NHS
Southern Health
NHS Foundation Trust

Southampton City Council
Health Overview and Scrutiny Panel
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Southern Health NHS Foundation Trust: Update on progress

Overview

Southern Health NHS Foundation Trust provides mental health, learning disability, and community services in Hampshire. In Southampton City, the Trust provides learning disability health services and adult and older people's mental health services. It operates Antelope House psychiatric unit and wards at the Western Community Hospital, as well as community mental health services in the city.

The trust has faced significant challenge and criticism over the last two years following the findings of the independent Mazars review in December 2015. This found the Trust's processes for reporting and investigating deaths of people with learning disabilities and mental health needs could have been better, and that families weren't always involved as much as they could have been. The Care Quality Commission (CQC) subsequently carried out an inspection of the Trust in January 2016, which resulted in a warning notice issued in April 2016.

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

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

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

Recent progress

Leadership changes

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

Lynne has a track record of almost 40 years public service, working in the NHS within mental health services. She began her career as a nurse in Dorset, before moving to London and has held a number of clinical and Board level roles. Most recently she has been Non-Executive Director and Vice Chair of Dorset Healthcare NHS Foundation Trust.

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

We have also appointed Dr Nick Broughton as our new, substantive Chief Executive, who will take up his post in early November. A consultant forensic psychiatrist by background, Dr Broughton was previously Chief Executive of Somerset Partnership NHS Foundation Trust.

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

New 'Crisis Lounge' pilot in Southampton

A new crisis-care service based at Antelope House began on 16 October 2017. Called the 'Crisis Lounge' – it is a safe and supportive space for people experiencing a sudden crisis with their mental health. It will be a place to go to seek help, advice and care from a team of health professionals and peer workers (people with a lived experience of mental health problems). The Crisis Lounge is based on similar successful schemes that have enabled more timely and appropriate care for people in crisis, and it represents a more suitable environment than acute hospital emergency departments for people with this type of need.

More beds for young people with severe mental health problems

Working with NHS England, and responding to a national shortage of these types of services, the Trust has successfully opened six additional beds for young people who require secure mental health care. It is hoped that this extra capacity will enable more vulnerable young people to receive this highly specialised care closer to home.

Progress on CQC actions and Quality Improvement
(Full CQC Action Plan – Members' Room Document)

- The action plan following the CQC inspection in January 2016 is now 98% completed and the September 2016 actions are 95% completed. The trust continues to provide evidence of completion and assurance against selected actions to the Quality Oversight Committee (chaired by NHS Improvement, our regulator) on a monthly basis.

- In March 2017 CQC carried out a focussed inspection of adult mental health community services, older people's mental health inpatient and community services,

inpatient, urgent care, end of life and community services in the Integrated Service Division.

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

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

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

- There have been no other inspections by CQC since the above.

Quality Improvement Strategy

- The Quality Improvement priorities have been agreed for 2017/18, with input from some of our patients and service users, and these are aligned with the five key CQC domains (safe, effective, caring, responsive, well-led).
- The Divisional Quality Performance Reporting framework is continuing, to ensure clear ward to Board visibility of quality performance. A Trust-wide Quality & Safety Pack, which reports against the key CQC domains, shows Trust quality and safety measures in detail down to directorate level across the Trust. This is supported by a quality meeting structure and agenda framework and a senior nurse weekly 'Back to the floor' programme.
- Every clinical team has its own quality improvement plan as part of the wider strategy, these were seen and noted by the CQC during the March 2017 inspection.
- The Central Quality Governance Team now has individual staff aligned to each of the divisions, to strengthen the links and accountability lines between the central team and divisional quality structures.
- The Quality Improvement Strategy was re-launched in August 2017 and we asked for a support worker from each team to be identified as a Quality Ambassador to support the implementation of the strategy at local level. Recruitment Quality Ambassadors commenced in September and the first training workshop took place on 5 October with a further two planned for October/November 2017.

- The Quality Ambassadors will share learning with their teams and will carry out at least one team quality improvement each quarter supported by the quality governance team.

- A dedicated online resource is being set up to support the Quality Ambassadors and as a central place to share learning. This will be further developed as more staff become ambassadors and will include a discussion forum and library of resources.

- The success of this initiative will be measured via a quarterly event where all Quality Ambassadors will share their quality improvement achievements and learning.

Patient and Family Engagement

- An Experience, Involvement and Partnership Strategy has been developed (as part of the wider Quality Improvement Strategy) and will soon be launched, to provide a greater focus and drive further improvements in how we engage patients, families and carers across the Trust.
- A Family Liaison Officer has been recruited and uses a referral process to support families throughout the serious incident investigation process. Members of the public have been recruited to attend the Mortality Working Group, and some of the Trust Mortality meetings, and further 'patient partners' are being sought.
- The Trust has commissioned an independent review of family involvement in investigations conducted following a death at Southern Health. The review highlighted the lack of communication with families as a key issue, and identified the need for a culture change across the organisation towards recognising the importance of family involvement in the care of loved ones. The Trust developed an action plan to address the recommendations made in the report (Members' Room Document).
- The Trust has reviewed the training materials, role descriptions and policies for serious incident handling and investigation. Some families have also been involved in this work.
- A network of families has been contacted and consulted about their experiences, and this feedback has been used as part of the action plan (mentioned above).
- A series of survey questions have been agreed with the CQC to ask of families after the incident investigation process has been concluded. The first of these surveys has been completed, which has showed improvements as well as other areas for consideration.
- A forum for families has been established, made up of those who want to support the Trust in making continued improvements in involvement and engagement. To date the group has reviewed Trust policies around incident investigation and duty of candour, and co-designed an information leaflet for patients and their families and carers which explains the investigation process. They have also co-designed the materials for a workshop on confidentiality and information sharing, intended to examine current processes and develop them where possible.
- Julie Dawes, Interim CEO, has met with families who feel very strongly about the Trust in order to listen to their individual concerns and understand their stories and backgrounds.

- The Trust is also supporting the national #hellomynameis campaign with its own campaign to embed the practice of introducing themselves to patients, carers and colleagues amongst all staff across the Trust.

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

Mazars report: actions and progress

Serious Incident Requiring Investigation (SIRI) process

- A new oversight process for serious incidents requiring investigation was established soon after the publication of the Mazars report. This new process has greater oversight from the Trust's Executives, including formal sign off of each report, which has led to improvements in the quality of the investigation reports.
- A central investigation team now takes the lead on investigating serious incidents. The team have been fully trained using external experts.
- A new policy for investigating patient deaths has been implemented and this is now reported to commissioners weekly.

As a result, SIRI completion rates within the 60 day timeframe have improved, with 100% success for the last 12 months. It should be noted, however, that bereaved families are not always able to participate in investigations. It is important that families are able to input into investigations when they are ready to do so, even if it's outside the 60-days timeframe.

Deaths are now subject to a review within 48 hours with a target of 95%, which has been met or exceeded three times in the last six months. Continuous monitoring of these statistics is carried out, so that any risks or issues are mitigated and addressed. An audit is performed every month to evidence the rationale for the decision to report as a serious incident or not. CCGs now receive initial reports at 72 hours post incident; these address the immediate actions to address risks.

Assessing effectiveness

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

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

- Grant Thornton are currently completing their assurance checks and the final report will be presented to Board on 31 October 2017 after which it will be published.

Prosecutions by the CQC and the Health and Safety Executive

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

In October 2017, the CQC successfully prosecuted the Trust under health and safety legislation in relation to an incident which took place at Melbury Lodge, Winchester, in 2015. The Trust pleaded guilty to the charges and received a fine of £125,000 plus costs. Since the incident in 2015, significant improvements to the building have been carried out to mitigate the risk of a similar incident occurring, as part of the CQC action plans discussed above.

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

Next steps for Southern Health services
See appendix 2 for more detail on our priorities ahead

Southern Health NHS Foundation Trust published its Clinical Services Strategy in May 2017; a plan for its mental health and learning disability services as well as an assessment of developments in the provision of community physical health services. A four month review was undertaken to develop this strategy, to understand how our services should be configured to best meet the needs of local communities in the future.

To help us do this work, we partnered with experts from Deloitte LLP and Northumberland Tyne and Wear NHS Foundation Trust (NTW). NTW is an organisation providing similar kinds of care to us and rated 'outstanding' by the Care Quality Commission. We also listened to the views of a variety of people, including health workers and experts, families and the people who use our services, as they are experts in the experience they have had.

The resulting strategy document (an overview of which is included as Appendix 3) contains seven priorities which are now the focus of our work. These include fundamentally improving access to care through a single point of contact, better 24/7 crisis support, greater inclusion of service users in the design and delivery of services, and ensuring people receive a more consistent level of service across Hampshire. They identify developments for those services as well as the organisation, and the overall direction provides for a dynamic and positive future. The strategy is now being implemented, including, for example, through the development of a new single point of access into mental health services in East Hampshire.

In particular, the Board has identified the benefits of much greater inclusion of service users and carers in the organisation as well as in the delivery of services, a systematic quality improvement methodology, the greater integration with primary care, and much greater involvement of clinical staff in the management and organisation of the Trust's services.

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