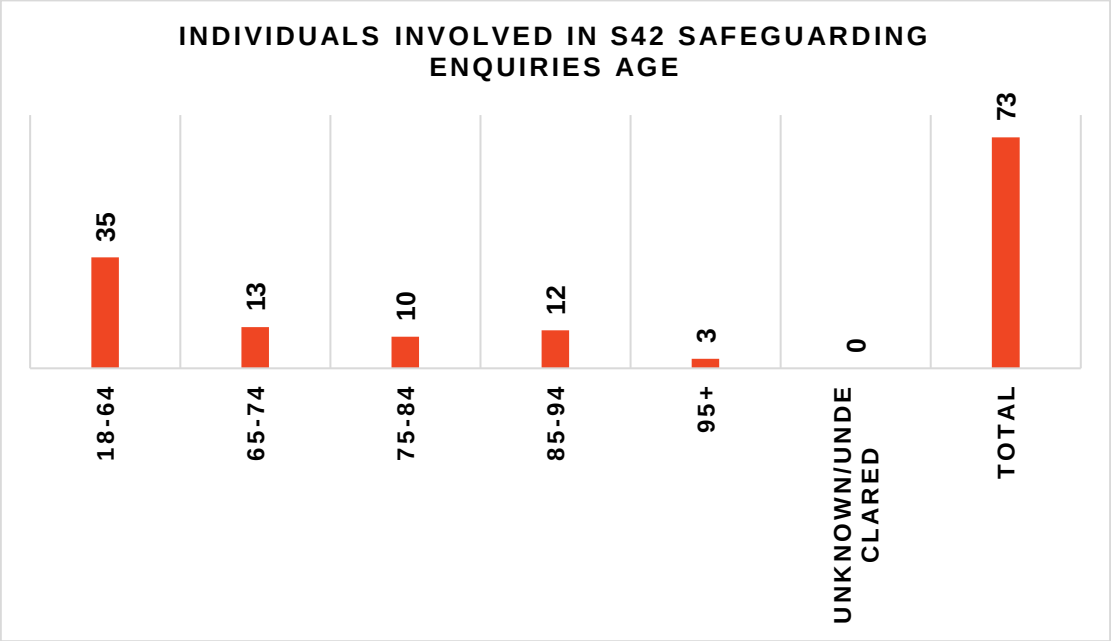
Of the concerns that become Section 42 enquiries, 10% more enquiries relate to women as compared to men, as seen in the figure below. However, given that this data is based only 73 cases completed during the period this may give a false impression of the gender profiles.



Age

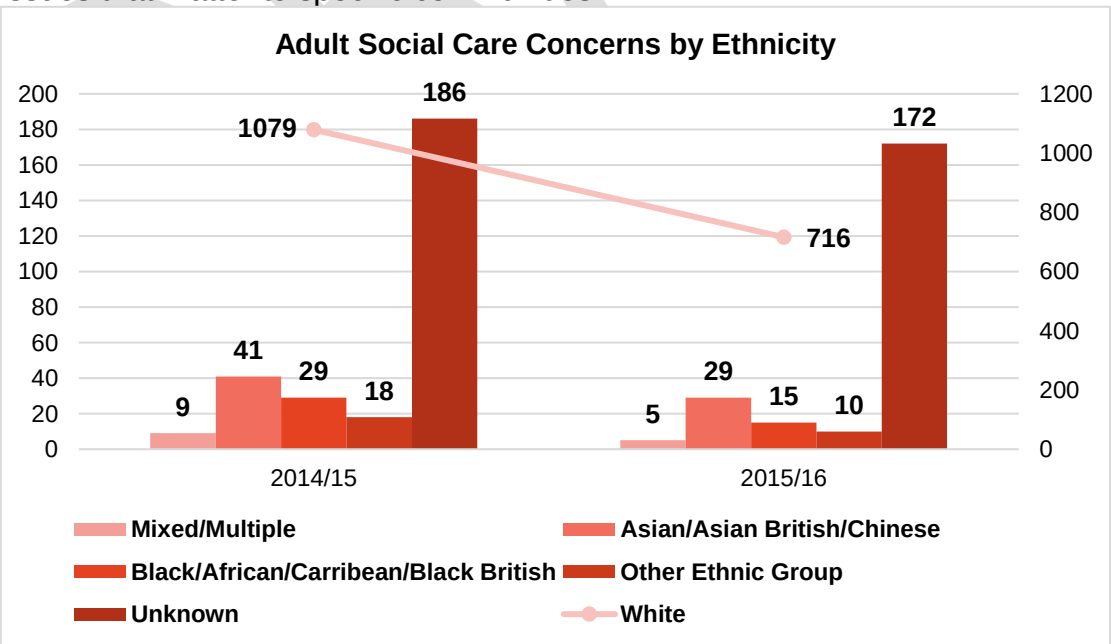


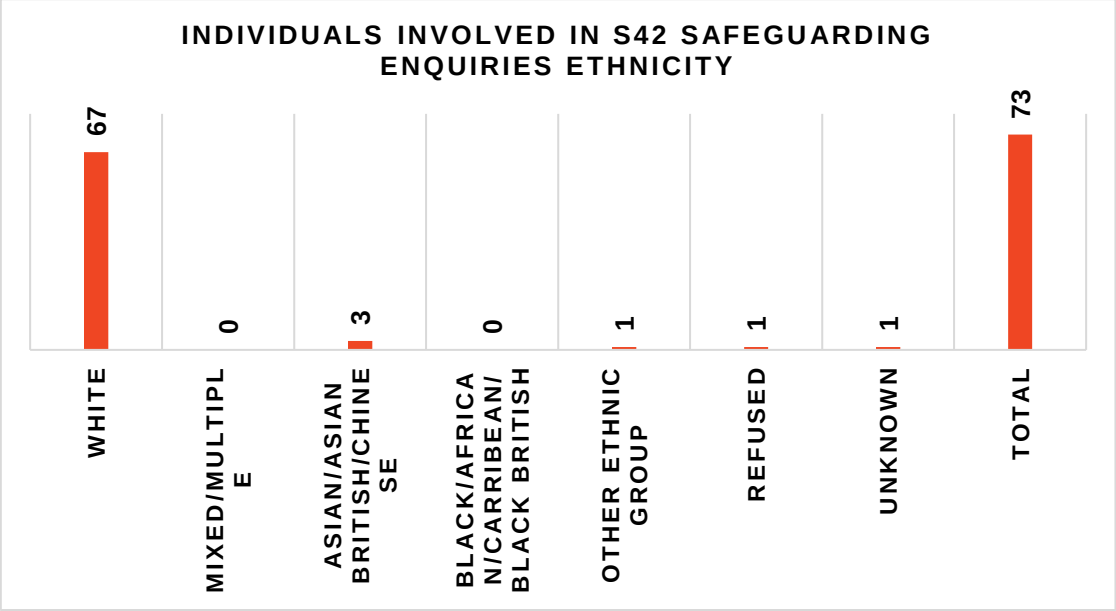
The age group with the most number of concerned raised is the 18-64 year age bracket. This is followed by the 85-94 and 75-84 age brackets. This is in line with what was seen last year, but again very different to the profile of need reported nationally which identified those aged 85+ as most likely to be subject to safeguarding interventions. The following figure shows the number of Section 42 enquiries that resulted from these concerns and as with the trend in the number of concerns, most section 42 enquiries are for the 18-64 age bracket.



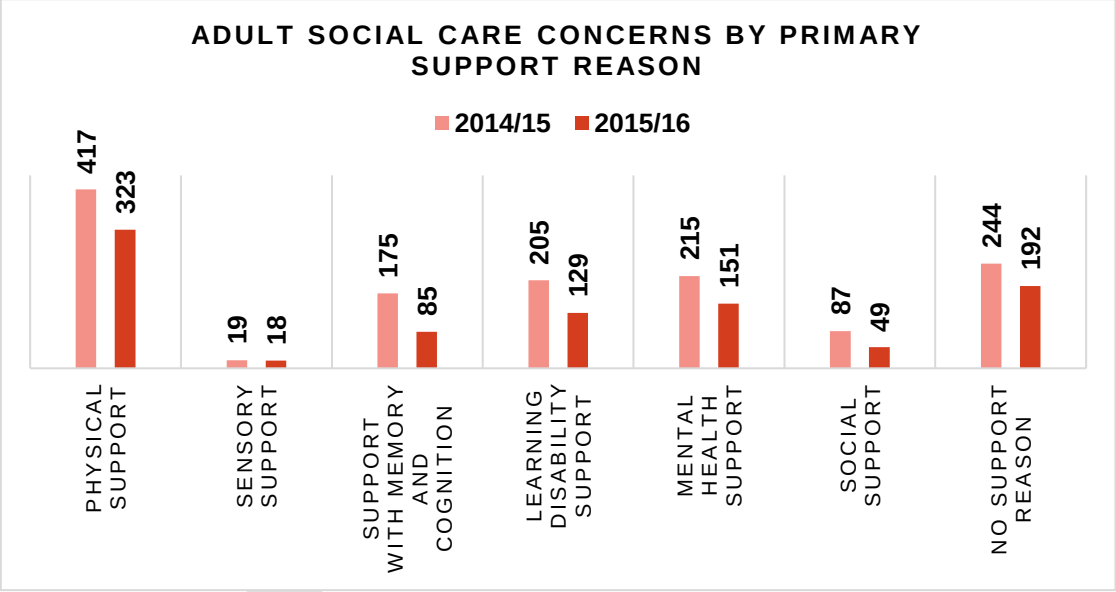
Ethnicity

The following figure shows the number of concerns received by Adult Social Care in terms of ethnicity. By far the most number of concerns were for the White Ethnic group. This is followed by the Unknown ethnicity group. A key priority for the LSAB and partners is to ensure more effective recording of ethnicity so that this can be more carefully monitored. We know that all our communities are at risk of abuse and neglect, we monitor this so that we can target information and support and engage more effectively with the issues that matter to specific communities.





Primary Support Reason

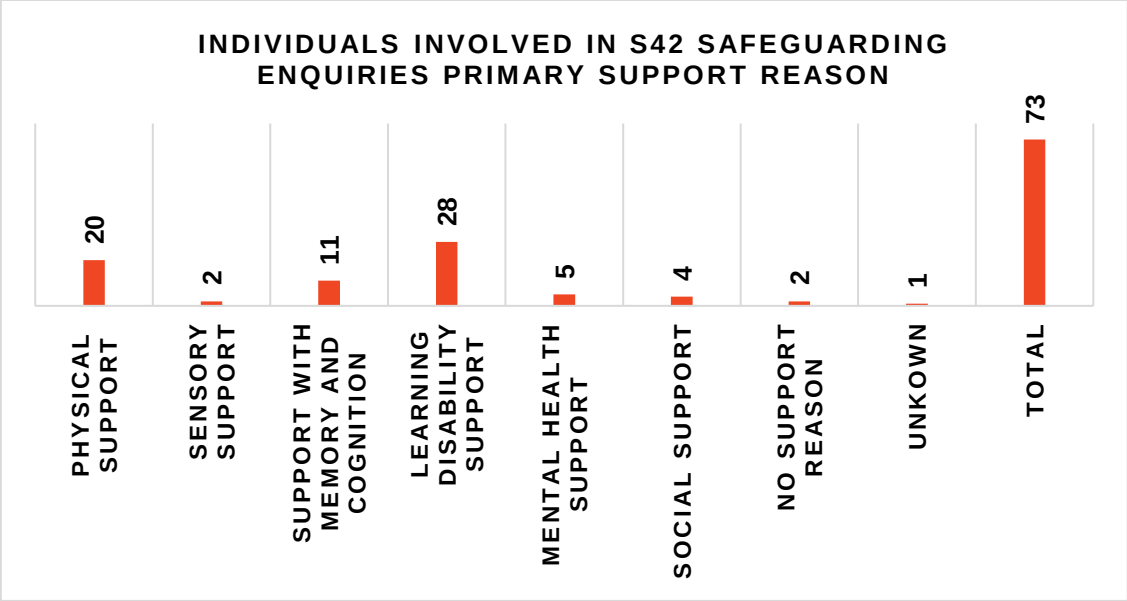


The figure above shows the number of concerns according to the primary support reason. Physical support is the most prevalent primary support reason. The next largest group is that of No Primary Support Reason and Mental Health Support. This is largely consistent with what it reported nationally.

Again it is believed that the number of 'no support reason' is as a result of poor recording or a misunderstanding by those raising concerns of the need for this information. The safeguarding obligation arises in respect of adults

who are in need of care and support. They do not need to be eligible for social care services, but it is vital that practitioners understand they notify (within the referral) why the adult is in need and therefore unable to protect themselves. This greatly assists those responsible for triaging concerns and ensures that the adult receives assistance at the earliest opportunity.

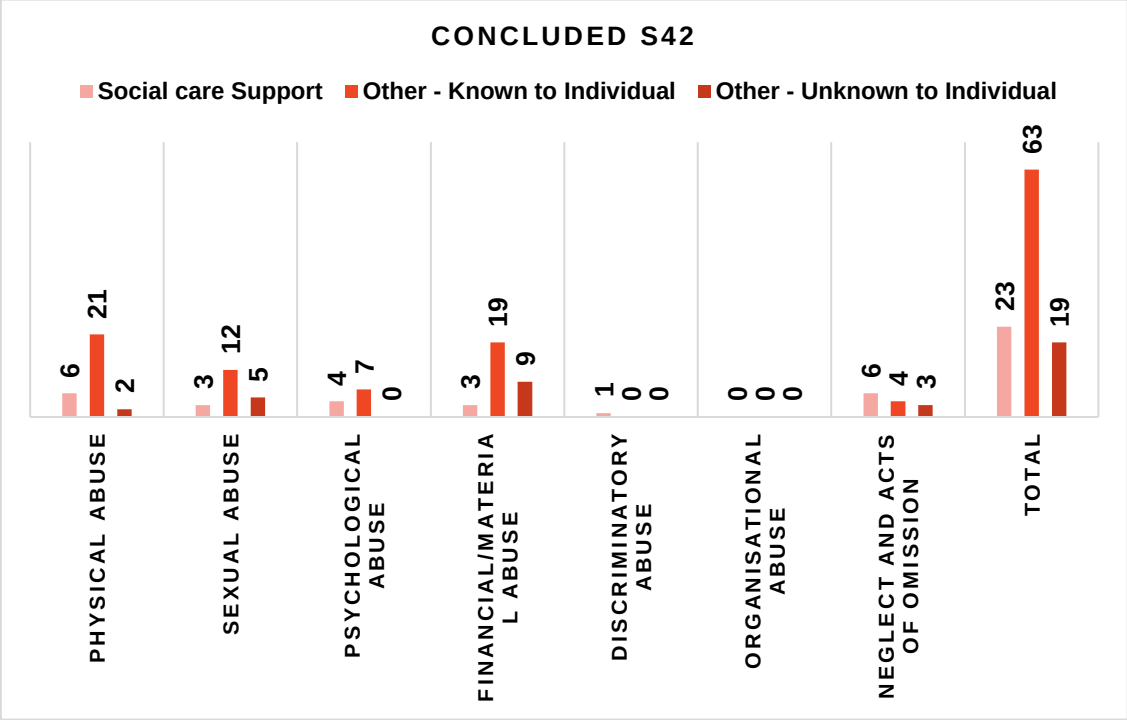
The LSAB will look to agree targets to reduce the numbers of not known or not recorded across all data fields so as to challenge professionals to ask these questions and record accurately. In addition, we will continue to closely monitor the primary support needs of adults when concerns arise to ensure that we are targeting our awareness campaigns and to ensure sufficient resources are made available to support those most at risk in Southampton.



Concluded Case Enquiries

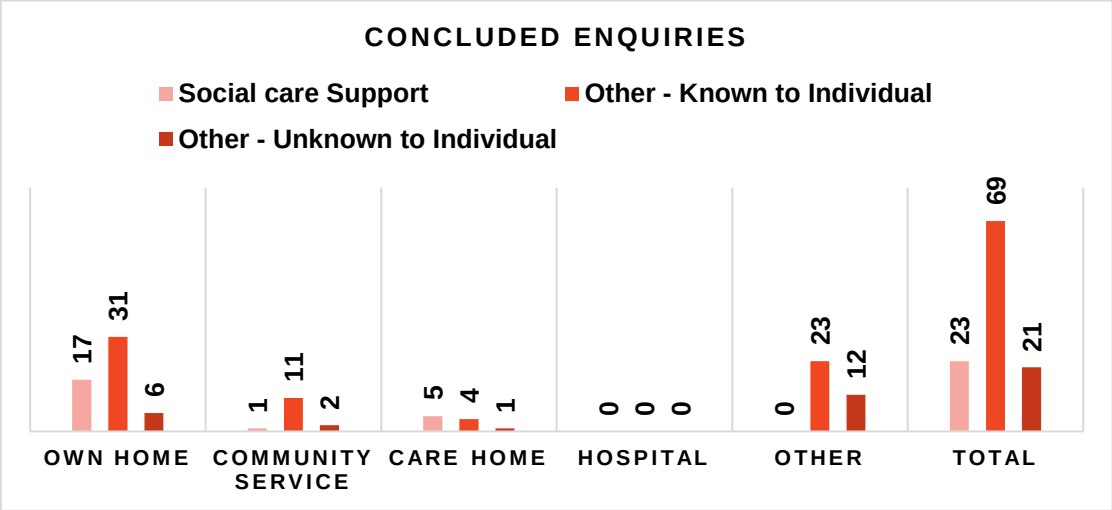
The following figures break down the number of the concluded Section 42 Enquiries.

Concluded case enquiring by type and source of abuse



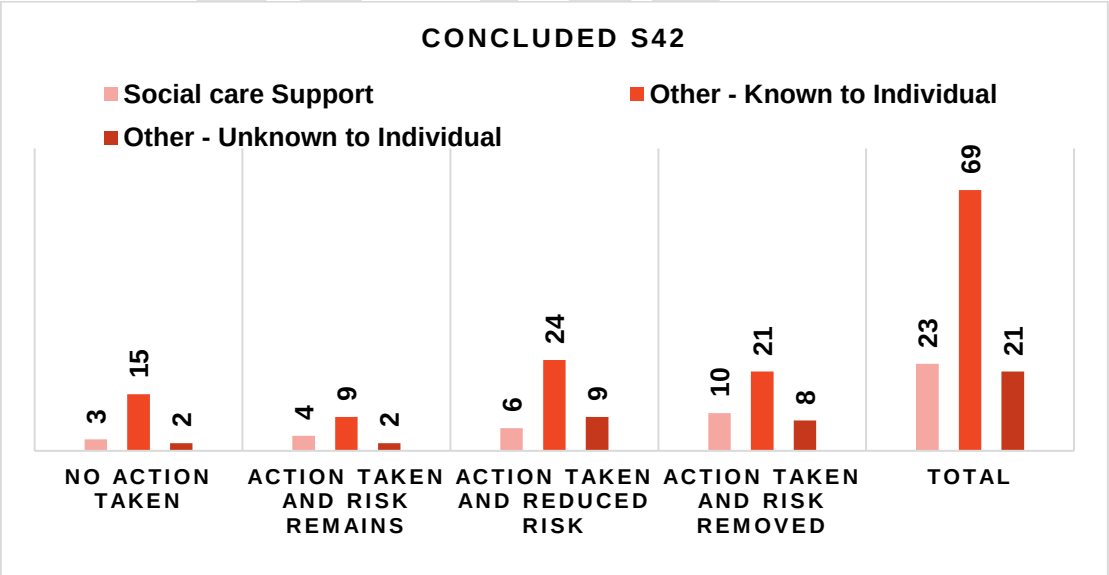
From SAC 2016, as reported by Adult Social Care, the category of abuse most prevalent in concluded Section 42 Enquiries is physical abuse and financial abuse. The data also shows that the source of risk for these types of abuse is mostly by someone known to the individual at risk. Again this is broadly consistent with what is reported nationally.

Concluded case enquiring by location and source of abuse



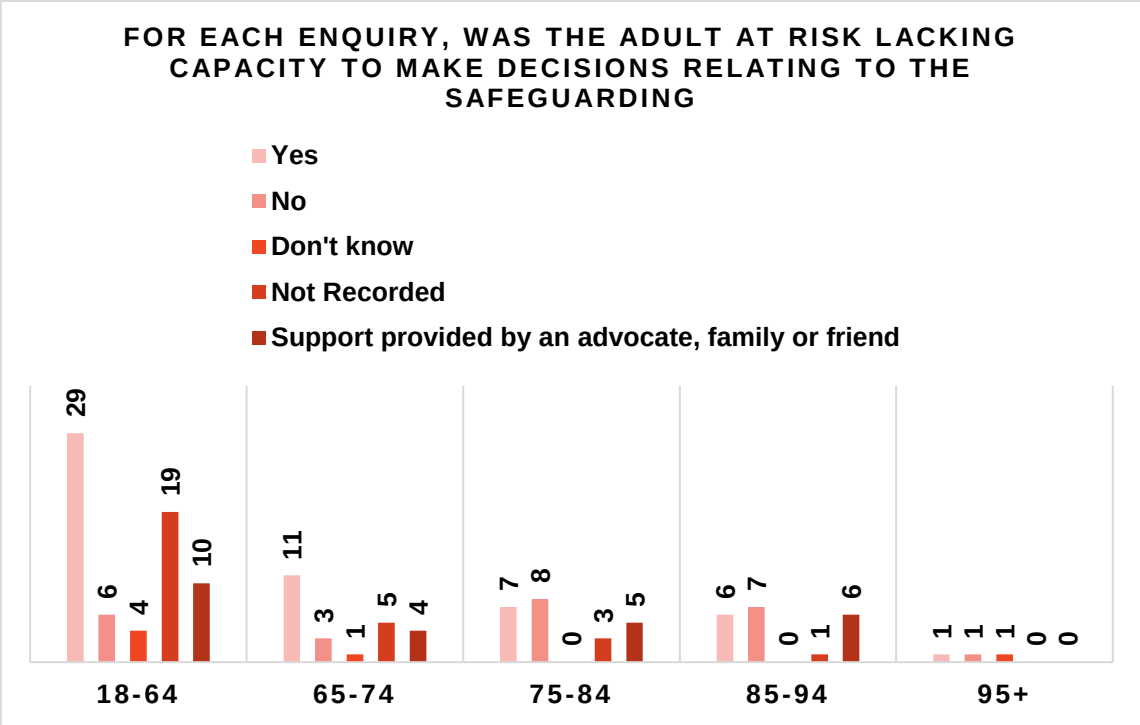
From SAC 2016, as reported by Adult Social Care, the data shows that the location of abuse is most often in the individual's own home. Once again the source of risk is predominantly someone known to the individual. This is similar to the pattern of abuse that is reported nationally, but it is noticeable that there is very little abuse reported in Care Homes and Hospitals within Southampton compared with what is reported nationally.

Concluded case enquiring by action taken and risk remaining



From SAC 2016, as reported by Adult Social Care, most concluded Section 42 Enquiries had action taken and either a reduced or removed risk. Both categories have 39 concluded enquiries each.

Mental capacity for concluded case enquiries



It is of concern that this data demonstrates there are still a high number of cases where the adults mental capacity is either not recorded or unknown at the conclusion of the case. It is also of concern that the data also suggests a large proportion of individuals who do not have capacity remain unsupported during a safeguarding enquiry despite this being a statutory obligations under s.68 Care Act 2014.

Following the finding of the House of Lords Inquiry into the Mental Capacity Act 2005 that showed the legislation was not well understood nor implemented, training was provided on behalf of the Southampton CCG to improve compliance. A series of workshops took place over a three month period in 2015. Staff from the NHS, Social Care, Police and the Ambulance Service and other partners attended the workshops. The workshops were focused on the practical application of MCA and DoLS within health care settings. The workshops were used to improve organisational and individual knowledge about legal responsibilities and accountability of the Mental Capacity Act whilst ensuring patients and users of services receive an effective service and safe care with minimal restraints.

How did the LSAB support adults at risk in Southampton 2015-2016?

The role of the Safeguarding Adults Board is governed by the Care Act 2014, Department of Health Guidance advises that Boards should:

- **Gather data so strategies are informed by an accurate picture of current risks faced by adults in need of care and support in Southampton.**

Gathering data on safeguarding activity undertaken by all partners has always proved challenging, but in 2015-16 partners appointed an analyst to the safeguarding boards' team to collate multi-agency data, analyse this and report any trends and key findings. In addition, the LSAB held a workshop with partners to review our Quality Assurance framework and agreed on key performance data that would be delivered by each partner to enable the LSAB's Monitoring and Evaluation group to start to build up an understanding of the picture of need within the city.

The data reports and performance reports from partners delivering frontline responsibilities were also reported directly to the full board throughout the year and have been summarised within this report. This should enable us to determine whether policy work, training and campaigns are having a practical impact on safeguarding interventions.

However, the Board recognises we still have notable gaps as key strategic partners continue to have difficulties in reporting certain data requested. In part this is due to amendments needed to IT systems to reflect the new Care Act duties and to meet different expectations for national data collections. The changes to national data requirements also make it difficult to compare data from year to year or form a true picture of progress made by partners. We continue to seek to address these challenges with all our

partners, but remain clear that our role requires this information and as such it is necessary for members to provide this in line with s.45 of the Care Act.

The Board has offered to assist partners improve record keeping and data collection so that a clearer profile of risk can emerge in the coming year. It is reassuring that senior managers within the partnership share an understanding that these data reports not only offer transparency and accountability but ensure operational practice accords with the statutory duties and that there is a clear evidence on which to base joint strategic decisions.

- **Seek assurance from partners that they are meeting core standards in safeguarding practice**

Within the 2015-16 Strategic plan we identified a need to obtain assurance that agencies understood pathways for referring safeguarding concerns. The LSAB also reviewed SCC operational guidance on the thresholds for s.42 safeguarding enquiries and were satisfied this complied with the obligations set out in the Care Act 2014 and the pan Hampshire safeguarding policy. The data, reported in previous pages, does identify areas for continued improvement. This information has informed our strategic plan and priority actions for 2016-17.

SCC and the CCG's Integrated Commissioning Unit provided bi-annual joint reports with the Care Quality Commission ['CQC'] on inspections and monitoring visits undertaken within residential, nursing home and domiciliary 'home care' services. In August 2015 they were able to report that the standards of care within the sector were improving in response to a more collaborative approach of working with providers to agree robust improvement programmes and firmer monitoring arrangements. For the second year running there has been no reports of any organisational abuse,

in addition the numbers of allegations made against social care staff and in care settings has reduced. CQC reported that their inspection regime had changed and was more challenging, particularly in respect of safeguarding. They confirmed 36% of providers in the city were rated good. However, as 54% of services inspected required improvement and 5% were inadequate, work will continue to raise standards of care to ensure adults in need receive a good quality of care and support which not only meets their day to day needs, but does so in a way that respects their choices, reflects their individual needs and upholds their dignity.

The Board received reports on emerging areas of risk, including work undertaken by Hampshire Constabulary to raise awareness and address national challenges such as honour based violence. The Police and the LSAB have provided 11 training opportunities for practitioners across statutory and voluntary services to learn more about their new duties in relation to Female Genital Mutilation and to assist frontline staff respond effectively to Forced Marriage and Human Trafficking. In 2015-16 the police obtained consent from twelve Southampton residents to refer them for support as victims of trafficking. This is a type of abuse is extremely difficult to identify so these figures likely represent only a fraction of the risk in the city. Currently partnership work on Human Trafficking is led by the Police and Crime Commissioner and, in Southampton, the Safer City Partnership [‘SCP’]. The safeguarding board’s joint Learning and Development sub group are working alongside the SCP to develop a programme of multi-agency training that supports those already offered by Hampshire Constabulary, aimed at raising awareness. We will continue to participate in the steering group set up to meet the local challenges to implement guidance (expected in the Autumn of 2016) on the new obligations for us all to recognise, report and respond effectively when adults at risk are exploited for domestic or commercial use.

The Police also reported on the success of pilot initiatives to address a rise in reports of missing people. This includes the use of new technologies to support people with dementia or other cognitive impairments and their carers who value their independence, but may require reassurance that they could easily, or if certain circumstances automatically, notify their carer if they were to find themselves in an unfamiliar area or in any difficulty. The police recognise that frontline officers play an important part in helping to locate and return missing people. However, we know from poor outcomes in the past, that anyone with caring responsibilities recognises the risk for any adult they care for and works to reduce that risk. Furthermore, when an 'adult at risk' does go missing carers must ensure they assist the police, providing all relevant information e.g. accurate description, usual routines, level and type of risk they may face and anything that might increase that risk (e.g. prolonged delay in accessing medication) as well as access to the person's home so that thorough investigations can progress quickly.

Southampton City Council reported on changes made to drug and alcohol services with increased focus on structured intervention services working in partnership with the voluntary sector. Public Health services and Hampshire Constabulary also reported on work undertaken to minimise drug activity and the harm that this causes to residents in the city. The Council report on plans to integrate MARAC responsibilities into the Multi Agency Safeguarding Hub ['MASH'] so as to build on the improvements to practice already starting to have an impact on responses to domestic abuse.

The Police also reported on the challenges they face addressing a significant rise in reported incidents of rape and serious sexual offences. The LSAB have long been concerned that this type of abuse is underreported, particularly when the victim has additional vulnerabilities. The tragic death of a Southampton resident served to reinforce our resolve to push for continued improvement in recognising such risks. We know

residents in Southampton share a common belief that, whatever our frailties, we are all entitled to live our lives free from abuse. These values underpin safeguarding practice and cores duties. The LSAB is working with all agencies to review this case and understand what lessons could be learnt. The findings and recommendations will be reported to the Board in due course. In 2016-17 the board will also undertake a thematic review to better understand how well partners work together to identify risks of sexual harm, protect those most at risk and successfully prosecute those responsible.

In addition, during the course of the year two key themes emerged from the performance reports and work of the sub groups which received significant attention from the Board.

Mental wellbeing

Representatives of member agencies play an active role in the development of the Mental Health Crisis Concordat action plan. During the course of 2015-16 partners regularly reported on the implementation of this plan and the impact for adults at risk. For example, training across agencies on Mental Health First Aid should increase support and reduce stigma for those affected by mental ill-health. Representatives from SHFT and the police reported an increase in joint working on ‘operation serenity’. This was a programme of joint training and practical improvements in service provision. Front line police officers were supported with direct access to mental health staff based in the police control room, SHFT staffing within the emergency mental health assessment unit and increased access for temporary assessment places for young people in the city. Also more flexible commissioning arrangements has enabled ambulance staff responsible for transporting those subject to s136 MHA to support a least restrictive response. All of this has seen a dramatically reduction in the use police powers under s.136 of the Mental Health Act to temporarily detain those at risk due to mental ill health.

Southampton University Hospital Trust ['SUHT'] and CQC reported they had undertaken a mental health thematic review detailing national and local issues. The report identified a number of areas of good practice in Southampton, but suggested that Improved out of hours access to Approved Mental health Professionals and s.12 Doctors particularly outside of normal working hours, would reduce delays for those requiring initial mental health assessments and decrease pressure on A&E services.

The way in which individuals experiencing mental ill health has been substantially redesigned over 2015-16. The LSAB were also consulted as part of the mental health matters consultation on the service redesign and will continue to seek assurance from commissioners and providers that these changes are effectively meet local people's needs.

Mortality review

Referrals received in 2014-15 under the LSAB's Learning Review Framework had identified a need to improve practice in mortality reviews and serious incident reporting.

Over the course of 2015-16 the LSAB received a number of reports from partners on research or learning reviews following the deaths of those in need of care and support. The Director of Public Health reported on work his team had undertaken reviewing drug related deaths and provided a separate report on research into risk factors for suicides in the city. It was noteworthy that 62% of those who sadly go on to commit suicide were not known to services set up to offer support. Following on from this, in August 2015, representatives from Southern Health Foundation Trust summarized key findings from a review they had undertaken in response to deaths by suicide and serious episodes of self harm of their service users that occurred over a 12 month period from April 2014 to March 2015. The review also included benchmarking against the National Confidential Inquiry into

suicide and homicide and other local reports and information relating to suicide and self-harm. Recommendations from these reviews form the basis of SHFT's improvement plan. They continue to report on the implementation of this and have agreed to submit key performance data to the LSAB so that the impact of practice and policy improvements can be monitored. The Board also agreed, as a result of this work, to seek to engage more closely with the work of the Director of Public health and the Health and Wellbeing Board to develop a local Suicide Prevention Strategy.

In December 2015 the release of the MAZARs report into SHFT's processes for undertaking mortality reviews brought this work to the attention of the public. Partners, including commissioners and SHFT, worked with adult safeguarding boards to acknowledge that processes for investigating and reporting a patient death, whilst improving, needed to be better. The LSAB acknowledged work already undertaken locally in Southampton had started to address many of the concerns raised within this report. The Chair of the LSAB's case review group confirmed they were receiving referrals, in line with what they would expect from SHFT, suggesting that practitioners were proactively engaging with the s.44 safeguarding adults review process. It also received confirmation that Southampton City Council will review the s.75 partnership agreement to ensure this complied with the safeguarding duties under the Care Act.

The LSAB is actively involved in multi-agency work to design a comprehensive process for learning from mortality reviews. This is a complex because it will need to take into account work already undertaken in line with the NHS's Serious Incident Reporting Framework, the role of the Coroners and partnership duties to conduct serious case reviews, safeguarding adults review, domestic homicides, MAPPA and mental health homicide reviews. It will also need to account for the changes anticipated to the Child Death Overview Panel's processes.

Lead on policy and strategy development for protecting adults

Operational staff from Southampton's LSAB partners played an active role in the development of the Pan Hampshire Safeguarding Policy and guidance. The draft document was then fully considered by the strategic leads at the Board. Suggestions made by Board partners were incorporated into the final version which was ratified by the Board in June 2015.

Another key action required within the 2015-16 strategic plan was to seek assurance that the local authority and relevant partners were using risk assessment and risk management process effectively. The high level of repeat concerns, reported over a number of years, raised questions over whether there was a well understood process for multi-agency assessment and management of risk including for concerns reported outside of normal office hours. In order to support practice improvement the operational and strategic members of the LSAB worked with colleagues across Hampshire, Portsmouth and the Isle of Wight to agree a joint framework for multi-agency risk assessment. This is due to be ratified by the Southampton LSAB in July 2016.

Work with other key partnerships to coordinate activity to meet common objectives across the partnerships

The Board continues to strengthen links between key partnerships in the city and with safeguarding boards across the region. In 2015-16 we continued to coordinate regular meetings with the 4 LSAB in Hampshire and the Isle of Wight and relevant partners to share learning, ideas and coordinate policy developments. During 2015 the board received reports from MAPPA, the LSCB and SCP on key data and strategic plans going forward. In addition, the Chairs of the Health and Wellbeing Board, LSAB, LSCB, SCP and Southampton Connects agreed a quarterly programme of

meetings to discuss issues affecting the city and look to coordinate activity. We have also worked with the LSCB and SCP in delivering joint awareness programmes on lessons learnt from case reviews and continued the practice of sharing annual reports so that our work could inform decisions where there are synergies.

In 2015-16 the LSAB Chair also attended meetings with Police and Crime Commissioner, Health Watch, the Health and Wellbeing Board and SCC's Overview and Scrutiny Committee to present the annual report and consult on our key priorities.

Audit organisations' safeguarding practice

In 2015-16 the LSAB launched its Quality Assurance framework and Organisational Audit Tool. This tool enables organisations to review the effectiveness of their internal safeguarding arrangements and to identify and prioritise any areas needing further development. The tool requires organisations evidence that the safeguarding responsibilities are embedded throughout the organization by looking at how it influences the leadership, policy and procedures, commissioning and contract obligations, workforce development and practice.

This is a self-evaluation, but on completion the report is scrutinised by the LSAB's Monitoring and evaluation subgroup who are encouraged to challenge if information is incomplete or there is insufficient evidence to support their self-evaluation. During the year audits were undertaken by Hampshire Community Rehabilitation Company, Southern Health Foundation Trust, Hampshire Constabulary, Hampshire Fire and Rescue Service, University Hospital Southampton, Solent NHS Trust, SCAS, SCC Licensing and SCC Regulatory Services. The Monitoring and Evaluation group made suggestions to a number of those agencies about how they may want to evidence improvements in future years. Each partner is

expected to feedback, according to their own internal governance arrangements, the advice given by the LSAB and use this when determining improvement plans or strategic priorities.

The process is a collaborative one, aimed at supporting organisations to improve with the support of the LSAB members. Many agencies reported they found the process of undertaking the audit very helpful to assist them in focusing on meeting the new statutory duties associated with safeguarding work. Common areas for improvement emerging from the audits included difficulties in collating data and staff knowledge of new legal obligations and practice standards.

Reviewing cases with poor outcomes: what we did, what we learnt and how we know this has improved practice

During 2015-16 the LSAB supported a MAPPA Review, through participation by the Safeguarding Board manager and SCC's Director of Social Care, a review into the death of a Southampton resident. That report has not yet been completed or the findings and recommendations finalised. The LSAB have agreed to undertake further work to look at whether services could have worked more effectively together to protect the victim from abuse.

The Board received a partnership review report following the death of an adult who was known to multiple services. Previously the Coroner had confirmed that the cause of death was not linked to abuse or neglect and as such there was no requirement to undertake a Safeguarding Adult Review. However, given the nature of the adult's needs and circumstances surrounding their death, the LSAB believed there were opportunities to learn lessons from this case. Each agency involved in the provision of care reviewed their practice and contributed to the review. The report found that many opportunities to proactively support the adult may have been missed,

because professionals were not working together to form a picture of the adult's needs, nor did they recognise the long-term impact of persistent low level health concerns. The review acknowledged practitioners from different disciplines often lacked detailed understanding of the roles of other professionals, be that police powers in missing persons enquiries, GPs involvement in monitoring mental and physical health or the role of a specialist health and social care professionals. They also found there was overreliance on lead professionals to undertake tasks to address needs that lay outside of their legal powers. Organisational change and the inevitable instability that brought to a workforce impacted on relationships of trust between staff and the adult at risk and between professionals, contributing to poor multi-agency risk management.

Out of respect for the wishes of the adult's family this review has not been published, but the key findings have been used to:

- Help shape service redesign.
- Reinforce the benefits of early intervention and preventative work that is 'person centred'.
- Encourage staff to implement the 'making safeguarding principles' of engaging adults and their wider community to agree ways of addressing safeguarding risks that lifestyle or deteriorating health may expose.
- Shape the content of specific training and briefing sessions with staff across the partnership
- Shape the self-organizational audit tool under the quality framework, specifically in respect availability of supervision and professional challenge.

The full board also received a report on a case reviewed by the LSCB where there were opportunities to improve responses to risks posed by adults in need of care and support. The shared safeguarding Board team

Keeping people safe is everybody's business……..

If you are concerned that someone you know is being abused or harmed please call Southampton City Council Single Point of Access for Adult Social Care on 02380 833003 or visit the website here.

If the person has been seriously hurt or a crime has been committed please call 999.

and Chairing arrangements for the LSCB's Case Review subgroup continued during 2015-16. This provided opportunities to discuss the needs of adults within the context of safeguarding children and young people to ensure that agencies consider a 'whole family' approach to safeguarding risks.

Engaging with communities and raising awareness

In 2015 the CEA sub group reviewed and refreshed its membership and agreed a new plan focusing on strategic development so that any awareness raising activity by the safeguarding boards more closely linked with partners' existing plans for community involvement across the city. The LSAB has continued to consult regularly with voluntary sector groups through SVS, attending a number of meetings to discuss their experiences of the safeguarding process, report on the annual report and consult on the strategic plan. As one supported housing provider stated, "I find working together with the safeguarding team to protect our clients is a very collaborative, positive process".

We recognise, however, that we need to continue to reach out to communities and raise awareness within the public if we are to reverse the reduction in concerns being raised by them. This is important because nationally in cases where the adult was not previously known to services, 82% of alleged abuse took place in the adult's home. It is therefore vital that family, friends and neighbours recognise if a person they know is experiencing or at risk of abuse or neglect and are confident that reporting their suspicions or concerns will result in safe, effective protection. A key action within the strategic plan for 2016-18 is to deliver a robust plan for better community engagement and the safeguarding boards held a week of awareness raising events in June 2016.

Providing training opportunities across partnership

The LSAB has provided training to a range of professionals across a wide variety of subjects to assist practitioner recognise types of abuse such as self-neglect and hoard, physical abuse and financial exploitation. Advisory sessions on substance misuse, adult mental health first aid, welfare benefit changes, debt management etc. also ensure that practitioners were better able to support vulnerable clients. In addition, the Board has run a number of awareness raising events on key topics such as learning from case reviews, 'making safeguarding personal' and equality and diversity issues. The Board has also provided briefing sessions to Southampton City Councilors in order that they are aware of the duties owed to adults at risk of neglect, abuse and exploitation and how the adults safeguarding corporate responsibilities affect their decision making.

The Board commended the work of Dr Ali Robbins and GP's from across the City who engaged in training on new responsibilities. This included the role of GPs in safeguarding adult's reviews and the preparation of individual management reports, Mental Capacity training, Clinical supervision standards and recording concerns on medical records (read codes/flagging systems). Future work programmes will build in this. The board were advised of established links with NHS England who were responsible for overseeing performance of GP's. It is noteworthy that during 2015-16 7 GP practices had received CQC Inspection and safeguarding had not been raised as a concern in any one of the inspections. The LSAB will look to work with the CCG and NHSE who have recently appointed a strategic lead for safeguarding adults to build on this work. We know, from the learning reviews undertaken in 2015-16, just how vital GP and primary health care services are to identifying safeguarding risks and to provide (as part of a multi-disciplinary team) support, which is person specific, for adults who are experiencing, or at risk of, abuse and neglect.

Board partners have also responded to the threat posed by extremism, partly in relation to preventing groups targeting adults at risk. As a result of the implementation of the Counter Terrorism Act the Local Authority are now responsible for the strategic lead role in implementing a 'PREVENT' strategy. The LSAB received an update on mechanisms for multi-agency coordination of any interventions needed to protect those vulnerable to exploitation by extremists. Further work is needed to raise awareness of how partners and communities should respond effectively to meet safeguarding duties to adults at risk across all agencies,

Mental Capacity and Deprivation of Liberty Safeguards ['DoLS']

SCC report continued pressure to meet the huge rise in requests for authorisations under the DoLS procedure. The Council, as reported in last year's annual report, act as Supervisory Body under this process. The law requires that if someone does not have capacity to agree to care arrangements, but requires constant supervision or would not be free to leave their care arrangements, the Supervisory body must commission an independent assessment to determine whether it is in that person's best interests to be subject to those care arrangements. The Supervisory Body cannot authorise the arrangements if there is a more proportionate way to meet the person's care needs. This applies whether the care is provided in a residential or nursing home setting or hospital. However, anyone providing care to a person which deprives them of their liberty, even within a family home, must obtain lawful authority to do so as our right to liberty is protected by article 5 of the European Convention of Human Rights.

It is important that staff from across health, social care and supported living sectors recognise when measures taken to provide protective care impose restrictions which amount to a deprivation of liberty. They must also know when and how to apply for authorisation, as without this those they care for can't benefit from the scrutiny such independent assessments provide. In

June 2015 the CCG reported they have provided a comprehensive programme of training for staff from NHS, Social Care as well as other partners of the local authority and clinical commissioning group, for example, police and ambulance service.
This was well attended and feedback from the events was very positive.

Southampton City Council's Adult social care department have also confirmed they have now provided training for 10 'Best Interest Assessors" (who qualified in 2015/16) so that more assessments can be undertaken within timescales. Despite this pressure remains acute as the legal, financial and reputational risk of non-compliance is high. Conversely the cost to the Local Authority of commissioning external experts to undertake the assessments within the timescales places significant impact on other operational duties and priorities. It is therefore disappointing that the Department of Health has refused to recognise the financial impact of this legal obligation.

The Board also received reports from partners responsible for providing care and treatment within in-patient settings identifying concerns regarding the impact that securing authorisation had in respect of palliative care provision. Recent guidance has meant that Coroners were now required to consider those who had died whilst subject to a DoLS authorisation as a 'death in state custody'. This is reported to have caused significant distress to many family members, especially where there isn't a dispute that the care provided to loved ones was necessary and proportionate in the circumstances.

The adverse impact on resources, staff and families is the subject of national concern and currently being considered as part of a Law Commission's consultation on the matter. The LSAB recognises the importance of the legal principles protected by the procedures, but is working to secure more effective means to implement these in practice. The Board was well represented by operational and strategic leads at the Law Commission's consultation event in Hampshire, we have also had discussions with the Coroner locally and provided extensive and detailed

responses to the questions and proposals contained within the Law Commission's consultation document. The LSAB will continue to monitor the how well the DoLS procedure operates locally and work with our partners to support effective, safe care. But equally we will work with national bodies to highlight concerns until a practical solution which respects individual's rights can be implemented.

Glossary

CCG	Clinical Commissioning Group
CQC	Care Quality Commission
DoLS	Deprivation of Liberty Safeguards
HFRS	Hampshire Fire and Rescue Services
LSAB	Local Safeguarding Adults Board
LSCB	Local Safeguarding Children Board
MAPPA	Multi Agency Public Protection Arrangements
MSP	Making Safeguarding Personal
SCAS	South Central Ambulance Service
SCC	Southampton City Council
SCP	Safe City Partnership
SHFT	Southern Health Foundation Trust
SVS	Southampton Voluntary Services
UHS	University Hospital Trust


LSAB
Southampton
Local Safeguarding
Adults Board

Introduction

This Strategic Plan outlines the work to be undertaken by Southampton Local Safeguarding Adult Board during the two year period 2016-18, it is a shared plan for organisations represented on the LSAB. The plan details how over this time the LSAB will work on key themes and priority areas to evaluate current service provision and ultimately how partners will work together improve outcomes for adults at risk of harm in some key areas of focus. These key areas have been agreed by LSAB and will complement the LSAB and its member's core safeguarding business as detailed in The Care Act 2014 and supporting Guidance from the Department of Health.

The plan should be viewed alongside the LSAB's Annual Reports which give details of the current position in Southampton in relation to the LSAB's work. These can be viewed on the LSAB website: www.southamptonlsab.org.uk. The Southampton LSAB also works within the '4LSAB' area of Southampton, Portsmouth, Hampshire and Isle of Wight. The 4 areas share common safeguarding policies, procedures and guidance for staff to work to. They share a working group to achieve consistency across the areas.

Priority Issues for 2016-17:

The LSAB has set the following issues as priorities for this coming year, using information presented to the Board throughout the year in terms of local intelligence and performance data, case reviews, audits and agency reports to the Board. A summary of information was also presented by partners to a planning day in February 2016. The LSAB also asked for input into its priority setting from multi-agency professionals involved in its network. Following this consultation the priority areas are:

1.	Ensure all services are identifying and responding to neglect and abuse, including self neglect
2.	Ensure that services are safe and comply with legal duties to protect adults at risk from abuse or neglect
3.	Embed Making Safeguarding Personal (MSP) across the partnership
4.	Improve community engagement and awareness.

The priority from the previous year Business Plan that has been removed was to make better use of local data. Please refer to the annual reports and other key LSAB documents, including recently agreed 4LSAB Policy and Procedures should be reviewed for details of what action has been taken to address this.

Business As Usual for the LSAB:

This plan gives detail of the key priorities for the LSAB beyond its 'business as usual' which is broadly set out below.

Safeguarding Adult Reviews: When there is any failure in safeguarding, the results can be severe and tragic and therefore demand a strong response. The LSAB will carry out Safeguarding Adults Review in some circumstances – for instance, if an adult with care and support needs dies as a result of abuse or neglect and there is concern about how one of the members of the LSAB acted. The Reviews are about learning lessons for the future. They will make sure SABs get the full picture of what went wrong, so that all organisations involved can improve as a result. The LSAB will deliver these according to a *Learning and Review Framework* for Southampton based on that agreed by the 4LSAB's of Southampton, Portsmouth, Hampshire and the Isle of Wight, and will also agree to review cases that do not meet the threshold for a SAR but where learning could be gained. This work is led by the LSAB's Case Review Group.

Quality Assurance: as detailed in its *Quality Assurance Framework* the LSAB will carry out a range of activities to be assured of local practice in keeping people safe, the LSAB will also collate service level information and data regarding local safeguarding services and report this regularly to the LSAB via the Monitoring and Evaluation Group.

Community Engagement: as detailed in the *Community Engagement and Awareness Strategy and Plan* which is shared with the Local Safeguarding Children Board (LSCB) and identified below.

Learning and Development: this work is led by the Learning and Development Sub Group which is shared with the Local Safeguarding Children Board (LSCB). The group will develop local plans to work within the framework of a *4LSAB Workforce Development Strategy for Safeguarding*. The LSAB will focus on multi agency safeguarding training for professionals and seek assurance of single agency plans for this area.

Monitoring of Success:
Progress against this plan will be reviewed and monitored by the LSAB, with Chairs of the relevant sub committees reporting on progress against their actions regularly to the Executive Group of the LSAB. Where necessary and appropriate the Chairs of each sub group will highlight areas of concern and good practice to the Executive for further action.

Key to abbreviations:

Board / LSAB:	The full board of the Local Safeguarding Adult Board
L&D:	Learning and Development Group
M&E:	Monitoring & Evaluation Group
4LSAB:	Hampshire, Isle of Wight, Portsmouth & Southampton
HWBB:	Health & Wellbeing Board
DVA:	Domestic Violence and Abuse
HBV:	'Honour' Based Violence
FGM:	Female Genital Mutilation
FM:	Forced Marriage.

Priority 1: Ensure all services are identifying and responding to neglect and abuse, including self neglect				
OUTCOME	**ACTION REQUIRED**	**BY WHO**	**BY WHEN**	**HOW WILL WE MEASURE SUCCESS?**
Adults at risk are safeguarded at the earliest opportunity due to higher awareness of risk indicators and through coordinated action to respond to concerns.	Hold a themed LSAB meeting to focus on securing system wide assurance by services including those providing primary care, early intervention or preventative support to enable the identification and management of risk of abuse/neglect including self neglect.	*LSAB*		
	Deliver thematic review of self neglect cases – using learning to inform future learning and development, awareness raising and services responses to this issue	*M&E*		
	Seek assurance from providers of accommodation to adults at risk and the wider community, that they are recognising and responding to the indicators of abuse and neglect	*LSAB*		
	Develop multi-agency professional knowledge of how to aid in the response to missing persons – alongside police response	*L&D*		
	Deliver a thematic audit of safeguarding issues in cases where there is dual diagnosis of mental health and substance misuse	*M&E*		
	Raise awareness of financial exploitation and abuse of adults	*LSAB*		
	Deliver a thematic audit of cases where there is inter familial financial abuse	*M&E*		
	Deliver a thematic audit of cases of sexual abuse	*M&E*		
	Deliver a joint Neglect conference with LSCB	*L&D*		
	Audit and evaluate the success of joint working procedures to safeguard young people in transition from Children services and likely to require support as adults, including those that have additional vulnerabilities such as; former asylum seekers, victims of exploitation and care leavers.	*M&E*		
	Seek assurance of developments to the MASH (Multi Agency Safeguarding Hub) including to include MARAC, to ensure appropriate representation from Adult services.	*LSAB*		

Priority 2: Ensure that services are safe and meet the legal duties to protect adults from abuse and neglect				
OUTCOME	**ACTION REQUIRED**	**BY WHO**	**BY WHEN**	**HOW WILL WE MEASURE SUCCESS?**
Adults at risk are safeguarded at the earliest opportunity due to higher awareness of risk indicators and through coordinated action to respond to concerns.	Seek assurance from the Local Authority and its partners that pathway is in place for; • Receiving alerts and concerns – i.e. a 'front door' • Assessing and managing risk levels • Clear thresholds for appropriate interventions and section 42 enquiries • Out of hour's provision	*LSA B*		
	Deliver a themed meeting to request assurance of compliance in the following areas: • Deprivation of Liberty Safeguards (DOLS) activity • Availability of BIA across social and health care providers	*LSA B*		
	Seek assurance that there are clear routes to information and advice services from across member agencies	*LSA B*		
	Ensure that operational redesigns in response to austerity measures are comply with legal obligations and that there is a clear risk assessment regarding the impact of changes on adults at risk of harm	*LSA B*		
	Evaluate local knowledge of and compliance with the Care Act safeguarding duties via survey of professionals from across the partnership	*L&D*		

Priority 3: Embed Making Safeguarding Personal Principles Across the Partnership				
OUTCOME	**ACTION REQUIRED**	**BY WHO**	**BY WHEN**	**HOW WILL WE MEASURE SUCCESS?**
Adults at risk are safeguarded through interventions which are person centred and reflective of their views and needs.	Seek assurance through the LSAB quality assurance work that board partners are involving: • Clients • Family and friends where appropriate, safe, & at the agreement of the client In the process of safeguarding adults at risk.	*M&E LSAB*		*Responses to I questions demonstrate increase in satisfaction with and success of interventions.*
	Ensure the principals of MSP are reflected in all 'levels' of learning and development work	*L&D*		
	Deliver workshops to promote 'MSP' principals to workers in Southampton	*L&D*		
	Develop toolkit for multi-agency professionals to enable a person centred / MSP approach to safeguarding interventions, including: • Providing written information in appropriate and accessible formats, including community languages • Using BSL and community language interpreters appropriately • Identifying and responding to issues of capacity and mental health needs • Identifying and responding to advocacy needs • Encouraging friends, family and carer involvement.	*L&D*		
	Develop 'I' questions to be multi-agency and person centred in design, and explore effective ways of collating responses.	*M&E*		
	Deliver a themed LSAB meeting for MSP	*LSAB*		
	Ensure a focus on MSP in LSAB Data Set	*M&E*		

Priority 4: Improve community engagement and awareness.				
OUTCOME	**ACTION REQUIRED**	**BY WHO**	**BY WHEN**	**HOW WILL WE MEASURE SUCCESS?**
Adults at risk are safeguarded at the earliest opportunity due to higher awareness of risk indicators and through coordinated action to respond to concerns.	Initiate a local campaign to advertise to the public when and how to raise alerts	*LSAB*		*Responses to I questions shows increase in satisfaction with interventions* *LSAB is able to use community views to influence developments in provision.*
	Increase awareness of what constitutes 'adults at risk' of harm, include a focus on: • Younger adults • Local communication as well as national campaigns • Link to local sources of information (e.g. Southampton Information Directory – SID) • Use local radio shows and community links such as Unity 101 to regularly promote safeguarding issues and highlight 'what to do' if you are worried about someone.	*LSAB*		
	Ensure targeted work with communities of interest including those from black and minority ethnic, refugee and asylum communities	*LSAB*		
	Engage with the local voluntary sector to deliver messages including; • Faith and community groups • Voluntary groups	*LSAB*		
	Consult on this strategic plan with local service users and community groups.	*LSAB*		

Areas not covered above but raised in Business Planning consultation:

- Increase co working with health partners so they understand duties and expectations
- Data – making best use (should be business as usual?).

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DECISION-MAKER:	HEALTH OVERVIEW AND SCRUTINY PANEL
SUBJECT:	ADULT SOCIAL CARE PERFORMANCE
DATE OF DECISION:	27 OCTOBER 2016
REPORT OF:	ACTING SERVICE DIRECTOR, ADULTS, HOUSING AND COMMUNITIES

CONTACT DETAILS

AUTHOR/ACTING DIRECTOR: Name: Paul Juan Tel: 023 8083 2530

E-mail: paul.juan@southampton.gov.uk

STATEMENT OF CONFIDENTIALITY

None

BRIEF SUMMARY

This report outlines the recent management restructure in Adult Social Care, describes performance as at September 2016 against an updated set of indicators, and describes some key issues for the service, which will form the basis of a transformation plan.

RECOMMENDATIONS:

(i) That the Panel notes performance as at September 2016 against an updated set of indicators for Adult Social Care.

(ii) That the Panel considers and agrees whether there are any recommendations that it wishes to make in respect of matters arising from this report.

REASONS FOR REPORT RECOMMENDATIONS

1. To provide the Health Overview and Scrutiny Panel with an update on current performance in Adult Social Care and information about the emerging transformation plan.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. Not applicable.

DETAIL (Including consultation carried out)

3. The second phase of the council's management restructure came into effect on 1 October 2016, following the merger of Adult Social Care with Housing Services. At this time, the Director of Adult Social Services (DASS) role was moved to the Integrated Commissioning Unit (ICU), with the Service Director, Adults, Housing and Communities having an operational focus. The new structure is attached at Appendix 1 and these arrangements will be reviewed in six months, to see how well they are working.

4. The Council's Strategy Unit has developed a monthly dataset for Adult Social Care that, from this month, is being used to monitor performance and help plan ahead. The indicators attached at Appendix 2 show performance as at September 2016, with a backwards look over the last year and some further analysis, including service demands. The graphs in Appendix 3 show trends over the last year.

5. A transformation plan for Adult Social Care is being developed. At the heart of this will be the implementation of the Care and Support Planning Policy that was approved by Cabinet on 20 September 2016, alongside an Adult Social Care Charter. This fresh approach will be underpinned by a comprehensive staff training and development programme, to ensure that Social Workers and Care Managers consistently support people to achieve independence and the best outcomes through the use of the support available in people's own networks and communities, care technology, Direct Payments and the increased use of extra care housing and Shared Lives schemes, wherever appropriate.

6. Following a successful pilot of a project to tackle the backlog of overdue Adult Social Care reviews, delivered in partnership with Capita, the Transformation and Improvement Board has recently approved the roll out of the full project, which will address all overdue reviews (including those arising) over the next six months. In the longer term, it is proposed that the assessment capacity freed up by the digital transformation programme, through the use of mobile devices and more efficient processes, will help ensure that regular and timely reviews are carried out on an ongoing basis.

7. Individuals receiving Direct Payments as a percentage of all eligible service users dipped to 17.2% in September, which is a cause for concern, not least because increasing this percentage is a key priority for the council. A recent visit to Brighton and Hove Council highlighted areas of good practice and a taskforce is being established to urgently implement actions that will improve performance in this area. This will include the trial of a new website, Choose Care, which is expected to make the process much more straightforward for individuals and their representatives to use. Payments would be made via an online account with the ability to link to a digital marketplace, matching people to the care and support that they need. Support for payroll could also be included. The results of the trial will be used to inform the improvement plan.

8. Plans for further integration with health, building on the success of the integrated Community Independence Service, continue to be developed through Better Care Southampton and the work taking place on the Sustainability and Transformation Plan (STP) for the Health and Care System in Hampshire and the Isle of Wight. This includes work that focusses on improving patient flow and reducing delayed transfers of care from hospitals, exploring new models of delivering integrated care and support (for example through a multispecialty community provider) and improving the quality of, capacity in and access to mental health services. The STP will be the subject of a report to Panel in December.

9. Following the implementation of a new adults safeguarding module in the Paris case management system, there is greater assurance that safeguarding alerts are now being recorded, triaged and dealt with appropriately, which has resulted in an apparent increase of 256% in the number of alerts when compared with the position in September 2015. The additional senior manager post in the new structure is currently being recruited to and will bring extra capacity to focus on adult safeguarding and adult mental health. Resources in the council's Approved Mental Health Professional (AMHP) team and the arrangements in place with Southern Health NHS Foundation Trust are currently being reviewed to ensure they are at a level that supports safe, high quality services. A plan to join health and social care services for

individuals living with a learning disability is also being progressed.

RESOURCE IMPLICATIONS

Capital/Revenue

10. The Housing and Adult Care Portfolio is currently forecast to overspend its revenue budget at year end. Corrective action plans that address this overspend are being developed. These include tracking the benefits that have been realised through current savings programmes, including the use of Erskine Court extra care housing scheme and increased referrals to Connected Care, the council's enhanced telecare service. An update on the financial position will be considered by Cabinet on 15 November 2016.

Property/Other

11. None.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

12. Not applicable

Other Legal Implications:

13. Not applicable

POLICY FRAMEWORK IMPLICATIONS

14. These performance indicators are aligned to the following outcome, contained in the Southampton City Council Strategy 2016-2020:

- People in Southampton live safe, healthy and independent lives

KEY DECISION No

WARDS/COMMUNITIES AFFECTED: None directly as a result of this report

SUPPORTING DOCUMENTATION

Appendices

1. Adults, Housing and Communities Structure Chart
2. Adult Social Care Monthly Dataset – September 2016
3. Adult Social Care performance - graphs

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

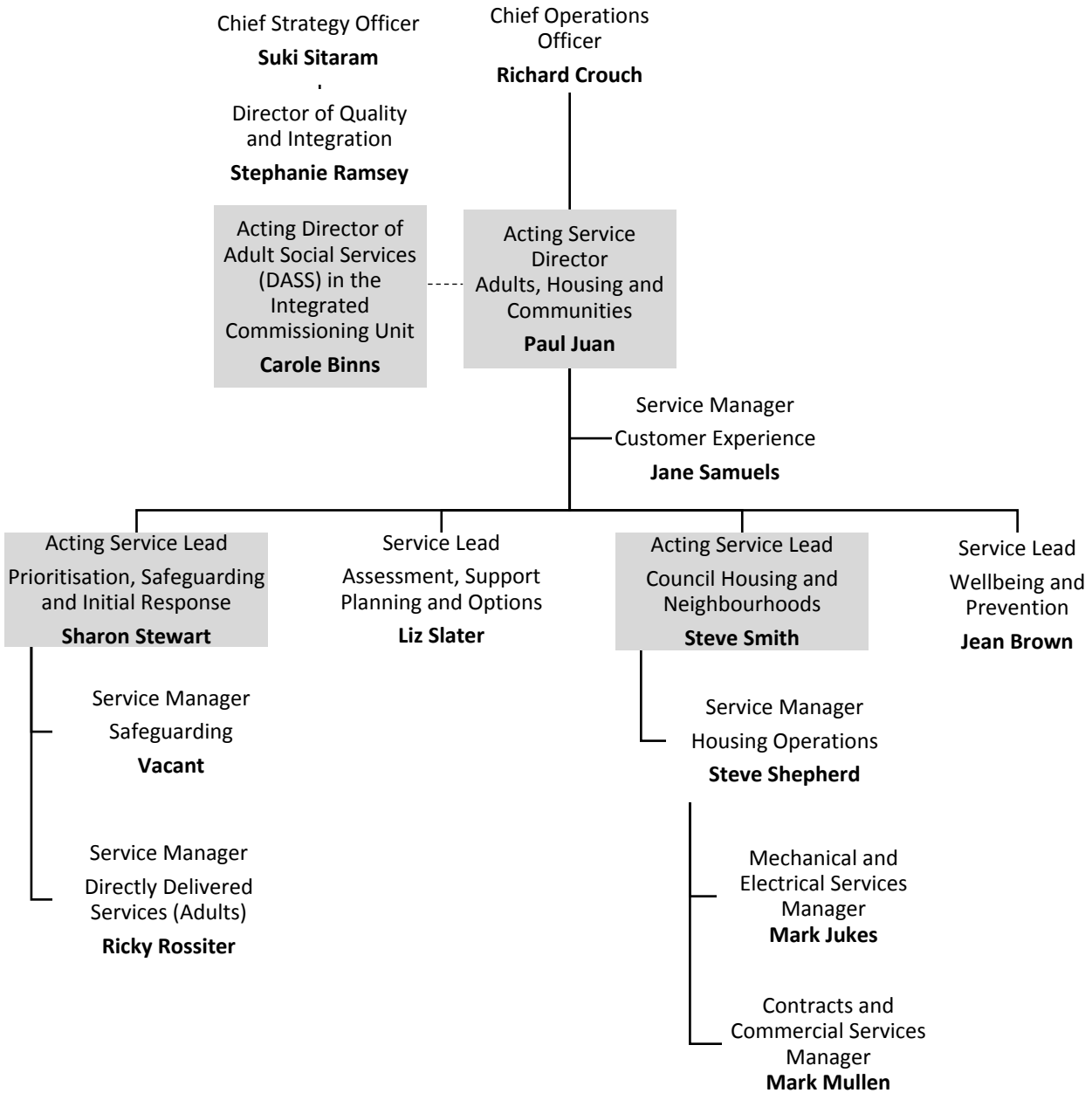
Equality Impact Assessment and Other Background documents available for inspection at:

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	

Appendix 1

Adults, Housing and Communities

New structure from 1 October 2016 with acting up arrangements and placing the Director of Adult Social Services (DASS) role in the Integrated Commissioning Unit (ICU)



Shaded boxes indicate people acting up into these positions

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Adults Monthly Dataset
Sep 2016

Key to direction of travel:

Increase 10% or more ⇧	Similar ⇨	Decrease 10% or less ⇩

Ref	Description	Aug 2015	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	June 2016	July 2016	Aug 2016	Sep 2016	% change from Aug 2016	% change from Sep 2015	*12 month average*	*12-mnth max value*	*Sot 12 rolling month*	*Nat.*	Notes
1	Number of referrals of all types received	2,205	2,369	2,592	2,992	2,630	2,740	2,771	2,616	3,042	2,765	2,883	2,107	2,898	2,853	⇨ (2)	⇧ 20	*2,712*	*3,042*			
2	Number of assessments completed	697	695	581	579	580	543	692	612	541	508	558	401	584	640	⇧ 10	⇨ (8)	*578*	*695*			
3	Number of care packages authorised	995	930	881	823	785	780	1,239	1,084	879	1224	1025	523	958	802	⇩ (16)	⇩ (14)	*918*	*1,239*			
4	Average cost of care package	£390.87	£389.22	£393.19	£390.71	£391.40	£391.13	£394.29	£396.34	£394.29	£395.18	£394.77	£396.42	£390.68	£392.01	⇨ 0	⇨ 1	*£393.05*	*£396.42*			
5	Numbers of residential placements	654	658	644	636	641	646	631	630	626	602	606	557	578	570	⇨ -1	⇩ -13	*617*	*658*			
6	Numbers of nursing placements	407	404	398	398	403	392	389	388	381	353	358	350	374	372	⇨ -1	⇨ -8	*382*	*404*			
7	Numbers of home care	2,294	2,295	2,279	2,293	2,283	2,279	2,281	2,279	2,273	2,295	2,289	2,288	2,271	2,292	⇨ 1	⇨ 0	*2,284*	*2,295*			
8	Enquiries resolved at first contact (%)	68.7%	69.2%	67.4%	62.4%	72.1%	72.6%	72.9%	72.3%	79.0%	76.8%	73.6%	73.6%	68.7%	69.2%	⇨ 1	⇨ 0	*71.5%*	*79.0%*			
9	People with eligible long term services assessed or reviewed during the past year (%)	30.4%	31.4%	34.1%	37.0%	36.3%	33.8%	37.8%	39.3%	39.6%	38.3%	39.5%	38.7%	36.3%	33.9%	⇨ -7	⇨ 8	*36.6%*	*39.6%*			
10	People with eligible needs supported to live independently (%)	79.0%	79.4%	79.2%	82.5%	79.5%	76.1%	80.6%	80.0%	80.9%	81.5%	81.1%	81.0%	80.9%	81.0%	⇨ 0	⇨ 2	*80.3%*	*82.5%*			
11	Direct payments as a percentage of all eligible service users	18.2%	18.5%	18.6%	18.7%	18.5%	19.3%	18.1%	17.7%	18.2%	18.8%	19.4%	17.6%	17.8%	17.2%	⇨ -3	⇨ -7	*18.3%*	*19.4%*	*18.3%*	*26.3%*	
12	Number of Direct Payment users	390	393	392	391	393	389	401	394	407	409	395	394	389	382	⇨ -2	⇨ -3	*395*	*409*			
13	Number of Adult safeguarding alerts received	9	9	13	23	11	23	21	27	65	58	52	48	31	32	⇨ 3	⇧ 256	*32*	*65*			*Alerts rather than referrals to safeguarding*
14	Number of permanent admissions of older people (over 65) to residential/nursing care homes	30	22	30	20	25	27	24	21	23	23	25	15	17	11	⇩ (35)	⇩ (50)	*22*	*30*			
14a	Number of permanent admissions of older people (over 65) to nursing care homes	21	13	16	8	15	11	10	11	12	5	13	6	9	5	⇩ (44)	⇩ (62)	*10*	*16*			
14b	Number of permanent admissions of older people (over 65) to residental care homes	9	9	14	12	10	16	14	10	11	18	12	9	8	6	⇩ (25)	⇩ (33)	*11*	*18*			
14c	Rate per 100,000 of permanent admissions of older people (over 65) to residential/nursing care homes	28	28	43	37	31	49	43	31	34	55	37	28	25	18	⇩ (25)	⇩ (33)	*35*	*55*	*429*	*669*	
15	Number of Delayed Transfers of Care per month (patients)	23	37	29	25	21	27	46	26	48	49	49	59			n/a	n/a	*38*	*59*			
15a	Delayed Transfers of Care per month (days)	819	664	919	606	640	792	956	1,114	1,191	1,632	1,483	1,945			n/a	n/a	*1,086*	*1,945*			
16	DToC Social care patients only	7	25	12	13	13	16	40	15	31	33	21	31			n/a	n/a	*23*	*40*	*225*	*2,147*	
17	DToC Social care days delayed only	354	365	450	274	303	356	520	740	706	1,133	705	1,116			n/a	n/a	*606*	*1,133*	*6,303*	*61,035*	
18	Total number of DOLS applications received	56	22	80	70	74	83	144	77	56	81	59	55	72	63	⇩ -13	⇧ 186	*72*	*144*			
19	Total number of DOLS authorisations	2	15	12	9	23	47	75	30	42	91	37	43	22	22	⇨ 0	⇧ 47	*36*	*91*			

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Agenda Item 9

Appendix 2

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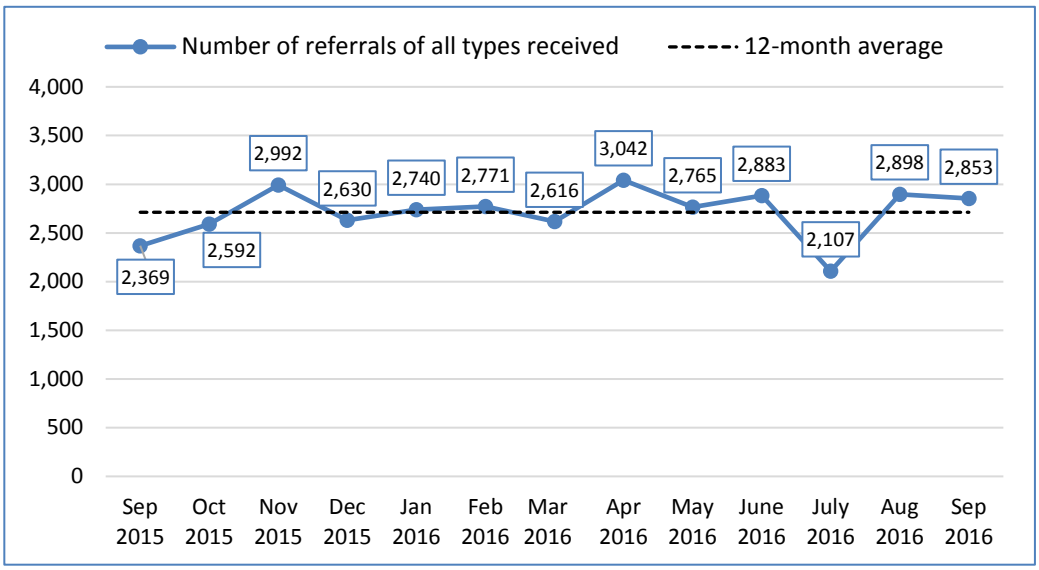
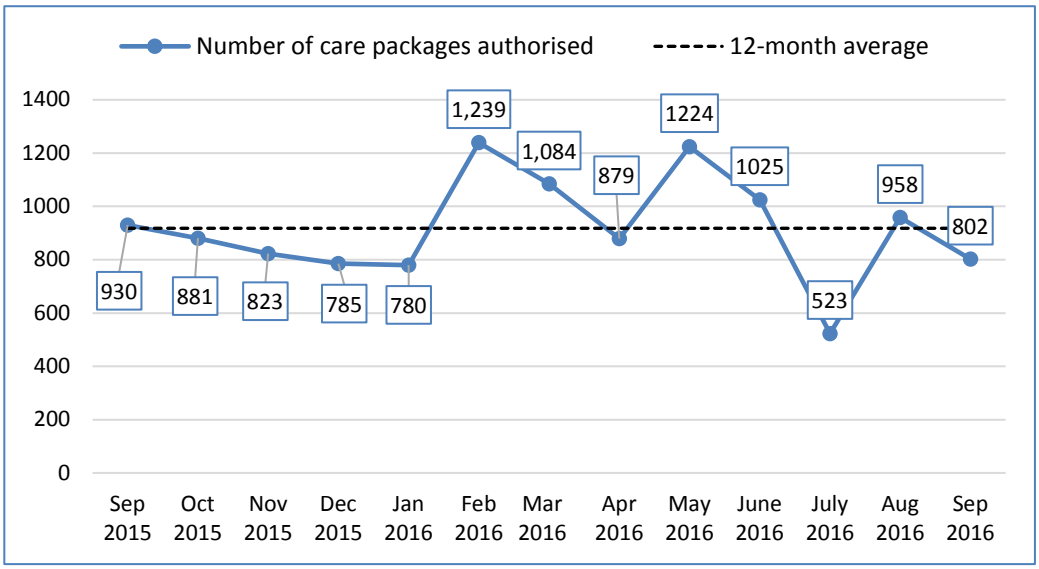
Adults Monthly Dataset

Sep 2016

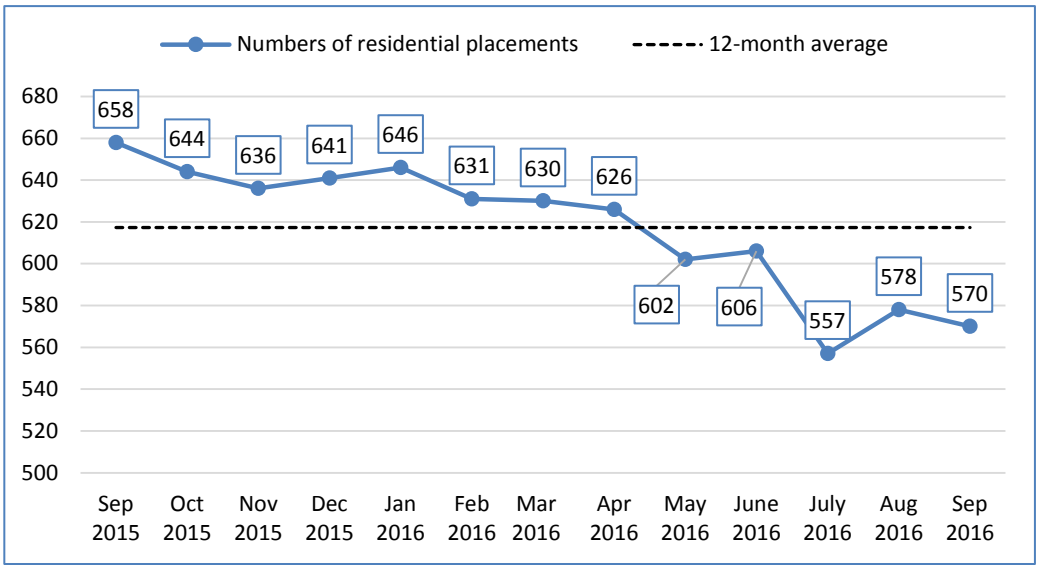
Number of referrals of all types received



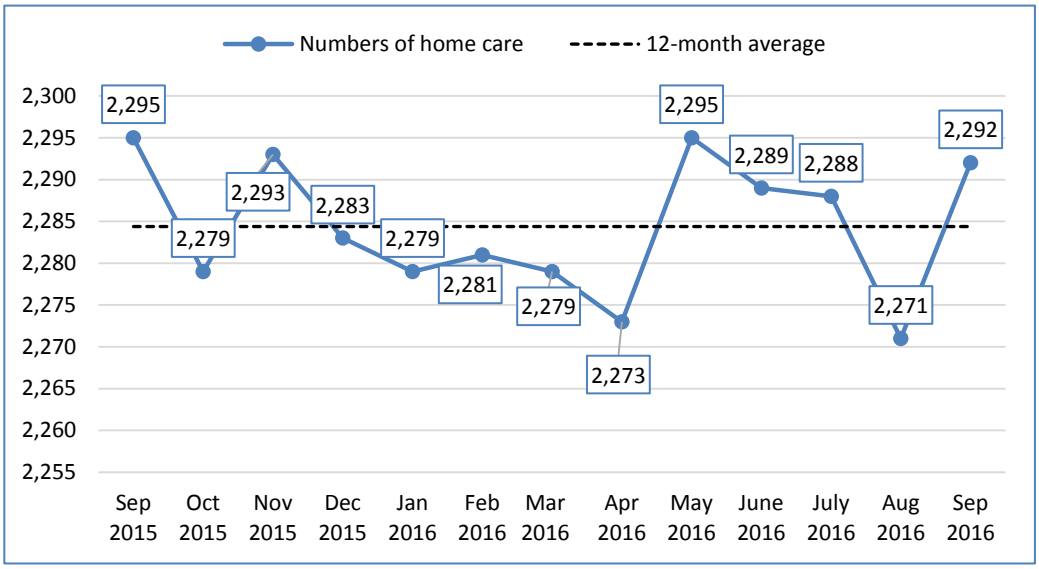
Number of care packages authorised



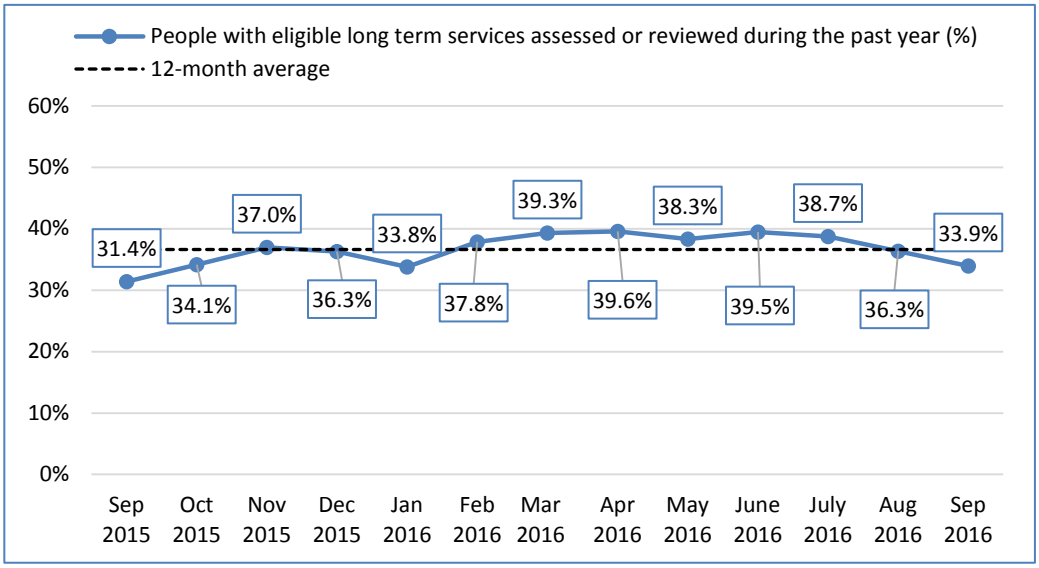
Numbers of residential placements



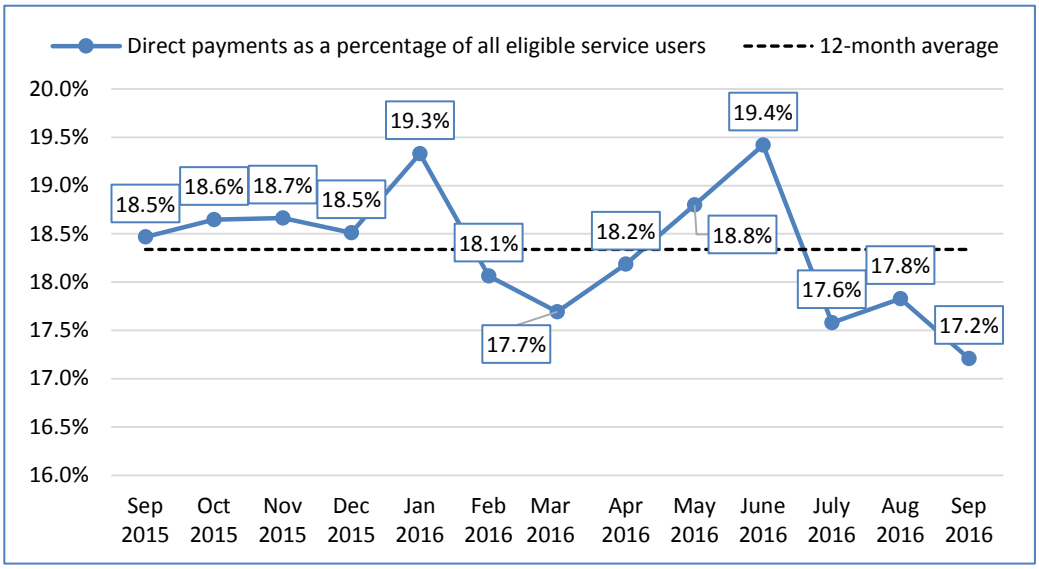
Numbers of home care



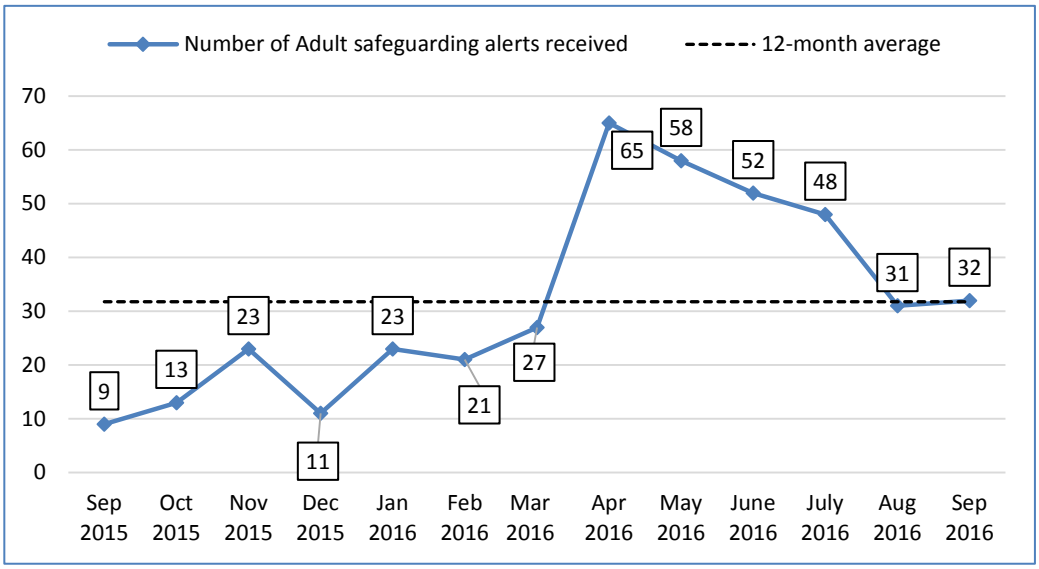
People with eligible long term services assessed or reviewed during the past year (%)



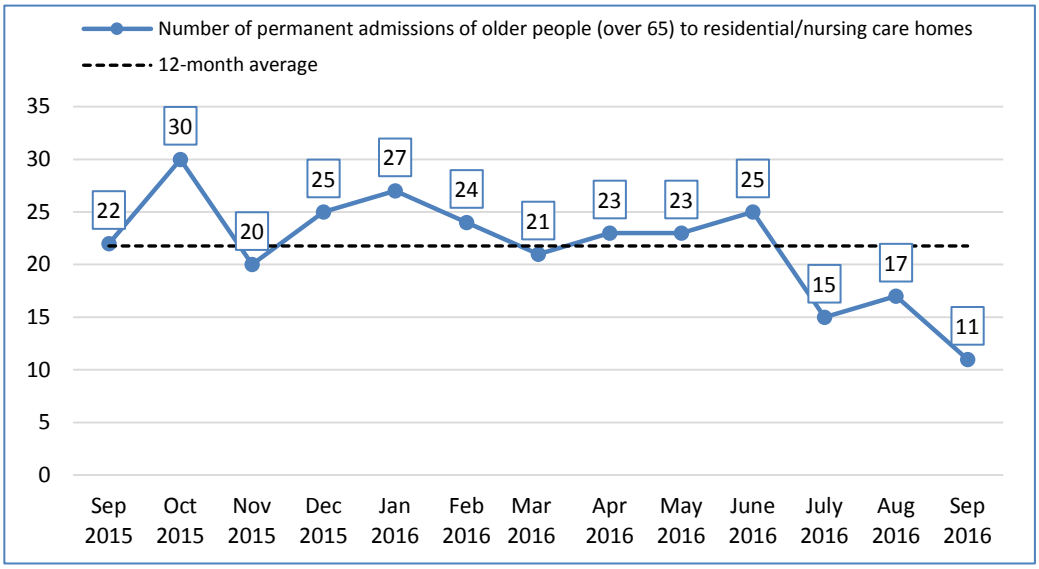
Direct payments as a percentage of all eligible service users



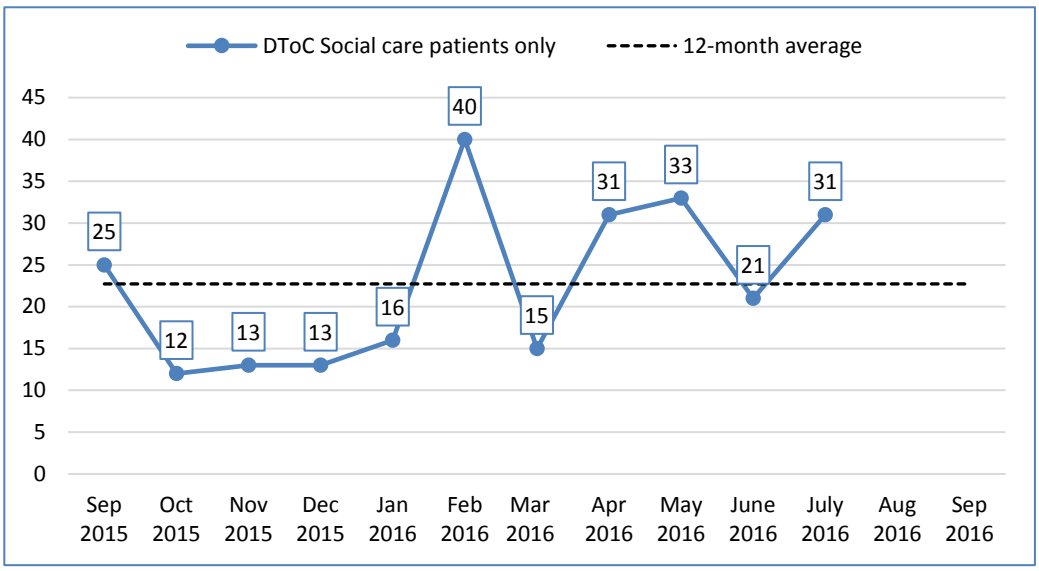
Number of Adult safeguarding alerts received



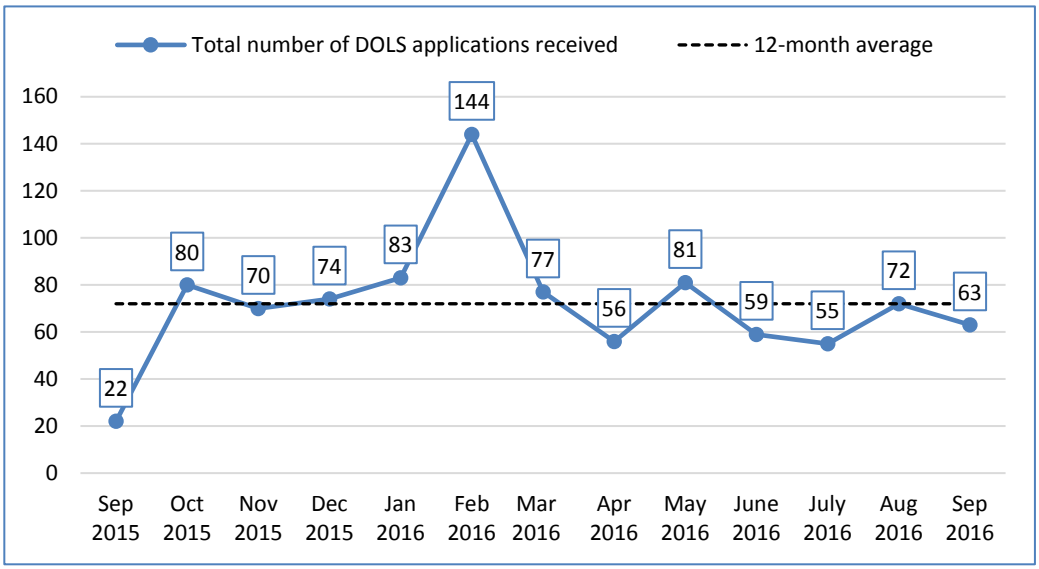
Number of permanent admissions of older people (over 65) to residential/nursing care homes



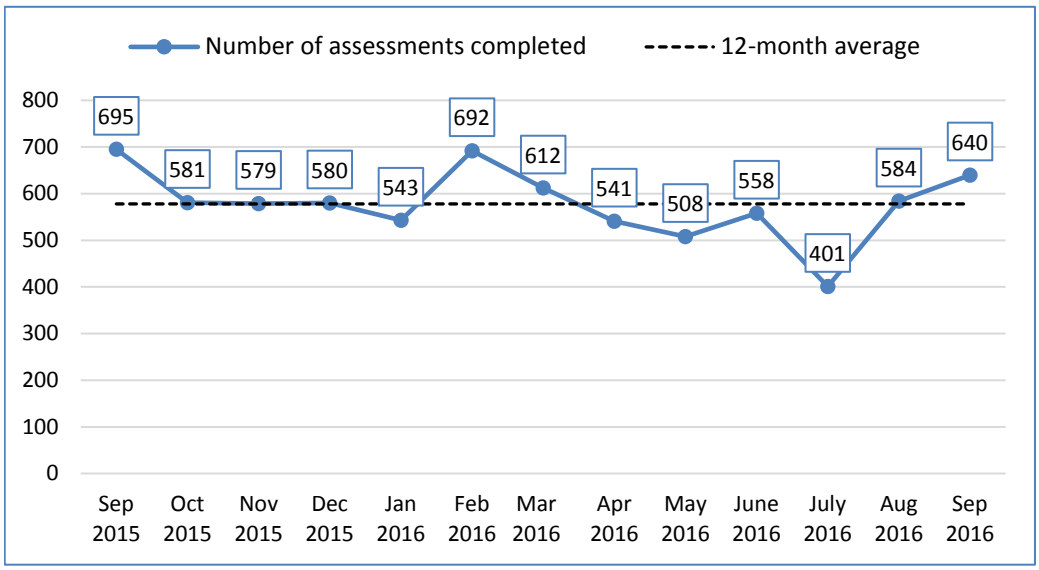
DToC Social care patients only



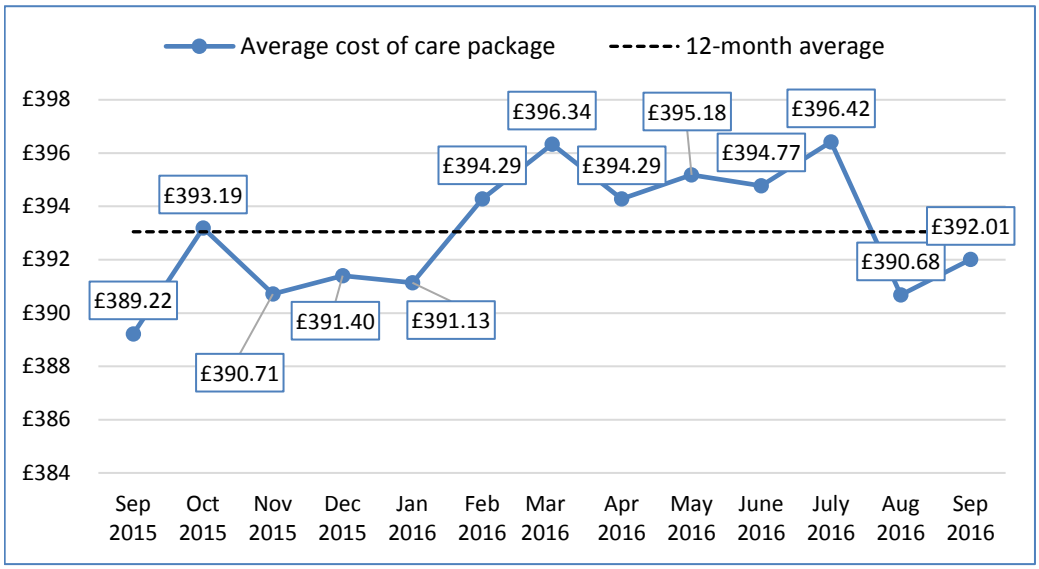
Total number of DOLS applications received



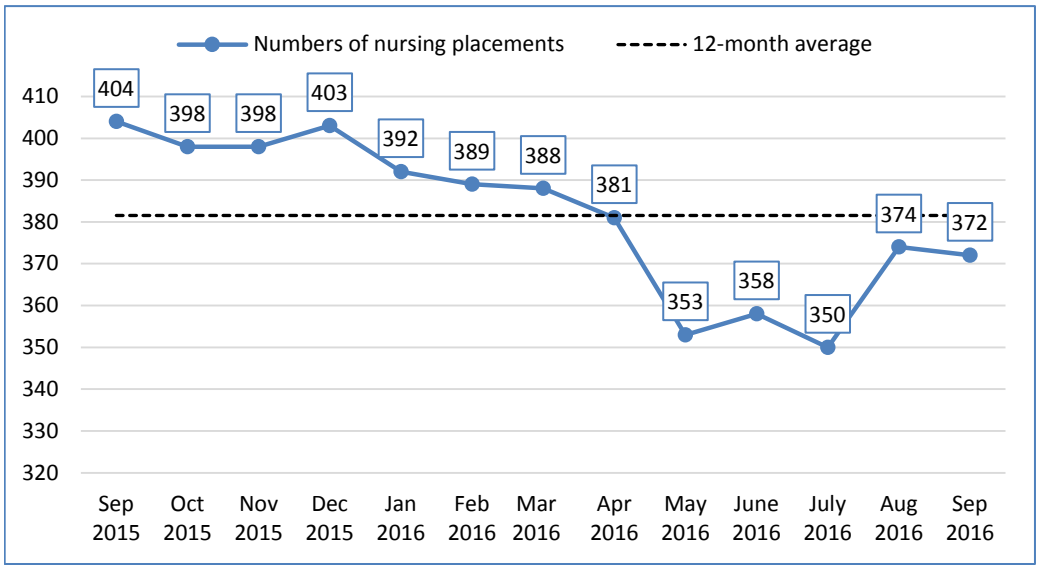
Number of assessments completed



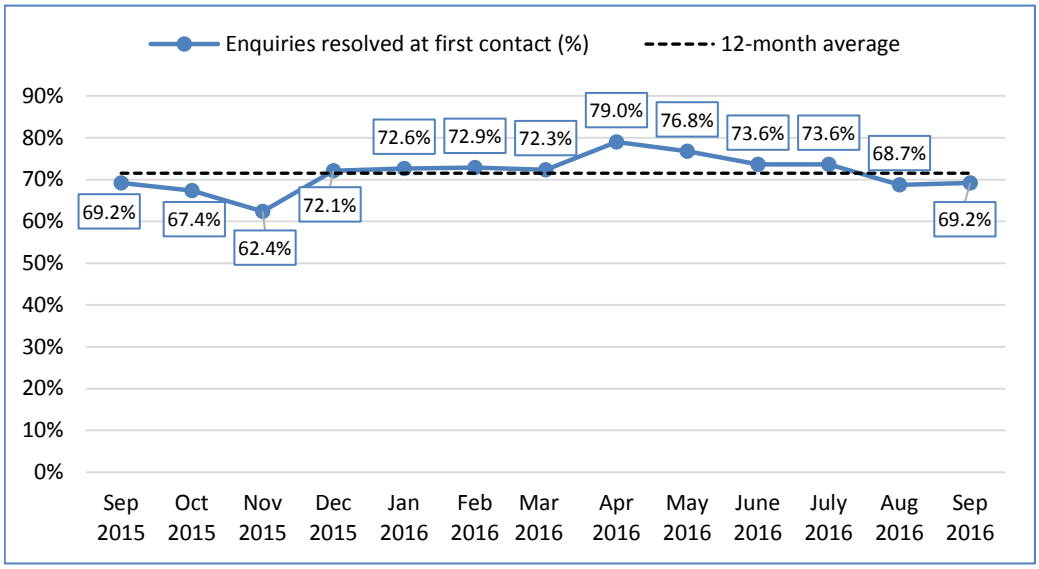
Average cost of care package



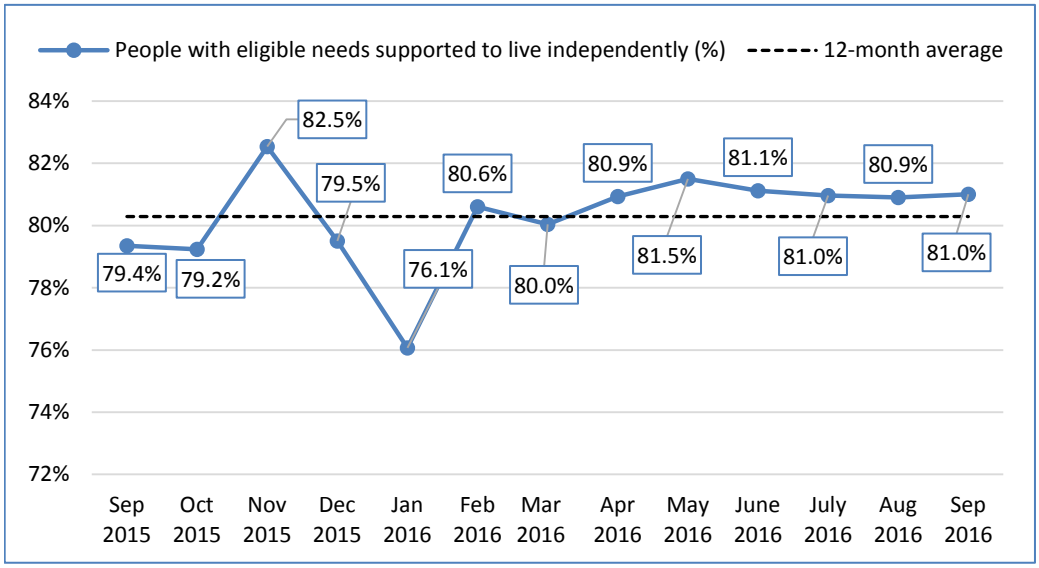
Numbers of nursing placements



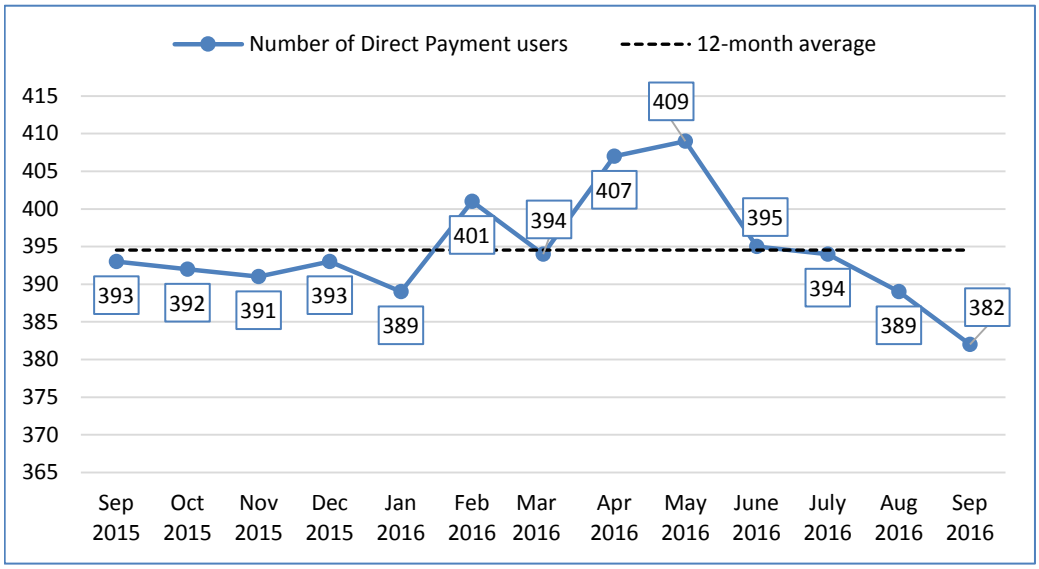
Enquiries resolved at first contact (%)



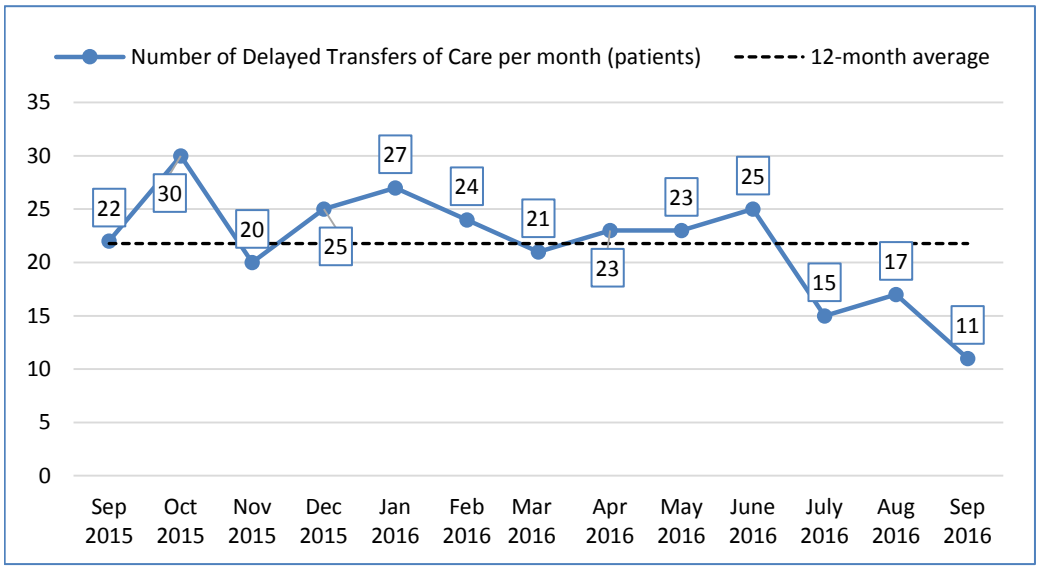
People with eligible needs supported to live independently (%)



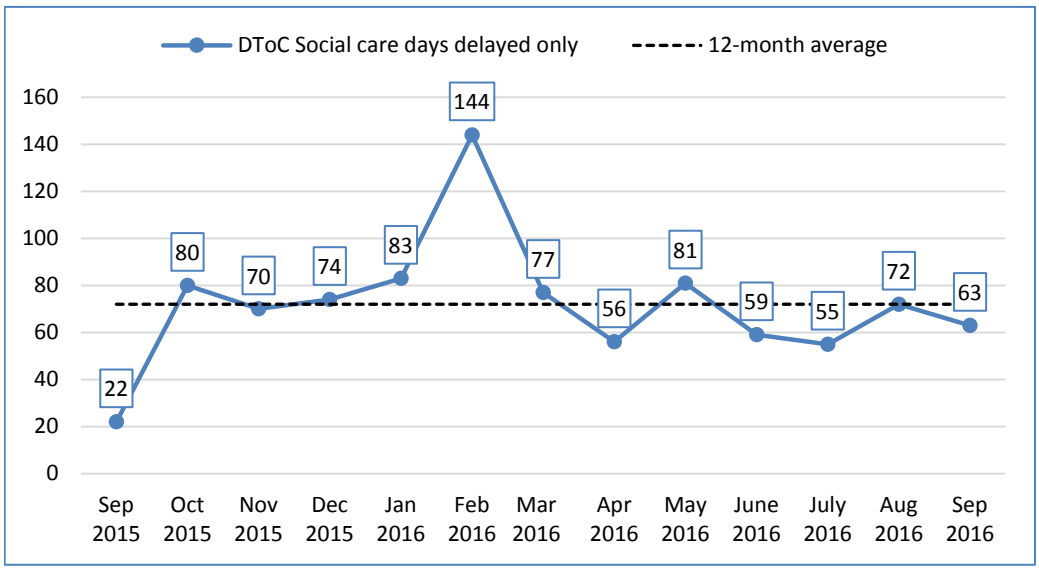
Number of Direct Payment users



Number of Delayed Transfers of Care per month (patients)



DToC Social care days delayed only



Total number of DOLS authorisations