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Hampshire County Council

NOTICE OF MEETING

Meeting Health and Adult Social Care Select Committee

Date and Time Tuesday, 20th June, 2017 10.00 am

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

Enquires to Members.services@hants.gov.uk

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

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

AGENDA

Approx. Timings

1. APOLOGIES FOR ABSENCE

To receive any apologies for absence.

2. DECLARATIONS OF INTEREST

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

3. MINUTES OF PREVIOUS MEETING (Pages 5 - 14)

To confirm the minutes of the previous meeting.

4. DEPUTATIONS

To receive any deputations notified under Standing Order 12.

5. CHAIRMAN'S ANNOUNCEMENTS

To receive any announcements the Chairman may wish to make.

6. INTRODUCTION TO SCRUTINY — 30 minutes

To receive a presentation on scrutiny, and the terms of reference of the Health and Adult Social Care Select Committee

7. INTRODUCTION TO ADULTS' HEALTH AND CARE — 30 minutes

To receive a presentation providing an overview of the Adult's Health and Care Department.

8. INTRODUCTION TO THE NHS LANDSCAPE IN HAMPSHIRE — 45 minutes

To receive a presentation from Hampshire CCG Partnership and West Hampshire CCG providing an overview of the NHS in the County.

SHORT BREAK

9. ISSUES RELATING TO THE PLANNING, PROVISION AND/OR OPERATION OF HEALTH SERVICES (Pages 15 - 134)

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

- Southern Health NHS Foundation Trust: Care Quality Commission and Mazars reports – update — 45 minutes

10. PROPOSALS TO VARY SERVICES (Pages 135 - 180)

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

Items for Action

- NHS Guildford and Waverley and NHS North West Surrey CCGs: West Surrey Stroke Services — 45 minutes

11. WORK PROGRAMME (Pages 181 - 192) — 5 minutes

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

ABOUT THIS AGENDA:

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

ABOUT THIS MEETING:

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

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

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AT A MEETING of the Health and Adult Social Care Select Committee of HAMPSHIRE COUNTY COUNCIL held at the castle, Winchester on Wednesday, 15th March, 2017

PRESENT

Chairman:
p Councillor Roger Huxstep

Vice-Chairman:
p Councillor Chris Carter

Councillors:

p Ann Briggs
p Graham Burgess
p Rita Burgess
p Adam Carew
p Charles Choudhary
p Alan Dowden
p Jacqui England
p David Harrison
a Marge Harvey
p David Keast
a Chris Lagdon
p Martin Lyon
p Fiona Mather
p Chris Matthews
p Floss Mitchell
p Frank Rust
p Bruce Tennent
p Martin Tod

Substitute Members:

Co-opted Members:
Councillors:
a Tonia Craig
a Alison Finlay
p Dennis Wright
VACANT

In attendance at the invitation of the Chairman:
Councillor Jackie Porter, County Councillor for Itchen Valley
Councillor Patricia Stallard, Executive Member for Health and Public Health

181. **APOLOGIES FOR ABSENCE**

Apologies were received from Councillor Marge Harvey. The Conservative standing deputy was not available to attend in her place. Apologies were also received for Councillor Chris Lagdon, and Co-opted Member Councillor Alison Finlay.

182. **DECLARATIONS OF INTEREST**

Members were mindful that where they believed they had a Disclosable Pecuniary Interest in any matter considered at the meeting they must declare that interest at the time of the relevant debate and, having regard to the circumstances described in Part 3, Paragraph 1.5 of the County Council's Members' Code of Conduct, leave the meeting while the matter was discussed,

save for exercising any right to speak in accordance with Paragraph 1.6 of the Code. Furthermore Members were mindful that where they believed they had a Non-Pecuniary interest in a matter being considered at the meeting they considered whether such interest should be declared, and having regard to Part 5, Paragraph 2 of the Code, considered whether it was appropriate to leave the meeting whilst the matter was discussed, save for exercising any right to speak in accordance with the Code.

Councillor Jacqui England declared a general Personal Interest, as she is the Chairman of the Lymington Hospital 'League of Friends'.

Councillor Martin Lyon declared a general Personal Interest in Item 7, as his wife is an enhanced nurse practitioner employee of the Friarsgate Practice.

Councillor Jackie Porter, attending for Item 7, declared a Personal Interest as she is registered at the Friarsgate Practice.

Councillor Frank Rust declared a general Personal Interest as he is a Member of the Wessex Clinical Senate, and undertook research in hospitals on behalf of the Nuffield Trust.

Councillor Martin Tod declared a general Personal Interest, as he is the Chief Executive of the Men's Health Forum, which receives funding from Public Health England and the Department of Health, and a Personal Interest in Item 7, as he is registered at the Friarsgate Practice.

183. **MINUTES OF PREVIOUS MEETING**

The Minutes of the meeting of the Health and Adult Social Care Select Committee (HASC) held on 17 January 2017 were confirmed as a correct record.

There were two matters arising in relation to the Minutes:

- Minute 175-177: The Public Health strategy had been circulated to Members, and the budget detail was being finalised and would be with Members shortly. The information on the use of agency staff by Adults' Health and Care had been circulated.

  The Director of Adults' Health and Care provided a brief update on the capital programmes at Bulmer House and Cornerways. For Cornerways, it was heard that day opportunities continued to be supported for older people at this site, with this service transferring to the new extra-care scheme facility at Chesil Lodge, Winchester in October 2017. For Bulmer House, Petersfield, procurement was underway for a new development partner, with an aim for a new site to be open in 2020.

- Minute 178: the Sustainability and Transformation Plan engagement plan had been requested and would be circulated to Members once finalised.

184. **DEPUTATIONS**

The Committee did not receive any deputations for this meeting.

185. **CHAIRMAN'S ANNOUNCEMENTS**

The Chairman made three announcements:

Briefings and Updates

Updates would be shared with the Committee on:

- The report relating to the recent CQC inspection of Solent NHS Trust, for information, as the Portsmouth and Southampton HOSPs were taking the lead for the scrutiny of the Trust
- Kingsley Ward, Melbury Lodge reopening *(Southern Health NHS FT)*
- Stefano Olivieri Unit – update on model of care, to include detail of work undertaken with nursing homes on timely discharge from mental health inpatient beds *(Southern Health NHS FT)*
- System resilience update *(lead: West Hants CCG)*

Stroke Care

Members had received information on stroke care for patients who cross the border from East Hampshire into Surrey. As the consultation was still ongoing, it would not be appropriate to consider this issue today as a final proposal had not been agreed. The Chairman had instead requested that this topic be added to the work programme for consideration in the summer, once the outcomes of the consultation were known. In the meantime, the Chairman had established contact with the two Hampshire CCGs affected and would discuss with them the likely impact of the proposals.

Dorset Clinical Services review

The Chairman had attended the most recent meeting of the Joint HOSC on the Dorset clinical services review on 23 February with Cllr Harrison, where an overview of the consultation to date was given, and details provided on the preferred option. Discussion was heard on the preferred option, for which Hampshire was supportive, as it would result in enhanced care for the population that use these two hospitals, and would have the least impact in terms of travel time. A consultation response was drafted following the meeting which encapsulated discussion. The next meeting would discuss the outcomes of the consultation and next steps. In the interim, the JHOSC continues to meet to discuss the mental health work-stream which does not affect the Hampshire population.

Councillor Harrison provided his view of the meeting, noting his support for the proposals and his contentedness with the consultation to date.

The Chairman noted to Members that this would be the last meeting of the Committee before the upcoming elections on 4 May, and thanked Members, officers, NHS colleagues and the scrutiny officer for their contributions to the work programme over the previous four years.

186. **PROPOSALS TO VARY SERVICES**

Solent NHS Trust: Proposals to Move the Kite Unit

Representatives of Solent NHS Trust presented a report on the proposed move of the Kite Unit (see report, Item 6 in the Minute Book).

A summary of the report was provided. In response to questions, Members heard:

- For most Hampshire patients and their families/carers, there would be a shorter distance to travel to the Unit in Western Community Hospital, Southampton. Public transport links were also better. For those who might financially struggle to travel to Southampton, funding had been identified through 'Headway', which would see individuals reimbursed if criteria were met.
- A formal consultation with staff had not yet been held as the Trust wished to gain support for the proposed move first, but through informal discussions and engagement it was thought that most staff would be willing to transfer to Southampton. Those who had signalled their intention to leave the service had noted this to managers, and a recruitment exercise was being held to fill these posts.
- Should the Kite Unit move to Southampton, staff would have protected travel costs reimbursed for a four-year period at 79p* per mile.
  **Post-meeting, this was corrected to 28p per mile.*
- The majority of clinical staff were supportive of the proposals, with the only concerns raised relating to how the new Unit would be staffed, and what support would be offered in terms of travel. All staff were supportive of the clinical strategic direction and agreed that the Kite and Snowdon wards should be co-located.
- The low level of GP feedback to the proposals was likely due to only a minority of doctors being aware of the Unit, as most would not have referred patients into the neurological rehabilitation pathway. Those who had responded had been positive about the proposals, alongside responses from acute and commissioning colleagues.
- Currently the Snowdon Unit is a stand-alone ward in Western Community Hospital and would remain unchanged. The Kite Unit would occupy a vacant ward in the hospital, which would be renovated and adapted to suit the requirements of a neurological rehabilitation ward.
- It was hoped that by co-locating the two Units, staff on Snowdon would improve their skills around acuity, and staff on Kite would be able to improve their physical therapy skills.
- It was additionally hoped that by being located on the Western site, conversations could be held with the major provider of mental health services in Hampshire, Southern Health NHS Foundation Trust, about a shared out-of-hours psychiatric rota given that the two providers would be in close proximity.

Members held discussion after questions which indicated their support for the proposals, particularly noting the positive indication of the two mental health trusts located on the Western Hospital site working together on shared rotas.

The Chairman moved to the recommendations.

RESOLVED

That Members:

1. Support the proposal to move the Kite Unit from St James' Hospital, Portsmouth, to the Western Community Hospital, Southampton.

2. Request an update on this service three months after the move has been completed. That this update includes information on the staffing of the Kite Unit post-move, and details of travel arrangements made with staff, patients and their families/carers.

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

Friarsgate Surgery and West Hampshire Clinical Commissioning Group: Update on Closure of Kings Worthy branch surgery

Representatives from West Hampshire Clinical Commissioning Group (CCG) and the Friarsgate Practice presented an update on the closure of the Kings Worthy branch of the Friarsgate surgery, Winchester (see presentation, Item 7 in the Minute Book).

The local County Councillors for the area covered by the Friarsgate Practice, Cllrs Jackie Porter and Martin Tod, spoke to the update. Cllr Porter noted local concerns raised relating to long patient journeys from Kings Worthy to Weeke, as well as access to medical appointments and the use of e-consult. Some negative feedback had also been received by Cllr Porter from patients regarding the availability of the patient transport service operated for a short time after the closure of the branch surgery. Cllr Porter also made the Committee aware that the structure of the Health and Wellbeing Café had changed to one focused around patient cohorts, rather than just the frail and elderly.

In response to Cllr Porter's concerns, the Practice's representatives noted that the Health and Wellbeing Café was always expected to evolve to best meet patients' needs, as there was no 'one size fits all' approach to this model, with each GP surgery finding what worked best for them. The patient participation group had been active in shaping the café through discussions with those who used them. It was still too early for a full evaluation of the café, but the Practice were aware that the café wasn't fully reaching its potential to date, and further evolution would be required.

In terms of the patient transport operated by the Practice, despite changing the hours of the service and promoting it to all registered Kings Worthy patients, there had been very little take-up of the service and therefore it had been decided to discontinue this. However, fares at a discounted rate were still available through the Dial-A-Ride service.

In response to questions, Members heard:

- That demand for same-day appointments and sessions with own-GPs would always outstrip supply, and similar Practices in Winchester and other urban areas were experiencing the same issues with waiting times. This required innovative thinking to resolve, especially as many GPs nationally are due to retire within the next five years, and not enough medical students were choosing General Practice as their specialty.
- The e-consult system, which was mobile-enabled, had been recently launched by Friarsgate and this was being used by approximately 180 patients per week, with a number more using the advice to self-diagnose and treat without making contact with the Practice.
- That the Practice were not aware of specific parking issues for patients visiting the site in Weeke; the Waitrose car park provided two hours of free parking, and although there were some peak times of year when the car park was busy, there hadn't been any significant issues raised by patients regarding this.
- That public transport availability and parking for staff remained an issue for those travelling to the Weeke Practice. Some staff had made agreements with local homeowners to use their driveways, and other solutions had been found. This issue was likely to escalate with the plans to make the area permit-controlled.
- At the June 2016 Committee meeting the Practice had noted that they had actively met and lobbied local bus services in order to change routes to ensure that those travelling from the Worthies could access services Weeke without having to change buses in the centre of Winchester. The Committee had also written to the Executive Member to discuss this issue, but to date Stagecoach, the primary operator of bus services in the City, had not agreed to introduce a new route or to change an existing route to take Kings Worthy patients to Weeke.

The Chairman moved to debate. Members discussed the issues relating to travel and transport to the Weeke site and agreed that it would be helpful to write to the Executive Member for Environment and Transport to understand if there were Community Infrastructure Levy funds available to support a travel plan for staff and patients travelling from the local geography to the Friarsgate Practice.

Members also agreed that in considering a future update on this item, further information on the demographics of the Kings Worthy patient group being discussed would be helpful, as well as details of the patient survey referred to in the presentation.

The Chairman moved to proceed to recommendations.

RESOLVED

That Members:

1. Note the evaluation update following the closure of the Kings Worthy branch of the Friarsgate Surgery, Winchester.

2. Request that the Chairman write to the Executive Member for Environment and Transport to suggest that work be undertaken in conjunction with Winchester City Council, in order to explore the feasibility of using Community Infrastructure Levy monies to support a plan for staff and patients travelling to the Friarsgate Practice in Weeke.

3. Request the following additional information:
   - Details of the GP patient survey results for the Friarsgate Practice, once available.
   - A breakdown of the demographics for the Kings Worthy population registered at the Friarsgate Practice.
   - A wider evaluation of the closure of the Kings Worthy branch surgery, in order to provide assurance that patients are able to access and receive appropriate pathways of care.

<u>Southern Health NHS Foundation Trust: Antelope House – update on urgent temporary closure of beds</u>

Representatives from Southern Health NHS Foundation Trust presented an update report on the urgent temporary closure of the Psychiatric Intensive Care Unit (PICU) located at Antelope House, Southampton (see report, Item 7 in the Minute Book).

Members were provided with a summary of the report. It was heard that the PICU was now open to admissions on a phased basis, but there still remained concerns in relation to the recruitment and retention of staff that the Trust remained focused on and committed to.

In response to questions, Members heard:
- The issue of staff retention in mental health services remained a significant issue, and particularly impacted Antelope House due to the complexity of the services it housed.
- The percentage of exit interviews completed was now significantly higher than when last reported to the Committee, with staff having the option to share feedback with senior officers and non-Line Managers if preferred. The data captured from these had helped to shape staff policy.
- Some staff who may have previously have left the Trust have managed to be retained due to greater flexibility with working locations.
- Success had been found by the Trust by upskilling current staff and enabling people to progress through the service by supporting them to access education and training.
- A number of non-registered roles had also been developed by the Trust aimed at supporting clinical staff in a number of specialties.
- There was an issue with mental health trusts poaching workers from each other, as well as the costs paid to agency workers, and to this end the Mental Health Alliance workstream of the STP would focus on staffing as a priority, following similar work undertaken in relation to social workers by the South East network of County Councils.
- The most recent National Staff Survey had shown general improvement across the board for the Trust, which was a reflection of the work undertaken to support and retain workers.

The Chairman moved to proceed to recommendations.

RESOLVED

That Members:

1. Note the progress by Southern Health NHS Foundation Trust to reopen the Hamtun Ward, Antelope House, and to recruit to staff vacancies.

2. Request a future update on staffing in six months' time.

188. **FRIMLEY SUSTAINABILITY AND TRANSFORMATION PLAN**

A representative from North East Hampshire and Farnham CCG attended to provided Members with an overview of the Frimley Sustainability and Transformation Plan (STP) and its delivery (see Item 8 in the Minute Book).

Members received a presentation which provided the background, challenges and work streams of the Frimley STP. The key work-streams and financial gaps were highlighted to Members, which required the NHS and partners to think differently and innovatively to meet these challenges.

In response to questions, Members heard:

- That work was beginning with local communities to better engage them on the STP and what it means for patients and the public. In North East Hampshire and Farnham, local delivery is being supported through eighty community ambassadors who are local patient and public representatives, of which 50 were currently active, who support us in our programmes of engagement and would be involved with the implementation of the work streams. Thought was being given on how to get as many people actively and appropriately involved in the work streams as possible, to give local people a voice in the Plan.
- The patient was at the centre of STP plans and this needed to be better communicated; the desire of the Plan was to get services right first time for patients, recognising that resources are limited and should be used in the most effective way possible.
- Currently the STP was in the 'process' phase, agreeing what the work streams look like in practice and how they will be delivered.
- There remained a significant amount of variation across the Frimley area for how pathways worked; part of the aim of the STP was to bring organisations together to share what works, both in terms of effectiveness and efficiency.
- Prevention was a key work stream of the Frimley STP, recognising that the cost of prevention was in most cases significantly less than treatment. An example of diabetes care was shared, which highlighted different approaches to this long-term condition.
- Local resilience work was taking place locally with GPs, balancing the demands of the public for access to primary care at a time that suits them, with the finances and limited staff resource of GP practices. Greater levels

of collaboration were being sought in the Frimley area in order to meet a move towards a 12-hours a day, 7 days a week offering to local people.
- The issues seen nationally with A&E attendances had impacted Frimley but they had managed to return to an above-95% statistic for those waiting less than four hours to be treated or admitted.
- The Government had recognised that STPs would require financial investment upfront. Currently, not all the investment lines had been clarified, although they were expected to be released incrementally.
- Partnership work between STPs was ongoing and Frimley was a close partner of the Hampshire and IOW footprint given their overlapping geographies, with representatives from each attending executive group meetings of the two Plans.

The Chairman noted that at the January 2017 meeting Members had discussed the possibility after the election of the HASC taking forward a specific working group on the STPs.

RESOLVED

That Members:

1. Add the ongoing scrutiny of the Frimley STP to the work programme.

2. Receive a further update on progress against the STP's work streams in six months' time.

189. **WORK PROGRAMME**

The Director of Transformation and Governance presented the Committee's work programme (see Item 9 in the Minute Book).

The following topics were suggested by Members as potential areas for scrutiny by the new administration:
- Scrutiny review of health scrutiny.
- An update on the use of Section 136 of the MHA.
- Nursing roles.
- Stoke services.
- Health service in Whitehill and Bordon.

RESOLVED:

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

Chairman, 20 June 2017

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HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Adult Social Care Select Committee
Date of Meeting:	20 June 2017
Report Title:	Issues Relating to the Planning, Provision and/or Operation of Health Services
Report From:	Director of Transformation & Governance

Contact: 01962 847336 / members.services@hants.gov.uk

1. Summary and Purpose

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

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

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

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

1.5. The recommendations included in this report support the Corporate Strategy aim of maximising wellbeing through the overview and scrutiny of health services in the Hampshire County Council area.

Topic	Relevant Bodies	Action Taken	Comment
Care Quality Commission (CQC) re-inspection of services Mazars report on 'deaths of people with a learning disability or mental health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015' *(Monitoring items)*	Southern Health NHS FT CCGs and partner organisations CQC	Follows on from original CQC report February 2015 (with re-inspections in January and September 2016), and Mazars report published in December 2015 and reviewed by HASC in February 2016. The HASC has monitored these items since this time – last reviewed September 2016. Southern Health's update report on these issues is attached as Appendix One. This document has four Appendices A – D.	The CQC's remit was, amongst others, to review the Trust's governance, particularly relating to identifying, reporting, monitoring, investigating and learning from incidents with a particular focus on deaths, and review how the Trust was implementing the action plan required by Monitor (now NHS Improvement) in light of the Mazars review.

Recommendations:

That Members:

a. Note the update from the Trust.

b. Request the outcomes of the most recent Care Quality Commission report on the Trust, once available.

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

d. Make any further recommendations as appropriate.

CORPORATE OR LEGAL INFORMATION:

Links to the Corporate Strategy

Hampshire safer and more secure for all:	yes
Corporate Improvement plan link number (if appropriate):	
Maximising well-being:	yes
Corporate Improvement plan link number (if appropriate):	
Enhancing our quality of place:	yes
Corporate Improvement plan link number (if appropriate):	

Section 100 D - Local Government Act 1972 - background documents

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

Document	Location
None	

IMPACT ASSESSMENTS:

1. Equality Duty

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

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

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

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

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

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

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

2 Impact on Crime and Disorder:

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

3 Climate Change:

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

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

No impacts have been identified.

Appendix One

Southern Health NHS
NHS Foundation Trust

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

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.

Fareham and Gosport, North Hampshire, South East Hampshire and West Hampshire Clinical Commissioning Groups all commission mental health and learning disability services from Southern Health. West Hampshire leads on behalf of the other Clinical Commissioning Groups for this contract.

The 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 as a result lifted the warning notice.

In March 2017 the CQC carried out a week long comprehensive inspection of mental health and learning disability services. The draft report is currently being finalised.

Mazars report: actions and progress (Appendix A)

Serious Incident Requiring Investigation (SIRI) process

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

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 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%, 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.

In order to ensure the effectiveness of the new measures put in place, methods of audit and assessment are currently taking place. An interim assessment into the quality of investigation reports has been carried out by Niche Grant Thornton, and has identified improvements in the narrative and context given in investigations but also highlights some areas where improvements could still be made. These reviews will be continuing with a final assessment report due to be delivered to the Trust Board in the Autumn.

Terms of reference have also been agreed for a project to evaluate the effectiveness of the SIRI investigation team, with initial feedback due to be reported by the end of June.

Patient and Family Engagement

- An Experience, Involvement and Partnership Strategy has been developed (as part of the wider Quality Improvement Strategy) and will soon be launched, to provide a greater focus and drive further improvements in how we engage patients, families and carers across the Trust.

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

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

CQC report: actions and progress (Appendix B)

During September 2016 the CQC undertook a follow up inspection across many of our sites, which resulted in the warning notice being lifted. A further week long inspection took place in March 2017 and we are currently reviewing the draft report for factual accuracy.

A weekly Quality and Improvement Planning and Delivery Group has been established to ensure that the action plans from the Mazars report and CQC inspections are closely monitored and updated. This works alongside the new project management approach to monitoring and reporting progress against the delivery plans has been set up, enabling the Trust to track pro gress much more efficiently.

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.

Estates improvements

The Ligature Manager, who was appointed early in 2016, developed site specific environmental work plans for all inpatient and community Learning Disability and Mental Health teams. This year she is working to review each one of these plans to ensure they are progressed and updated as necessary. A Sharepoint site has been created to provide a central location for all ligature risk assessment paperwork and advice, accessible for every member of staff in the Trust. Additional ligature training has been carried out, and a review of the mandatory training package is also underway.

All estates actions on the CQC action plans from the January 2016 and September 2016 inspections will have been completed by the end of this month. A Trust Environment Plan has been written, that includes a quality programme called ‘Back to the tools’ Launched in November 2016, this involves estates staff going site visits, assessments and checks on a continuing basis, to identify maintenance issues and remedial work for completion. Over 200 actions have been created as a result, which is more than would have been identified using previous processes, and has improved working environments and patient areas. This has also improved staff relations for the estates teams.

Kingsley Ward in Melbury Lodge, Winchester, was closed in November 2017 to allow for planned modernisation of the environment, including redecoration of the ward, the removal of key walls to improve lighting and lines of sight, and some gardening work. Patients were moved for their comfort and safety, and the ward was reopened in March 2017. At Elmleigh in Fareham, more building work has taken place including ensuite bathrooms all refurbished and anti-climb guttering installed.

Quality Improvement Strategy

- Southern Health NHS Foundation Trust is currently reviewing and updating the Quality Improvement Strategy that was launched in 2016.
- 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 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 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 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 areas.
- 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.
- A new project will soon begin to appoint Quality Ambassadors across the Trust. The vision is to have one member of staff taking on this role within each team in the Trust, at Health Care Support Worker level, to ensure quality improvement is a focus at team meetings and during other discussions. These ambassadors will receive additional training in quality improvement methodology to allow them to identify actions and embed changes locally.

Staff engagement

We have continued to develop and implement a number of initiatives in place to support staff 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.
- A series of 'Your Voice' staff engagement events, aimed at promoting and evaluating the methods currently used for engagement, and exploring how effective these are in different areas of the Trust.
- The Trust website and intranet site are being separated and the intranet is being redesigned to make it more user friendly and increase accessibility. This project has been carried out using feedback from staff through surveys and workshops.
- The Team Brief monthly email newsletter that is circulated across the Trust has been updated and is now supported with a live briefing session led by Interim CEO Julie Dawes, open for all staff to attend or dial into as a conference call.
- 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.
- Our Interim CEO Julie Dawes sends a weekly email to the whole Trust, and has put in place a series of dedicated 'Listening Events' across the Trust aimed at discussing staff's views and concerns and answering questions.
- Using feedback from staff, the Trust values have been refreshed and the annual appraisal paperwork has been updated in line with these, to help staff feel more aligned to the aims of the organisation.

Leadership

We are continuing through a period of change within the leadership at Southern Health, in order to create a strong team to lead the Trust as it moves ahead with developments within the health service locally.

On 25 May Lynne Hunt was appointed as Chair of Southern Health. 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. Lynne will begin as Chair on Monday July 3.

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 will be 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 Plan.

The current leadership team at Southern Health:

- The Non-Executive Directors resigned their positions in April 2017, and recruitment will now begin for new candidates.
- The advert for a substantive Chief Executive Officer has been published and it is anticipated that interviews for this role will be held during the Summer.
- Sara Courtney continues to act up as Director of Nursing and AHPs whilst Julie Dawes fills the Chief Executive role.
- Chris Ash ??
- Gethin Hughes is going on a secondment and joining colleagues at Western Sussex Hospitals NHS Foundation Trust to support them as Director of Integrated care. Whilst Gethin is away, Paula Hull (Director of Nursing for the ISD) will be taking on elements of his role and helping support the business units.
- Dr Lesley Stevens is joining the Hampshire and Isle of Wight Sustainability and Transformation Plan as Chief Officer for Mental Health. Dr Sarah Constantine, Clinical Chair of the ISD (Integrated Service Division) will be stepping up into the role of Medical Director on an interim basis.

The future

Southern Health NHS Foundation Trust has now launched its Clinical Services Strategy; 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 in support of 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 a company called 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 (attached as Appendix D) 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.

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. These plans mark a turning point in the Trust's life and the opportunity to move forward in a different way from the past.

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Serious Incidents and Mortality Improvement Action Plan

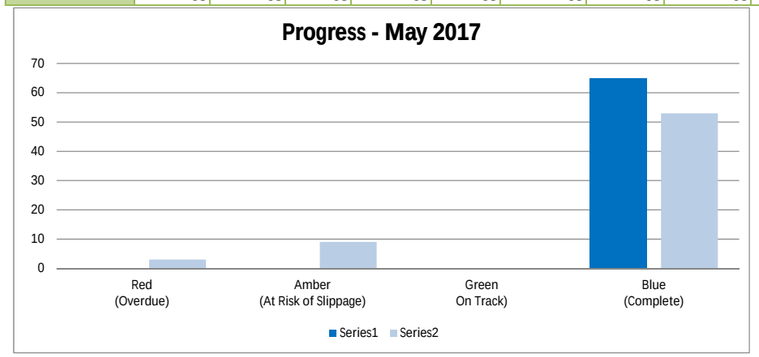
Version No 16.95

Date 31/05/2017

Leads Helen Ludford, Associate Director of Quality Governance
Briony Cooper, Programme Lead (Quality and Improvement Planning)

Completion 90%

RAG status	December		January		February		March		April		May		June	
	Process Input	Outcome Achieved	Process Input	Outcome Achieved	Process Input	Outcome Achieved	Process Input	Outcome Achieved	Process Input	Outcome Achieved	Process Input	Outcome Achieved	Process Input	Outcome Achieved
Red (Overdue)	3	4	3	1	0	1	0	4	0	4	0	3		
Amber (At Risk of Slippage)	0	0	0	0	0	0	0	9	0	9	0	9		
Green On Track)	7	28	7	32	8	32	0	0	0	0	0	0		
Blue (Complete)	55	33	55	32	57	32	65	52	65	52	65	53		
TOTAL	65	65	65	65	65	65	65	65	65	65	65	65		



NHS Southern Health NHS Foundation Trust

Change record

Date	Author	Version	Page	Reason for Change
27.04.17	B Cooper	v16.91	All	Set up change record and version number system
27.04.2017	B Cooper	v16.92	master pla	exception of spec services; 16.1 48 hour reporting onto StEIS target not met (36% in March); 18.7 Duty of
9.5.17	L. Connor	v16.93	All	5/5/17 Chased for updates, 9/5/17 . 11b physical health percentages added, 16 Childrens compliant,
25.5.17	Lconnor	V16.94	MP	Updated evidence on 9, 10, 11, 12, 16, 18.7, 18.9 for 26th May Evidence review panel
31.5.17	B Cooper	v16.95	All	18.7 changed from overdue to completed following evidence review panel

Theme	Mazars Recommendations	Process Completion Date	Process Status	Process Progress Evidence	Evidence of Outcome Achieved	Measuring Success Date	Recovery Date	Outcome Status	Progress Update	Outcome Measure
Thematic reviews	11. The Trust should provide staff with regular training and guidance to help them manage physical health conditions of long-term mental health service users. Diabetes management stands out as an area for greater awareness from a number of cases we reviewed.	31.07.16	**Complete**	Evidence required: Course content and learning outcomes (11.1a) Percentages of for the staff who have undertaken it by service (11.b) Attendance registers (11.1c)	Divisional and service level training records to 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	26.05.17 revised recovery date tbc	**Overdue**	11.1a Course content reviewed by the ADoNs from AMH and LEaD. Additional options being scoped alongside the 5 day course. Alternatives are physical health specialist subject sessions and e learning. Subject matter inclusive of diabetes and respiratory. 11.1b & c Training records being obtained by L Hartland LEaD. 04.08.16 Input evidence request made for information - meeting was held with ADoNs to discuss e learning and shorter course options October 2016: 5 day physical health course reviewed. The duration of the course does not make it a feasible option for inpatient staff. AMH, Specialised Services & LD Plan - Agreed all qualified nurses and HCSW's working in inpatient services will need to demonstrate competency in the following; - Physical Observations, - Track and Trigger Tool and SBAR(d), - Blood Glucose Monitoring . LEaD practice educators will assess the competency of senior nurses. Nurses achieving level 4 competency will then cascade assessments. LEaD will be introducing 3 skill buttons for the competencies on the training accounts of all staff in the target group on 25/10/16. Staff will be required to e-verify via the LEaD system when they have achieved each competency. All verifications will require manager authorisation. Target is for 80% of staff to be deemed competent in Track and Trigger and SBAR(d) by end of December 2016. Training/education is available via face to face or electronic delivery to support staff to acquire the knowledge and skills in physical health assessment and monitoring. LH meeting Kathy Jackson, Head of Nursing Inpatients (OPMH) 25/10/16. KJ is aware of this action. LH will present plan (as per action 11 above) to the ward managers at the meeting and arrange roll out of assessments for senior nurses. 11/10/16 A summary recovery plan was submitted by Steve Coopey for all actions: - 11.1a Discussions held with divisional leads to agree actions and attendance at physical health steering group commenced. Carole Adcock completed the review of 5 day physical health course. Divisional leads to agree actions following review, share work drafted on education pathway for registered staff and to confirm use of core physical health training workbook which supports competency assessment in practice. - 11.1b To agree which staff require core + additional training and confirm % targets trained in physical observations for mental health inpatients by 31.12.16 - 11.1c Louise to provide on-going attendance data on request or in line with agreed targets 17.10.16 11.a The risk related to physical health training in the MH inpatient units has been added to the divisional risk register (for MH) following discussion at AMH MOM in October 2016. Risk no.1100 - AMH - management of physical health care of service users. Risk states that currently the 5 day course is not attended and is being replaced with other training options. 20.10.16 11.1a Specialised Services have devised a project called improving access to physical health for the forensic patient; course developed - trainee advanced nurse practitioner masters pathway. 03.11.16 Further update re OPMH physical health course (CUSP) rolled out. 05.01.17 Update on 11.1d - Physical health assessment and monitoring policy now updated and circulated to the Resuscitation Committee for comments due back by 06.01.17. Task and finish group to be formed once the policy is agreed. A physical health strategy for AMH has also been drafted to ensure staff recognise and respond to patients' physical health needs, and work with service users in the community and look to reduce the incidence of premature mortality. Further update to be received from physical health task and finish group which will convene on 06.01.17	Evidence required: Course attendance records - site / service percentage (11.1b & 11.1c) - Saved 20feb17 data - T&T 87%, Phys obs 84%, Blood Gluc 81% March 2017 agreed that target training figure should be 90% trained. Results of the physical health audit of AMH sites (11.1a) 11.1a. physical health clinical audit report - MH (nov16). 11.1a nov16 audit results 93% - Helen Alger - full physical health review completed within 7 days of admission Audit of SI reports proving a reduction in physical health contributory factors (11.1a) Review of the published Physical Assessment and Monitoring Policy and Procedure for Mental Health and Learning Disability Services which includes a reference to diabetic monitoring (11.1d) AMH Physical Health Strategy (11.1d) Nov16 draft already saved.
Timeliness of Investigations	16. Reporting to StEIS should be undertaken within the 2 working days of notification as required by the national guidance.	30.06.16	**Complete**	Evidence obtained: Serious Incident Management Policies and Procedures rewritten (16.1a) Dashboard monitoring reporting to StEIS within 48 hrs (16.1a) 48 hour panel process (16.1b)	Timescale calculation - percentage of SI's reported on to StEIS within 48 hrs of reporting to be presented as a Key Performance Indicator on the dashboard. Please note that the timescale for measuring success is: (16.1a) 31.03.16 (16.1b) 30.06.16	31.03.16 30.06.16	30.06.17	**Overdue**	March 2017 : 16.1a Compliance to 48 hour reporting onto StEIS: 36% (Jul-16), 19% (Aug), 42% (Sep), 59% (Oct), 75% (Nov), 44% (Dec), 65% (Jan-17) 71% (Feb) 16.1b Compliance to 48 hour panels being held within 48 hours: 55% (Jul-16), 36% (Aug), 46% (Sep), 64% (Oct), 77% (INov) 67% (Dec) 78% (Jan) 71% (Feb-17) Levels of compliance with the mortality panels being held within 48 hours is monitored through Tableau on a daily basis and this is actively discussed at the MF. The compliance to the requirement to report onto StEIS withi 48 hours is monitored on a monthly basis and whilst improvement has been seen in the pressure ulcers, compliance to other serious incidents has deteriorated. It is recommended that this action remains red until indicators have reached the required trajectory. Further discussed at QIP Delivery Group the need for divisions to telephone the central SI team at end of 48 hour panel so can put any SI onto STEIS within deadline. Need to continue to monitor. A recovery date for this action has been set for June 2017. 27.04.17 16.1a Compliance to 48 hour reporting onto StEIS: 36% (Jul-16), 19% (Aug), 42% (Sep), 59% (Oct), 75% (Nov), 44% (Dec), 65% (Jan-17) 71% (Feb) 36% (Mar) 16.1b Compliance to 48 hour panels being held within 48 hours: 55% (Jul-16), 36% (Aug), 46% (Sep), 64% (Oct), 77% (INov) 67% (Dec) 78% (Jan) 71% (Feb-17) 82% (Mar) 48 hour panel guidance for ISD been amended to highlight that panel needs to call central SI team if decided that incident is SI. Performance discussed at QIPDG on 25.04.17 with ISD flowcharts/guidance shared for MH division to use if helpful. 5.5.17 Chased for status - Kay and Divisional leads / Requested summary recovery plan - Liz Taylor 8/5/17. We have not breached this in children and Families and are within compliance for reporting - updated divisional leads AMH was Mary Kloer - now David Kingdon, ISD Was Peter Hockey now Rachel Anderson. 25/5/17 evidence review panel - target not met. A change in process has ocurred with SI team attending/linking into 48 hour divisional panels to get immediate update re decision making re whether incident is SI.	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)
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)	31.10.16	**Complete**	Evidence required: Record keeping procedure stipulating the responsibility (18.9a) Serious Incident procedure (18.9b)	An informatics report will provide a base of line of recorded next of kin details which can be improved through a targeted unit based communications and monitoring supported by the record keeping group.	31.10.16	30/09/2017	**Overdue**	04.08.16 New action to address the lack of next of kin details for some patient / service users. 06.09.16 Specialised Services - maintained on Rio- Next of Kin, on details where available (18.9a) 09.10.16 (18.9a and 18.9b due 31 October) showing 80% of patient records have a next of kin listed and SI investigations where next of kin details have been obtained through an alternative means Recommendation – Action to remain red until required trajectory is achieved. Currently discussions are progressing whether the Next of Kin field in Rio could be changed to a mandatory field. 05.01.17 100% (24/24) involvement of families/next of kin in serious incidents. 100% trajectory achieved since October 2016: - Oct 100% (15/15) - Nov 100% (10/10) - Dec 100% 24/24) Outcome status changed from overdue (red) to on track (green). Continue monitoring status of the action until 31 March 2017 and ensure that the process has been embedded. 15.03.17 record keeping guidance in place. Next of kin not always being recorded - new tableau report showing % with N of K recorded - 80% not met therefore changed to red. There is evidence that Nof K information is sought from other sources e.g. coroner (18.9b). 27.04.17 100% compliance with families or next of kin being involved in SI where possible: -Jan 100% 24/24 - Feb 100% 16/16 -Mar 100% 30/30 Tableau report as at 27.04.17 shows that 80% target of next of kin or other relationship being recorded not yet met. AMH 64.9% LD 87.6% ISD physical health 59.5% ISD OP therapy 38.5% OPMH Community 76.7% **5.5.17** Requested summary recovery plan from Divisional owners (Not LD)	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)

CQC Improvement Action Plan - Inspection September 2016

Version No	3.6
Date	02/06/2017
Leads	Sara Courtney, Chief Nurse Tracey McKenzie, Head of Compliance and Assurance Mehreen Arshad, Programme Lead (PMO - Quality and Improvement Planning) Briony Cooper. Programme Manager (PMO- Quality and Improvement Planning)

CQC September 2016 Action Plan Dashboard

Completion	**62%**

Action Plan Position Status

RAG status	Dec	Jan	Feb	Mar	Apr	May	June
Overdue	0	2	0	2	2	1	
At risk of Slippage	0	0	0	0	1	0	
On track	17	15	16	9	5	4	
Complete	0	0	0	5	5	23	
Unvalidated	20	20	21	21	24	9	
TOTAL	37	37	37	37	37	37	0

Assurance and Validation Process

	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Unvalidated	7	5	3	3	0	1	1
Validated	0	0	0	0	0	0	4

	Apr	May	Jun	Jul	Aug	Sep	Oct
Unvalidated	5						
Validated	2						

Version Control

NHS Southern Health NHS Foundation Trust

Change record

Date	Author	Version	Page	Reason for Change
19.4.17	L Connor	V3.1	All	Set up change record and version number system
27.04.17	B Cooper	v3.1	IP	41.8 bathrooms Parklands - changed to at risk of slippage. 42.6 and 42.7 anti roll guttering Elmleigh at risk of not meeting recovery date 30/05/17.
5.5.17	Lconnor	V3.2	all	Chased for update on over due, at risk and unvalidated actions.
12.05.17	B Cooper	v3.3	IP	guttering completed - changed from overdue to complete-unvalidated; 41.8 Parklands bathrooms should be completed by May 18th and so changed to on track from risk of slippage; 43.3 updated
18.5/17	I Connor	V3.4	All	42.6 building work complete-unvalidated. Added evidence to 41.4, 44.1, 45.2.
02.06.17	B Cooper	v3.5	All	41.8 building works completed - change to complete-unvalidated; 42.3 changed form on track to overdue with recovery date 16/06/17.

UIN	Trust Action	Completion Date	Action Status	Recovery date	Progress Update	Evidence	Executive Validation
RN043 43.1	Fully deliver and embed all the actions from the January 2016 CQC inspection and the Mortality & Serious Incident Action plan. In addition to include:	30/09/2017	On Track	n/a			
RN043 43.2	INTERNAL REVIEW: Embedment of the new committee structure for quality governance	30/06/2017	On Track	n/a			
RN043 43.3	EXTERNAL REVIEW: Well-led review carried out by NHSI in Q4 2016/17 or Q1 2017/18 (tbc by NHSI)	30/06/2017	On Track	n/a	09/5/17: Discussed at QIPDG, SC stated External well-led review was not carried out by NHSI and it was thought that CQC inspection would be a focused Well Led inspection. However, although CQC inspection in March 17 had some well-led elements, it was not a Well Led focused inspection. Expect it will form part of the comprehensive CQC review in Q4 2017-18.		
RN043 43.4	EXTERNAL REVIEW: Niche / Grant Thornton Phase 2 review and testing of Mortality & Serious Incident Action plan	31/08/2017	On Track	n/a	07 April 2017: Niche gave initial feedback on phase 2 testing and overall felt good progress being made and could see significant improvements in Board visibility and culture. Had yet to look at all evidence and will ask for additional evidence as original request did not include everything required for assurance.		

actioned 28april1

UIN	Ref No	Requirement Notice?	CQC Domain	Core Service	Location	Theme	CQC Action	Regulation Breached	Cause of Regulation Breach	Trust Action	Executive Accountability
RN043 43.1	43	REQUIREMENT NOTICE	WELL-LED	n/a	Trust-wide	Governance processes	The trust must continue to review and embed more effective governance systems to ensure effective monitoring of quality and safety	Regulation 17 HSCA (RA) Regulations 2014 Good governance	Whilst a number of new processes had been introduced and strengthened, the trust had not embedded systems and processes to ensure quality and safety of services.	Fully deliver and embed all the actions from the January 2016 CQC inspection and the Mortality & Serious Incident Action plan. In addition to include:	Sara Courtney - Interim Chief Nurse
RN043 43.2										INTERNAL REVIEW: Embedment of the new committee structure for quality governance	
RN043 43.3										EXTERNAL REVIEW: Well-led review carried out by NHSI in Q4 2016/17 or Q1 2017/18 (tbc by NHSI)	Paul Streat, Director of Corporate Governance
RN043 43.4										EXTERNAL REVIEW: Niche / Grant Thornton Phase 2 review and testing of Mortality & Serious Incident Action plan	Sara Courtney - Interim Chief Nurse

UIN	Ref No	Requirement Notice?	CQC Domain	Core Service	Location	Theme	CQC Action	Regulation Breached	Cause of Regulation Breach	Trust Action	Executive Accountability	Month	Evidence of Action Completed	Outcome Measure
RN039 39.1	39	REQUIREMENT NOTICE	SAFE	n/a	All inspected	Documentation & Record Keeping	The trust must ensure better consistency in relation to the quality and detail of risk assessments across the wards	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Reg 12(1)(2)(a)12(2)(d)12(2)(c)	There was inconsistency in the quality and detail of risk assessments across the wards	All patients, where environmental risks have been identified, will have an environmental safety plan recorded within RiO. This will record the mitigations for the risks identified with their risk assessment.	Mark Morgan - Operational Director	Jan-17	AMH Environmental meeting minutes Acute Care Forum minutes Review of safety plans within RiO	Risk assessments that are up to date and evidence that that are reviewed following incidents.
RN039 39.2					Elmleigh					The use of MDT care plans will be standardised across all AMH units and wards through the work carried out by the task and Finish Group, established via the Acute Care Forum.		Apr-17	Discussion will be evidenced in the minutes of the ACP Forum	
RN039 39.3										Elmleigh Ward Managers will review each individual's risk assessment on RiO to ensure that, where appropriate, the mitigations for environmental risks are clearly recorded within the patient's record.		Jan-17	Environmental risks mitigations are recorded within RiO- evidence provided via AMH CQC minutes	
RN040 40.1	40	REQUIREMENT NOTICE	SAFE	Forensic inpatient / secure	Ravenswood House	Documentation & Record Keeping	The trust must ensure that staff at Ravenswood House review risk assessments regularly and following incidents.	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Reg 12(1)(2)(a)12(2)(d)12(2)(c)	The risk assessments at Ravenswood House were not reviewed and updated following incidents.	Carry out a review of all HCR20s and rectify any breaches	Mark Morgan - Operational Director	Nov-16	Up to date HCR20s	Risk assessments that are up to date and evidence that that are reviewed following incidents.
RN040 40.2										NHSE to carry out external review of HCR20s		Nov-16	Up to date HCR20s	
RN040 40.3										Conduct audit by reviewing all risk assessments, RiO summaries and progress notes		Sep-16	Audit results showing full compliance	
RN040 40.3										Communicate to all staff the importance of updating risk assessments in light of risk incidents		Sep-16	copy of staff briefing minutes of team meetings	
RN041 41.1	41	REQUIREMENT NOTICE	SAFE	Forensic inpatient / secure	Ravenswood House	Environmental	The trust must complete plans to improve and make safe the range of environments across the mental health and learning disabilities services in line with its estates improvement plan.	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Reg 12(1)(2)(a)12(2)(d)12(2)(c)	The premises at several locations, identified in this report, were subject to plans to improve and make them safe. This work had not yet been completed	The service to be placed in derogation by the commissioners due to Medium Secure Standards in relation to the perimeter fence not being met.	Mark Morgan - Operational Director	Sep-16	Copy of Derogation Notice from the commissioners	Safe environment
RN041 41.2										The Estates Department to produce options and costings for fencing for the service to consider		Dec-16	Fencing option paperwork	
RN041 41.3										Due to the perimeter fence all leave in the grounds will now be classed as community leave via section 17 and will be approved by the MOJ where required.		Sep-16	Section 17 leave records	
RN041 41.3--->41.4										Review daily perimeter check log back to May 2016 to identify gaps. All relevant staff will be reminded of their requirement to complete the log on a daily basis. Additionally, individual staff who were present on the days of the missed sign off will also be spoken to.		Oct-16	Team meeting minutes Audit data	
RN041 41.3-->41.5				Adult mental health rehab	Forest Lodge					Carry out remedial paintwork on ceilings to address immediate concerns prior to full works being completed		Apr-17	Completed works, signed off by service	
RN041 41.4-->41.6										Full refurbishment of the communal bathrooms to be undertaken as part of wider refurbishment work at Forest Lodge. A 12week refurbishment programme of work is starting on 3 January 2017 and due to be completed in April 2017. The bathroom refurbishment will include the ceiling repair as well as addressing the current mechanical ventilation issues, which are causing condensation.		Apr-17	Completed works, signed off by service	
RN041 41.5--41.7				Acute mental health inpatients	Parklands					The maintenance issues in the en-suite bathroom to be addressed immediately. This includes replacing the cistern, some pipework and the damaged wall panelling, as well as full deep clean. The bathroom will be reopened by 14th October 2016.		Oct-16	Completed works, signed off by service	
RN041 41.5-->41.8										Bathrooms will be fully refurbished as part of a wider refurbishment programme in Parklands Hospital. The works are due to start in January, and they have been programmed to focus on bathrooms first, with completion anticipated by the end of March, however this may run into April. The rest of the works should be completed by the end of May.		May-17	Completed works, signed off by service	
RN042 42.1	42	REQUIREMENT NOTICE	SAFE	Acute wards for adults of working age and psychiatric intensive care units	Elmleigh	Environmental	The trust must review the risks identified at Elmleigh in relation to lack of action following incidents, poor lines of sight, multiple ligature risks, safe management of mixed gender areas, risks from patients absconding and ineffective staffing arrangements.	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Reg 12(1)(2)(a)12(2)(d)12(2)(c)	The premises at several locations, identified in this report, were subject to plans to improve and make them safe. This work had not yet been completed	POOR LINES OF SIGHT: Parabolic Mirrors and CCTV to be installed to increase visability Any remaining gaps in visibility will be mitigated via nursing risk assessment or other methods, as appropriate	Mark Morgan - Operational Director	Feb-17	Mirrors and CCTV in place to increase visibility	Safe environment
RN042 42.2										POOR LINES OF SIGHT: The risks are being mitigated by risk assessment of the individual patients. This is reviewed every time there is a change in patient's need/ presentation and reflected within the patient's RiO record. Observation levels may be increased in order for staff to monitor more frequently their mental state and risk to self and others. Additionally, staff may be allocated to the central observation area (at the top of the T) so that they have patient's bedrooms and main ward corridor in their line of sight.		Sep-16	Up to date risk assessments on RiO	
RN042 42.3										LIGATURE RISKS: Replacement programme of Elmleigh Green Bay windows has been identified as phase 1 priority to reduce the ligature points. The windows in the other bedrooms are being replaced in phase 2. The works will be undertaken March to May 2017		May-17	New windows installed	

UIN	Ref No	Requirement Notice?	CQC Domain	Core Service	Location	Theme	CQC Action	Regulation Breached	Cause of Regulation Breach	Trust Action	Executive Accountability	Month	Evidence of Action Completed	Outcome Measure
RN042 42.4										LIGATURE RISKS: Suspended ceilings at Elmleigh to be reviewed for replacement. Quotes are being obtained at present and the use of Single Tender Waiver is being considered. The programme of work is then to be agreed as part of the capital bid for the unit.		tbc	Ceilings do not pose a risk to the patients	
RN042 42.5										Elmleigh Ward Managers review the each individual's risk assessment on RiO to ensure that, where appropriate, the mitigations for environmental risks are clearly recorded within the patient's record.		Oct-16	Environmental risks mitigations are recorded within RiO	
RN042 42.6										ABSOND RISK: Obtain the quote and fit anti roll guttering to the remaining two courtyards and anti roll guttering on all roof at rear of building which is patient accessible. The programme of work is yet to be confirmed.		Feb-17	Anti roll guttering fitted to the roof	
RN042 42.7										ABSOND RISK: Obtain the quote and fit anti roll guttering to the top of the fence in the blue bay. The programme of work is yet to be confirmed.		Feb-17	Anti roll guttering fitted to the fence	
RN042 42.8										ABSOND RISK: Remove the tree in the courtyard		Nov-16	Tree removed	
RN042 42.9										STAFFING LEVELS: When staffing numbers are low the following actions are completed by the ward to mitigate the risks: 1. Safer staffing is completed every morning which reviews the staffing levels, skills mix, acuity of the patients, availability of the PRISS team, this informs ward of staff deployment requirements, identifies the need to request urgent NHSP shifts etc. 2. Every day the ward reviews the staffing and acuity for next 48 hours and plans accordingly as above. 3. Staff training is cancelled if required to ensure safe staffing levels on the ward 4. Staff are moved from one bay to another to ensure adequate cover through the unit 5. If Registered Nurse staffing levels are low, HCSWS are over recruited to provide additional support to the Registered Nurse 6. Ward managers are supernumerary on the rota, when staffing levels are low, they become ward based and carry out clinical duties for the shift. 7. Band 6s who have management days are requested to complete clinical duties for the shift.		Sep-16	Safer staffing figures unit rota	
RN042 42.10										ACUITY & DEPENDENCY: audit is carried out every 6 months on all of our units to ensure the staffing levels are appropriate for the acuity and dependency of the patient group, in line with the safer staffing requirements.		Sep-16	Acuity and Dependency audit results	
RN043 43.1	**43**	**REQUIREMENT NOTICE**	**WELL-LED**	n/a	Trust-wide	Governance processes	The trust must continue to review and embed more effective governance systems to ensure effective monitoring of quality and safety	Regulation 17 HSCA (RA) Regulations 2014 Good governance	Whilst a number of new processes had been introduced and strengthened, the trust had not embedded systems and processes to ensure quality and safety of services.	Fully deliver and embed all the actions from the January 2016 CQC inspection and the Mortality & Serious Incident Action plan. In addition to include:	Sara Courtney - Interim Chief Nurse	n/a	Delivery of the outcomes as detailed within the two action plans	Robust governance processes are in place and evidence of embedding is being monitored
RN043 43.2										INTERNAL REVIEW: Embedment of the new committee structure for quality governance		Jun-17	Minutes of Safe, Effective & Caring group meetings Minutes of Quality & Safety Committee Board minutes	
RN043 43.3										EXTERNAL REVIEW: Well-led review carried out by NHSI in Q4 2016/17 or Q1 2017/18 (tbc by NHSI)	Paul Streat, Director of Corporate Governance	Jun-17	NHSI Well-led Review report	
RN043 43.4										EXTERNAL REVIEW: Niche / Grant Thornton Phase 2 review and testing of Mortality & Serious Incident Action plan	Sara Courtney - Interim Chief Nurse	Aug-17	Phase 2 report	
SD044 44.1	**44**	**Should**	**SAFE**	Child and Adolescent mental Health Wards	Bluebird House	Incident reporting	The trust should ensure the arrangements for agency staff to access the incident reporting system at the Bluebird Unit are embedded	n/a	n/a	Long standing agency workers in post at Bluebird House who have been working on the unit for over 6 months have access to the reporting systems. Additionally, there is a generic agency log-in account set up which enables staff to log on to the system and then they can create their own Ulysses account. Substantive staff should be made aware of this and this should be communicated to agency staff as part of their induction on to the ward	Mark Morgan Operational Director	Oct-16	Increased reporting from agency staff	All incidents are reported in a timely manner
SD045 45.1	**45**	**Should**	**SAFE**	n/a	Bluebird House	Staff engagement	The trust should engage staff to understand the actual extent and impact of staffing levels and mix across the older person`s mental health wards and Bluebird House.	n/a	n/a	Local QIP is in place to manage staffing and the vacancy rate has reduced. There have been new starters in September and another Band 6 started in the first week of October 2016. There are daily reviews of staffing by ward managers and band 6 staff to ensure that staffing is allocated to facilitate leave and escorts .All instances of leave cancellation are reported. There are no reports of observations not being completed as required.	Mark Morgan Operational Director	Oct-16	Daily staffing reviews and QIP minutes	Safe staffing levels

UIN	Ref No	Requirement Notice?	CQC Domain	Core Service	Location	Theme	CQC Action	Regulation Breached	Cause of Regulation Breach	Trust Action	Executive Accountability	Month	Evidence of Action Completed	Outcome Measure
SD045 45.2					OPMH wards					Recruitment plan has been drawn up with input from Head of Nursing & AHP, HR & Recruitment. New models of working have been worked up and costed. Letter from HoN sent to all OPMH staff September 2016 explaining what senior staff were doing about vacancies. Further comms sent to GWM staff December 2016 to futher improve engagement. There have been qualified new starters. An agreed plan to over recrut to HCSW in each OPMH ward has had some success in the organic wards. Further recruitment initiatives planned for hard to recruit to areas. Daily review of staffing with ward managers escalating challenges to Matrons & HoN where required. Recriutment/vacancies will be on QUIP plans where appropriate. Visits planned in Jan & Feb 2017 of Matrons & HoN to ward team meetings to engage staff further. Skill mix review taken place in GWM - engagement improved with staff.All incidents concerning staffing levels reported via Ulysses - escaltion will also have ocurred to mitigate risk. Qualified nursing vacancies on risk register.	Gethin Hughes Operational Director	Dec-16	Daily staffing reviews and QIP minutes. Team meeting minutes. Comms sent to staff. Risk register. Recruitment plan.	
SD046 46.1	**46**	**Should**	**WELL-LED**	n/a	Trust-wide	Staff engagement	The trust should continue to actively engage and meet with staff during this time of uncertainty change of leadership	n/a	n/a	Fully deliver and embed all the actions from the January 2016 CQC inspection relating to staff engagement. In addition:	Paul Streat, Director of Corporate Governance	n/a	Staff survey results Your Voice Feedback external visits by stakeholders	A workforce who feel valued, listened to and safe to raise concerns as well as empowered and able to generate new ideas and make decisions to implement positive changes
SD046 46.2										Recruit staff engagement expert to carry out review and gap analysis		Dec-16	Expert in post	
SD046 46.3										Launch staff engagement programme		Dec-16	Presentation of staff engagement phased approach	
SD047 47.1	**47**	**Should**	**SAFE**	n/a	AMH rehab	Patient acuity & dependency	The trust should ensure it monitors the changing requirements of patients that may be admitted to the rehabilitation and older person`s wards, to ensure that patient and staff safety is maintained within the environment.	n/a	n/a	An admission protocol will be written for service users who are temporarily transferred from the Acute Mental Health wards to AMH Rehabilitation units	Mark Morgan - Operational Director	Feb-17	Admission protocol will be in place	Safe environment for both patients and staff
SD047 47.2					OPMH					The Admission, Transfer & Discharge Protocol to be followed. Escalation Protocol to be written for patients who require transferring to other mental health units and for patients whose discharge required expediting.	Gethin Hughes - Operational Director	Feb-17	Escalation Protocol will be written, shared & available.	

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ACTION PLAN FOR REVIEW OF FAMILY INVOLVEMENT IN INVESTIGATIONS

NHS Southern Health NHS Foundation Trust

Version No 4.3 Discussed at Caring Group on 13/04/2017 with Sara Courtney confirming approval of plan

Date 02/06/2017

Produced by Dr Mayura Deshpande, Associate Medical Director (Quality, Governance & Patient Safety)
Paula Hull Deputy Director of Nursing & Allied Health Professionals
Mehreen Arshad, Programme Lead (Quality Governance)
Chris Woodfine, Interim Head of Patient Experience and Engagement Task and Finish Group Family Involvement

Version Control

NHS Southern Health NHS Foundation Trust

Change record

Date	Author	Version	Page	Reason for Change
16.5.17	B Cooper	V4.2	All	First version re monitoring of plan. Deadline dates for actions reviewed.
02.06.17	B Cooper	v4.3	All	Updated progress

ACTION PLAN FOR REVIEW OF FAMILY INVOLVEMENT IN INVESTIGATIONS

Completion 0%

RAG status	April		May		June		July	
	Process Input	Outcome Achieved	Process Input	Outcome Achieved	Process Input	Outcome Achieved	Process Input	Outcome Achieved
Red (Overdue)	0	0	0	0	0	0	0	0
Amber (At Risk of Slippage)	0	0	0	0	0	0	0	0
Green On Track)	11	3	17	3	0	0	0	0
Blue (Complete)	0	0	0	0	0	0	0	0
Complete-unvalidated	5	0	6	2	0	0	0	0
Total*	41	41	41	41	41	41	41	41

* there are 41 actions in total, however 2 actions are duplicated with action 1.1e covered by 2.5 and action 4.1 covered by actions 2.3 and 3.4.

UIN	Carolan Theme	Recommendation	Trust Actions	Process Input (measures)	Responsible Lead	Essential Partners	Executive Accountability	Process Completion Date	Process Status	Progress Update	Expected Outcome	Measuring Success Date (Outcome Completion)	Outcome Status	Outcome Measure	Evidence in folders (Process)	Evidence in folders (Outcome)
1.1a	Recognising that family involvement begins with the very first patient contact, and that it is critical to delivering effective healthcare services	1.1 Working with service users, patients, families and staff to identify, develop and implement best practice on engaging with families who have relatives who are accessing services provided by the Trust	1.1a The Trust will work with patients, service users and families to develop and implement best practice on engagement	1.1a Establishment of a Task and Finish Group for the Family Involvement Action Plan and the family first involvement group 1.1a Contacting and engaging with service users, families and staff to establish a network of stakeholders interested in working with the Trust 1.1 Identifying best practice of involvement and engagement of families	Chris Woodfine, Head of Patient Engagement and Experience	Carla Roadnight, Area Head of Nursing and AHPs Pam Sorensen, Engagement Advisor	Sara Courtney, Chief Nurse	30/04/2017	Completed-unvalidated	A Family first involvement group was formed in January and continues to meet on a monthly basis. There was a learning network in AMH Southampton to engage staff and hear their ideas. The Triangle of Care has been identified as a collection of best practice that will address issues expressed by families. April 2017 Experience, Involvement and Partnership Strategy developed with patient involvement - with comms dept for final version to be formatted. Implementation plan for strategy in place. Best practice guidance developed and circulated to staff. Task and finish group amended terms of reference so they can continue involvement with this plan. Family First Group continues to meet. Complaints working group had final meeting in April with a planned feedback in 6 m to show improvements made. May 2017 bi-monthly Task and finish group monitors plan.	Divisional champions and accountable leads will work with service users, patients and families to agree a set of principles to support a culture that truly values user involvement in physical and mental health teams.	30/04/2017	Completed-unvalidated	A plan that will be developed to ensure that there is a focus on culture which truly recognises the importance of family involvement from the outset.	1.1 Task and Finish Group ToR 1.2 Task and Finish Group Minutes/agendas 1.3 Family First Involvement Group ToR 1.4 Family First Minutes/agendas 10.02.17;06.03.17;31.03.17 1.5 Learning network event AMH 1.6 Best Practice for involvement and engagement of families. 1.7 Task and Finish Group amended ToR 1.8 Story Telling Toolkit (for staff) 1.9 Best practice guidance 2.0 Complaints Working Group T of R 2.1 Complaints working group minutes 06.12.16;07.02.17;14.03.17	1.1 Experience, Involvement and Partnership Strategy draft v7.1 2017/18 1.2 Strategy Implementation Plan 2017/18 1.3 Family Experience in Engagement agenda/minutes 25052017
1.1b	Recognising that family involvement begins with the very first patient contact, and that it is critical to delivering effective healthcare services	1.1 Working with service users, patients, families and staff to identify, develop and implement best practice on engaging with families who have relatives who are accessing services provided by the Trust	1.1b To put in place the enabling strategies to support the successful implementation of the Triangle of Care standards	To launch enabling strategies: 1.1b Carer involvement in developing and co-producing plans and actions as described in actions 1.1 1.1b Creating a communications plan 1.1b Refine/adapt HR processes to support alignment of family involvement to clinical practice e.g. job descriptions, objectives, appraisals, clinical supervision and pre and post qualification training	Chris Woodfine, Head of Patient Experience and Engagement Emma McKinney, Head of Communications Graeme Armitage, Interim Head of HR	Sarah Cole, Family Therapist Specialised Services	Sara Courtney, Chief Nurse	30/09/2017	On Track	April 2017 Experience, Involvement and Partnership self assessment for clinical services to complete presented at April PT Exp workstream meeting. May 2017 Quality Account priorities include objectives on care planning - use same evidence. CW meeting JR in comms on 7.6.17 to develop communication plan. CW meeting with F & G CCG to explore carers event with PHT and CCG. 'Sharing information' workshop on 24.5.17 with service users/carers/families/staff - reviewed leaflet for sharing information and made recommendations for changes. Relationship with 3rd sector organisations eg "Carers together", "Carers in Southampton". Divisions have some mechanisms in place to talk with carers.	In the identification of best practice methodologies, there are a set of enabling strategies that need to be delivered.	30/04/2018		Co-produced plans which are coherent	1.1 Experience, Involvement and Partnership self assessment April 2017 1.2 examples of above 1.3 Sharing Information workshop agenda and materials 24.5.17 1.3 Sharing Information workshop facilitator notes 24.5.17	
1.1c	Recognising that family involvement begins with the very first patient contact, and that it is critical to delivering effective healthcare services	1.1 Working with service users, patients, families and staff to identify, develop and implement best practice on engaging with families who have relatives who are accessing services provided by the Trust	1.1c Phase 1: Ensure carers are identified at the first contact or as soon as possible thereafter	1.1c Co-produce a carer's charter/statement of principle that aligns with HCC development of a carers strategy 1.1c Develop guidance and training for staff to enable high levels of care planning skill within staff groups, including the importance of involvement of families and service users	Pam Sorensen, Engagement Advisor(now left) Records Keeping and Care Planning work stream (Paula Hull)	Chris Woodfine, Head of Patient Experience and Engagement External carer groups Hampshire County Council MH/LD/SS	Sara Courtney, Chief Nurse	30/06/2017	On Track	Guiding principled being drafted (March 2017) following joint work with 'Carers Together'. Draft to be shared more broadly for comment etc. On track to meet June 2017 date. April 2017 Carers Charter in draft format attached. May 2017 Training programme for staff in care planning reviewed with revised programme in development; guidance for staff on expected record keeping standards in development. Clinical audits for holistic assessment and care planning will be repeated this year. Clinical reference cards with top tips on record keeping being printed for clinical staff. Patient Exp workstream to draft principles for patients/engagement in general to complement the guiding principles for carers. Aim to have core principles for any involvement whether patient/carer etc. SJ, Head of Essential Training, reviewing the training portfolio to see how family involvement currently reflected in training and then to look at how to weave principles of family involvement in all relevant training.	Staff understand what is expected of them with regards to family involvement; Equally, families understand what to expect from our services	30/04/2018		Staff understand what is expected of them with regards to family involvement; Equally, families understand what to expect from our services	1.1c Carers Charter draft v3 1.2 Families First minutes 31.03.17 1.3 Record keeping and care planning minutes 1.4 QIPDG minutes section 6.6 23052017	1.1 Experience, Involvement and Partnership self assessment April 2017 1.2 examples of above
1.1d	Recognising that family involvement begins with the very first patient contact, and that it is critical to delivering effective healthcare services	1.1 Working with service users, patients, families and staff to identify, develop and implement best practice on engaging with families who have relatives who are accessing services provided by the Trust	1.1d Phase2: Ensure staff are carer aware and trained in carer engagement strategies	1.1d Run staff and carer events and forums to encourage development of practice	Heads of Nursing and AHPs		Sara Courtney, Chief Nurse	30/04/2018		May 2017 Quality Conference Oct 2017 will have family/carer involvement.	Divisional champions and accountable leads will work with service users, patients and families to encourage development of practice	30/04/2018		Divisional champions and accountable leads will work with service users, patients and families to encourage development of practice		
1.1e	Recognising that family involvement begins with the very first patient contact, and that it is critical to delivering effective healthcare services	1.1 Working with service users, patients, families and staff to identify, develop and implement best practice on engaging with families who have relatives who are accessing services provided by the Trust	1.1e Phase 3: Ensure that the Trust strategy on engagement is linked to the staff engagement strategy	1.1e Develop policy and practice protocols on confidentiality and information sharing (covered under action 2.5)												
1.1f	Recognising that family involvement begins with the very first patient contact, and that it is critical to delivering effective healthcare services	1.1 Working with service users, patients, families and staff to identify, develop and implement best practice on engaging with families who have relatives who are accessing services provided by the Trust	1.1f Phase 4:Ensure families/carers have an introduction to the service and staff, with a relevant range of information across the care pathway	1.1f Co-produce an information leaflet for family with service and care co-ordinator contact information	Carla Roadnight, Area Head of Nursing and AHP	Carer groups	Sara Courtney, Chief Nurse	30/08/2017		May 2017 CW to speak to MF who has developed leaflet for her team and discuss whether can be replicated across AMH.	Families know who to contact if they have any questions	28/02/2018		Families know who to contact if they have any questions		
1.1g	Recognising that family involvement begins with the very first patient contact, and that it is critical to delivering effective healthcare services	1.1 Working with service users, patients, families and staff to identify, develop and implement best practice on engaging with families who have relatives who are accessing services provided by the Trust	1.1g Phase 5: Develop a range of carer support services or covering all the key points on the care pathway	1.1g Map out the key points of the care pathway 1.1g measures to be developed in later phase	tbc	tbc	tbc	tbc		tbc	Carers needs are assessed and support provided	tbc		Increased levels satisfaction on patient experience survey question and AMH carer survey		
1.1h	Recognising that family involvement begins with the very first patient contact, and that it is critical to delivering effective healthcare services	1.1 Working with service users, patients, families and staff to identify, develop and implement best practice on engaging with families who have relatives who are accessing services provided by the Trust	1.1h Phase 6: Develop defined posts responsible for carers	1.1g Map out the key points of the care pathway 1.1g measures to be developed in later phase	tbc	tbc	tbc	tbc		tbc	Within services there is a local lead/champion	tbc		Within services there is a local lead/champion		
2.1a	Improving the way the Trust communicates and engages with families	2.1 Ensuring that policy, guidance and procedure related to investigations recognises and supports the iterative process of family engagement	The Trust will improve the way communication and engagement is undertaken with families ensuring that there is a recognition of the process of family engagement within the policies and guidance in relation to investigations by: 2.1a Conducting a review of the policies and procedures related to SIRI and complaint investigations to ensure that they are informed by the same principles of engagement with families	2.1a Undertake a review of all policies and procedures relating to SIRI and complaint investigations with input from front-line clinical staff 2.1a Update policies and procedures pertaining to SIRI and complaint investigations which include the elements of engagement with families as principles	Helen Ludford, Associate Director of Quality Governance Paula Hull, Divisional Director of Nursing & AHP (ISD)	Complaints Working Group Family First Involvement Group Mortality Forum	Sara Courtney, Chief Nurse	31/07/2017	On Track	January 2017 The SIRI policy and procedure has been reviewed with input from the Family First Involvement Group. Version control tables in policy/procedures show their input. March 2017 Complaints working group reviewed the complaints policy. The policy is to be reviewed by July 2017. May 2017 The SI policy will be reviewed again once national guidance issued. Complaints policy review underway.	All Trust policies and procedures relating to investigations are aligned to ensure that communication with families is meaningful.	30/09/2017	On Track	Involvement of families' in the review of the SIRI policy and procedure and complaints policy, as identified by the reviewers/contributors within the policies.	1.1 Family First Involvement meeting minutes (Jan 2017). 1.2 Complaints working group minutes (Feb 2017).	1.1 Policy for Managing Incidents and Serious Incidents 1.2 Procedure for the Reporting and Management of Serious Incidents 1.3 revised complaints policy
2.1b	Improving the way the Trust communicates and engages with families	2.1 Ensuring that policy, guidance and procedure related to investigations recognises and supports the iterative process of family engagement	The Trust will improve the way communication and engagement is undertaken with families ensuring that there is a recognition of the process of family engagement within the policies and guidance in relation to investigations by: 2.1b Incorporating the principles of engagement with families to the admissions and discharge policy (including inclusion in crisis contingency care plan).	2.1b Update admissions and discharge policy to include the principles of family engagement (care planning, family communication and liaison)	John Stagg, Associate Director of Nursing & AHP (Learning Disabilities)		Sara Courtney, Chief Nurse	30/09/2017			All Trust policies and procedures relating to investigations are aligned to ensure that communication with families is meaningful.	30/09/2017		Involvement of families' in the review of Admissions discharge and transfer policy as identified by the reviewers/contributors within the policy.		
2.2a	Improving the way the Trust communicates and engages with families	2.2 Recognising that Duty of Candour is not the same as family engagement and ensuring that policy, guidance and procedure reflects this	2.2a Development of a Trust strategy for involving patients, families and the public with specific reference to families	2.2a Develop a Trust strategy on Experience, Involvement and Partnership	Chris Woodfine, Head of Patient Engagement and Experience	Pam Sorensen, Engagement Advisor	Sara Courtney, Chief Nurse	30/04/2017	Completed-unvalidated	March 2017 The Caring group received the final draft of the strategy and is due to be submitted to the QSC at the end of March for final sign-off. April 2017 slight amendment made to strategy and ready for launch. Implementation plan in place. May 2017 Strategy with comms team for final design prior to circulation.	There will be increased levels of involvement of patients and families in their own care and in the way the Trust develops and improves services.	30/04/2018		Compliance with the standards outlined in the overarching Trust strategy.	1.1 Experience, Involvement and Partnership Strategy draft v7.1 2017/18 1.2 Strategy Implementation Plan 2017/18	
2.2b	Improving the way the Trust communicates and engages with families	2.2 Recognising that Duty of Candour is not the same as family engagement and ensuring that policy, guidance and procedure reflects this	2.2b Trust to set the expectation that staff and services will engage with families as a matter of course from the point of first contact with the patient	2.2b All "My assessment of the patient" should include staff making contact with patient/service user's family)	Paula Hull, Divisional Director of Nursing & AHPs (ISD)	Record Keeping and Care Planning Workstreams	Sara Courtney, Chief Nurse	tbc		April 2017 An example of this is within the Children and families business unit who have developed a new template called 'My Plan' which will require a collaborative approach to care planning with parents. May 2017 CW meeting with PH in early July to discuss family involvement in care planning.	Better clinical outcomes and patient experience as well as reduced spend	tbc		Staff are directly involving families in care-planning.		
2.2c	Improving the way the Trust communicates and engages with families	2.2 Recognising that Duty of Candour is not the same as family engagement and ensuring that policy, guidance and procedure reflects this	2.2c Trust to ensure that staff and services are aware that Duty of Candour is about being honest when things have gone wrong (training of the duty of candour through providing an e-learning training package)	2.2c Develop an e-learning package (short session of 45 minutes) on "Being Open and Duty of Candour to ensure staff and services are aware of being honest when things have gone wrong 2.2c Duty of Candour module in the Investigating Officer training workshop 2.2c Masterclass on sharing findings of investigations	Helen Ludford, Associate Director of Quality Governance Elaine Ridley, Family Liaison Officer	Vicki Tinkler, Project Manager (LeAD) Tom Williams, Ulysses System Developer Nick Fennemore, Head of Chaplaincy, Spiritual & Pastoral Care	Sara Courtney, Chief Nurse	30/06/2017	Completed-unvalidated	10/04/17 Bulletin article launching e learning module for duty of candour. April 2017 duty of candour session in the Investigating Officer training has been up dated and is now given by the Family Liaison Officer. May 2017 Masterclass 'sharing investigation reports' developed by FLO and chaplain with two provisional dates set for training - 3.7.17 and 17.7.17.	Staff are aware of the difference between Duty of Candour and family engagement and there is a culture that fosters staff being open with families which also supports a "No Blame" culture	31/03/2018		Compliance with Duty of Candour as monitored through the SI and mortality KPI dashboard and audit of records	1.1 Bulletin article 1.2 E-learning programme 1.3 IO programme	1.1 SI KPI dashboard

2.2d	Improving the way the Trust communicates and engages with families	2.2 Recognising that Duty of Candour is not the same as family engagement and ensuring that policy, guidance and procedure reflects this	2.2d Review policy for Duty of Candour and ensure that it sits under the overarching position statement and ensure that this is interlinked to the complaints policy and the serious incident policy and procedure	2.2d Review the Being Open policy incorporating the legal Duty of Candour 2.2d Review the SI policy and procedure 2.2d Review the complaints policy 2.2d Review the safeguarding policy 2.2d Ensure all the above policies align.	Sarah Pearson, Head of Legal and Insurance Services, Chris Woodfine, Head of Patient Engagement and Experience Caz Maclean, Associate Director of Safeguarding	Complaints Working Group Patient Safety Group Family First Involvement Group	Sara Courtney, Chief Nurse	30/09/2017	On track	January 2017 The SI policy and procedure has been reviewed with input from the Family First Involvement Group . February 2017 The complaints working group reviewed the policy. March 2017 DoC Policy agreed through policy ratification group on17/03/17, uploaded to intranet 21/03/17, for sign of via Caring Group on 13/04/17. The documents that have been uploaded state that they are to go to Caring group in April but it was agreed that as changes largely minor it could be uploaded in the meantime. May 2017 Complaints policy under review. Safeguarding adult policy reviewed Feb 2017 and Safeguarding children policy reviewed March 2017. ? Family First group reviews these.	Staff are aware of the difference between Duty of Candour and family engagement and there is a culture that fosters staff being open with families which also supports a "No Blame" culture	31/12/2017		Staff are competent in applying the Duty of Candour readily and where appropriate; and there is a clear understanding amongst staff in the difference between family engagement/involvement and duty of candour	1.1 Family First Involvement meeting minutes (Jan 2017). 1.2 Complaints working group minutes (Feb 2017).	add policies
2.3a	Improving the way the Trust communicates and engages with families	2.3 Ensuring that steps taken to engaging families in investigations, and the results of those steps are recorded in the investigation report	2.3a The SIRI procedure should state that steps are to be taken to engage families and this should be documented	2.3a Review the SIRI procedure and add statement regarding the engagement of families'	Helen Ludford, Associate Director of Quality Governance	Family First Involvement Group	Sara Courtney, Chief Nurse	31/05/2017	Completed-unvalidated	Jan 2017 The SI policy and procedure have been reviewed - section 4.5 in procedure details the involvement of patients/ families/loved ones. Policy is to be reviewed again July 2017 following publication of new national SI Framework.	Staff are consistently documenting the involvement of families during/following an investigation	30/11/2017		Investigation and reports demonstrate involvement of families where families wish to be involved.	1.1 Policy for Managing Incidents and Serious Incidents 1.2 Procedure for the Reporting and Management of Serious Incidents	
2.3b	Improving the way the Trust communicates and engages with families	2.3 Ensuring that steps taken to engaging families in investigations, and the results of those steps are recorded in the investigation report	2.3b Consistent use of the CCG Quality checklist at the 48 Hour Panel and Corporate Panel as a reference guide	2.3b Add the use of the CCG Quality checklist as a reference guide at the 48 Hour Panel and the Corporate Panel in the SIRI reporting procedure	Helen Ludford, Associate Director of Quality Governance	SI Team Lead Investigating Officers Chair of the 48 Hour Panels	Sara Courtney, Chief Nurse	31/07/2017	On track	Jan 2017 SI policy and procedures reviewed. Appendix 11 contains the commissioner checklist. Use of this is at corporate panel is in section 9.2 of procedure. Si policy /procedure to be reviewed July 2017 following publication of new national SI Framework.	Staff are consistently documenting the involvement of families during/following an investigation	30/11/2017		All checklists demonstrate that families have been invited to contribute to the terms of reference		
2.3c	Improving the way the Trust communicates and engages with families	2.3 Ensuring that steps taken to engaging families in investigations, and the results of those steps are recorded in the investigation report	2.3c Review and modify the structure of the Ulysses to include specific headings to record any notes/detail on the steps taken to engage with families	2.3c Add consistent headings within Ulysses SIRI reports in family engagement	Helen Ludford, Associate Director of Quality Governance	Tom Williams, Ulysses System Developer	Sara Courtney, Chief Nurse	30/06/2017	On track	May 2017 BC discussed possible changes to headings with TW.	Staff are prompted to document the involvement of families during an investigation	31/08/2017		The Ulysses systems contains a section to document on the steps taken to engage with families		
2.3d	Improving the way the Trust communicates and engages with families	2.3 Ensuring that steps taken to engaging families in investigations, and the results of those steps are recorded in the investigation report	2.3d Add family engagement and its recording to SIRI training workshop	2.3d Add family engagement and its recording to SIRI training workshop	Helen Ludford, Associate Director of Quality Governance	n/a	Sara Courtney, Chief Nurse	31/05/2017	Completed-unvalidated	April 2017 Investigating Officer training has information and video on involvement of families, loved ones and patients. Training also has specific session on Duty of Candour. Feedback forms form training very positive with staff feeling better and knowledgeable about carrying out investigations.	Investigating Officers are trained on steps taken to engage families and how to record onto Ulysses	31/12/2017		Investigating Officers feel confident on engaging families in investigations	1.1 Investigating Officers 2 day training presentation. 1.2 Investigating Officers training - Duty of Candour presentation.	1.1 Feedback forms Oct 2016 1.2 Feedback forms April 2017 1.3 Feedback forms May 2017
2.4a	Improving the way the Trust communicates and engages with families	2.4 Co-producing with families a leaflet that can be sent to all families following a death that explains how investigations are conducted, how the families can get involved, and signposts families to appropriate support and advice	Families have said that written information is important, but that it should not be sent to families, but should be handed to them, following a discussion with the IO. 2.4a The Family Liaison officer will develop with families a leaflet that will be given by the IO as an aide memoire to their conversation with the family detailing the investigation process and signposting and support; this will form part of the suite of documents that sits within the SIRI procedure - with inclusion from the Family Reference Group.	2.4a Co-produce leaflet for families on the investigation process and support.	Elaine Ridley, Family Liaison Officer Helen Ludford, Associate Director of Quality Governance	Family First Involvement Group Chris Woodfine, Head of Engagement and Experience Investigating Officers	Sara Courtney, Chief Nurse	31/03/2017	Completed-unvalidated	March 2017 Leaflets have been developed with input from family workshops and the Family First Involvement Group and planned for publication by 31 March 2017. April 2017 leaflets printed - given to IOs on Investigating Officer training days.	Families feel involved in the investigation as they wish to be.	31/03/2017	Completed-unvalidated	Families understand how investigations will be conducted, how they can get involved and be signposted to appropriate support and advice	1.1 Leaflet for families on serious incident investigations.	1.1 Family Liaison Officer report
2.4b	Improving the way the Trust communicates and engages with families	2.4 Co-producing with families a leaflet that can be sent to all families following a death that explains how investigations are conducted, how the families can get involved, and signposts families to appropriate support and advice	2.4b Seek regular feedback from families regarding their experience of the investigation process	2.4b Undertake a quarterly survey of families' experience of the investigation process	Elaine Ridley, Family Liaison Officer Helen Ludford, Associate Director of Quality Governance	Family First Involvement Group Chris Woodfine, Head of Engagement and Experience Investigating Officers	Sara Courtney, Chief Nurse	31/12/2017	On Track	March 2017 The Family Liaison Officer sent 15 questionnaires to families involved in investigations of deaths of loved ones. ¾ questionnaires returned by date of report to Caring Group in March. Feedback positive re contact with IO and support given, however families say reports not easy to understand and unclear on what actions being taken by Trust. To repeat survey on quarterly basis. May 2017 ER completing quarterly surveys with families.	Families feel involved in the investigation as they wish to be.	30/04/2018	On track	Families report positive feedback in their involvement and support offered	1.1 Questionnaire appendix 1 Family Engagement FLO report 07/03/17 Caring Group. 1.2 Questionnaire appendix 1 Family Engagement FLO report June Caring Group.	1.1 Family Engagement FLO report 07/03/17 Caring Group 1.2 Family Engagement FLO report June Caring Group
2.5a	Improving the way the Trust communicates and engages with families	2.5 Improving the recording of next of kin data, including where consent to share has not been provided	2.5a Ensure that the Next of Kin section on Rio is made a mandatory field and the Change Control Board oversee a range of training and guidance to ensure that Next of Kin data is completed in all care records	2.5a Amend the Next of Kin section on Rio to ensure that this field is made mandatory 2.5a Embed review of training and guidance for Next of Kin data within the Change Control Board Terms of Reference 2.5a Devise a Trust procedure on what staff should do if there is no Next of Kin data included	Paula Hull, Divisional Director of Nursing & AHP (ISD)	Change Control Board Technology Transformation Team	Paula Anderson, Director of Finance Sara Courtney, Chief Nurse	31/10/2017	On track	May 2017 Performance on meeting next of kin recording has been added to Tableau and is monitored closely by divisions. Inconsistent performance with some teams very high % of next of kin details recorded while other teams have low %. Section 8.3 of openRio Standard Operating Procedure and section 8.2 of SyStmOne Standard Operating Procedure has instructions to staff on recording next of kin data. These are to be updated with clarification regarding recording information where there is no known next of kin or the patient declines to give next of kin details.	A strengthened process for Next of Kin recording is standardised across the Trust with staff understanding that this is a crucial aspect of clinical record-keeping and care planning.	31/10/2017		Next of kin recording is in place consistently across the Trust	1.1 OpenRio/SystmOne Standard Operating procedures re Next of kin	
2.5	Improving the way the Trust communicates and engages with families	2.5 Improving the recording of next of kin data, including where consent to share has not been provided	2.5b Ensure that the monitoring of next of kin recording is carried out	2.5b Data extraction from Tableau for reporting and remediation	Simon Beaumont, Head of Informatics	Divisional Records User Group	Paula Anderson, Director of Finance	31/10/2017	On track	May 2017 Performance on meeting next of kin recording has been added to Tableau and is monitored closely by divisions. Inconsistent performance with some teams very high % of next of kin details recorded while other teams have low %. Not yet meeting 80% target set by Trust across all divisions.	A strengthened process for Next of Kin monitoring is in place across the Trust	31/10/2017	Complete	A metric is developed on Tableau for monitoring next of kin data	1.1 screenshots of tableau	1.1. screenshots of tableau
2.5	Improving the way the Trust communicates and engages with families	2.5 Improving the recording of next of kin data, including where consent to share has not been provided	2.5c Co-produce guidance across the Trust for information sharing based on the consensus statement	2.5c Deliver a families workshop to understand their perspective on barriers to engage 2.5c Understanding the staff perspective on blocks to information sharing 2.5c Workshops involving family, service users and staff to develop guidance	Chris Woodfine, Head of Engagement and Experience	Lesley Barrington, Head of Information Governance MH division Sarah Cole, Family Therapist Specialised Services		31/10/2017	On track	A family workshop was delivered in January and February 2017 which were highlighted that information sharing was a primary issue The IG training resources now include the consensus statement on information sharing and suicide prevention. May 2017 'Confidentiality' workshop for staff in development. 24.5.17 Sharing Information workshop. Information governance team to rewrite information sharing leaflet based on feedback and reflecting what used by other trusts.	Staff are competent in managing confidentiality and information sharing with families	31/03/2018		RiO records show the judgements staff have made on information sharing when working with families and service users	1.1 Sharing Information workshop agenda/materials 24.5.17	
2.6a	Improving the way the Trust communicates and engages with families	2.6a Keeping families fully informed of the progress of the investigation and making this an explicit part of the Investigating Officer's role	2.6a Provide better training for Commissioning Managers as practice	2.6a Scoping of improved training for Commissioning Managers on the SIRI procedure which should be standardised across the Trust 2.6a Ensure roll out of improved training for Commissioning Managers 2.6a Undertake an audit of the findings om implementing improved training of Commissioning Mangers	Elaine Ridley, Family Liaison Officer Helen Ludford, Associate Director of Quality Governance		Sara Courtney, Chief Nurse	31/12/2017	On track	Jan 2017 Role of the IO and CM included within the revised SIRI procedure. Investigating officer and commissioning manager role descriptions reviewed and updated version added to the SIRI policy. May 2017 SI policy/procedures to be reviewed in July 2017 following new national SI Framework. More CM training planned.	There is clarity on the roles for the Investigating Officer, Commissioning Manager and Family Liaison Officer and that these roles have an appreciation of the importance of keeping families involved on the progress of the investigation	31/12/2017		Robust and clear descriptors and expectations of Trust staff roles who are involved in the investigation process	1.1 Policy for Managing Incidents and Serious Incidents 1.2 Procedure for the Reporting and Management of Serious Incidents	
2.6b	Improving the way the Trust communicates and engages with families	2.6b Keeping families fully informed of the progress of the investigation and making this an explicit part of the Investigating Officer's role	2.6b Ensure that the Investigating Officer and Commissioning Manager training gives clarity of their roles and responsibilities as well as the roles and responsibilities of the Family Liaison Officer role	2.6a Ensure the SIRI policy and procedure clearly outlines the roles of the Investigating Officer, Commissioning Manager and the Family Liaison Officer Remaining actions covered by 3.4	Helen Ludford, Associate Director of Quality Governance	Elaine Ridley, Family Liaison Officer	Sara Courtney, Chief Nurse	31/07/2017	On track	Jan 2017 Investigating officer and commissioning manager role descriptions reviewed and updated versions added to the SIRI policy. Need to add role description of Family Liaison Officer to revised policy. May 2017 Serious Incident Policy will be reviewed once national Serious Incident framework is published- to include job description of FLO.	There is clarity on the roles for the Investigating Officer, Commissioning Manager and Family Liaison Officer and that these roles have an appreciation of the importance of keeping families involved on the progress of the investigation	31/12/2017		Robust and clear descriptors and expectations of Trust staff roles who are involved in the investigation process		

2.7	Improving the way the Trust communicates and engages with families	2.7 Providing counselling (as appropriate) or signposting families to suitable organisations that can provide bereavement or post-traumatic stress counselling	The Trust accepts responsibility for the need to signpost to families relevant support and to be proactive in seeking support where it is not immediately available. 2.7a Increase awareness of the FLO role amongst staff and families.	2.7a FLO to attend governance and business meetings across divisions to raise awareness of her role and follow up after 6 months 2.7a Investigating Officer makes contact with the FLO via the IMA panel	Elaine Ridley, Family Liaison Officer	Investigating Officers	Sara Courtney, Chief Nurse	31/12/2017	On track	May 2017 FLO is regularly attending the Caring Group and makes contact with Investigating Officers and attends panels. FLO has attended some governance meetings in services and will continue to go out to teams.FLO is receiving referrals from IO.	FLO post is embedded within the Trust	30/06/2017	On track	FLO receives referrals from Investigating Officers in a timely manner	Caring group minutes	FLO reports
2.7	Improving the way the Trust communicates and engages with families	2.7 Providing counselling (as appropriate) or signposting families to suitable organisations that can provide bereavement or post-traumatic stress counselling	The Trust accepts responsibility for the need to signpost to families relevant support and to be proactive in seeking support where it is not immediately available. 2.7b FLO to identify the key resources that families may need access to	2.7b Family Liaison Officer to identify the key resources that families may need access to 2.7b FLO to develop a resource bank of community resources	Elaine Ridley, Family Liaison Officer	Third sector networks (external)	Sara Courtney, Chief Nurse	31/12/2017			Families receive information for support according to their needs	30/06/2018		The Trust has robust processes in place to ensure that families are provided with comprehensive information and resources regarding how an investigation is undertaken and signposts to appropriate support and advice		
2.8	Improving the way the Trust communicates and engages with families	2.8 Providing a central telephone number and email address for families so that they can contact the investigating team and not be reliant upon Investigating Officers who may have changed role or changed organisation	The Trust accepts the principle that families need to contact someone who is informed. 2.8a Commissioning Managers to create a communications plans with families at the outset and ensure that there is a proactive mechanism for advising families upon change of IO	2.8a Communication plans to be created including contact details of CM and IO Also covered under action 2.4a and 4.6a	Commissioning Managers	Investigating Officers	Sara Courtney, Chief Nurse	31/10/2017			Staff provide the right contact details to the families and that there are clear processes of handover when a staff member changes their role	31/12/2017		All investigations to have in place a communication plan with families		
3.1	Increasing the competency of staff to engage with families	3.1 Co-producing with families training for staff on engaging with families	3.1a Conduct a review of training for staff on the importance of engaging with families in investigations with input from the Family First Involvement Group.	3.1a Conduct a review of training for staff on the importance of engaging with families in investigations with input from the Family First Involvement Group. 3.1a Conduct a training needs analysis with IOs and CMs 3.1a Review of the training programme	Helen Ludford, Associate Director of Quality Governance	Chris Woodfine, Head of Engagement and Experience	Sara Courtney, Chief Nurse	31/10/2017	On track	May 2017 SJ, Head of Essential Training, reviewing the training portfolio to see how family involvement currently reflected in training and then to look at how to weave principles of family involvement in all relevant training.	Training for Investigating Officers and CMs are co-produced with families	31/12/2017		Training for Investigating Officers and CMs are co-produced with families		
3.2	Increasing the competency of staff to engage with families	3.2 Involving families in the delivery of training to staff, which can be achieved through co-delivery of the training, or through video or written case studies/testimonies.	3.2a The training content includes personal stories, videos, case studies/testimonies	3.2a Scope improved training programme including training content 3.2a The training content includes personal stories, videos, case studies/testimonies 3.2a Include and implement competency documents to assess fitness to practice and testing communication skills of staff training as well as best practice models	Elaine Ridley, Family Liaison Officer	Chris Woodfine, Head of Engagement and Experience Learning Education and Development (LEaD)	Sara Courtney, Chief Nurse	31/12/2017	On track	May 2017 CW to link with SC training lead who is undertaking a review of competencies staff require for care planning, risk assessment.	Training resources includes personal accounts of families	31/12/2017		Training resources includes personal accounts of families		
3.3	Increasing the competency of staff to engage with families	3.3 Increasing the amount of training on working with families offered to Investigating Officers as part of their core training	Training for Investigating Officers and also crucially for Commissioning Managers will align within the context of the Trust position statement on engaging with families following death of a service user 3.3a Deliver the training programme as defined by action 3.2	3.3a Training to be made available online or a folder resource 3.3a Ensure roll out of training programme through LEaD	Helen Ludford, Associate Director of Quality Governance	Learning, Education and Development (LEaD)	Sara Courtney, Chief Nurse	31/03/2018			Staff have a detailed resource on training for their roles as Commissioning Manager and Investigating Officer	30/06/2018		Undertake an audit on implementation of improved training for Commissioning Mangers and IOs		
3.4	Increasing the competency of staff to engage with families	3.4 Developing person specifications for the Investigating Officer role that includes the competencies needed for successfully engaging with families	Training for Investigating Officers and also crucially for Commissioning Managers will align within the context of the Trust position statement on engaging with families following death of a service user 3.4a Review the role description and person specification for the CM and IO role and develop specific competencies	3.4a Undertake a review job descriptions of the IO, CM and FLO 3.4a Ensure clarity of roles and responsibilities 3.4a Include competencies needed for successful engagement with families	Helen Ludford, Associate Director of Quality Governance	Associate Directors of Nursing & AHPs (all divisions)	Sara Courtney, Chief Nurse	31/07/2017	On track	May 2017 job descriptions reviewed.	IOs and CMs are clear about their roles and meet the person specification	31/07/2017		Robust and clear descriptors and expectations of Trust staff roles who are involved in the investigation process		
3.5	Increasing the competency of staff to engage with families	3.5 Providing clarity about the role of lead Investigating Officers in supporting Investigating Officers with the role	As covered in action 3.4. In addition: 3.5a To review the capacity of the central investigation team	3.5a To review the capacity of the central investigation team 3.5 Produce a business case following the review as appropriate	Helen Ludford, Associate Director of Quality Governance	SIRI team	Sara Courtney, Chief Nurse	30/06/2017	On track	May 2017 project to review investigating officer role underway - will look at capacity;training and feedback on the role.	There is clarity on the roles for the Investigating Officer, Commissioning Manager and Family Liaison Officer and that these roles have an appreciation of the importance of keeping families involved on the progress of the investigation	31/10/2017		Robust and clear descriptors and expectations of Trust staff roles who are involved in the investigation process	1.1 Investigating Officer Review terms of reference	
3.6	Increasing the competency of staff to engage with families	3.6 Providing peer support opportunities and administrative help for Investigating Officers	3.6a To assess the IOs need for supervision and support and devise a programme	3.6a Undertake an anonymised questionnaire survey and quantitative analysis of current lead Investigating Officers to ascertain their experience of role so far, and clarify what resources they may require 3.6a Commission Psychologists to review roles and conduct an analysis and feedback 3.6a Develop a peer support network of lead Investigating Officers 3.6a Scope a programme of psychological supervision for divisional investigating Officers	Helen Ludford, Associate Director of Quality Governance Hazel Nicholls, Clinical Director, Primary Care & IAPT	Lead IOs Divisional IOs	Sara Courtney, Chief Nurse	31/10/2017			Staff have a strong network of support and information sharing to enable their role competencies	31/12/2017		Staff have a strong network of support and information sharing to enable their role competencies		
4.1	Improving the quality of reports	4.1 Ensuring that investigators contact the families as soon as possible and that any concerns or questions that the family may have are incorporated into the terms of reference for the investigation	Covered under actions 2.3 and 3.4	Covered under actions 2.3 and 3.4												
4.2	Improving the quality of reports	4.2 Giving families access to findings of any investigation including interim findings.	4.2a Establish a protocol on sharing interim findings with families whilst maintaining factual accuracy and adhering to timescales	4.2a Establish a protocol on sharing interim findings with families whilst maintaining factual accuracy and adhering to timescales	Helen Ludford, Associate Director of Quality Governance	Elaine Ridley, Family Liaison Officer Families with experience of an investigation	Sara Courtney, Chief Nurse	30/09/2017			Reports are accurate and sensitive to the feelings of the families	31/12/2017		Reports are accurate and sensitive to the feelings of the families		
4.3	Improving the quality of reports	4.3 Giving families the opportunity to respond/comment on the findings and recommendations outlined in the final report and be assured that this will be considered as part of the quality assurance and closure process undertaken by the commissioners	4.3a Ensure that families are given the opportunity to comment on the findings and that this is a clear step in protocol	4.3a Ensure that families are given the opportunity to comment on the findings and that this is a clear step in protocol	Helen Ludford, Associate Director of Quality Governance	Investigating Officers	Sara Courtney, Chief Nurse	31/12/2017			Reports are accurate and sensitive to the feelings of the families	31/03/2018		Reports are accurate and sensitive to the feelings of the families		
4.4	Improving the quality of reports	4.4 Sharing updated action plans with the families six months after the report has been completed	4.4a Revise SIRI procedure to include the updated action plan to be shared with families subject to families agreement	As covered in action 2.1a and 2.3a. In addition: 4.4a Action planning with families to be monitored at the WAGs and MOMs 4.4a Revise the SIRI procedure to include that the IO should establish with families on an individual basis whether they would like to see the updated action plan	Helen Ludford, Associate Director of Quality Governance	Complaints Working Group Family First Involvement Group Mortality Forum	Sara Courtney, Chief Nurse	31/12/2017			Families are informed where they wish to be of progress made on agreed actions	31/12/2017		Families are informed where they wish to be of progress made on agreed actions		
4.5	Improving the quality of reports	4.5 Writing the report in plain English, avoiding jargon, or provide comprehensive glossary of terms and a list of abbreviations	4.5a Ensure that the reports are written in plain English, avoiding jargon, or provide comprehensive glossary of terms and a list of abbreviations	4.5a A new revised checklist to be incorporated into the Area and Trust Corporate Panels to including the criteria that all reports must be written in plain English 4.5a Each divisional SIR panels and corporate SIRI panel will have a lay member representative 4.5a Provision of a checklist for Ulysses, to ensure that the author includes a glossary 4.5a Develop training or resources for staff on report writing	Helen Ludford, Associate Director of Quality Governance	Associate Director of Nursing & AHPs (all divisions) Investigating Officers Tom Williams, Ulysses System Developer	Sara Courtney, Chief Nurse	31/12/2017		May 2017 quality of serious incident reports is being reviewed. Workshop on best practice in June 2017.	All reports are clear and easy to understand for families	30/06/2018		All reports are clear and easy to understand for families		
4.6	Improving the quality of reports	4.6 When families do not feel able to engage with the investigation immediately following the death of their loved one, ensuring that they have the opportunity to raise questions and concerns and input into the review at a time of their choosing	4.6a Ensure adherence to timescales of the 60 day limit whilst also ensuring that staff are aware that they should open the investigation at any stage/allow an opportunity for discussion with the families	As covered in action 2.8a. In addition: 4.6a Communications plan to include detail/note of family preference for timely contact 4.6a Ensuring that SIRI procedure details clear arrangement for point of contact following closure of an investigation	Investigating Officer		Sara Courtney, Chief Nurse	31/12/2017			Families are able to be involved at a time that is suitable to them	31/03/2018		Families are able to be involved at a time that is suitable to them		
4.7	Improving the quality of reports	4.7 Considering how the resulting improvements in services following changes recommended by investigations can be measured	4.7a Develop mechanisms for feedback from families to enable Trust to measure changes in involvement of families in investigations	4.7a Generate qualitative data from surveys and interviews with families to evidence families' involvement 4.7a Evidence of families attending the Improvement Panel to observe the improvements made as a result of the recommendations from the investigations 4.7a Inviting families to visit the service to illustrate the changes 4.7a Consider a review to be repeated in 2 years time to ascertain embedding of improvements	Elaine Ridley, Family Liaison Officer Helen Ludford, Associate Director of Quality Governance Associate Director of Nursing & AHPs (all divisions)	SIRI team	Sara Courtney, Chief Nurse	31/03/2018		May 2017 FLO is sending questionnaires to families for feedback. Results are included in reports to Caring Group.	Families are assured that the improvement within the services are embedding following the actions developed from the recommendations of the investigation have been completed	31/06/2018		Survey responses are positive and attendance levels of families at improvement panels	FLO reports	

Southern Health
NHS Foundation Trust

Mental Health and Learning Disabilities

Statement of Strategic Direction

March 2017

Contents

1 Executive Summary

This document sets out the strategic direction for the Mental Health and Learning Disabilities services provided by Southern Health NHS Foundation Trust that will ensure that the care service users receive is consistent, of high quality, responsive, and delivers improved outcomes.

In developing this, our starting point has been the insight and views of the people who use services, their families and carers, our staff, and the wider system. This has enabled us to understand what is needed from services and where there is room for improvement. This has not always made for easy listening, but an open and honest assessment of our services was necessary if we are to move forward and improve.

We have also drawn on best practice and from advice from an Expert Reference Group (ERG) convened specifically to support the development of this work, to ensure that the improvements we are proposing will improve the quality of care that our service users receive. Finally we have been informed by the national policy directives including the Five Year Forward View for mental health, and Building the Right Support for people with a learning disability.

Further details on the approach adopted in developing our strategic direction can be found in Chapter 4 – "Approach"; whilst an assessment of our starting point and the reasons for needing to make improvements can be found in Chapter 5 – "The starting point for this strategic direction".

Our service principles

Our staff have developed a set of core principles against which all our services will be developed and delivered. Chapter 6 – "Future Service Design Principles" sets these out in more detail, but in summary, we will:

provide **high quality, safe, person-centred** and **holistic** services which improve the health, wellbeing and independence of the people we serve;

deliver **needs-led services**, which are **timely, proactive** and **easy to access by all**, **24/7**;

have the **right people doing the right job**, taking ownership and pride in good communication;

adopt a **recovery-focused** approach, with a positive attitude to strengths, resilience and risk-taking, and which is adaptable to change; and

fully participate in strong partnership working to provide continuity across interfaces and transitions, supporting prevention and early intervention.

Our priorities

We have therefore identified the following key priorities to improve the services we provide and to deliver on these principles (further details can be found in Chapter 7 – "What does this mean in practice"):

- **People who use our services, their families and their carers will be actively involved and included** in the in the delivery and design of services. Our service users are experts by experience, and by working together to collaboratively lead on the design and delivery of services we will improve the services that we provide.
- We will **fundamentally improve access to services** to ensure that we are able to respond to all requests for help and to avoid people being 'bounced' around the system – adopting the ethos that a request for help is an opportunity to help. We will develop a single point of access (from a service user's point of view) that will be accessible to everyone (whether they are a service user, carer, GP, the police or a social worker) and regardless of the diagnosis, age or IQ of the service user.

- Linked to improving access, we will ensure that there is **robust and responsive support for people with urgent needs** by transforming the urgent care pathway, ensuring that resource is ring-fenced to provide robust alternatives to admission. Examples of this include ensuring that our hospital at home service has adequate resource to visit people at home multiple times per day, and exploring alternatives to provide support in the community, such as street triage.
- We will improve outcomes for those who use our services through the delivery of **needs-led, evidence based pathways** for functional mental illness, organic mental illness and learning disabilities. These pathways will provide purposeful, proactive support. They will link into local delivery systems of care. By mapping resource in this way we will also further develop specialist pathways that support some of our most vulnerable people.
- We will ensure that there is robust support to enable people to be cared for in the most appropriate setting, but where people require support in a hospital setting, we will deliver **consistent, purposeful inpatient care** around needs-led pathways. Our recovery ethos will be central to this – we will ensure that people only stay in hospital for as long as they need to by providing services such as in-reach from community teams.
- We will develop tertiary services to provide care across a complete pathway with pathways that are consistent across the trust. This will involve working with commissioners to develop new services such as low secure facilities for both adults and children, and resolving the physical environment issues within some of our adult forensic facilities.
- We will work with primary care and the local delivery systems to develop **primary care based mental health services** that keep people well, closer to home. We will continue to develop italk services (including italk for long term conditions and italk at work), and we will work with partners to identify any further opportunities to support people better in primary care.

Realising our ambition

These priorities represent a transformation of the services we provide that will require a significant shift in our culture. If we are successful in ensuring that we are a service user, carer and family centric organisation, we will be successful in delivering this strategy. Delivering truly person centred care will require a change in emphasis to ensure that the patient is at the heart of everything, and meaningfully engaged and included in our services.

Developing the culture to support this transformation also relies on our leadership. Strong leadership and governance will be crucial to the delivery of our priorities. By ensuring that our staff are empowered and supported to deliver change and having strong clinical and operational leadership in place, we will ensure that change sticks. This will include an emphasis on clinical leadership including earned autonomy, accompanied by clear accountability.

Working in partnership with our Service Users, their Families, Carers and staff, along with our commissioners, social care and voluntary sector colleagues will be critical to realising the service principles and improving outcomes for the users of our services. In addition, the way in which services map onto and integrate with local delivery systems and primary care will be vital to their effectiveness.

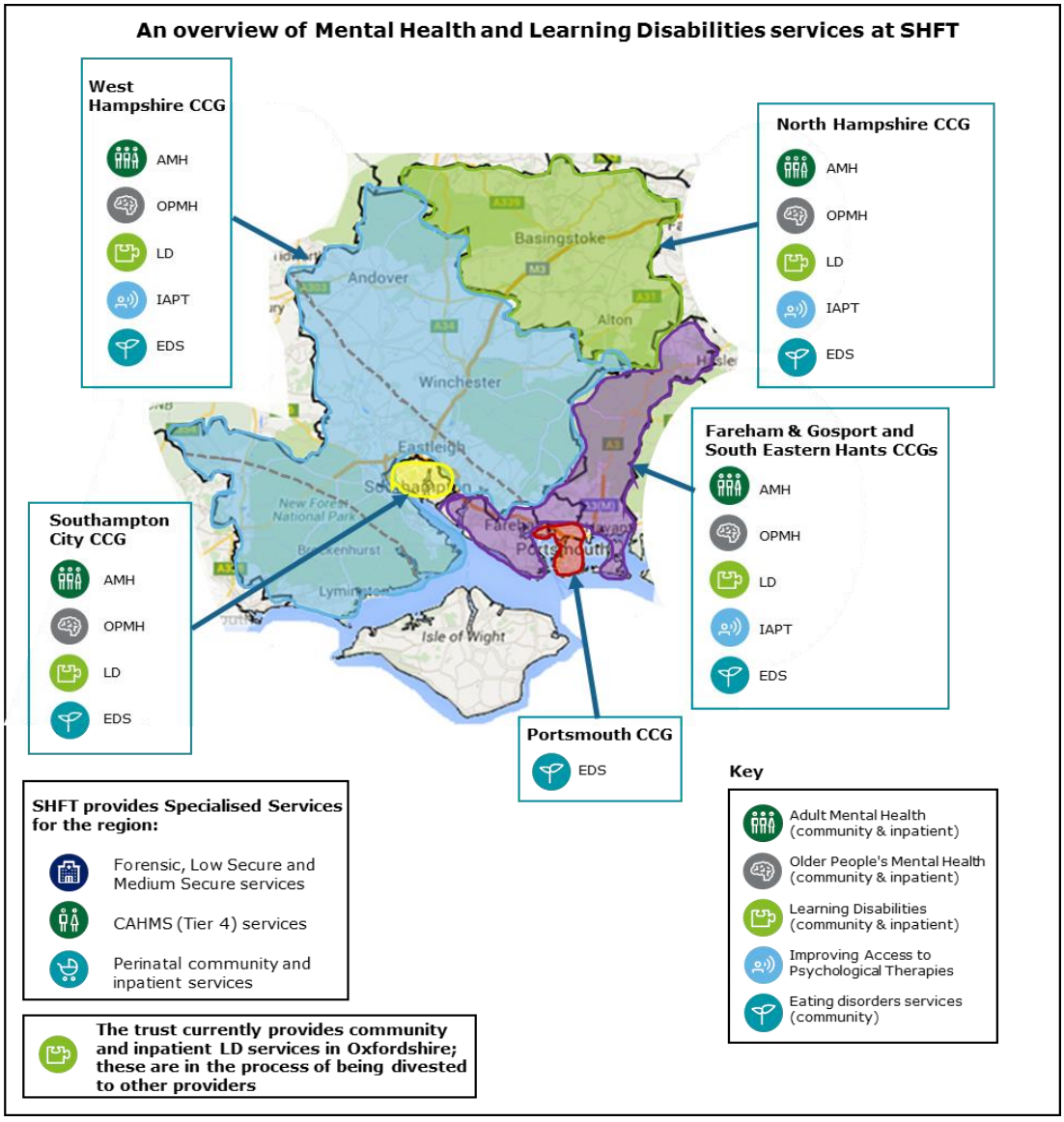
There are also a number of core enablers that we will put in place to ensure that the scale and pace of our ambition is realised which are outlined in further detail in Chapter 8 – "What do we need to deliver our strategy?" These include having a robust quality improvement methodology and resource in place to support change, ensuring that we have the right information and outcomes data available to drive positive improvement, and developing workforce, technology and estates strategies that will help us to realise our ambitions.

2 Introduction and context

The services we provide

Southern Health NHS Foundation Trust formed in April 2011 following the acquisition of Hampshire Community Health Care (HCHC) by Hampshire Partnership NHS Foundation Trust and is currently one of the largest Mental Health and Community Services providers in the country. We employ circa 6,000 staff and see around 45,000 Mental Health and Learning Disability Health Service Users every year. We provide inpatient and community services in Adult Mental Health (AMH), Older People's Mental Health (OPMH) and Learning Disabilities (LD) for people living in Hampshire and Southampton, along with Forensic services for children, adults, and people with Learning Disabilities, Perinatal services and Eating Disorders services. We also currently provide community and inpatient Learning Disabilities services in Oxfordshire, however these services are currently transferring to providers in Oxfordshire.

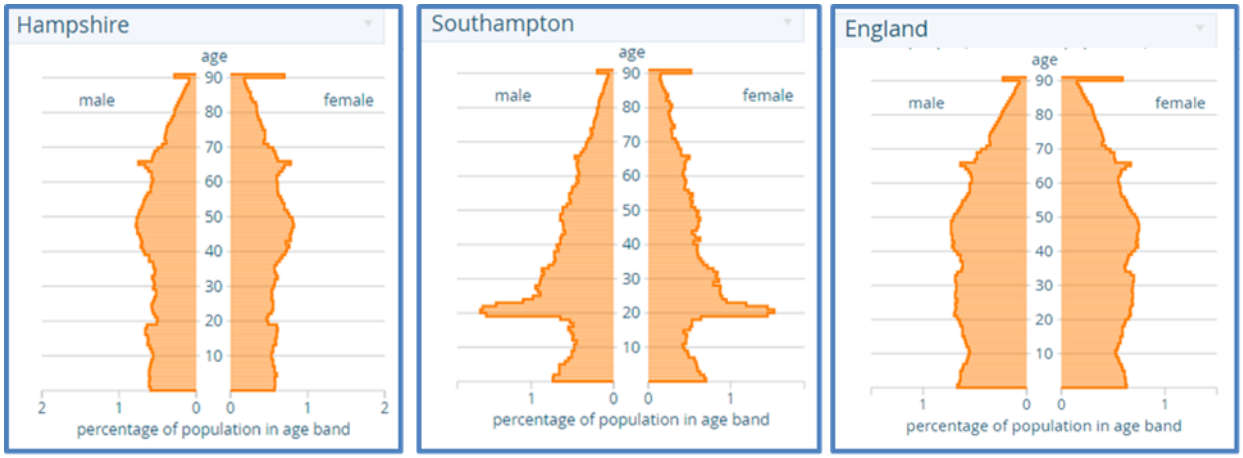
In addition to this, we provide community physical health services in Hampshire; a wide range of scheduled and acute physical health services at Lymington Hospital; children's public health services and smoking cessation services across Hampshire.



Population

We serve a population of c. 1.2 million people across parts of Hampshire and Southampton, and we also provide a range of specialist services to a wider population[1]. Our population is complex and heterogeneous, with an ageing population, particularly in Hampshire, contrasting with a younger demographic in Southampton.

Population characteristics by age and gender[2]



Southampton

With a population of around 250,000, Southampton is more ethnically diverse than Hampshire and England overall and, in part due to its student cohort, has a high population turnover. Its population is also younger than that of Hampshire and the national average – 21% of the population are under 25 versus 12.5% nationally.

Deprivation is relatively high in Southampton and the proportion of people living in the most deprived areas in England is more than three times higher than the national average. Rates of childhood poverty are also high in Southampton, with a higher proportion of children in care than the national average. Southampton reports a significantly higher proportion of school children with social, emotional and mental health needs versus the England average, and the second highest rate of children with learning disabilities of all Local Authorities in the country. There are also higher rates of violent crime, drug use and admissions for alcohol issues in Southampton when compared with the rest of England.

Overall, the population of Southampton is younger, more diverse and more transitory in nature, than the rest of Hampshire. The rates of identified common mental illness, severe mental illness, depression and self-reported feelings of anxiety are subsequently significantly higher than the average in England. As a result, the rates of people in contact with specialist and functional Mental Health services is also above average.

Hampshire

The population of Hampshire is c. 1.3 million, of which we provide services that cover a population of c. 1 million.[3] The population is older compared with England as a whole - 18.5% of the population are aged over 65 (above the national average of 16.3%) and a significantly higher than average number of those people live alone. Hampshire is also less ethnically diverse than Southampton and England overall.

[1] SHFT serves a population of c.250,000 in Southampton, and 1m across Hampshire (excluding North East Hampshire).
[2] Population characteristics by age and gender, Office for National Statistics, Neighbourhood statistics http:''www.neighbourhood.statistics.gov.uk
[3] SHFT provides mental health services for the majority of Hampshire excluding North East Hampshire

Hampshire is a relatively prosperous area, ranked the tenth least deprived local authority in England (out of 150) and has lower rates of homelessness and long-term unemployment in people of working age than the England average.

Although relatively lower rates of childhood poverty exist in Hampshire when compared with Southampton and the rest of England, more than one in ten children still live in low income households. The rates of admissions for self-harm amongst young people are higher than the UK average and that of Southampton.

Except for the populations served by South East Hampshire CCG & Fareham & Gosport CCG, the rates of identified common mental illness, severe mental illness, depression and self-reported feelings of anxiety in Hampshire are lower than the rates in Southampton and lower than the average in England. This theme is also reflected in the rates of people in contact with specialist Mental Health services. Overall, due to its higher ageing population there is a higher demand for services related to older people's services including the dementia care pathway.

Partner organisations

System-wide working

We are part of the Hampshire and Isle of Wight (HIOW) Sustainability and Transformation Plan (STP), to deliver the shared priorities for health and care across Hampshire and the Isle of Wight.

One of the key objectives of the HIOW STP is to improve the quality, capacity, and access to Mental Health services across the footprint. We are working with partners in a **Mental Health Alliance** that includes the three main Mental Health providers in the region, GPs, commissioners, Local Authorities, third sector and Service Users, Families and Carers that will work to standardise care. The Alliance has identified Mental Health crisis pathways, acute and community pathways, rehabilitation and out of area placements as priorities in the first instance and is in the process of developing a plan to achieve this.

The STP is developing six **Local Delivery Systems** (LDS), which bring the local commissioners and providers together to articulate the changes required at a local system level, and how and when they are going to be achieved. This will include taking forward the development of new care models which will include an integrated model of out of hospital care. Whilst this has a greater impact on the physical health services that we provide, the way in which Mental Health and Learning Disabilities services interact and integrate with the LDSs will be critical.

Learning Disability strategy in the region is driven by the **Southampton, Hampshire, Isle of Wight and Portsmouth Transforming Care Partnership** (SHIP TCP) in line with the strategy set out in the **Building the Right Support** Report. We are an active partner in the SHIP TCP which aims to transform services to ensure they build on a Child's, Young Person's or Adult's unique strengths and abilities, getting it right for the person first time by ensuring there is the right care in the right place at the right time, that is consistent across the SHIP TCP. This includes placing a greater focus on early intervention and prevention, developing community-based services in place of inpatient facilities where possible, and ensuring that good physical health is supported via upskilling general practice.

Commissioners

We provide secondary care Mental Health and Learning Disabilities services on behalf of five Clinical Commissioning Groups (CCGs). The Hampshire CCGs jointly commission Mental Health and Learning Disabilities services whilst Southampton City CCG commissions Mental Health and Learning Disabilities services separately.

In Hampshire, the Joint Hampshire Adult Mental Health Commissioning strategy was published in 2012 and was developed by **Hampshire County Council** and NHS Hampshire (now the **Hampshire 5 CCGs**). The strategy was developed following a public consultation and aimed to commission: needs-led services; the roll-out of IAPT; physical health checks for those who are mental health inpatients; single points of access where possible; and mental health wellbeing centres. The strategy is due for renewal in 2017.

In partnership with Southampton City Council, the CCG launched the **Southampton 'Mental Health Matters' (MHM) strategy** as part of a review of Mental Health services in the city. Following a period of wide public consultation, a set of key focus areas were identified including ensuring a needs-based rather than age-based service in AMH and CAHMS; closer working with primary care to provide early intervention and prevention; launching a primary care pilot to aid the development of a primary care mental health model; increasing the IAPT access rate in line with the 5YFV aspirations; and developing services in the city around three integrated hubs (East, Central, and West). Work on some of these initiatives has commenced and a review of progress and further consultation is taking place at the moment.

Specialised services (across the South of England)

We also provide a number of tertiary services that are commissioned by NHS England. These include perinatal inpatient services and forensic services for adults, young people and people with learning disabilities, and a tier 4 CAMHS facility.

Specialised services commissioners have outlined a desire to commission further forensic services for the benefit of Service Users across the whole of the South of England. A key area of development is low secure CAMHS inpatients facilities. In addition, national pathway design and clinical decision making protocols are commencing and investments are being made in non-specialised care to enable parts of the pathway.

We are also part of a New Care Model in Tertiary Mental Health Services for secure Adult Mental Health services, which aims to incentivise clinicians and managers to ultimately eliminate inappropriate out of area placements. In order to do this we will work with partners to strengthen care pathways so that access to community support is improved, preventing avoidable admission and reducing length of inpatient stays through a clinically-led programme to develop services that meet the needs of the local population.

National context

Mental health problems are widespread and it is estimated that one in four adults in the country will experience a Mental Health problem in any given year. To this extent, it is estimated that mental Health problems are responsible for the largest burden of 'disease' in the UK - 28% of the total burden compared to 16% each for cancer and heart disease.[4] And yet, whilst mental Health problems are estimated to cost the economy £105 billion a year (similar to the cost of the entire NHS)[5], only 13% of the NHS healthcare budget is spent on mental health problems.[6]

In recent years there has been increasing recognition of the need for a parity of esteem between Mental Health and Physical Health, as set out in the previous national strategy for mental health in England - **No Health without Mental Health**,[7] and a growing commitment in society to change how we think about Mental Health.

Although the national strategy has made tangible improvements, including changing public attitudes towards Mental Health through the 'Time to Change' campaign, there have been system wide challenges to implement this, with budget constraints and increasing demand putting services under strain. **The Five Year Forward View for Mental Health,** commissioned by NHS England, sets out a framework to guide local clinical strategy and service delivery over the next five years, based on the views of 20,000 people.

It sets out a number of priority actions for the NHS by 2020/21 around **improving access to care** (in particular crisis care, which is central to the Crisis Care Concordat), adopting an **integrated approach to Mental and Physical Health,** and **promoting good Mental Health** and **preventing poor Mental Health,** starting in childhood.

[4] Fundamental Facts about Mental Health 2015. Mental Health Foundation
[5] Mental Health Taskforce, NHS England, February 2016
[6] Fundamental Facts about Mental Health 2015. Mental Health Foundation.
[7] No Health Without Mental Health: a cross-government mental health outcomes strategy for people of all ages. Department of Health, February 2011

This strategy encourages organisations in the public, private and voluntary sectors to work in partnership to identify the needs of their local population and opportunities for early intervention and prevention, designing services through co-production with Service Users and Carers to provide person-centred, recovery focussed care in the least restrictive environment.

For people with Learning Disabilities, the **Building the Right Support** Report,[8] outlines how to ensure the experience of care for people with Learning Disabilities is a positive one, with the creation of 48 locality-based Transforming Care Partnerships across England. Each Transforming Care Partnership is tasked to plan services that build local provisions, as noted earlier, and develop whole care pathways that enable people to be supported where, how and by whom they want, along the themes and priorities as outlined above.

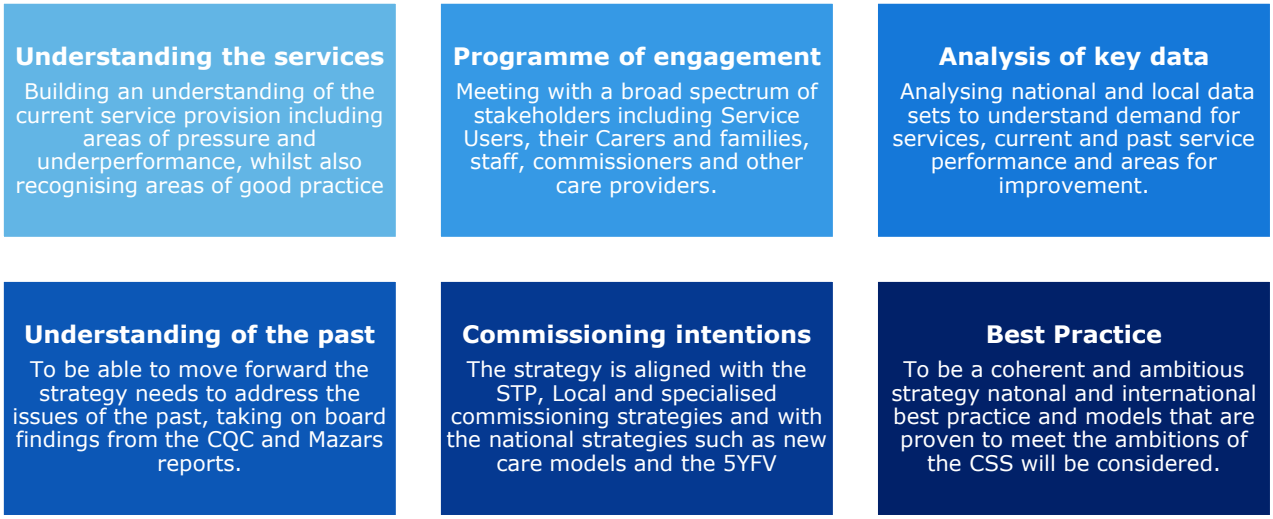
The success of these national strategies relies on strong links with Local Authorities and Social Care providers, which operate under the statutory requirements of the **Care Act 2014**,[9] the aims of which are aligned to the overall goals of the Mental Health reforms.

[8] Building the right support. NHS England, Local Government Association and Association of Directors of Adult Social Services, October 2015.
[9] Care Act 2014, c.23, Department of Health.

3 Approach

Approach to developing the Clinical Services Strategy

In developing the strategy, we have gathered insights from a number of sources including extensive stakeholder engagement, and analysis of population, national, local and Trust data sets. We have taken a systematic approach to developing a strategy that is informed and shaped by our service users, carers, families and staff, which is summarised in the diagram below.



In developing this strategy we have undertaken an extensive programme of engagement with a broad spectrum of stakeholders, which is explored further below. In addition, detailed analysis of key data has been undertaken to help inform the stakeholder events, but also in understanding the current position, which can be found in Chapter 4. This has also included exploring some of the causes of the shortcomings of the past. In demonstrating an understanding of lessons learnt, the strategy looks to incorporate mechanisms to help avoid a repeat of these and to demonstrate improvement. An example of this, which is outlined in Chapter 7, suggests ways to improve active inclusion and engagement of Service Users, Carers and Families.

Programme of engagement

Outlined below are some of the core components of our approach to engagement.

Service Users, Families and Carers

The development of this strategy began with listening to Service Users, Families and Carers, who shared their opinions via an online questionnaire and a series of workshops. These took place with a number of groups across Hampshire and Southampton and focused on understanding what needs to improve, and

provoking positive, forward-thinking idea generation about the future of the services that they use (further details of the feedback received can be found in appendix 1).

In addition, Learning Disability Advocacy Services supported us by facilitating discussions and gathering information from those service users who may find accessing workshops or completing questionnaires online difficult.

Staff engagement

Our staff are critical to the delivery of services and to the success of the transformation journey to come. By positively reflecting on the feedback gained from Service Users and Carers, and on their own experience and expertise around the services that they deliver, staff views have been pivotal in helping to shape the emerging strategy.

We have engaged with our staff via an anonymous online survey, and by visiting a range of services to speak to staff and managers to understand the challenges that they face, and asking what would improve the care that the organisation delivers.

In addition, a three day Clinical Strategy Design event with representatives from our organisation and partners was held, along with additional Medical and Psychology engagement sessions at which staff developed a set of core principles for the new service design and delivery. This was based on the feedback from Service Users; their Families and Carers; fellow colleagues; and key data.

Engagement with wider stakeholders and partner organisations

In developing this strategy, we have also gained insight from the wider system including Commissioners, the voluntary sector, the STP and local providers, all of whom were invited to the clinical design workshop.

Commissioning intentions

In addition to meeting with commissioners and their involvement in a number of the engagement events, commissioners also formed a large part of the membership of the Programme Steering Group that was set up to help oversee the development of this Strategy.

The membership includes members of our Executive Team, NHS England, NHS Improvement, the STP Senior Responsible Officer, and Chief Officer's from the Hampshire and Southampton CCGs. The Group is chaired by the Chair of SHFT and members of the Deloitte and Northumberland, Tyne and Wear (NTW) NHS Foundation Trust project team attend as required.

The role of the Steering Group has been to:

- Provide strategic oversight of the programme
- Resolve barriers to progress
- Ensure delivery against plan
- Resolve escalated risk including financial and clinical
- Provide support e.g. delivery, resourcing
- Ensuring coordination across the wider health economy

Commissioners have contributed not only to the above and to the debate more generally, but have also been asked explicitly to outline their commissioning intentions for mental health and learning disability services.

Best practice

Finally, an Expert Reference Group (ERG) has been convened, chaired by Dr Geraldine Strathdee (National Clinical Lead for the Mental Health Intelligence Network), and comprising national and international experts across the fields of Mental Health, Learning Disabilities, Integrated Community

Models and patient and service user experience. (For further information see appendix 2) to provide independent clinical expertise, and test and challenge the emerging themes that have arisen from this strategy.

The group was tasked with providing advice to the clinical services strategy programme to ensure that the models developed are consistent with wider system thinking, and reviewing and testing our emerging thinking and strategy, highlighting risks and issues requiring action.

4 The starting point for this strategic direction

4.1 Quality and safety issues highlighted by a number of external reviews

The development of this strategy has arisen in part as a response to significant quality and safety issues encountered by the Trust over the last three years. This includes concerns raised by a number of Families whose loved ones have been in the care of the Trust, the Care Quality Commission (CQC), and the Mazars report into the investigation of deaths in the Trust[10].

Deaths and Serious and Untoward Incidents

Over the past three years there have been significant concerns about the quality and safety of a number of services that we provide arising from a number of serious and untoward events. In December 2015 an independent report by the auditor Mazars, commissioned by NHS England following a death in one of our inpatient units, found a failure to properly investigate and learn from the deaths of people with Learning Disabilities and Mental Illness.[10] The report outlined a number of failings and was highly critical of the systems in place for investigation and learning from deaths, and the low number of investigations following deaths which involved Families.

In response to this report, we commissioned a review of how we involve families in investigations following a death, to learn first-hand from families who had been involved in the experience of a Trust investigation following the death of a loved one.[11] The review had contributions from 17 people from 12 different Families. The review highlighted the need for us to recognise the importance of involving Families in delivering effective services; and to improve the way in which we communicate and engage with Families when there is a death.

CQC assessment of services

At the last full CQC inspection, in October 2014, the Trust was rated as "Requires Improvement" overall. While the CQC found many areas of good practice in our services including perinatal services, Eating Disorders services and Community Mental Health teams, it was found that there was a lack of consistency in the services provided. In addition, the inspection found that there were problems regarding access to crisis services and the availability of inpatient beds, along with inconsistent staffing and issues with the ability to provide a safe environment for care.

The inspection status of each service is shown overleaf.

Following the publication of the Mazars report, the Secretary of State asked the CQC to undertake a further inspection of our services in January 2016. The CQC issued the Trust with a warning notice to take immediate action to monitor and improve the safety of services and assess, monitor and mitigate risks to the health, safety and welfare of patients.

The CQC re-inspected our services in September 2016. The inspection concluded that we had taken sufficient action to meet the requirements set out in the warning notice.[12] However, the CQC acknowledged that there are areas which still require improvement including the environment at several sites; achieving and maintaining safe staffing levels, and embedding governance processes. The CQC continues to be in regular contact with us.

[10] Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015. Mazars, December 2015.
[11] Statement on the publication of the report into how we involve families in investigations following a death. http://www.southernhealth.nhs.uk/news-archive/2016/statement-on-the-Family-involvement-report/
[12] Southern Health NHS Foundation Trust Quality Report. Care Quality Commission, November 2016

Rating by service CQC October 2014:[13]

Service	Overall rating	Safe	Effective	Caring	Responsive	Well led
Acute wards for adults of working age and psychiatric inpatient units	Requires Improvement	Requires Improvement	Requires Improvement	Good	Good	Good
Child and adolescent mental health wards	Requires Improvement	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement
Community-based mental health services for adults of working age	Good	Good	Good	Good	Good	Good
Community-based mental health services for older people	Good	Good	Good	Good	Good	Good
Forensic inpatient/secure wards	Requires Improvement	Inadequate	Good	Good	Good	Requires Improvement
Long stay/rehabilitation mental heath wards for working age adults	Good	Good	Good	Good	Good	Good
Mental health crisis services and health based places of safety	Requires Improvement	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement
Perinatal services	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding	Outstanding
Specialist eating disorder services	Good	Good	Good	Good	Good	Good
Wards for older people with mental health problems	Good	Requires Improvement	Good	Good	Good	Good
Wards for people with learning disabilities or autism	Requires Improvement	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement
Community mental health services for people with learning disabilities or autism	Good	Good	Good	Good	Good	Requires Improvement

Outstanding
Good
Requires Improvement
Inadequate

We remain in breach of a number of regulations of the Health and Social Care Act 2008 relating to risk assessments and quality of premises, and embedding systems and processes to ensure quality and safety of services.[14] Most recently, the CQC gave notice that it intends to prosecute the Trust over an alleged failure to provide safe care and treatment resulting in avoidable harm to a patient in December 2015, when a patient sustained serious injuries during a fall from a low roof at Melbury Lodge, Royal Hampshire County Hospital, Winchester.[15]

We are working hard to address the concerns raised over the past 3 years. This has involved putting in place a number of action plans to further strengthen governance including a CQC action plan and Serious Incident and Mortality improvement plan. NHS Improvement, NHS England, and our Commissioners are overseeing these developments and providing support via a Quality Oversight Committee. This mechanism is also being used as a way to provide external assurance on progress regarding the improvements and how these are being embedded in the organisation. We are also in the process of transferring our Learning Disabilities Services in Oxfordshire and Buckinghamshire to other providers, as well as all of our Social Care Services (TQ21), allowing the Trust to focus on a reduced set of services over a smaller area.

4.2 Service User and Carer experience:

Feedback from our Service Users, Carers and Families has formed the starting point for much of the approach to developing our Strategy. Engagement with Service Users, Families and Carers has revealed that whilst there are numerous examples of members of staff who deliver excellent care, there is a significant challenge for the Trust in listening to, and acting on feedback from Service Users and Carers.

The diagram below show the most frequently used words in the feedback from the workshops that were held with Service Users and Carers:

[13] Southern Health NHS Foundation Trust Inspection Reports. Care Quality Commission, February 2015
[14] Southern Health NHS Foundation Trust Quality Report. Care Quality Commission, November 2016
[15] https://www.cqc.org.uk/content/southern-health-prosecution

Service Users expressed significant concern around receiving help when they need it, sometimes struggling to speak to clinicians with the right skills, and having to "jump through hoops" to get support. They also described not feeling listened to and their opinions not taken into consideration, with limited help to resolve other issues such as social and physical health needs. Other themes around communication and experience included carers not feeling respected for the support they provide, and a sense of being too worried to ask for help in case their loved one is "taken away". In addition, Service Users and Carers felt there are significant opportunities to do more to help people to lead meaningful lives, and reduce their dependency on services and joining up approaches with other health and social care agencies.

Service User, Carer and Family inclusion

"Carers need a fast track system to access services"

"Need to listen to families and carers and give them more support"

A significant theme emerging from the feedback from our Service Users, Carers and their Families is one of feeling that they do not have a 'voice'. On an individual level, in their own or their Family member's care and treatment, Service Users cite issues in terms of being listened to, and communicated to clearly and transparently.

Our Service Users, their Families and Carers recognise what needs to change, to make care better for the people, and express frustration at not being listened to in this respect. Reports such as those by Mazars have also highlighted shortcomings in how we have engaged Families in regard to investigations and complaints.

Service User experience

The proportion of people who are likely to recommend our services in the Friends and Family test has recently increased, from significantly below the national average for mental health of 88% - 67% in February 2016 - to 81% in November 2016. This demonstrates a vast improvement, and is closer to the national average for mental health services of 88%,[16] but shows that we still have work to do.

[16] Friends and Family Test Mental Health November 2016. NHS England.

4.3 Services overview

We provide a number of services across Hampshire and Southampton. There are numerous areas of good practice and innovation. A number of examples of these our outlined below (although this is not an exhaustive list).

The **Community Forensic rehab** team works flexibly to support people to live in the community

The Adult Mental Health team in Southampton has developed an **MDT for vulnerable, treatment resistant people** across agencies

The trust recognises the huge part carers play in the recovery of service users and as such provides **an 'IAPT Carers pathway'** which gives carers access to IAPT assessment and treatment.

The development of **Integrated frailty and dementia clinical pathways** that brings together physical health and mental health expertise around the needs of the person

Bluebird House is a specialist, secure mental health inpatient unit, forensic care for young people, both male and female aged 12-18 years. Young people using the service have complex mental health problems which mean they pose a risk to themselves or others. Bluebird recently launched an initiative which makes use of innovative graphic and communication tools to support young people to understand and become more involved in their care.

The OPMH service runs an bespoke **Old Age Psychiatry** on call rota that supports older people

The **Recovery College** is run by the trust and offers courses for Service Users, Carers, and staff. The courses aim to increase the participants' knowledge of recovery and self-management of their mental health. The College opened in 2013 and is a key part of the strategy to embed recovery oriented practice in all aspects of care and treatment.

Collaborative care planning at **Leigh House** (an adolescent acute inpatient psychiatric service) works by involving young people in shaping their care plan. The approach has received positive feedback from young people at service user groups meetings.

The **Perinatal** (mother and baby) service at the trust is highly regarded nationally, and was the first in the country to receive an independent accreditation from the Royal College of Psychiatrists. The team has also won 'The Psychiatric Team of the Year' at the national 2013 Royal College of Psychiatrists Awards due to the excellent service provided by in the community and at the specialist unit.

The development of the **Care Navigator** role at the trust has been highlighted by the Crisp report as an example of good practice ('Old Problems, New Solutions: Improving Acute Psychiatric Care for Adults in England'). The Care Navigator supports the team with the safe transition of patients through the acute care pathway.

The Learning Disabilities service has developed **maps of interventions** developed along core pathways

Willow Assessment and Treatment Unit supports people with complex learning disabilities effectively embedding a team-wide approach to positive behavioural support.

The **Tableau** platform supplies services with up to date data in a usable visual format to allow real time access to data and information

Consultancy And Support Team (CAST) are a group of Service Users who have experienced complex mental health problems who help Service Users get the most from therapy programmes and treatment by sharing their personal experiences of recovery. CAST were involved in co-producing the EUPD pathway with clinicians

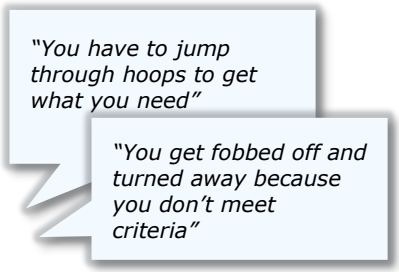
The **Southampton Primary Care Mental Health 'STAR' Project** was funded by the Prime Ministers Challenge Fund, and aimed to reach more of the population who may have mental health problems. This was done by providing structured needs and symptom assessment to people who were referred to the STAR team by GPs. This service was aimed at those not currently receiving care from a substance misuse team, IAPT, or a mental health team.

Peer support workers work in adult mental health inpatient facilities to provide credible, recovery-oriented care

Whilst there are numerous examples of good practice, there is often inconsistency in our services. This has been highlighted by Trust data, feedback from our staff working in services and from Service Users and Carers, along with the CQC in their 2014 inspection.

4.3.1 Access to services including urgent response

Access to our services is a significant issue, as cited by Service Users, Families, Carer, staff and the wider system. Service Users fed back that getting into services is a significant challenge, and that they can end up feeling "fobbed off" due to a lack of ownership on the part of those services. At present, most of our services (excluding IAPT) do not accept self-referrals.



A number of our teams also describe issues with capacity, with CMHT clinicians raising issues in the Design Workshop around balancing the demands of urgent and routine Service User needs, which can limit the level of support that services are able to provide. Service Users and Carers gave numerous examples of asking for urgent help and either being turned away, or having to wait several days for support to be given.

The acceptance criteria of some services can mean that some of the most vulnerable people can fall through the gaps due to artificial thresholds. This is exacerbated by each service having its own processes and approaches to how referrals are handled and triaged. In addition, access to different services within the Trust can also be an issue, with referrals required between teams, and challenges with capacity in areas such as Psychology –which in some cases has had to stop any new referrals due to capacity.

4.3.2 Urgent response/crisis services

Provision for urgent need is critical for the delivery of a high quality mental health service, as recognised by the 5YFV. The model for 24 hour crisis provision for working age adults is limited. There is currently no commissioned out of hours crisis provision for older people or people with Learning Disabilities, which means that when out of hours provision is required for specific patients, a solution has to be negotiated with the Working Age Adult Mental Health Teams who can then contact the on call psychiatrist for support.

In our Adult Mental Health services, there are differing models for how crisis care is provided, including the community mental health team (CMHT) 'shared care' approach in the daytime, and the AMHT (acute mental health team) providing support in the evenings. CMHTs are open Monday to Friday between 9am and 5pm and AMHTs are open 24/7 all year round. However, overnight the level of cover in an AMHT can be limited, which means that it is not possible to provide home visits, which can be required in order to prevent admission.

The result of this, along with other factors (including in primary care access, changes in police practice and lack of social support), is that often, the only option for people in difficulty is to present at services which are not equipped to provide the care that they need. Local acute Trusts have raised that the pressure on A&E is a significant challenge, with high numbers of people attending A&E with mental health needs. Referrals to our services from A&E have increased by 44% versus the equivalent period a year ago, and attendances at A&E for a psychiatric disorder are significantly above average in Southampton.[17] The pressure on A&E means that our Liaison Psychiatry services in the local Acute Trusts (University Hospital of Southampton NHS FT, Hampshire Hospitals NHS FT and Portsmouth Hospital NHS Trust) becomes focused on people in A&E. Levels of cover vary in the Liaison Psychiatry services with no 24/7 service in place (cover tends to be limited or none after 6pm or 10pm depending on the area). The model often sees lone workers on duty, and is not resourced to provide crisis cover in the community.

The lack of crisis provision can also lead to Service Users or others calling the Police to deal with acute episodes of crisis. In the absence of other services, the Police can sometimes have to resort to using their

[17]Attendances at A&E for a psychiatric disorder, rates per 100,000. 2012/13, Public Health England - Public Health Profile 'Fingertips'.

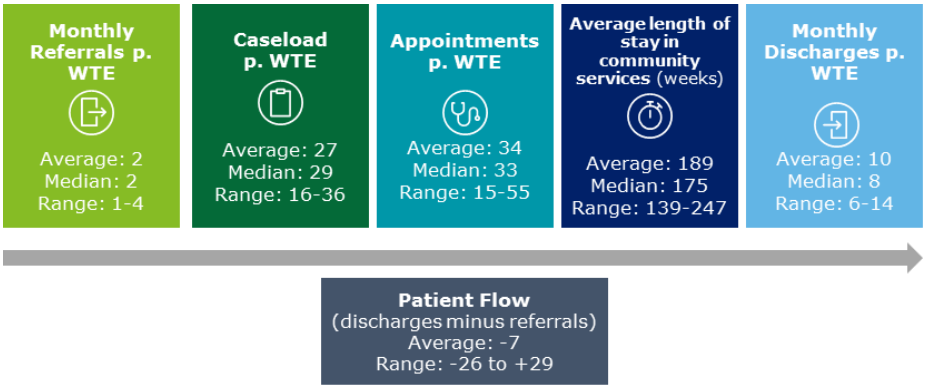
powers to detain people, which is distressing for Service Users and their Families. NHS Benchmarking shows that the number of section 136 assessments[18] for the population served by the Trust are significantly above average (fourth in the country), which may be related to the lack of crisis provision, whilst acute admissions under the Mental Health Act are below the national average (for further information, see appendix 4).[19] This may suggest that if there was the appropriate support available in the community in the first instance, a number of people could potentially have been managed at home.

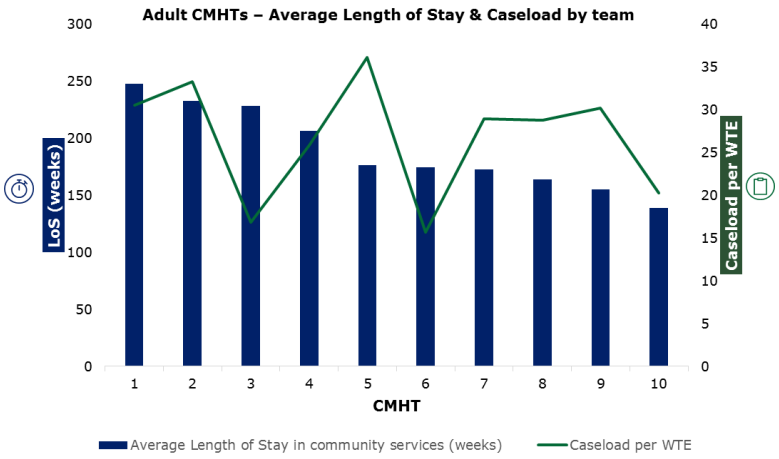
4.3.3 The adult mental health pathway

Linked to the issue of provision of urgent response care is the overall adult pathway. There is not currently a consistently applied model of how care pathways are delivered for community teams and how their roles and responsibilities work and interact with each other.

Variation in delivery and variance from pathways

Performance metrics: Adult CMHTs[20]



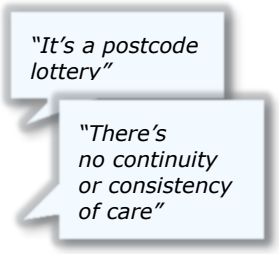


The data above gives key metrics, weighted by whole time equivalent staffing resource, to enable some comparison across teams. This data shows that teams are working differently with significant variation in the caseload per team member, which has implications for how much capacity teams have to work with their caseload. In addition the average length of stay of Service Users in some teams is double that of other teams, which again suggests different practices for delivering care. Whilst variation in performance metrics between teams needs to be interpreted on the basis of variation in population need, and caseload

[18] Section 136 of the Mental Health Act 1983 allows a police officer to remove a person from a public place to a place of safety in the interest of that person or for the protection of others, if they think that person is mentally disordered and 'in immediate need of care or control.'
[19] NHS Benchmarking Network: Mental Health Inpatient and Community Benchmarking 2016.
[20] SHFT Clinical Performance Dashboards, SHFT Tableau System.

weighting, in general terms the metrics should be more comparable. Our ambition is to configure all CMHTs to standardise service delivery at the highest quality.

Whilst we have developed a number of pathways, including Psychosis, Borderline Personality Disorder, and Affective Disorders, these have not been systematically implemented across teams. This is in part because in moving from policy to implementation, the resource and skills required to deliver these pathways have not been aligned to the requirements of these pathways. There is not currently a systematic approach to caseload weighting in the Trust, or access to the granularity of clinical data required to support a mapping of resource in this way.



In addition, some of the variation seen in CMHTs is due to the different ways in which teams deliver care to people with urgent needs - in the East our AMHTs receive direct referrals from GPs for all 'urgent' and 'new crisis' referrals; whilst the 'routine soon' and 'known urgent' referrals are sent to the CMHTs. In all other areas both of these functions are performed by the CMHT meaning the CMHT has to triage the crisis referrals and refer them to their area AMHT. These differences are due to the configuration of the Primary Care pathways across the different areas of the organisation. However, these factors mean that the CMHTs can be consumed by supporting people with urgent needs as best as they can between 9-5pm, which can limit their ability to provide proactive, planned care.

Challenges in delivering alternatives to admission

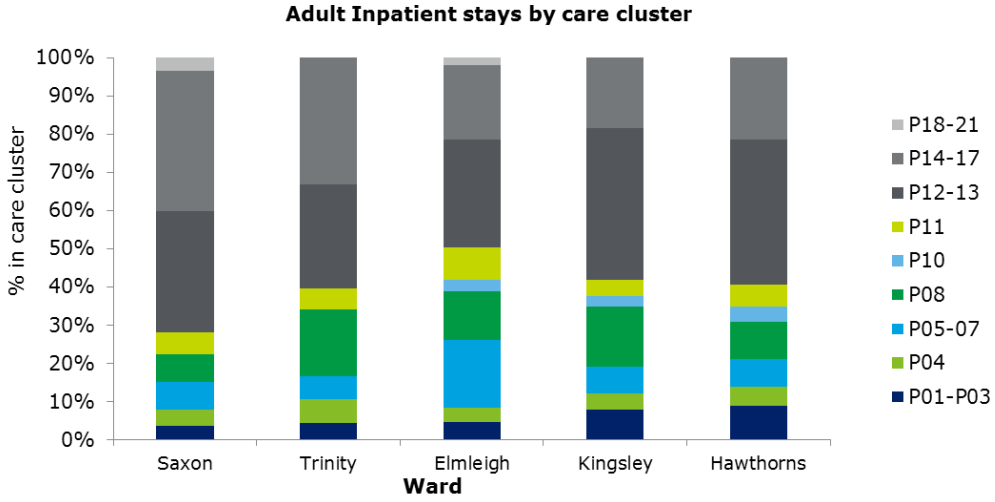
The impact of urgent demand also has an impact on the Acute Mental Health Teams (AMHTs) that are designed to deliver an alternative to admission by providing 'hospital at home' and facilitating early discharge from inpatient units. Our AMHTs are often unable to deliver a full crisis response due to a lack of capacity, which means that they cannot be as proactive in delivering care. This is evidenced by the fact that 67% of people under the care of the AMHT do not have a crisis plan in place.[21] Commissioners have acknowledged the gap in urgent response, and have signalled their intentions to develop this service in 2017/18.

The pathway components in the community – in terms of crisis provision, hospital at home and community care – can have an impact on who is admitted to a hospital bed. There are a number of factors that impact on admissions including the preventative service provision upstream (which is designed to keep people functioning well in the community), and once people are in hospital, the provision that exists in the community to support people post discharge (in terms of housing and social services). The lack of this infrastructure can sometimes mean that admissions are a result of no alternative, rather than necessarily being the best therapeutic option.

Inpatient admissions

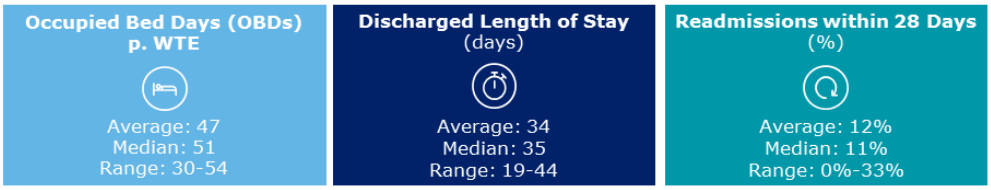
NHS Benchmarking data shows that the number of adult beds per 100,000 population is largely in line with the national average (for details of this see appendix 4).[22] However the care cluster data of people on our wards that shows the needs and severity of Service Users (see appendix 3), suggests that some people may be in hospital due to the lack of an alternative. The chart below shows that 25% of episodes are for clusters which may not always require an inpatient bed: 6% of people on the wards are in care clusters 1-3 which are low to severe non-psychotic common mental health conditions; 13% of episodes are in cluster 8 which covers people with non-psychotic chaotic and challenging disorders where alternatives to admission may be preferable, and 6% are cluster 11, which represents people with psychosis who are stable. This suggests that there may be opportunities to support more people in the community.

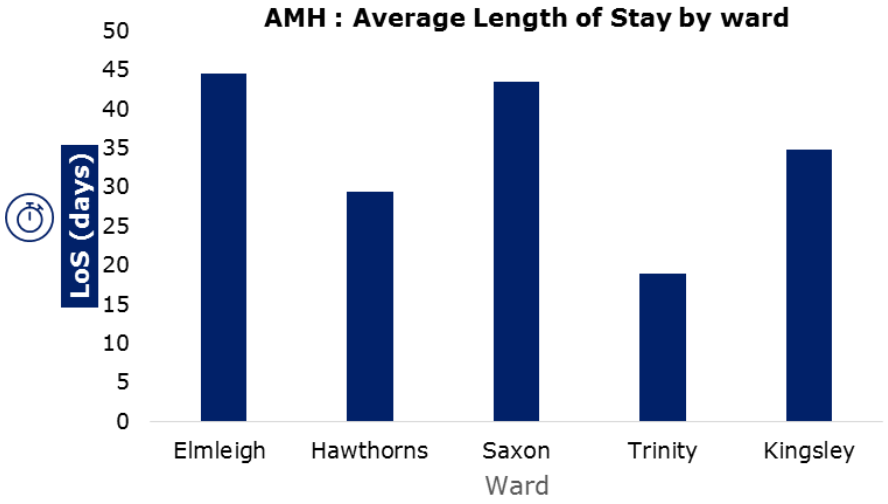
[21] SHFT Clinical Performance Dashboards, SHFT Tableau System.
[22] NHS Benchmarking Network: Inpatient and Community Mental Health Benchmarking 2016



Wards are managed locally, by each site and area management team, with local processes and procedures. Data suggests that there is variation in how people are managed and with what resource as shown below:

Performance Metrics: Adult Mental Health – Acute Inpatient wards[23]

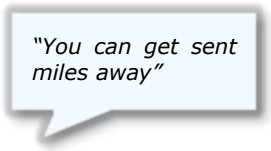




The data above shows that there is a significant difference in the length of stay between similar wards, with the average length of stay ranging from 19 to 44 days which suggests variation in clinical practice. In addition, the staffing models on the wards appears to be different, as evidenced by the difference in Occupied Bed Days (OBDs) per WTE between wards which varies from 18 in the North to 61 in Southampton. Whilst some of this variation may be due to differences in clinical remits of the wards, the difference in these metrics suggests that there is variation in approach in inpatient facilities.

[23] SHFT Clinical Performance Dashboards, SHFT Tableau System.

Out of area beds



The use of out of area beds by AMH has been highlighted as a concern by Service Users, Carers, staff, and in Trust-wide performance reporting. Sending people out of area can be distressing, and can also lead to longer length of stay. We currently have to use out of area beds on a regular basis, including a block purchase of beds. The need to use out of area beds is in part due to short term issues (due to the temporary closure of Hamtun ward Psychiatric Intensive Care Unit and Kingsley ward inpatient unit at Melbury Lodge). However, factors such as delayed transfers of care due to issues with community and social care agencies can also play a part in the need to send people elsewhere due to lack of bed capacity. In recognition of this problem we have developed a Care Navigator role which aims to support managing the admission and discharge of patients on wards.

4.3.4 Older People's Mental Health Services

Age-led service model

Our OPMH services currently provide care for functional and organic mental illness, focused primarily but not exclusively for people over the age of 65. Memory assessment services are provided for individuals of any age, and provide care for those younger people (under 65) with a diagnosis of early onset dementia. Services and their staffing resource are not currently organised along needs-led formalised pathway functions, but do deliver treatment focused on the individual, holistic, needs of each Service User.

As with AMH services, a key issue for this service is the lack of a commissioned out of hours crisis response for older age adults. Whilst there is an on call rota for older age psychiatrists, (when out of hours crisis monitoring is required for known patients), consultants must negotiate on a named individual-basis with services such as the AMHTs and/or Liaison workers to provide an urgent response to support people out of hours. This is not a full crisis service, which means that the level of intervention can only be at an arms' length. As in AMH, a robust approach to crisis would greatly improve the experience of Service Users and their Families.

People with functional illness are accepted into OPMH services from the age of 65, creating a transition point from AMH services to OPMH services. The transition and how this is managed varies according to Consultant, and is dependent on the capacity of 'receiving' teams as the pathway is not managed in a continuous flow.

The pathways for functional mental illness are not consistent across older people and working age adults. The size of the OPMH service means that it does not have the scale to provide access to the same breadth of resource as the adult mental health pathway. For example, there are only three psychologists in the whole service and as a result access to psychological therapies is limited.

Organisational integration with physical health

OPMH Services currently sit within the Trust's Integrated Service Division. The service merged with community physical health services in 2015, with a view to delivering more integrated, joined up care across mental and physical health. The OPMH service is distributed across multi-disciplinary teams which include old age psychiatry, CPNs and community physical health nursing. The integration of physical and mental health teams has happened to varying degrees – in some teams "integration" refers to the merging of operational management only, whilst in other teams, mental and physical health teams have clinically integrated, to greater or lesser degrees depending on locality. In one area, CPNs report monitoring physical health conditions such as pressure sores.

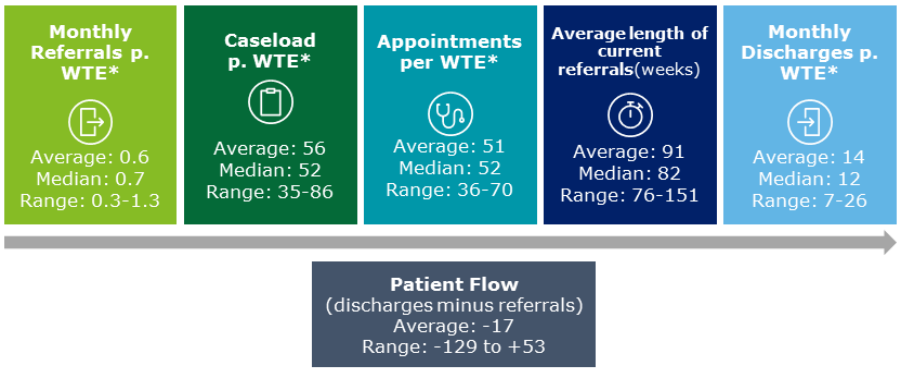
While positive benefits to Service Users have been noted from this approach, the result has been a small service spread thinly across a number of teams, leading to concerns about a loss of professional identity

amongst doctors in particular. This may be reflected in the vacancy rates which are higher than most parts of the Trust in OPMH at 16.5%, and 37% vacancy rates amongst medical staff.[24]

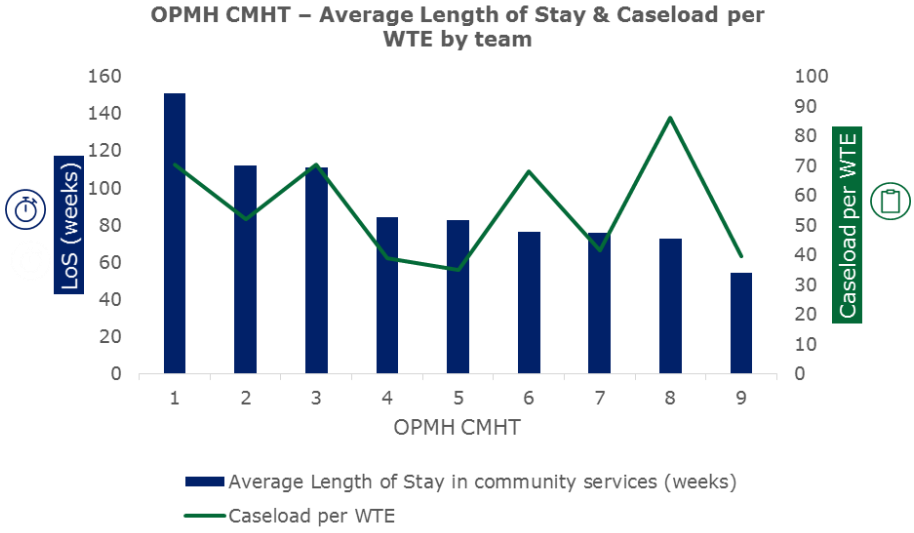
Variation in service delivery

As a result of both the integration with physical health and historical arrangements, there is no single consistent model of service delivery across OPMH teams, or defined pathways that services are working towards. Trust data suggests that there is variation between community teams and how they are assessing and treating patients.

Performance metrics: Older People's CMHTs[25]



*calculated based on adjusted WTE (where Funded WTEs for the specific OPMH CMHTs (Andover, Eastleigh and New Forest East) are adjusted for over recruitment of 50%, 28%, 35% respectively to those teams)



The data above shows that the caseload per WTE in teams is nearly three times higher in one team than another, which suggests that the time staff have to support people is very different. In addition, the length of stay in the community teams varies from 75 weeks to 151 weeks, which also indicates a difference in practice.

Inpatient admissions

[24] Staff Vacancy Report, Southern Health NHS Foundation Trust Tableau System & Information received from Southern Health NHS Foundation Trust Human Resources Information team
[25] SHFT Clinical Performance Dashboards, SHFT Tableau System.

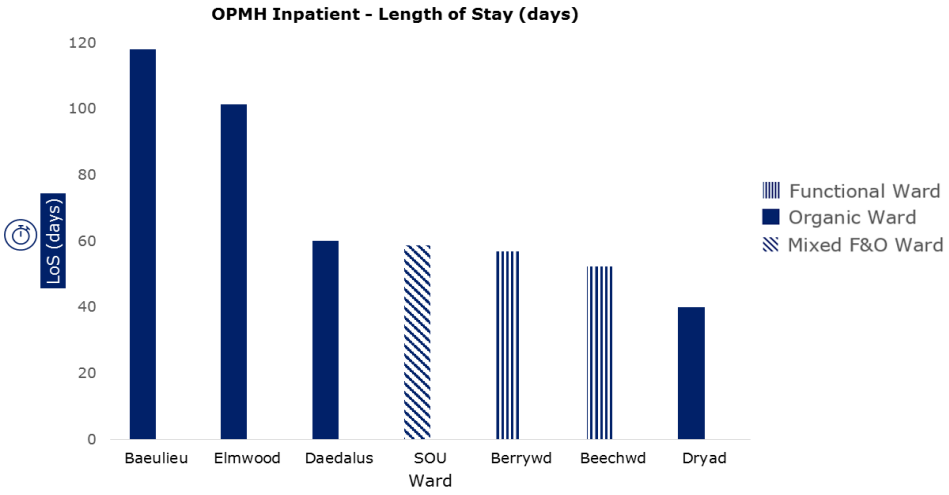
NHS Benchmarking data shows that we have a higher reliance on inpatient stays in older people's services than average (see appendix 4). There are significantly more beds for older age adults than national average (49 per 100,000 population versus 32 average), along with a higher rate of admissions versus the national average (c. 160 per 100,000 weighted population compared with national average of 142 per 100,000).[26] In addition, the average length of stay is also above average – our average length of stay is 111 days length of stay vs. the national average of 81 days. This could be influenced by the fact that the Hospital at Home service is for working age adults only, which limits the alternatives to admission for older people who require an intensive level of support.

Inpatient areas are generally diagnosis-led, although the service has considered taking a more flexible approach to admission so that people are offered admission to an environment which matches their need. For example, it is not suitable for a robust 68 year old man experiencing a manic relapse of his bipolar disorder, to be placed with frail Service Users with a similar diagnosis.

There is variation between inpatient wards. Data indicates that wards with similar specialisms show a threefold difference in length of stay, and staffing figures suggesting a difference in staffing models, both of which suggest a difference in approach to care delivery. However, there are other factors to consider, such as the differences in Social Services arrangements and availability of suitable placements across the localities.

Performance metrics: Older People's Mental Health – Inpatient wards

Occupied Bed Days (OBC) p. WTE	Discharged Length of Stay (days)	Readmissions within 28 Days (%)
Average: 68 Median: 62 Range: 52-96	Average: 70 Median: 59 Range: 40-118	Average: 1.6% Median: 0% Range: 0%-11%



Proactive support to Care Homes and similar providers can enhance the care that Service Users with dementia receive, and deescalate acuity before crisis occurs. This is currently delivered by individual nurses on an adhoc basis, with work by the service to build pathways models ongoing. The CPNs usually organise a rota to cover the Care homes between themselves.

[26] Mental Health Inpatient and Community Benchmarking 2016, NHS Benchmarking Network.

4.3.5 Learning disabilities

Our Learning Disabilities services include community and inpatient facilities for adults with Learning Disabilities in Hampshire and Oxfordshire. There has been significant criticism of some of our services in Oxfordshire over the past 3 years, and reports have focussed on the urgent need for change. At the time of writing we are in the process of transferring our community and inpatient facilities in Oxfordshire to another provider, which will allow us to focus on services on a smaller geography.

We will continue to provide services in Hampshire. Our services in Hampshire include Community Treatment Teams, Intensive Support Teams (focusing on individuals displaying behaviours which challenge), an Assessment and Treatment Inpatient Unit, Liaison Nurses in Acute hospitals, and an Autism Assessment Service for adults with a learning disability in Hampshire.

Transforming Care Partnership

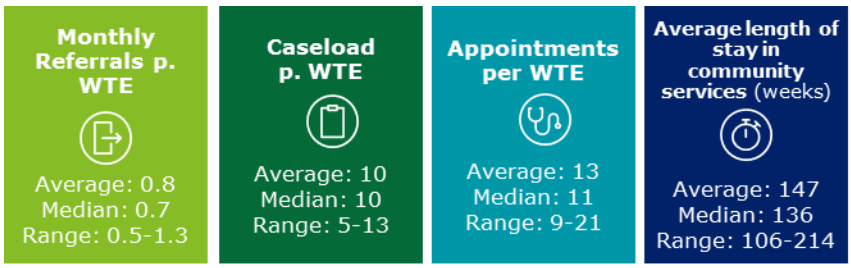
We are a key partner within the Southampton, Hampshire, Isle of Wight and Portsmouth Transforming Care Partnership (TCP), the remit of which is to deliver pathways across primary, secondary and community care including social services, and to reduce the reliance on inpatient beds. Following the direction from 'Transforming Care for People with Learning Disabilities' in 2015, 'Building the Right Support'[27] outlines the national service model and associated principles, which all Trusts are required to deliver by March 2019.

Our strategy is to prioritise community-based provision, and reduce the need for inpatient admission to only those cases where acuity means the issues cannot be managed safely in the community. We are committed to working with organisations and sectors to prevent the 'revolving door syndrome' of admissions and discharges, improve planning and delivery of care placements where needed, and reduce the likelihood and impact of placement breakdown.

Community services

A review of the Learning Disability pathways is underway in the region, under the leadership of the TCP. Our services have undertaken a significant programme of work to develop a series of needs-led, evidence-based clinical pathways which focus on the primary need of the individual. These pathways are flexible around primary need, and are visualised as "maps" of interventions around epilepsy, mental health, dementia, autism, complex needs, challenging behaviour and forensic needs. Services strive to be proactive and empowering in their approach, instead of paternalistic and life-long.

Performance metrics: Learning Disabilities Community Teams[28]



Data suggests that there is variation in how our community teams deliver care, with the average length of stay in community team ranging from 106 weeks to 214 weeks, and a threefold difference in the average caseload per WTE, which suggest difference in practice. Whilst some of this variation may be due to differences in the nature of the caseloads in the teams, the difference in these metrics suggests that there is variation in the delivery of care. Resource is not currently mapped to the pathways that have been developed, this will be the next step to ensure their effective implementation.

[27] Building the right support. NHS England, Local Government Association and Association of Directors of Adult Social Services, October 2015.
[28] SHFT Clinical Performance Dashboards, SHFT Tableau System.

Access and urgent need

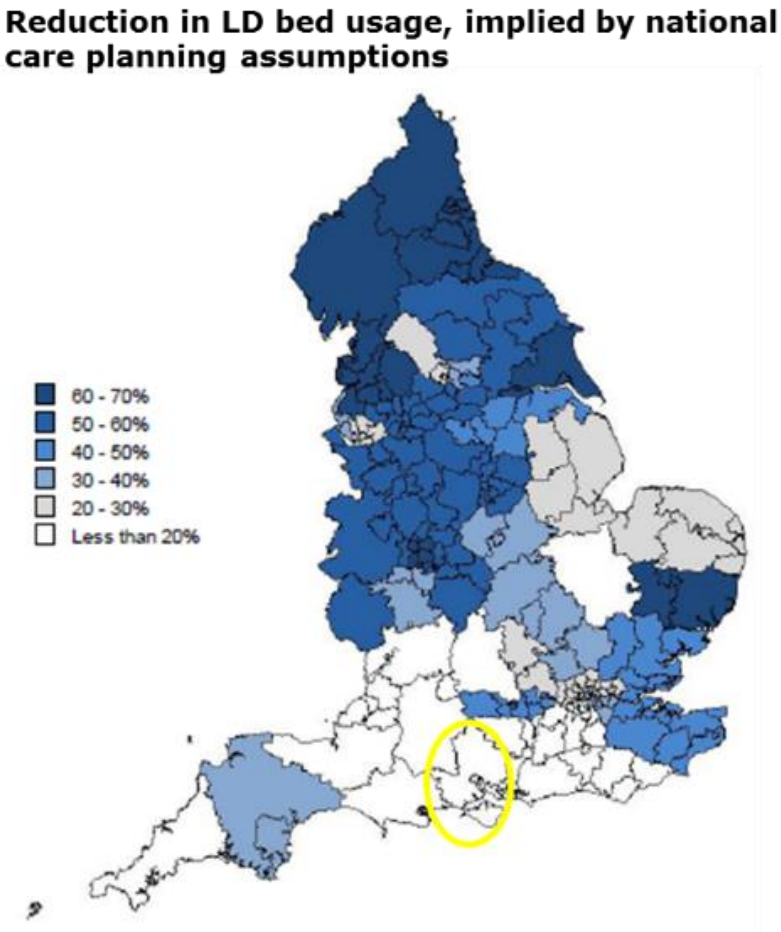
"There is no consistency in the first point of contact"

Currently there is no built-in 'urgent response' for people with Learning Disabilities. This includes people with learning disabilities who have mental health issues, as mainstream mental health services currently distinguish based on IQ. Intensive Support Teams (ISTs) operate flexibly to support known individuals outside of Mon-Fri, 9am-5pm using a positive behavioural support approach. However, this is only open to people who are known to the IST.

Inpatients

The Trust provides inpatient care in Willow Assessment and Treatment Unit. This is spot purchased by commissioners both within and outside the county, the team follows the 'Blue Light Toolkit' which supports decision making to prevent people being admitted unnecessarily to inpatient facilities.[29]

The service has a comparatively low bed footprint versus other areas of the country, as illustrated below:



Reviewing inpatients under the framework of 'Care and Treatment Reviews' is an additional national directive, and links with the recommendations of the Lenehan Review on the need to review those adolescents who may soon require transfer to adult Learning Disabilities wards, in both cases providers are tasked with proactively working on community-based solutions. This is currently in progress as part of the Transforming Care work.

[29] https://www.england.nhs.uk/wp-content/uploads/2015/10/ld-blue-light-protocol.pdf

Transitions and interfaces

Services for children with Learning Disabilities are currently provided by other organisations. The number of children with Learning Disabilities known to schools in the region is significantly higher than average – there are 44.8 children known to schools with Learning Disabilities per 100,000 children in Hampshire and the figure is 69.1 in Southampton versus an average of 33.7.[30] Children with Learning Disabilities currently receive a mixture of services depending on where they live, varying from only having GP and occasional Paediatric support (described as a medical-only model), to CAMHS services which in some areas include Learning Disabilities as a function.

The transition from children's to adult services is a crucial period that currently relies on relationships across different organisations. Staff highlighted that the transition can be difficult and requires clinicians in adult Learning Disabilities services to 'start again'. 'Building the Right Support' requires agencies to create all age solutions, with continuity of high quality care between providers where necessary.

The breakdown of the integrated LD teams between health and social care in Hampshire has created a risk of artificial transitions for Service Users. It is vital that teams in health and social care work closely together for the benefit of the Service User, despite the disaggregation of teams.

Engagement with Service Users and Carers

Engagement with Service Users and Carers has been previously noted as a significant issue for our Trust. Family Carers have described receiving very little support, often only suggested when crisis point has been reached, and then not available out of hours. Proactive service offers by health and social care are a key element of 'Building the Right Support', but little experience of this has been noted by individuals and their Carers.

Advocacy services who support those with significant Learning Disabilities have cited issues around information sharing with Service Users, Families and Carers, and in ensuring the professionals work as a team across agencies and specialisms, sharing knowledge and coordinating care.

4.3.6 Specialised services

We run a number of tertiary services across Mental Health and Learning Disabilities services. These include perinatal services, which are rated Outstanding; a tier 4 CAMHS service, and various forensic services for adults, young people and people with Learning Disabilities.

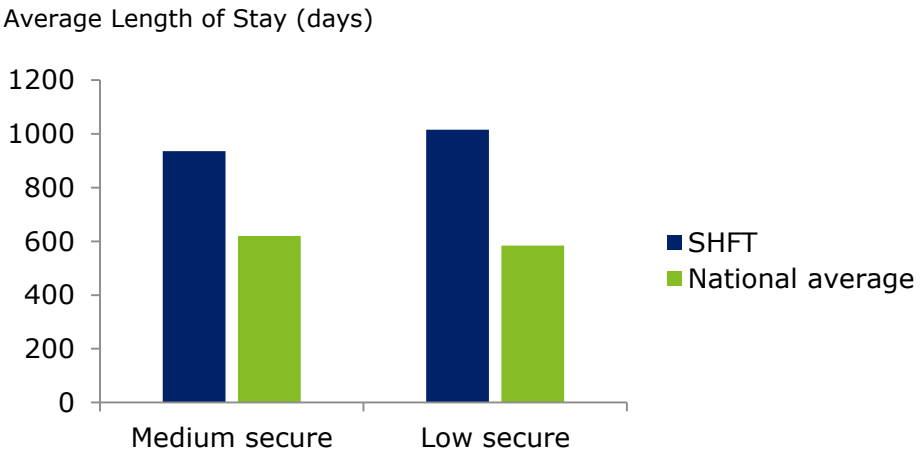
Forensic Services

We provide 78 adult medium secure beds at Ravenswood, 23 low secure step down rehab beds and a small community forensic service, along with low and medium secure forensic services for people with Learning Disabilities.

The lack of provision of acute low secure beds for adults in Hampshire represents a gap in the pathway and can mean that people requiring this level of care either have to go out of area, or in some cases, are stepped up to the medium secure unit, neither of which are optimal for patent experience. The average length of stay in our units is longer than the national average for both medium secure units and low secure units. The variance to the national average in our low secure units is likely to be because we only deliver low secure rehab facilities, but may also be connected to the amount of community forensic capacity that is available. The longer than average length of stay in our medium secure wards may also be due to the other provision that is available, as there is not currently acute low secure provision.

[30] Public Health England - Public Health Profile 'Fingertips.'

NHS Benchmarking: Average Length of Stay versus national average[31]



The physical environment within Ravenswood presents a significant challenge to the delivery of the service. It is an old building that requires a great deal of maintenance and lacks clear lines of sight. Although recent refurbishment has resulted in marked improvements as noted by the CQC, there continue to be challenges, and the site has to mitigate those areas where it cannot meet current national standards. Whilst in the past, plans have been considered to develop a new medium secure facility which were not feasible due to the significant capital investment that they required, progress is now being made on an affordable solution with a business case being developed during 2017.

The service has established a community forensic team that supports people transitioning out of forensic services, for which mainstream CMHT support would not be appropriate. This small team works flexibly and resourcefully to support this cohort of patients in the community. The service is currently exploring how to increase and augment community provision to support people in the community.

Children and Young people

There are 21 beds in Bluebird ward which is a medium secure unit for people aged 18 years and under which specialises in treating emerging personality disorder. It is one of seven medium secure facilities in the country that support young people who have been detained under the Mental Health Act.

Whilst the Trust provides medium secure facilities, the overall pathway is incomplete locally, as there are no low secure beds within the South of England, and there is not clear gatekeeping process that coordinates and supports the forensic pathway. The lack of low secure provision means that people either have to go out of area, or often have to be rehabilitated in the medium secure ward, which adds complexity to the ward and is not the best setting for the patient. In addition, the absence of low secure provision presents a problem to non-forensic patients who are at high risk of causing harm to themselves.

There are also gaps within the CAMHS mainstream pathway. The absence of a Psychiatric Intensive Care Unit (PICU) means that there is a significant gap between tier 4 inpatient beds and the medium secure provision, and there is no means of managing acute periods of risk that do not meet forensic thresholds.

4.3.7 Primary care based mental health services

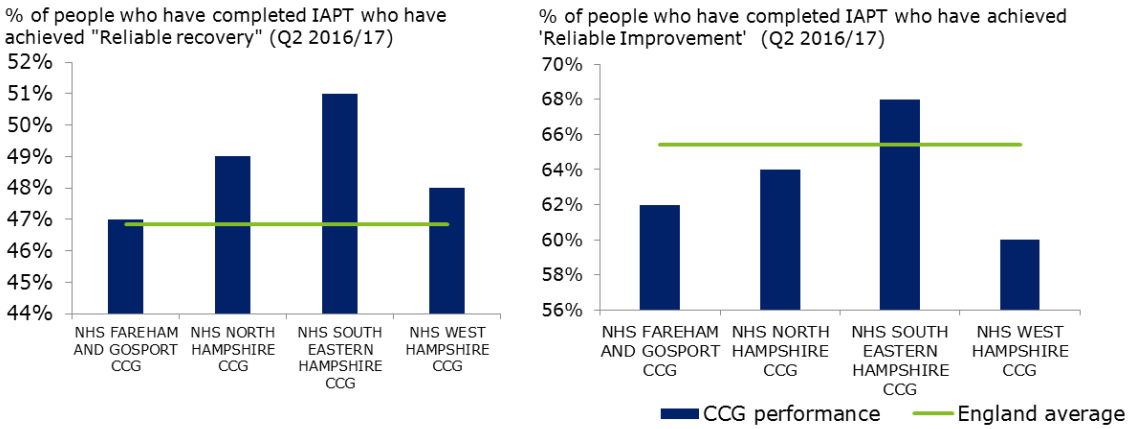
Evidence suggests that outcomes are better when people receive early identification of and treatment for mental health conditions. The majority of people with mental health difficulties present to primary care,[32] with GPs reporting that 1 in 3 consultations involve a mental health component.[33]

[31] NHS Benchmarking Network: Inpatient and Community Mental Health Benchmarking 2016
[32] Mental ill health in primary care. Rees et al. http://www.birmingham.ac.uk/Documents/college-mds/haps/projects/HCNA/08HCNA3D31.pdf

Improving access to psychological therapies (IAPT)

We deliver italk – a step 2 and 3 psychological therapies service in partnership with Solent Mind. This service is for the population of Hampshire (North Hampshire, West Hampshire, South Eastern Hampshire and Fareham and Gosport CCGs) for people aged 16 and over who are not already in contact with other mental health services. People can either self-refer directly to the service or be referred by their GPs or any other healthcare practitioner.

Outcomes data shows that the percentage of people achieving reliable recovery is slightly above the national average, although the proportion achieving reliable improvement is below the national average in three of the four CCGs that commission our italk services.[34]



Access to italk is lower than average, with 2.9% of people with depression and/or anxiety disorders accessing services versus the national average of 3.8% and the national target for 2016/17 of 3.95%[35]. Improving access to these services requires a system wide effort with general practice to direct people to these services. The proportion of people being referred in the higher clusters is significant with over 50% of referrals in cluster 4, 5, 6, 7 and 8 which leads to waits at step 3, whereas the proportion of people with milder presentations is low.[36] There is an opportunity for milder cases to be seen by the service.

In addition to access, there are issues with capacity in the italk service. Although the waiting times for italk are generally ahead of target – on average 87% of people received an appointment within six weeks of referral versus the target of 75%[37] - the waiting times between the first and second treatment appointments suggest a secondary waiting list as 32% of people wait more than 28 days between their first and second appointments. Whilst part of this is due to an agreed 90 day treatment time for step 3 services, as access increases work will need to be done to ensure that there is the workforce available to support an increase in referrals. [38]

Practice based mental health services

Mental ill health in primary care ranges from sub-syndromal symptoms, to clear cases of mental disorder which range significantly in severity and the disability they cause. The current lack of systematically commissioned practice based mental health services means there is limited opportunity to provide support for those who are in a situation where more support than that available from GP practices is needed, but the full services of community mental health teams are not required.

> *"GPs should have more information on which Mental Health services are available to offer to people"*

33 A commissioner's guide to primary care mental health: Strengthening mental health commissioning in primary care: Learning from experience. London Mental Health Strategic Clinical Network for Mental Health, 2014.
34 NHS RightCare CCG data packs, NHS England.
35 Mental Health Five Year Forward View Dashboard - Q2 2016/17, NHS England.
36 SHFT cluster data for open IAPT referrals 6th March 2017
37 SHFT Clinical Performance Dashboards, SHFT Tableau System.
38 August 2016 to October 2016 data for SHFT, NHS Digital IAPT Reports.

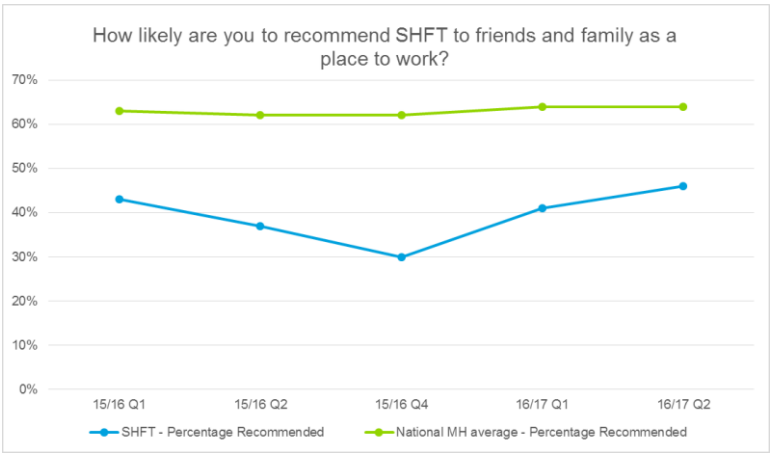
There have been a number of pilots, however there is not at present a commissioned model. An example of this is the Southampton 'STAR' project which has been developed around primary care hubs in Southampton to support emotional needs of people providing structured needs, symptom assessment, problem-solving, activation & connecting people to community resources. Another example is the italk community model with Psychological Wellbeing Practitioners embedded in GP practices in Gosport, with a direct booking facility.

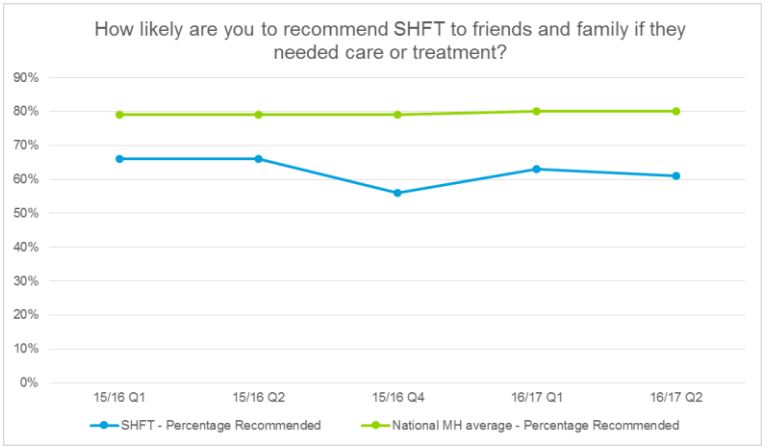
There is an opportunity to work with local delivery systems to identify the need in primary care and work together to develop a solution that addresses this. The newly commissioned italk model with italk core, italk health and italk@work goes some way to support this.

4.4 Staff experience

Staff survey results

The results of our Friends and Family test echoes that there is a need for change in the Trust, both in terms our services and as a place to work. Only 61% of our staff would recommend SHFT to their friends and Family for care and treatment, which is significantly below the national average of 80%.[39] In addition, only 46% of our employees would recommend the trust as a good place to work, which is significantly below the national average of 64%.[40] It is of note that the completion rate of the survey at SHFT which is 5%, is below the national average of 12%.





Staff feedback

[39] Staff Friends and Family data, Q2 2016/17. NHS England.
[40] Southern Health NHSFT, Board paper, October 2016

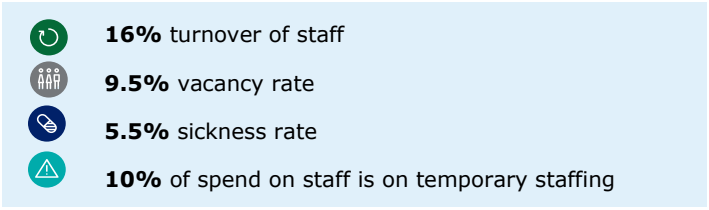
In developing the strategy our staff have been engaged in a variety of ways, via one to one interviews, service visits, online anonymous surveys and workshops. Whilst there was a lot of praise for the dedication, commitment and resilience of their colleagues, the culture of the organisation was a significant theme that emerged, which echoed the views of our Service Users, families and Carers.

The issues raised by staff centred on a perceived lack of expert clinical leadership, lack of autonomy given to staff to deliver quick wins, and the lack of support that staff felt they received from the organisation, particularly during difficult times. Staff felt that there is room for improvement by the Trust leadership, for example giving frontline staff who have greater understanding of their business, leadership roles to develop services and improve patient pathways.

The impact of the scrutiny that the Trust has been subject to in the national press has undoubtedly had an adverse impact on staff experience, with some quoted as "fearful of ending up on the 10 o'clock news" and worried about taking measured positive risks to improve Service User care. In addition to this, staff recognised that this pressure has been a significant distraction for the organisation, and in some cases has impacted upon local service delivery, with staff noting they feel "under a microscope" and exposed, which presents risks to the sustainability of the workforce.

4.5 Workforce sustainability

Workforce challenges present a significant issue for the Trust. Issues such as the lack of availability of band 5 nurses are a nationwide problem, however this is coupled with reputational challenges the Trust has as a result of the events of the past three years.



The impact of the reputational issues on the ability of the Trust to retain staff is seen in staff turnover, which is significantly higher than the national average for mental health trusts of 12% (16% in AMH and 15% in OPMH[41]), and in a number of inpatient facilities and community teams it is as high as over 20%.[42] The vacancy rate in the mental health division is 9.5% (versus a national average of 12%) with a number of teams experiencing significant issues with high vacancy rates. [43] Whilst sickness and absence rates are currently below the national average for mental health (7%) in AMH (5.5%), they are considerably higher in OPMH, where sickness levels are 8.9%.[44]

Workforce challenges pose a risk to the delivery of services. For example, Hamtun Ward, the Psychiatric Intensive Care Unit in Southampton, was closed between July 2016 and March 2017 due to chronic staff shortages, and services such as Hawthorns Psychiatric Intensive Care Unit, and the Ashford Unit, have a vacancy rate over 20%.[45]

As is the case throughout the NHS, workforce shortages pose a significant risk to the Trust and as outlined above, shortages have impacted on the Trust's ability to deliver services. Vacancies and absence can also lead to plugging gaps with bank and agency, which impacts on quality, safety and finances.[46] In the Mental Health and Learning Disabilities division, temporary staffing accounts for 10.7% of staffing costs, with particular issues on certain teams – especially a number of inpatient facilities,

[41] Southern Health NHSFT Workforce data - turnover is calculated as the number of WTE leavers over the rolling 12 month period divided by the average monthly staff in post over the 12 month period
[42] NHS Benchmarking Network: Inpatient and Community Mental Health Benchmarking 2016
[43] Trust Tableau System, NHS Benchmarking. Whilst this appears better than average it will be impacted by the fact that the trust has had to temporarily close facilities whilst it undertakes refurbishment/due to vacancies.
[44] Southern Health NHSFT Workforce data – sickness % Dec 16, NHS Benchmarking Network: Inpatient and Community Mental Health Benchmarking 2016.
[45] SHFT Clinical Performance Dashboards, SHFT Tableau System.
[46] Workforce planning in the NHS. The King's Fund, April 2015.

where the spend on temporary staffing exceeds 30% (such as Willow Assessment and Treatment Unit, Hawthorns PICU and three older people's mental health ward).[47]

4.6 The future of mental health services

Rising demand due to population changes

The current challenges that we face are also set against a context of a growing and an ageing population. The need for health services is set to increase as the populations of Hampshire and Southampton are projected to increase by c. 73,000 people between 2014 and 2021[48], which will mean there are more people with mental illness. In addition, the population is ageing. Between 2014 and 2021, the number of people aged over 65 is projected to increase by 15.5% in Hampshire and 8.8% in Southampton. An ageing population brings with it increasing demand on services as older people are vulnerable to mental illness, including organic illness, depression and anxiety.

The increase in demand with limited resource requires us to develop different ways of working with Service Users, Carers, General Practice, the voluntary sector and Local Authority to ensure that the needs of our population are met, and that best practice approaches are taken.

Realising national ambitions for Mental Health

The Five Year Forward View for Mental Health, commissioned by NHS England, sets out an ambitious framework to guide local clinical strategy and service delivery over the next five years. Delivering this vision will require mental health organisations and wider systems of health and care to work together to expand the provision and delivery of care to people suffering with mental health issues.

The table below summarises the metrics that apply to SHFT, and our progress against them:

Ambition for 2020/21		SHFT progress against 16/17	
Perinatal mental health	30,000 more women each year nationally can access evidence-based specialist perinatal mental health care	🟢	Award-winning perinatal MH team recently extended to Portsmouth, IOW and NE Hampshire & Farnham
Adult mental health: common MH problems	At least 25% of people with common MH conditions can access psychological therapy each year (2016/17 target: 15.8%)	🔴	All 4 CCGs where IAPT is provided by SHFT has not met this year's target so far
Adult mental health: community, acute and crisis care	60% people experiencing a first episode of psychosis will access NICE concordant care within 2 weeks	🟢	Target met. SHFT has achieved 86% in the past 12 months.
	Specialist EIP provision are in line with NICE recommendations	🟡	Audits against NICE standards were completed in Sept 2016 (at time of writing only known for Southampton)
	People with severe mental illness receiving a full annual physical health check to increase to 280,000 nationally by 2020/21	🔴	Below England average in all 5 CCGs
	All areas will provide best practice, 24/7 crisis resolution and home treatment as alternative to admission by 2020/21	🔴	Hospital at home teams are 24/7 but not full scale provision
	Acute adult mental health care out of area placements will be eliminated by 2020/21	🟡	The trust is using out of area placements but there is a plan to reduce.
	All acute hospitals to have all-age mental health liaison services with at least 50% meeting the 'Core 24' service standard by 2020/21	🟡	Provides liaison psychiatry in all acute trusts but is not 24/7 and is consumed with A&E
Secure care pathways	NHSE to address existing fragmented pathways in secure care, increase provision of community-based services and trial new co-commissioning funding and service models	🟡	Working with Oxford Health in the NHSE vanguard to ensure the secure pathways are seamless
Suicide prevention	By 2020/21, the number of people taking their own lives will be reduced by 10% nationally compared to 2016/17 levels	🟡	Suicide levels are below average in Hampshire and above average in Southampton. Hampshire County Council has a multi-agency suicide prevention strategy that links with the Crisis Care Concordat
Commitment to mental health funding	NHSE 5YFV MH Dashboard: Mental health 2016/17 planned spend as a proportion of overall CCG funding allocation	🔴	Below England average of 13.1% for all CCGs except Southampton which is in line with national average
	Parity of Esteem achieved in 2016/17 planned period	🟡	Achieved for all areas except Southampton CCG

🟢 On track
🟡 In progress
🔴 Significant gap

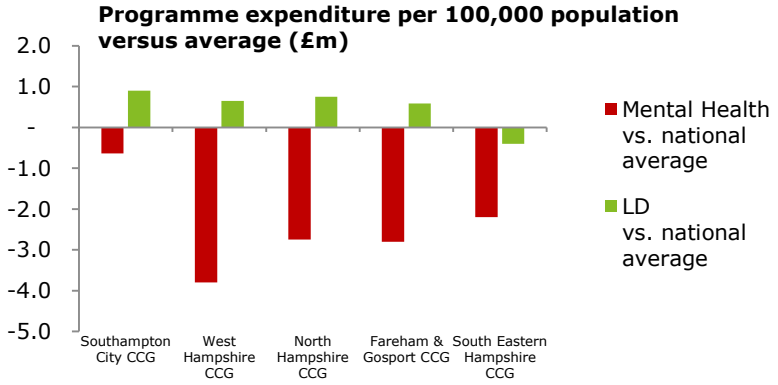
Progress against 5YFV metrics:[49]

[47] Bank and Agency Report, Southern Health NHSFT Tableau System
[48] UK Population Projection Estimates, Office for National Statistics.
[49] Implementing the Five Year Forward View for Mental Health, NHS England July 2016. Mental Health Five Year Forward View Dashboard - Q2 2016/17, NHS England. Categories such as children's where SHFT does not provide services have been excluded. RAG rating is based on SHFT data in relation to the metrics.

Whilst the Trust is making progress on some of the more specialised metrics, the key areas where there is work to do are:

1. Delivering access to crisis care and liaison services;
2. Increasing access to psychological therapies; and
3. Increase physical health checks for people with serious mental illness.

In addition to this, it is of important context that benchmarking suggests that expenditure on mental health per 100,000 population is below average versus both the national average and the peer group average for all our CCGs in Mental Health. Conversely the expenditure on Learning Disabilities by all CCGs, with the exception of North Hampshire CCG is above average as outlined in the chart below:[50]



Across all CCGs, this equates to spend of c. £30-38m below average on mental health services, and c. £7-7.5m above average on Learning Disabilities services.[51]

4.7 Summary

Service users, families and carers are not sufficiently prominent and included in our organisation

Service users, carers, families and professionals **struggle to access services**, due to thresholds and strict criteria that are not needs led

There is not a sufficiently robust **24/7 crisis response service**, with sufficient alternatives to admission, which means that community teams pick up the slack

There is **variation** in community services that are not always needs-led, and resource is not configured around embedded pathways, and instead often consumed by urgent needs

Inpatient care is sometimes a result of a lack of an alternative. As with community services there is variation in provision

The absence of embedded care pathways means that **specialist pathways are not always consistent** with mainstream pathways, and there are gaps in provision which mean that people can end up out of area

There are opportunities to further develop practice based services and improve access and capacity, in italk

These challenges are set against increasing demand due to population growth and the ambitions for parity of esteem, and increasing concerns about the sustainability of the workforce

[50] NHS England 2015/16 Programme Budget
[51] This relates to total spend on Mental health and Learning Disabilities services and not just Southern's share. It has been calculated by extrapolating spend per 100,000 population to the population level of each CCG.

4.8 Time to act and transform services

Although we are making progress in addressing the concerns of the CQC around governance and safety, and we have already taken steps to focus services on a core footprint, it is acknowledged that there needs to be a concerted focus on redesigning Mental Health and Learning Disabilities Services, in order to deliver consistently high quality services to our population.

The scale of change required is significant, and will only be achieved if we work in partnership with commissioners and the wider health and care system, Service Users, Families and Carers, to co-design services that deliver high quality care for the people that use them. This will require a significant shift in culture.

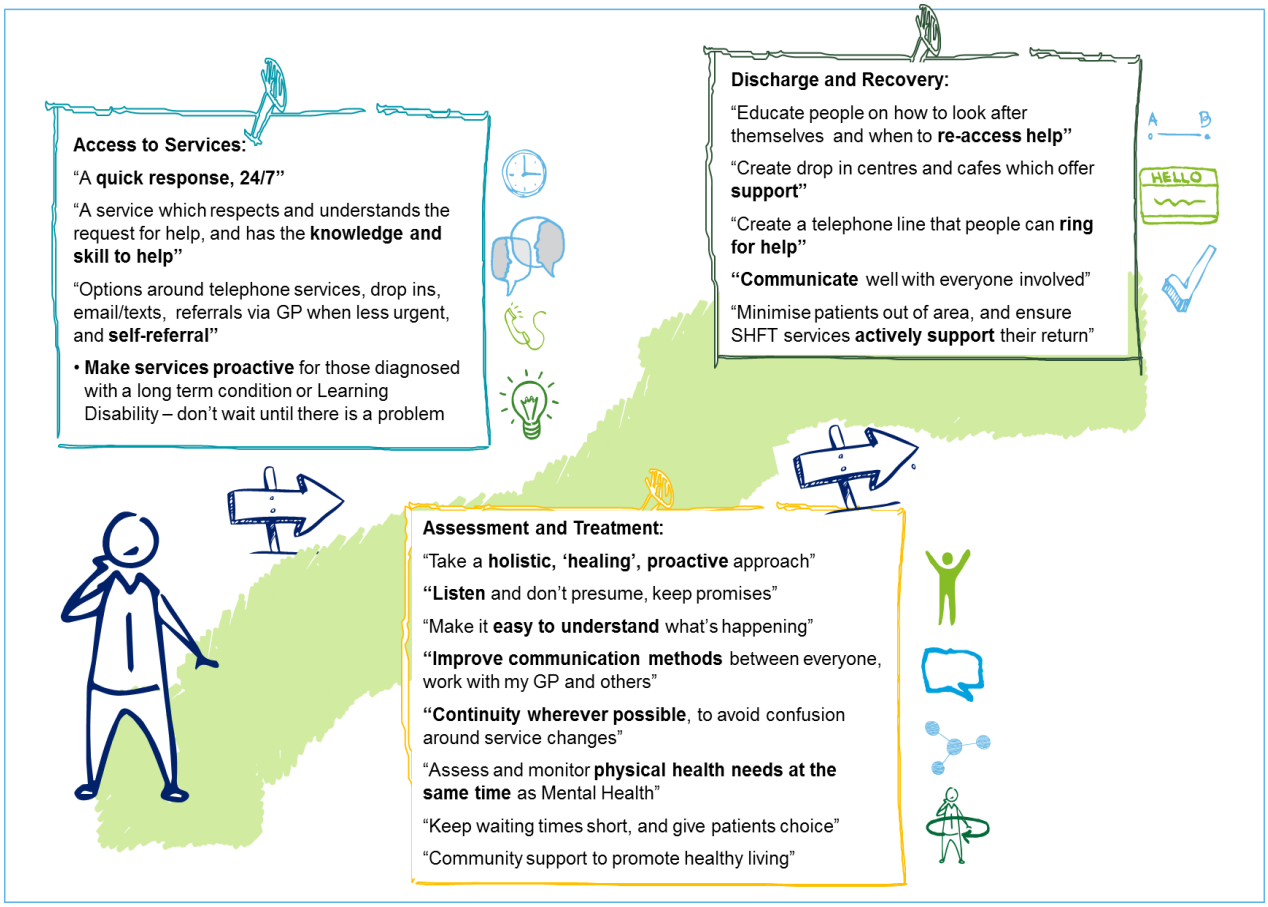
5 Future Service Design Principles

Our approach to developing this strategy has involved working with a wide group of stakeholders including Service Users, Families and Carers who experience our services first-hand; our staff; and national and international experts. Their feedback has informed the development of the strategic service design principles which underpin our services.

What does good look like for our Service Users and Carers?

Understanding the needs and requirements of our Service Users, Families and Carers has been the starting point of this work. We have engaged with our Service Users, Families and Carers via workshops, conversations and a questionnaire to understand what 'good' care would look like. Further information can be found in appendix 1.

Below is a graphical representation of a 'good' service user journey based on the feedback from our service users and carers, which has informed this strategy.

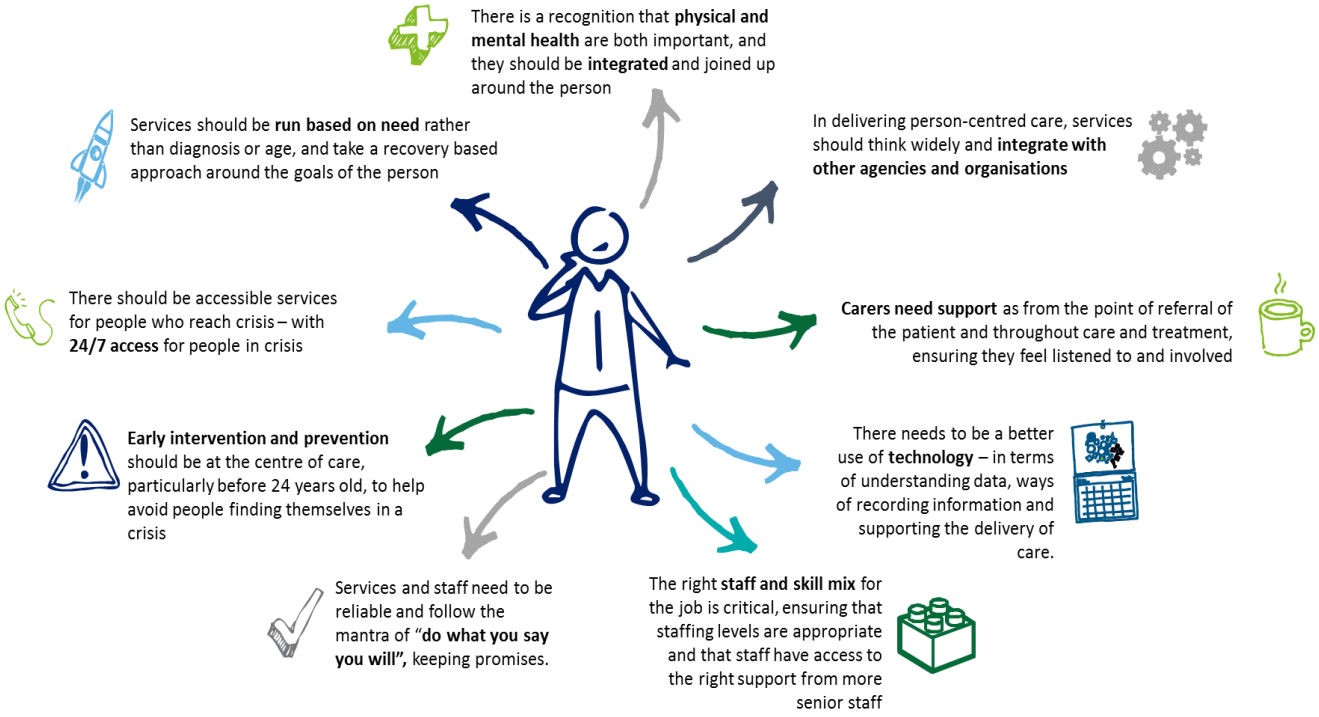


This work is the beginning of an ongoing conversation and collaboration with our Service Users, their Families and Carers to improve services and include them in decisions that affect the services they use.

What does good look like to our staff?

Our staff are the core of our organisation, and have a unique insight into how our services work. Our staff shared a number of clear and inspiring ideas about opportunities to improve the services they deliver. An overwhelming message from our staff was that personalised care and treatment based around the needs of the person is essential.

Our staff provided the following clear messages about how our services can be improved:



Overarching Strategic Principles for the delivery of Clinical Services

Our staff have developed a set of core principles in a 3 day clinical design workshop, where over 80 staff members of all professions and grades came together with partners to hear the feedback from our Service Users, Families, Carers and their colleagues. They then incorporated this into a future way forwards by designing a set of service principles which are a starting point to base our service design on. Our services principles are:

- To provide **high quality, safe, person-centred** and **holistic** services which improve the health, wellbeing and independence of the people we serve
- To deliver **needs-led services**, which are **timely, proactive** and **easy to access by all**, **24/7**
- To have the **right people doing the right job**, taking ownership and pride in good communication
- To adopt a **recovery-focused** approach, with a positive attitude to strengths, resilience and risk-taking, and which is adaptable to change
- To participate in **strong partnership working** to provide continuity across interfaces and transitions, supporting prevention and early intervention.

Below is further detail on each of the principles, how we will deliver on these principles and the benefits of these principles for Service Users, their families and Carers.

High quality, safe, person-centred care delivered around the holistic needs of the person

Delivering person-centred care means that care is delivered based on the needs and strengths of service users, rather than around how services happen to be configured and operated in that area. This means working in equal partnership with the individual, their family and carers, and partner organisations in the planning and delivery of their care. People using services should feel confident that they have ownership of, and clarity around, the care they are receiving, and be actively involved in shared decision-making. Service Users are treated as a whole person, creating a plan about their Mental Health diagnosis that considers their physical, emotional, spiritual and social needs. The 'bio-psycho-social' clinical approach delivers this as it encompasses the biological (physical health), psychological and social needs of the person.

How:

- We will actively involve and include Service Users, Families and Carers in the development of our services
- We will strengthen links with other agencies, including the Local Authority, Social Services, General Practice and the Voluntary Sector
- We will work with our staff to develop our skills in co-production, Service User and Carer experience and care planning
- We will listen, and understand how Service Users wish to access their care records, to promote the concept of having a shared understanding and person-centred plan
- We will commit to supporting Service Users and Carers to get to the right service via 'warm transfers'

Outcomes for service users and carers:

- Service users will have a better experience of care, as care is coordinated around their needs
- Service users will have better physical health outcomes as care is more joined up

Needs-led services, which are timely, proactive and easy to access, 24/7

Needs-led services are designed around the individual need of the person, rather than applying thresholds which result from categorising the person according to age, ability or other parameters. This requires a more flexible approach to accessing the right services by pulling clinical skills across all pathways, in a multi-disciplinary approach. It means that the service adapts to the individual, rather than the individual adapting to the service. This includes providing care 24/7 for people with urgent needs.

How:

- We will develop urgent care services that provide delivery of assessment and treatment 24/7 for all Service Users
- We will redesign our services around needs-led pathways. For example the psychosis pathway will be consistent for Service Users whatever their age or ability. As complexity and severity increase we will draw on more specialised skill sets for example in LD or older people's services.
- We will develop a holistic assessment and formulation processes which includes assessment of physical health status and any social needs.
- We will seek further opportunities to work proactively with local delivery systems of care and Primary Care.

Outcomes for service users and carers:

- Service users, their carers and families will have an improved experience of care as services are available and accessible
- Outcomes will improve for our service users as they are cared for in the right setting, with the right level of support for their needs, without the need to resort to other services such as A&E.

Having the right people doing the right job, taking ownership and taking pride in good communication

Getting it right first time is critical in delivering high quality services, and our staff are vital to delivering this. Continuing to foster a culture where staff are compassionate, caring and listen to Service Users and Carers, while being honest and transparent about what is and is not possible, is key. This will require a solid understanding of the skills and capabilities required in the workforce, where there are gaps, and how the appropriate deployment of these skills and resources can be managed. Ensuring effective, respectful communication between all parties prevents unnecessary repetition of Service User and Carer stories and supports the delivery of a seamless package of care.

How:

- We will develop a clear understanding of the pathways and packages of care, and what skills and capabilities are required to deliver these
- We will develop an up to date workforce strategy which supports the delivery of this Strategic Statement
- We will consider front-loading clinical expertise, for the benefit of our Service Users, and of our staff, in providing support, leadership and opportunities for upskilling
- We will ensure that communication, clinical and non-clinical, is clear and transparent at all levels in the Trust

Outcome for service users and Carers:

- Service users' experience of care will improve as we get it right first time.
- Service users will achieve their goals more effectively.
- Clinical outcomes will improve as service users feel supported to manage their condition by the right staff.
- Our staff will be supported and empowered to deliver high quality clinical care.

A recovery-oriented approach, with a positive attitude to strengths, resilience and risk-taking, and which is adaptable to change

Recovery is a way of living a satisfying, hopeful and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life. It also means understanding the limitations imposed by illness, but finding a way to live a fulfilling life despite this. Recovery and personalisation approaches see people who use services as 'whole people in their whole context' building on their strengths and abilities and supporting them when and where this is needed.[52] This means working to identify things that people are good at and recognising, valuing and building upon them; empowering the individual by supporting them to identify potential risks and develop coping strategies with the ability to cope with life's challenges.

How:

[52] Brewis, R. & Fitzgerald, J. (2010) Citizenship in Health: Self-direction theory to practice. Wythall, West Midlands: In Control Partnerships.

- We will systematically and consistently work alongside Service Users to set their own goals, and continuously review these
- Our Service Users and Carers will be supported by staff in collaborative risk assessments and crisis planning, to develop greater resilience, which will require close links with other services, partner agencies and voluntary sector organisations
- We will develop an organisational approach to supporting staff with positive risk-taking
- We will build on existing good practice, further developing peer worker roles across the whole pathway and further utilising the Recovery College in Southampton
- Our services will identify appropriate outcome metrics and use these to drive improvements for and with Service Users

Outcomes:

- Service users will have a sense of meaning and purpose and hope and optimism.
- Clinical outcomes will improve as service users will feel empowered to take more responsibility for their own health and wellbeing

Strong partnership working to provide continuity across interfaces and transitions, supporting prevention and early intervention

Our services sit within a broader landscape of support for people who use services, including general practice, social care, support from the voluntary sector, and importantly, support from the community. Delivering high quality care requires close working with other agencies to develop joint strategies that maximise the available resource to deliver the best outcomes. This requires continuity across interfaces and transitions to ensure that there are not issues such as further waits for other service involvement. Interfaces can occur within pathways, across multiple departments and across different organisations and sectors.

How:

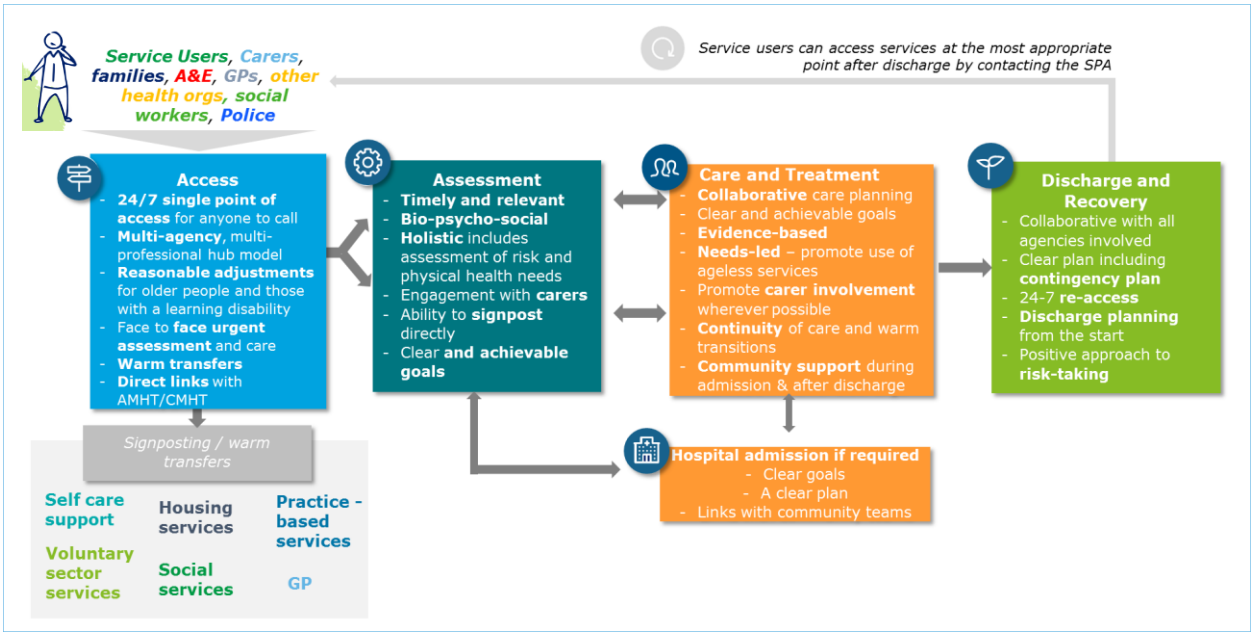
- We will work with the wider system to support people with mental illness and learning disabilities
- We will work collaboratively across specialisms and with other providers to plan how to deliver more joined up care including reviewing technology systems to provide better information flow, and consideration of how services can 'pull' one another's expertise without relying on lengthy referral processes
- We will enhance links with primary care and other providers to support prevention and early intervention agendas

Outcomes for service users and carers:

- Experience of our services will improve as service users see that professionals are helping them manage their condition in a joined up way.
- Outcomes will improve as service users will be able to access the right support as quickly as possible.

High Level Stages of the Pathway:

Our staff have developed a set of core principles for each stage of the pathway, building on Service User and Carer feedback. These principles provide a framework against which our services will be delivered at each stage of the Service User journey. While there will be adaptations for the different services that we provide, the core principles outlined below will hold true for all Mental Health and Learning Disabilities services.



In developing our services according to these principles, we will ensure that services consistent and of high quality:

Principles for access to services

There are significant opportunities to improve access into our services, and the speed of onward assessment, including where there is urgent need. We will ensure that our services deliver the following principles around access:

- **24/7 access point**, for the whole of Hampshire, accessible to Service Users from across all pathways, Carers, GPs, professionals and anyone else to call, particularly for access to urgent Mental Health services, and to gain advice, information and support
- To include **reasonable adjustments** for Older People, those with Learning Disabilities and anyone else with additional needs, to maximise the ability to access and benefit from services. Examples of this might include adapting the communication style, the amount of time spent with the person, or the environment or venue within which the person is seen
- To take telephone calls **without waiting** or use of answerphones, and to use other forms of technology such as text, web chat, apps and email
- A **multi-agency, multi-profession** Hub model, with sharing of information systems, to be staffed by qualified professionals, supported by non-clinical staff
- The 'spokes' of the access service to provide support close to home for Service Users, enabling rapid and frequent support to be delivered locally
- To have provision for **Face to Face urgent assessment** and care using a bio-psycho-social model that can be adapted to circumstance but is in its approach across all locality teams to provide support at home as an alternative to hospital admission when appropriate
- To have provision for inpatient **admission** to crisis beds when needed, as well as other options such as Crisis Cafés, Safe Havens or a Mental Health Bus
- To work in collaboration with GPs and other providers in the care of those with **long-term conditions**
- To provide **advice and support** to GPs and other partners, including Carers
- To **signpost** callers when necessary, with warm transfers wherever possible, using a service directory which is kept up to date and maintained on a frequent and regular basis by the Trust and its partners

- To **facilitate re-access** when needed, at the point in the pathway which is most appropriate for that individual at that time
- Direct links to locally-provided AMHT and CMHT teams from across the specialisms, who will support the triage clinicians in the access point by providing **additional expertise** and advice when needed

What this will mean for service users and Carers:

- Service users will have rapid access to skilled advice and support, 24/7
- No need to attend A&E unless physically unwell or injured
- Admissions only when necessary – cared for closer to home
- Improved clinical outcomes as a result

Improvements to assessment processes

Delivering person-centred, recovery-focused care across interfaces starts with a holistic, consistent assessment process that takes into account the needs of the whole person and is co-produced, engaging Service Users and Carers. We will ensure that the assessment process for all services adopts the following key principles:

- **Timely and relevant, non-judgmental, validating of experience**
- **Bio-psycho-social** model which includes assessment of risk, and holistic including physical health, spiritual and cultural needs
- **Multi-agency and service** wherever possible, to also identify and support social and other needs
- **Engagement with Carers**, listening to their concerns and respecting their knowledge – taking a common-sense approach to confidentiality
- **Supporting clinicians** by allocating preparation time and admin support in producing notes, reports and onward referrals/follow up
- Ability to **signpost** directly to other services, not make Service Users wait again or repeat their story
- **Communication and processes** which are easy to understand, and add value for the Service User and Carer(s)
- Formulation of needs, sharing of expectations, with **clear and achievable goals**
- **Being honest** about what can and can't be done, be radical and genuine

What this will mean for our service users and Carers:

- All needs are considered at once
- Service users, their families and their carers feel listened to and involved, by skilled clinicians who have the time to engage
- Clear understanding of the process and the outcomes
- Able to contribute their expectations and plan towards clear goals
- Improved clinical outcomes as a result

Principles for care and treatment

Care and treatment is usually the longest part of the intervention which encompasses many different services and pathways. The transformation of care and treatment will happen at a pathway level, underpinned by the following core principles:

- **Evidence-based**, **needs-led**, and **timely**
- Treatment planning which is **collaborative, with clear and achievable goals and is always recovery-focused** with agreed metrics for evaluating progress, helpfulness and wellbeing
- **Continuity of care and warm transitions**
- To promote the use of **needs led, mainstream Mental Health services** wherever possible, and to ensure those who need specialist support from Learning Disability, Older People's and Specialist Services clinicians can access that, in tandem or alone
- **Consistency of services** – removal of the postcode/commissioning lottery as far as possible and clarity about what limitations exist.
- **Use of senior staff** skills and experience, to upskill and support others
- To promote **Carer inclusion** wherever possible, listening even if sharing is not possible
- To facilitate the **'stepping up'** of care and treatment when needed, within community-delivered services
- To ensure **inpatient admission has clear goals and a plan**, with community support during the admission and after discharge
- Using the staff with the right skills at the right point, without waiting

What this will mean for service users and Carers

- All needs will be taken into account at the same time, in services that don't create barriers or transitions around age, diagnosis or other parameters
- Service users feel listened to and involved, by skilled clinicians who have the time to engage
- Additional support is available quickly when needed, to prevent crisis and reduce the need for admissions
- Able to work towards clear goals from the start
- Improved clinical outcomes as a result

Principles for Discharge and Recovery

Preparing Service Users for recovery and leaving services right from the start of their pathway is critical. It ensures that they, their Carers and the staff with whom they work, are focussed, well prepared and confident that they can move forward to life in the community, safe in the knowledge that support is available easily and quickly should they need it. As with care and treatment, the transformation of the approach to discharge and recovery will happen at a pathway level, and will be underpinned by the following principles:

- **Collaborative planning** from the start of agreeing the care and treatment plan, with Service User, Carer(s), and partners including GPs involved
- Clear plans, including **contingency plans**, and 24/7 re-access available if needed
- **Integrated** to include physical health, social, spiritual and cultural needs
- Clarity regarding the words 'discharge' and 'recovery' and what they mean in different pathways – consider alternatives to 'discharge' such as 'transfer of care'
- Positive approach to **risk-taking**

- Specific strategy for **long term, vulnerable people** who may be resistant to treatment – working collaboratively with GPs and other partners involved as needed for the individual

What this will mean for service users and Carers:

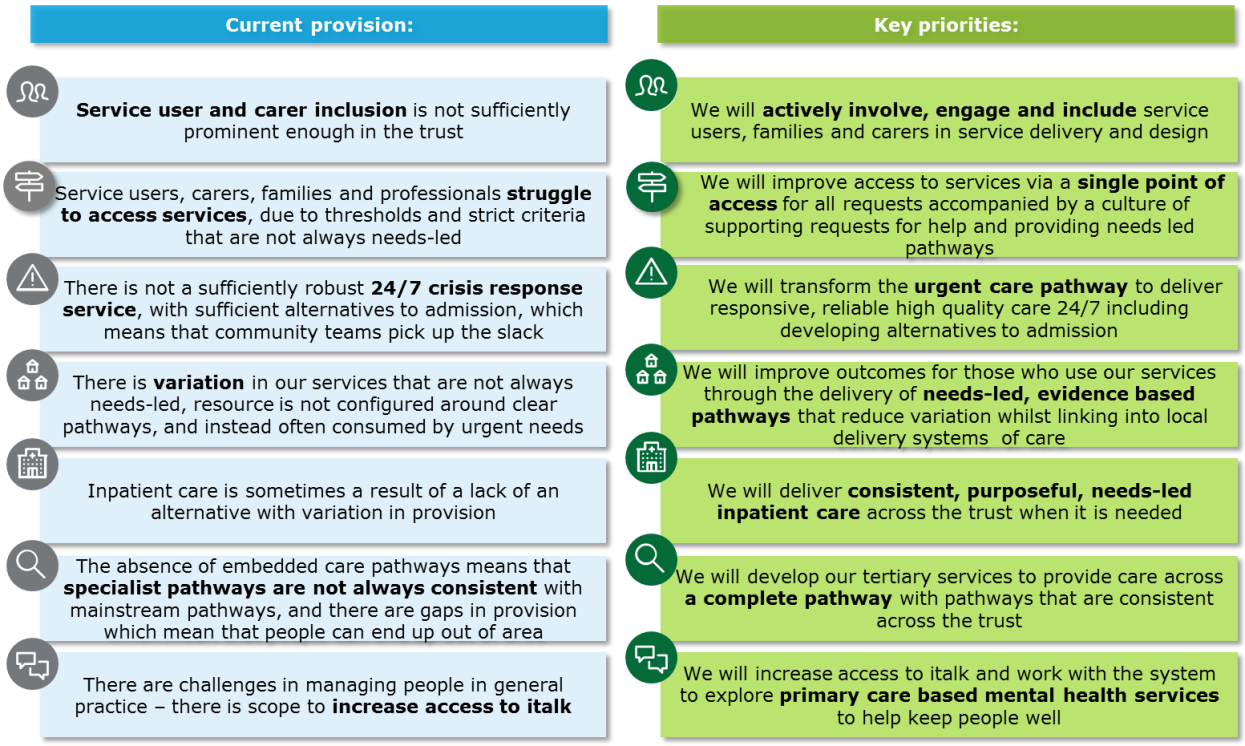
- Focus on leading a meaningful life, and only accessing care and support when needed
- Feel listened to and involved, by skilled clinicians who have the time to engage
- Additional support and advice available quickly when needed, to prevent crisis and reduce the need for admissions, and empower individuals to care for themselves
- Able to work towards clear goals from the start
- Improved clinical outcomes as a result

These principles relate to the design and delivery of Mental Health and Learning Disabilities pathways delivered by the Trust. There are a number of interdependencies both with the other services that we deliver, as well as with other agencies including primary care, social services and the voluntary sector. Collaboration with these other organisations will be crucial to the success of any service development.

There is also a need to focus on prevention and collaborative work in the community, in particular supporting emotional wellbeing in the Local Delivery Systems. Our Mental Health Pathways will not function without strong preventative initiatives in local areas, which will improve the health of the population in general, supporting those at the less severe end of the spectrum of services, and also supporting those who have required a more intensive intervention and are moving towards recovery. These services will be improved by confidence in a high quality Mental Health and Learning Disability service which is accessible and reaches out to work with others.

6 What does this mean in practice

We have identified a number of priorities that will improve the care that service users receive and deliver on our service principles to ensure that our Mental Health and Learning Disabilities services offer consistently high quality care. These are outlined below, and in more detail in this chapter:



We will actively involve and engage people who use our services, their families and carers, in service delivery and design

Our aims and vision

We will work with people who use services, their families and carers to engage meaningfully in the coproduction of delivery and design of the services that we provide. Service users are 'experts by experience', and by working together we will improve the quality, safety and effectiveness of our services. This will include ensuring that people who use services, families and carers are central to decision making about their care, and working in partnership to identify how we will work together to develop and improve the services that we provide.

Benefits to service users and Carers

- Improved patient outcomes as services are tailored to the needs of people receiving care.
- Improved patient experience and satisfaction.
- Involvement can be a personally therapeutic experience.
- Families will be better supported to maintain their health and wellbeing.
- Our staff value working in collaboration with people who use services, and an enhanced staff experience will result in improved quality of care

How we will deliver this:

Including people who use services, carers and families meaningfully is a journey which we must work together to navigate. We recognise that this will require a shift in thinking about how our staff and service users, families and carers work together.

In order to achieve this we will co-develop a strategy with people who use our services, their families and carers that will determine how we work together to improve our services both in terms of delivery and development of services. We will also involve advocacy services to support cases where individuals need support to express their views, to ensure that their opinions are heard.

Collaborative involvement in assessment and treatment and discharge

We will work in partnership to ensure that people who use services, their carers and families are always at the centre of decisions about care and treatment. This will include agreeing the purpose and goals of care collaboratively, and making sure that service users are given appropriate choice and control - for example over what kind of treatment they receive.

In addition to service users, we will include families and carers in decisions about care where appropriate. Families and carers usually have a good understanding of a person's strengths, weaknesses, symptoms, likes and dislikes, and can share these particularly when someone is unwell, in order to gain a clear picture of what is going on in the lives of their loved ones. We will consider how we engage carers to enable their full inclusion in care and support, decision making and service delivery, including adopting tools such as the Triangle of Care, which provides a framework to help services to improve their engagement with carers. We will also ensure that carers are provided the opportunity to have a Carers Assessment in relation to their caring role and their own mental and physical well-being.

The Triangle of Care

The Triangle of Care is a self-assessment tool for mental health providers developed by the Carers' Trust in 2010. It is based on the principle that care is made better by making sure there are good working relationships between the service user, the mental health professional and the carer. It sets out a programme for service development with regard to supporting carers. It provides 6 Key Elements (Standards) required to achieve better collaboration:

1. Carers and the essential role they play are identified at first contact or as soon as possible thereafter
2. Staff are 'carer aware' and trained in carer engagement strategies
3. Policy and practice protocols re confidentiality and sharing information are in place
4. Defined post(s) responsible for carers are in place
5. A Carer introduction to the service and staff is available with a relevant range of information across the care pathway
6. A range of carer support services are available.

Involvement and inclusion in service delivery

We will work with service users and carers to establish the best way of including them in the delivery of services, including the Recovery College and also expanding the use of peer workers throughout community and inpatient mental health services.

Involvement and inclusion in service level and strategic redesign of services

In addition to putting people who use our services, their carers and families at the centre of decision making about their care, we will harness their invaluable insight and experience in the design and improvement of our services.

We will build on the work that we have started as part of this process to work in partnership with people who use our services, their families and carers to agree a shared purpose and goals, and to define what service user and carer leadership will look like. Through use of approached such as experience-based co-design, we will ensure this collaborative way of working is embedded at all stages of service improvement.

Underpinning this, we will work to identify the support that we will require to meaningfully include service users, carers and their families. This is likely to include training for staff and service users, families and carers and looking for ways of engaging that ensures that involvement takes account of the needs of those taking part.

Examples of good practice

Case study: Somerset Partnership NHS Foundation Trust

The *Triangle of Care* model is mandatory as a Quality Improvement Plan for every service, and is integral to the governance of the Trust. The Triangle of Care Steering Group is part of the key management lines of accountability, and has Carer, Service User, Third Sector and staff representatives. The Trust's Lead for this initiative is also the operational manager of the Carers Assessment Service.

Staff buy-in is achieved through training, consultation, promotion by managers, policies and protocols. Every team has a Triangle of Care Champion who promotes Family and Carer-inclusive thinking.

Case study: Well London Health Champion Programme, Lambeth

The Lambeth Living Well collaborative gives mental health Service Users an equal voice with providers and commissioners. The collaborative brings together mental health (NHS and social care) Service Users, Carers, practitioners and commissioners at monthly meetings. This provides participants with opportunities to share experience and design new systems based on what works for them.

Outcomes: The collaborative developed a support plan with Service Users stuck in hospital aimed at supporting them to achieve their ambitions and goals. The service was developed within existing resources and has so far worked with 210 people, discharging them into the community to live more independent, but supported lives at a considerable saving to the NHS.

Lambeth Cabinet member for wellbeing, Cllr Jim Dickson said*: 'The Collaborative demonstrates that co-producing with mental health service users and Carers' produces excellent results and efficiencies.'*

We will improve access to services via a single point of access for all requests for help accompanied by a culture of supporting all requests for help

Our aims and vision

We will improve access to our me Mental Health and Learning Disabilities services, by ensuring that all those who need support can easily reach services (including via self-referral) and simplifying how people access our services, avoiding people being 'bounced' around the system. This is a priority for both urgent referrals and routine referrals. Our proposed design is to create a 24/7 single point of access, that is accessible to all regardless of their diagnosis, age or IQ, and will provide the entry point for our Mental Health and Learning Disabilities services.

Benefits to service users and Carers:

- A clear way of accessing support, with the ability to self and Family /Carer-refer.
- Quick and reliable response to requests for help
- 24/7 urgent service delivery
- Access to advice and information for professionals, service users, Families, Carers and other services.

How we will deliver this

Improving access to our services will require a major shift in culture to ensure that people are **supported to reach the right care.** We will respect the principle that mental health crisis is self-defined, accepting referrals from anyone (including self-referrals) and we will review the thresholds for our teams. The development of needs-led pathways will also support people to access the most appropriate service quickly. When a person's needs are better met by another organisation, we will facilitate warm transfers to support the person to get to the right place. This will require us to work with partners to develop an up to date service directory across health, social care and the voluntary sector.

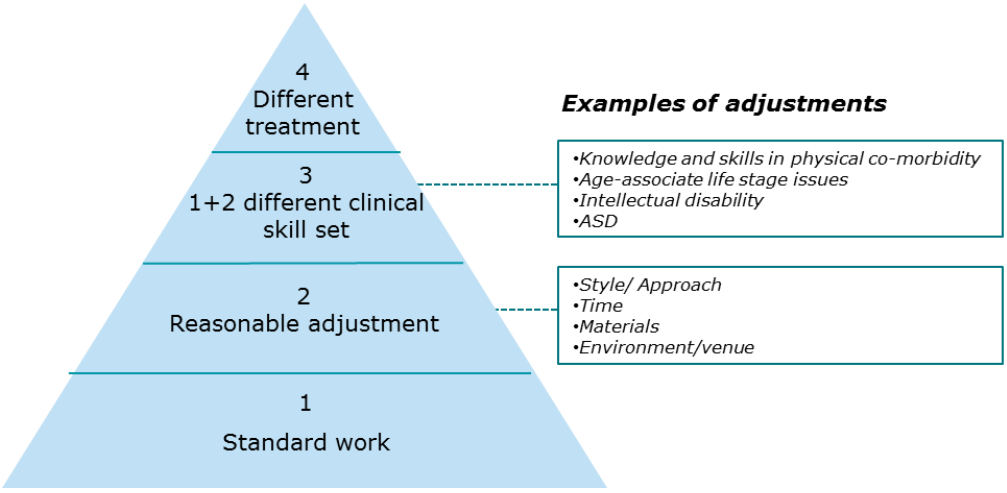
Our proposed solution to improve and simplify access is a **24/7, single point of access** which would be a multi-professional hub and spoke model, for urgent and routine referrals and requests for help. This will be accessible to everyone who uses our services, regardless of age or ability including those who use our Adult Mental Health services, Older People's Mental Health and Learning Disabilities services. The single point of access would include provision for a clinical advice line, for Service Users, Carers and partners to access. It should be noted that this may not be a single point of access from an organisational point of view, depending on the footprints at which it is planned, but it will be a single point of access from a service user's point of view.

Our single point of access will be the route for all referrals. It will triage referrals every day, as they are received and allocate them to the correct pathway using the expertise of specialist clinicians, and will include a **hub and spoke crisis model** which will provide Service Users and their Families with the care and support they need close to home. This will help to prevent the escalation of need both within our Mental Health and Learning Disabilities services, and reduce the need for people to resort to other services such as A&E.[53]

We will ensure that these responses have the correct level of capacity and resource to cope with urgent demand, and that all who need support are aware of our services, to ensure that people get to the right place, first time. We will work in partnership with 111, 999, social services and the Police to streamline urgent access and improve outcomes for the people who use our services.

[53] Based on experience of Bradford District Care Trust

The Single Point of Access will not discriminate based on age or IQ, and will take a reasonable adjustment approach, to meet the specific needs of people with Learning Disabilities or older people. The way in which we will adapt our approach for people with additional needs is reflected in the Reasonable Adjustments triangle, where clinicians from across specialisms support one another with additional expertise to support the service user:



The development of a single point of access will require **the alignment of commissioners and the broader system** to define the scope of services, and footprints over which it operates. It is our ambition to work with the system and the local delivery systems to develop a clinically and financially sustainable solution that is agreed on a system wide basis.

Good practice examples

A number of trusts in the country have seen positive results from this model, including Bradford District Care NHSFT and Northumberland, Tyne and Wear NHS FT.

Case study: Initial Response Service (IRS) - Northumberland, Tyne and Wear NHS FT

What is it? The IRS provides a 24/7 response to telephone requests for both urgent and routine help, to provide practical advice and emotional support from qualified nursing staff and when appropriate, routing to the right service. This service does not discriminate and includes clinical expertise from learning disabilities and older adult services, meaning that all of those individuals can receive a 24/7 urgent response as well as better access to planned care.

Working alongside the crisis team, nurses provide clinical triage and lead the Rapid Response. In addition, through skill and experience sharing there are now interchangeable roles across the IRT and Crisis team.

Outcome: As a result, there has been an increase in number of service users with urgent mental health needs receiving an intervention from the service along with improved response times for home visits for face to face assessment (average 30 minutes from call to door). Avoidable harm has reduced, with no "bounced referrals" (these are now routed to the most appropriate service). Finally, less time is spent by the ambulance service in relation to service users with urgent mental health needs and there have been fewer breaches of 4hr A&E target relating to service users presenting with mental health problems.

Case study: Single Point of Access for crisis response - Bradford District Care NHS FT

In 2014, the Trust was spending £1.8m on out of area beds. The trust embarked on a journey of transformation, and has found that one of the biggest impacts in addressing these issues has been the Bradford First Response service. The Service gives a single phone number for all urgent care and provides crisis response by trained staff who identify the most appropriate action to take.

Patient story

Daniel

Daniel is a 27 year old man who has recently separated from his girlfriend of 5 years. He has become withdrawn and isolated and his mood is very low. Daniel went to see his GP who gave him some advice and information about depression and explained that medication was not appropriate at this time. He suggested referring Daniel to mental health services for some support, but Daniel did not want to do this at this time. The GP respected his wishes and gave Daniel the contact number for the mental health single point of access (SPoA) should he need their help and support in the future.

Two weeks later, Daniel's mood had worsened and he had begun to have thoughts of ending his life. This was frightening Daniel and so he contacted the telephone number provided by his GP. Daniel was tearful on the phone and explained how he was feeling. He spoke to Sarah, a nurse, who told him that he would be seen at home by a clinician within the hour.

Daniel was seen by the Crisis Team at his home that day, and it was agreed that a full assessment would be carried out. A plan for a period of Home Based Treatment was agreed. Daniel was happy with this plan, and agreed he would contact the SPoA in between appointments if needed. Daniel was asked if he had any support at home or through friends and family, and he replied that he did not.

Daniel was seen daily by the Crisis Team for a period of 2 weeks and received treatment for his depression. It was agreed at the beginning of his treatment that he would benefit from further depression management from the Community Treatment Team and a referral was made. His ongoing care was allocated to a Community Psychiatric Nurse, David, and Daniel was seen jointly by the Community and Crisis Nurses before the Community team took over his care.

Daniel is now fully recovered and has been discharged from services. He has a Wellness and Recovery Action Plan for the future. He has the phone number of the SPoA should he need further help in the future.

We will transform the urgent care pathway to deliver responsive, reliable, appropriate, high quality care 24/7

Our aims and vision

A key priority within the 5YFV is to ensure that there is **consistent high quality, responsive crisis care**, to deliver the fastest resolution to people in need, helping to avoid escalation, or inappropriate treatment such as A&E or being unnecessarily detained by the police. In order to do this we will transform our urgent care pathway to ensure that there is robust and responsive care for people with urgent needs 24/7, regardless of age or IQ. This will mean that there is provision for urgent needs for all of our service users.

Benefits to service users and Carers:

- Urgent treatment delivered closer to home – local delivery of services
- Less need to go to A&E or be taken to a place of safety – reduced use of Section 136
- Alternatives to admission which mean that people are more likely to receive support at home than require admission
- Improved patient satisfaction

How we will deliver this

We will ensure that when urgent assessment is needed, it is delivered in a short timeframe, regardless of age or IQ and tailored to the needs of the person. In order to do this, we will develop **effective and capable triage**, underpinned by senior resource along with locally delivered rapid response functions, and a streamlined, safe, consistent and pragmatic approach to assessment that is proportionate to the needs presented, and includes, as standard, an evaluation of physical health. This has been successfully delivered as part of a full single point of access model in Northumberland, Tyne and Wear. Following

assessment, support will be agreed with the Service User (and with Families and Carer if appropriate) and implemented immediately either by the access team, the hospital at home team or if necessary via an admission.

In order to deliver this we will **redesign our current pathways and services** to ensure that there is the correct amount of ring-fenced resource to support people with urgent needs – including a 24/7 crisis response that can support all people with urgent needs. This will include support for older people and people with learning disabilities using the reasonable adjustments approach, and a robust hospital at home service that is equipped to provide intensive home–based treatment which will include multiple daily visits for those who require it.

Building on the current shared care model in the Trust, the **Hospital at Home service** will have a clear remit around intensive management of high risk patients in the community, with the capacity to visit or contact people multiple times per day, and to facilitate early supported discharge for people from inpatient units.

We will also explore additional alternatives to admission such as street triage, (building on the triage that has been trialled across parts of Hampshire in police control rooms), crisis cafes and crisis houses.

Good practice examples

Case study: Innovations and improvements in access to acute care in North East London

North East London NHS Foundation Trust (NELFT) established the **Access Assessment & Brief Intervention Service:** This is a single point of access/referrals service to all mental health services for adults aged 18 years and over. The service provides biopsychosocial assessments with care planning focused on the psychological, physical, social and occupational needs of each individual. Only 2% of referrals are referred on to acute mental health services, and the majority of these patients are treated and discharged back to primary care (70%).

The Home Treatment Teams are an essential component of this integrated model. They act as gatekeepers to inpatient care and attend daily ward handovers to identify early discharges. This is important as it allows a single point of access to inpatient care and enables a reduction in the time spent as an inpatient. The HTT is also involved in all Mental Health Act assessments to ascertain if community care can be provided as an alternative to admission.

Outcome: NELFT now provides the highest ratio of acute home treatment to inpatient care and the lowest acute bed base across London.

Case study: Operation Serenity –Isle of Wight

Operation Serenity is a collaboration between the police, ambulance and NHS staff to develop innovative standards in the response, assessment, safeguarding and care of people with mental health problems. This involves a mental health practitioner and police offer responding to mental health crisis calls in a marked police car.

Outcome: As a result of the number of section 136 assessments were found to decrease by 50%; the use of police custody as a place of safety has been completely eliminated; and the accuracy of s136 has risen from 20% to around 75% (percentage of s136 detainees converted to an admission)

Case study: Street Triage - improving access to care

Street Triage is a service that comprises a mental health nurse, working alongside a dedicated police officer in mobile community units to improve access to Mental Health services and avoid preventable detentions by police when using section 136. Patients are taken to a place of safety where the Mental Health nurse supports the patient while waiting for formal assessment by the appropriate professionals.

Outcome: The annual rate of detentions under Section 136 reduced by **56%** in the first year.

Patient story

Serena

Serena suffers from paranoid schizophrenia. She becomes very distressed and believes that her neighbours are spying on her and have been recording her telephone conversations. She begins to scream and bang on the walls, and a concerned neighbour calls the police.

On arriving, the officers believe that Serena is suffering from mental health problems and they contact the single point of access for support. On accessing Serena's records the clinician sees that Serena has recently been discharged from the service, and that one of her relapse indicators is that she believes she is being spied on.

The clinician agrees with the Police that a member of the Crisis Team will attend Serena's home to triage her mental health. The police agree to stay with Serena until the Crisis Team arrive.

The Crisis Team arrives 30 minutes later. As Serena had recently been discharged from services with a contingency plan, another assessment is not necessary. Serena is re-established on her medication regime and seen by the Crisis Team for 5 weeks for Intensive Home-based Treatment.

We will improve outcomes for those who use our services through the delivery of needs-led, evidence based pathways that are linked into local delivery systems of care

Our aims and vision

We will improve outcomes for service users by delivering needs-led, evidence based pathways to those who use our services regardless of their age or IQ. The community teams that deliver these services will be the engine-room of the delivery of care, assessing and treating people as well as helping people to stay well and avoiding escalation to crisis and admission. We will ensure that these services are able to be as proactive and preventative as possible, by engaging with primary care, ring-fencing resource for people with urgent needs, and focusing on well planned community-based, purposeful, NICE guidance compliant interventions delivered collaboratively with Service Users, their Carers and their Families. Linked to this, we will ensure that meaningful clinical, outcomes and operational metrics are collected and analysed to enable service improvements with an ability to compare with national parameters.

As well as driving improvements and consistency internally throughout our pathways, we will ensure that these pathways are mapped onto local delivery and link well with primary care, to wrap care around the needs of the person. We will adopt this approach in all of our services, including our current adult mental health, older people's mental health and learning disabilities pathways.

Benefits to service users and Carers:

- Care will be proactive, evidence based and purposeful
- Outcomes will improve as interventions are targeted to the particular needs of the individual, by drawing additional expertise as required
- Patient experience will improve as care will be proactive and co-developed with the person.

How we will do this

The needs led pathways that we will deliver are described below:

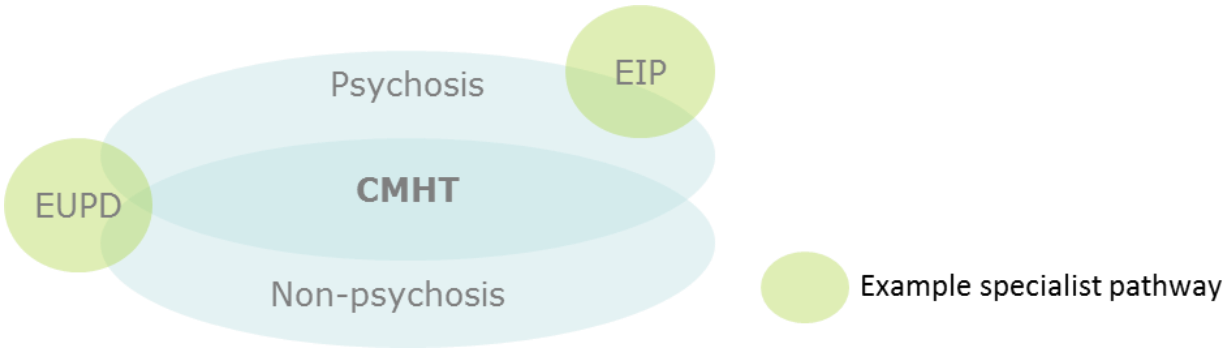
- Functional illness
- Dementia and functional illness in older people
- Learning Disabilities

i) Functional illness

The **Community Mental Health Team is the engine-room** of the delivery of care to people with Mental Health needs. By ring-fencing urgent capacity we will ensure that the community team will be able to undertake planned work, as assessment and treatment clinics and home visits will not be disrupted by the need to respond to urgent requests for help. Care will be **person-centred, and recovery-oriented**– focusing on working collaboratively with service users to building strength and resilience. Teams will work with partner organisations including primary care, physical care, housing and social services around the needs of the person. The team will use the reasonable adjustments approach to working with individuals with learning disabilities, frailties and co-morbidities.

Whilst our services will be flexible according to a person's need, practice will be standardised by co-developing a set of **evidence-based interventions** for core needs. We will build on the pathways that we have developed around psychosis and affective disorders, ensuring that resource is mapped to the delivery of these interventions. This will in turn allow services to monitor gaps in intervention, skill set and capacity more easily, resulting in better patient outcomes.

The skills of our teams will be configured around the needs of these interventions/pathways. Wherever possible our teams will draw on support from all sources (such as CBT or Family intervention therapies). When a Service User needs to have additional input from these specialist services, this will be done according to need, as outlined in the reasonable adjustments diagram – ranging from the CMHT clinician receiving support to enhance their practice to, in a case of highly specialist need, having the care of the patient transferred to the specialist. We will also ensure that specialisms are preserved and developed to provide skills and expertise that will be drawn upon to provide the best quality care for our Service Users.



Examples of the specialist pathways that we will continue to develop include:

- **Emotionally Unstable Personality Disorder:** These are some of the most complex Service Users to engage and support who require specialised skills and the establishment of a clear and consistent pathway. We will further develop this pathway to build resilience in the whole system of care by providing specialist support, supervision, consultation and training, including the development of Service User and Carer networks. We will consider how best to provide care for the most complex and high risk Service Users, which may be via a specialist team which 'reaches into' the CMHTs using a hub and spoke model.
- **Early Intervention in Psychosis (EIP):** The skills of our EIP teams will be made available to the rest of the team working with a wider spectrum of presentation, as the needs of these individuals can be augmented by the skills held in the specialist team. There are a variety of ways to achieve this.

One is by embedding the team within CMHTs, defining and monitoring patient flow to ensure that capacity is not overwhelmed. Another approach is to maintain separate service groupings but ensuring that the expertise in EIP is available to support clinicians working in the CMHTs. In addition, we will ensure that services plan for the transition for when an individual reaches 35 years old.

- **Difficult to reach/high intensity users:** we will expand on the work that we have started on treatment-resistant long term conditions, working with GPs, the ambulance service, social services and other organisations to develop a plan that meets the needs of this cohort.
- **Dual Diagnosis:** we will ensure that care is well coordinated across services both within and beyond the Trust.

The redesign of CMHTs and alignment of resource to evidence based pathways presents an opportunity for our services to develop further specialisms that enhance the quality of care that service users receive.

Examples of good practice

Case study: Redesign of the acute care pathway - Greater Manchester West Mental Health NHS Foundation Trust

60% of relatively short inpatient admissions were occurring outside the hours of 9-5 Monday – Friday. The obvious conclusion was not that people were more ill then, but that their community services were not structured or extensive enough to offer the service required. Service-redesign started from the premise of "what should first class community services look like" and how to deliver them for less cost.

CMHTs – now open 8am-8pm Monday-Friday and 9am-5pm Saturday and Sunday. The Crisis Teams have been redesigned and expanded and have adopted the name of "Home Based Treatment". This multi-disciplinary service works 24/7 and is modelled to enable capacity to ensure individuals can receive up to three intensive visits in any 24 hour period. This avoids admission and accelerates safer discharge. A seven-day telephone helpline has been implemented for "known" patients to enable instant access for talking to a professionally qualified member of staff.

Outcome: Whilst the community team developments were "pump-primed" with non-recurrent resources c. £1m, the redesign enabled the **closure of 50 beds**, which released £3.5m per annum. Of this, £1.3 million was recurrently reinvested to expand the community services and the remaining £2.2m to support the Trust's CIP.

Case Study: Specialist Personality Disorder service locally – Leeds Personality Disorder Managed Clinical Network

The Network is a city-wide multi-agency and multidisciplinary service that aims to work effectively with people who present with personality disorder, complex needs or are at significant risk. To meet the needs of the people it serves, the Network provides a range of different services such as care co-ordination, Journey Occupational Therapy Group work programme, dialectical behaviour therapy (DBT), and informed skills groups as part of the city wide DBT service.

Outcome: The benefits recorded include, reduced mental distress, improved recovery and improved quality of life for each Service User living in Leeds, compared with their counterpart in Sheffield (where no specialist service exists).

[1]*A cost and economic evaluation: Kane, E Reeder N, Keane K, Prince S. Personality and Mental Health. 2016 Aug; 10(3):169-80.*

ii) Dementia and functional illness (in older adults)

The development of a needs-led ethos underpinning services will mean more flexibility and agility around the needs of Service Users, based on the development of needs-led pathways rather than criteria that is based on age. This will mean that our current OPMH services will integrate much more closely with adult mental health pathways.

Access to our services, and urgent response will not discriminate on the basis of age but will always make reasonable adjustments for older people including staff with the appropriate skills to offer home-visiting in coordination with physical care support services, and robust out of hours support. The development of a single point of access will also provide support to those providing care in the community including Care Homes and GPs.

A key next step will be to design how needs-led services and pathways will be configured for older people versus adults. There is a national debate as to how Older People's services are best delivered within Mental Health, via specialist teams or ageless services. There is little hard evidence to support either argument and we will ensure that robust outcome measurement is built into any service developments.

We will ensure that the needs of older people with **functional mental illness** are addressed according to a consistent pathway regardless of age, so that the standards of care delivered are the same. We will work to design how we will deliver needs-led pathways, which may be done via standardised pathways across both older people's teams and adult teams, or it could mean moving to merging resource and eligibility criteria, with support provided by the older people's specialism into the community team who assess and treat all people with functional illness. When further developing our pathways, we will consider how best to deliver needs-led pathways to older adults with functional illness.

We will ensure that needs of all people suffering from **memory difficulties and dementia** are met according to an organic pathway in line with the national dementia strategy, regardless of age. This will mean that the skills to support memory difficulties and dementia in younger patients will be supported by the teams with skills in these areas. We will also ensure that our services are proactive and recovery-oriented, and as with functional illness we will further develop specialisms, such as challenging behaviour, to ensure that we have specialist pathways that support all levels of need. As part of this we will also ensure that carers have appropriate support and are linked into the support that exists, working in partnership with other agencies.

Whilst the development of needs-led pathways will closer align our current OPMH services with adult mental health, it is critical for all pathways that care is clinically integrated with physical health services. A recent report by the Old Age Faculty of the Royal College of Psychiatrists highlights the importance of integration of physical and mental health for older people, the success of which is reliant on the establishment of effective working relationships.[54] In redefining the older people's pathway, we will continue to ensure that the way in which our services interact with other services in the local delivery systems is joined up and seamless.

Our adult mental health and older people's mental health services will work together with service users to co-design pathways to ensure seamless care and to draw on appropriate resources around the needs of the person regardless of age and focussed on need.

Example of good practice

Case study: The Newcastle Challenging Behaviour model

The Newcastle Challenging Behaviour model provides a framework and process in which to understand people living with dementia who present with behaviours that challenge. Its main premise is that behaviour that challenges is a poorly communicated expression of unmet need.

The model is a process that aids the clinical formulation, helping to understand why a person behaves as they do and the triggers associated with this. This then becomes the basis of a Behavioural Support Care Plan that is developed in collaboration with carers and family members which supports carers to manage behaviours using a biopsychosocial model.

Outcome: The model and the clinical expertise within it has achieved significant positive outcomes for Service Users and Carers, with residential home staff who receive formulation-led individualised-case interventions attributing much of the change to increased understanding of the individual's personality and history, which leads to a new conceptualisation of the challenging behaviour.

[54] Integration of care and its impact on older people's mental health. The Faculty of Old Age Psychiatrists, Royal College of Psychiatrists, November 2016.

Patient story

Carl

Christine is a carer for Carl, a 45 year old gentleman with a long history of depression. Carl is currently receiving treatment for his depression from Julie, a CPN in the Community Mental Health Team.

Julie has received several concerns from Christine about Carl's memory. Julie contacts her colleagues in the Cognitive and Functionally Frail (CFF) Specialist Team to ask for some advice. The team suggest a Multi-Disciplinary Team (MDT) meeting to discuss Carl's care, treatment and current symptoms. Following the MDT meeting it is decided that an assessment by the CFF service would be beneficial. Julie agreed to do a joint visit with her colleague from CFF as Carl is familiar with her.

After the assessments, it was agreed by the MDT that Carl was suffering from dementia as well as depression. It was agreed by Carl, Christine and both teams that Julie would continue to treat Carl for his depression as this remains his primary problem. In addition though, they would all receive specialist support from the CFF team regarding Carl's emerging dementia, and they would work jointly in order to provide the best possible care for Carl, and support for Christine.

Carl and Christine feel that he is receiving the best possible care and the expertise for all of his needs.

iii) Learning Disabilities pathways

As in Mental Health, we will ensure that we deliver person-centred, recovery-oriented care around needs-led pathways for people with Learning Disabilities. Delivering needs-led services will mean that our services no longer discriminate or distinguish based on intellectual ability, but are instead based on responding to the individual needs of the person in the most appropriate way. This may mean that more care for people with a learning disability who have mental health needs is delivered in mainstream services with reasonable adjustments to support care. This will require our staff to have the appropriate skills and training to ensure this.

We are a key partner within the Southampton, Hampshire, Isle of Wight and Portsmouth Transforming Care Partnership. At the heart of this our system-wide vision is "to build on a child/young person/adult's strengths and abilities, getting it right first time giving the right care in the right place at the right time" through working closely with other health and care partners.

We are committed to ensuring that people with learning disabilities have their needs met in the community as much as possible, by delivering a series of needs-led pathways to support people with specialist needs to live in the community. We will also ensure that the services that we provide are proactive and preventive, around the needs of the person. We will continue to work seamlessly and proactively with the wider system to ensure that the care that people with a learning disability receive is appropriate to their needs, through a number of initiatives that join up specialist care with the wider system. This includes the providing liaison services into acute hospital settings and supporting Primary Care, noting the increased prevalence of epilepsy, dysphagia, dementia, and stroke and kidney disease amongst people with learning disabilities.[55] We will work with the system to develop 'at risk' registers, where placements are at risk of breaking down, and developing multi-agency relapse strategies with the people who use services will ensure that there are contingency strategies to prevent deterioration.

Our Intensive Support Teams will continue to focus on Positive Behavioural Support strategies with Carers, paid and unpaid, of individuals whose behaviour challenges. In addition, the developments in access and urgent response functions will be open to all users of our services including those individuals with learning disabilities. We will ensure that staff in the single point of access and urgent response functions are equipped with appropriate skills and training, to ensure that there are reasonable adjustments in place to deliver high quality 24/7 appropriate support.

In line with 'Building the Right Support', we will ensure that hospital admissions are limited to times when this is the best clinical option for care and treatment. We will ensure that goals for admission and

[55] Public Health England - Public Health Profile 'Fingertips'.

discharge is planned from the outset with service users, families and carers. Again, we will work closely with other agencies are to deliver this.

We are committed to improving the transitions for children with Learning Disabilities who need to move into adult services, working closely with other service providers, and providing expertise to ensure that children are appropriately supported as they transition to adult services.

In all of this, Service Users and Carers will be fully engaged in the transformation process, at a local and strategic level, as well as on a personal level in their own treatment and support. Viewing Service Users and Carers as partners in the delivery of care and support, and coordinating that across agencies, will ensure proactivity at the earliest possible point in the service delivery pathway. Where individuals need additional support to engage and participate, we will work collaboratively with advocacy services across the region.

We will deliver consistent, purposeful, high quality inpatient care when it is needed

Our aims and vision

By improving access to both services for people with urgent needs and planned services, we will ensure that people can be cared for in the community as much as possible, and we will eradicate the need to send people out of area, unless there is a clear reason for this. When inpatient support is needed, we will ensure that there is a consistent approach across all inpatient areas ensuring that people are cared for in the **most appropriate setting** according to their needs, with a clear purpose, and a plan developed with the Service User, and a clear path to recovery. We will ensure that our inpatient services work closely with families, carers and community services to ensure a seamless transition into and out of our inpatient facilities.

Outcomes for service users and Carers:

- Reduction in length of stay and improved independence
- Improved patient experience and outcomes
- Reduction in the need for out of area placements
- Seamless transitions into and out of in patient care.

How we will deliver this

We will ensure that the people in our inpatient beds are there as a result of a need to have the augmented services available in those settings and not other factors such as the absence of community support. We will ensure that every admission has a clear **purpose, aims and a plan**, and wards will follow the mantra of 'know your patients and what you are doing with them'. The care plan each Service User will be co-developed, and treatment will be relevant and purposeful as well as being delivered efficiently in a timely way. This will include having clear admissions and discharge criteria, ensuring the right adopting standardised protocols and pathways. Linked to this we will ensure that the range of interventions is comprehensive and accessible for the full duration of the admission.

This approach to inpatient care will be underpinned by a systematic and robust use of performance metrics and outcome measures such as HONOS to measure the effectiveness of inpatient care across the whole inpatient episode.

The development of **needs-led pathways** within the community will extend to our inpatient wards, to ensure that people are cared for in the most appropriate setting. We will need to undertake more work to understand the implication of this, but it is expected that this will provide opportunities to specialise resource to deliver on the needs of inpatients.

We will ensure that the **recovery ethos** is central to planning, and this will be co-developed with Service Users, Families, Carers and partner organisations, which will include further developing the peer worker role. Linked to this we will ensure that community teams in-reach into the wards, although the continuing locus of clinical responsibility will be clear so there is no risk when a patient is transferred. Our Community mental health teams will establish close links with wards to facilitate both admission and discharge so that care is provided seamlessly. In ensuring that transitions are as seamless as possible, we will design how teams interface with each other across community teams, urgent teams and the inpatient pathway.

In order to ensure that our inpatient services comply with the Healthcare Commission's 'Standards for Better Health' and implement NICE Guidelines and the National Service Framework, we will explore using a tool to drive improvements in acute psychiatric wards such as the Accreditation for Inpatient Mental Health Services (AIMS).

Good practice examples

Case study: The Purposeful Inpatient Admissions model – Tees, Esk and Wear Valleys NHS FT

The Trust looked at new ways of working to remove waste and maximise quality through a 'Rapid Process Improvement Workshop' method learned from Seattle's Virginia Mason Medical Centre.

Occupancy was running at up to **106%** in two of the Trust's adult wards with an average length of stay of 29 and 47 days.

The main output of this project –the Purposeful Inpatients Admissions model (PIPA) set out a completely new way of working on the wards which included the introduction of an MDT formulation meeting, held 72 hours after admission, to assess the patients current state an agree the purpose of admission. Standard work processes were then developed for every step of the patient journey and for each staff member.

Outcome: In the 12 months following the work there was a **22%** reduction in bed occupancy, **57%** reduction in length of stay, **63%** reduction in sickness absence, and **72%** reduction in reports of violence.

Case study: Digital Patient Status "At-a-Glance" Tool (5 Boroughs Partnership NHS FT)

The Trust was trying to improve multi-disciplinary coordination and create opportunities for recovery-focused care. The teams from two wards developed a Digital Patient Status "At-a-Glance" Tool to support multi-disciplinary coordination of case planning, discharge planning and risk management.

Ward teams worked together to identify strengths and weaknesses using information from care planning, risk management, safeguarding data and management, and performance information. The data showed one ward should focus more on individual physical health needs and the other on a more person-centred approach to assessment risk and intervention. They involved service users using the Recovery-Focused Pathway to reflect the service user journey.

Outcome: By improving multi-disciplinary coordination and involving service users, the teams determined the need to introduce initiatives to support recovery, including - Assistant Practitioners and Activity Co-ordinators to focus on improving therapeutic engagement with service users and a weekly magazine to summarise service user achievements. The project also helped ward efficiency in relation to discharge planning and bed management.

We will develop tertiary services to provide care across a complete pathway with pathways that are consistent across the trust

Our aim and vision

We will provide highly skilled tertiary services for adults, young people and people with learning disabilities who have additional needs. We will ensure that the standard of practice in all tertiary services, is consistent across the Trust to ensure that reliable safe and effective care is provided by all services no matter what the specialism.

We will also look to develop services where this could benefit those who use services. We will work with commissioners to ensure (as part of a wider network of providers), that the forensic pathways have provision that allows for people to be cared for in the setting most appropriate to their needs, which will entail further developing our tertiary services for people with low secure needs across both adults and children, and reaching a conclusion about how adult secure services can best be provided safely with the available estate.

Benefits to service users and Carers

- Improved outcomes as people are cared for in the least restrictive environment
- Improved transitions as standards of pathways are consistent across the trust
- Reduced out of area placements
- Fit for purpose environment for adult services will improve patient experience

How we will deliver this

Continuity of standards and sharing of expertise

We will ensure that our needs led pathways of care extend to and are consistent with our forensic services. We also have a vast amount of expertise across the many pathways within our organisation, and there is a significant opportunity for teams and services to learn from each other, enhancing the quality of services and aiding transitions between services. Examples of this include aligning forensic wards with psychiatric inpatient units to draw on similar skills; and further developing community forensic pathways in conjunction with CMHTs and rehabilitation pathways.

We will ensure that the skill base in forensic services is shared with other services using the reasonable adjustment model. Similarly there will be the routine use of addiction expertise and psychology skills and services to inform, advise, support and provide high level care as is required for each individual patient. This will require a careful assessment and analysis of skill base and capacity, to ensure feasibility and timely, high quality delivery.

Adults

A continued key priority for forensic adult services is to agree the nature of the re-provision of beds to ensure that the needs of the people who use our services are met. This includes addressing the issues of the physical environment at Ravenswood House. As part of this there is an opportunity to increase the provision of acute low secure beds, to ensure that people are cared for in the most appropriate setting as close to home as possible.

As well as the inpatient pathway, we are committed to developing services to support people with forensic needs in the community whose needs cannot met in an adult CMHT. We will build on a number of existing services around the needs of this group of Service Users, including augmenting the role our community forensic service, and ensuring that innovative services such as the NOMS Personality Disorder Pilot and Stalking Treatment Service are integrated as part of a wider network of community support.

In addition to developing the pathway in Hampshire, the Oxford and Thames Valley tertiary new care models pilot presents exciting opportunities to develop innovative solutions that meet the needs of Service Users and Carers across a larger footprint that we are keen to play an active role in.

Children and Young people:

Within children's forensics services we will work with commissioners to develop our tertiary services, including a low secure provision to ensure that our service users can be supported in the most appropriate setting. This will both ensure that people who have been in a medium secure setting and are ready to be stepped down can be rehabilitated in the most suitable setting, and that people with low secure needs can be cared for in the appropriate setting, closer to home. Within this, there are also

opportunities to develop low secure provision for children and young people with learning disabilities, which will also help to repatriate people from out of area.

In addition to the extra capacity required in low secure pathways, we are committed to working with the wider system to strategically plan for adolescent secure and enhanced needs across the pathway. The new care models programme offers an opportunity to plan for Tier 4, PICU and low secure more strategically across the South that we are keen to contribute to. Considerations around the CAMHS pathway will be developed as part of a wider regional strategy for CAMHS, which also provides the context within which rehabilitation of patients from our Specialist services return to the community in Hampshire.

We will develop primary care based mental health services to keep people well

Our aims and vision

We will continue to improve access to psychological therapies and ensure that as many people as possible are benefiting from the service, with continued strong outcomes. In addition we will work with primary care and local delivery systems to consider how people with mental health needs are best supported in primary care to ensure that people receive the right support as early as possible.

Benefits to service users and Carers:

- Improved access to support in primary care will reduce the escalation of need and demand in secondary care services
- Improved patient experience

italk

We will improve access to italk to deliver the ambitions set out in the 5YFV by working in partnership with Solent Mind, GPs and other key partners to publicise our services.

We will continue to innovate and develop relevant services for those who need it, including an assessment and treatment service for Carers to help support those who are likely to require support; the continued development of italk Health for people with long term conditions, who may not recognise that they have mental health needs; and the development of italk@work focussing on improving wellbeing in the workplace.

We will also explore different modes of access to the service such as a digital platform to increase choice and access opportunities for patients and upskill and train primary care staff to identify and deliver low intensity interventions.

As we expand access we will ensure that we have the workforce to support this to ensure that waiting times do not deteriorate as more people access the service, and to help reduce waits between first and second appointment. As part of this, we will review the service (including the proportion of people being stepped up to step 3) to ensure that the right people are within the right part of the service and that capacity is being maximised to best effect.

A strategy for broader primary care based mental health

In addition to expanding our italk service, and ensuring that our CMHTs are well integrated with local delivery systems, we will work with commissioners and primary care to ascertain how best to strengthen primary care based support, to work proactively, and ensure that people receive support as early as possible in the pathway.

Examples of good practice:[56]

Case study: Primary Care Plus, West London

Primary Care Plus is a service in West London (Hammersmith and Fulham, Hounslow and Ealing) based in GP practices for those who may need some extra mental health support over and above what is available from their GP. By moving those with stable mental health problems from receiving support from specialist services to their GP practice, they receive care in the least restrictive setting, closer to home, and they'll have both their physical and mental health needs met.

Primary care mental health workers are employed by West London Mental Health NHS Trust and are attached to GP practices. GPs are able to refer people directly to them. Importantly there is no strict criteria for referral, except for an assessment to determine whether people require more support.

Other mental health professionals such as consultant psychiatrists and psychologists also provide support to the service. The primary care mental health workers provide one-to-one support to people within GP practices, helping with discharge from secondary care, liaising between services and providing ongoing mental health support. They are also able to signpost to wider social support in the community. These workers also provide support to other primary care staff by providing advice on consultations, as well as training for staff (reception staff, practice nurses, GPs etc.) to meet their needs.

[56] Mental health in primary care: A briefing for Clinical Commissioning Groups. Mind, June 2016.

7 What do we need to deliver our strategy?

There are a number critical success factors that will need to be in place in order for us to successfully implement this strategy:

Service User, Families and Carers at the centre

Strong leadership & culture

Transformation tools: Quality Improvement Methodology & resource

System-wide vision and strong partnerships

A sustainable workforce

Finance and other enablers

Service users, families and carers at the centre

One of the core standards in the Care Quality Commission Standards for Mental Health Services is that the views of patients, their Families, Carers and others are sought and taken into account in decisions, planning, delivering and improving health care services.[57] Service Users, Families and Carers are "experts by experience" by actively involving them we will ensure that our services are shaped by the people best placed to know what works and what doesn't.

Just as we have put Service User, Families and Carers at the heart of the development of this strategy, Service User, Families and Carers should continue to be at the centre of the delivery of the strategy as well.

Adapting our approach to truly engage and collaboratively lead with service users, families and carers throughout the organisation is a key priority within this strategy. This will entail a significant cultural shift for the organisation, making sure that everything - from clinical services through to corporate services - is based in the needs of service users. This is critical in ensuring quality, accountability and value and importantly ensuring that positive change occurs.

By being accountable to 'experts by experience' our transformation will be held to its true purpose. When people are equipped and supported to help design, deliver and quality check the services they and their peers use, those services improve and the people involved gain in confidence, skills and an enhanced experience.

> ***"Only by transforming services in the way that the people who use them want us to can better outcomes be achieved at a time of real budget constraint."***
>
> **Dr Geraldine Strathdee, National Clinical Director for Mental Health, NHS England.**

[57] Core Standard 17, Standards for Better Health, Department of Health (April 2006)

Linked to this, we will pursue a relentless focus on outcomes, which is critical to driving improvement and delivering truly patient centred care. This will require teams to work to systematically measure and evaluate outcomes data, which requires access to the right granularity of clinical data.

Leadership, governance and culture

Critical to the successful implementation of this strategy will be having expert, committed and stable leadership in place to drive service improvement and the cultural change required. Additional and complementary skills and capabilities are likely to be required as well as expertise in transformational change experience.

In looking to address criticisms levelled at the Trust in the past, and delivery of the future strategy, the Trust Board will require strengthened expertise in running Mental Health and Learning Disabilities services, accompanied by extensive experience of Quality Improvement, service user and carer inclusion and clinical service expertise.

Leadership qualities must extend to individuals and teams regarding service transformation and change management, where the importance of good governance and accountability is critical. Leaders must set out clearly the need for change and support the process to make the changes happen, operationalising them and ensuring that outcomes are continually and closely monitored and that the change "sticks".

The Board will foster an environment that is open, accountable and compassionate, and puts patients first. This will entail a cultural shift towards autonomy, responsibility and accountability, whereby devolved decision making is predicated on clear lines of accountability, good governance, earned autonomy and continuous improvement. This will represent a significant change for the organisation. Creating an atmosphere of accountability is critical to leadership and is reliant on establishing clarity on roles and expectations, ongoing dialogue, and an organisational commitment to accountability rather than blame. In this way a culture of earned autonomy accompanied by accountability will foster ongoing improvement.

This will require effective leadership, that is able to lead change in a complex and changing environment, with multiple stakeholders who do not all share the same interests.

Clinical leadership

Clinical Governance is often cited as the main vehicle for continuously improving the quality of patient care. [58] Clinical governance and leadership are both central to the delivery mechanisms of the strategy. Whilst this is part of ongoing organisational form discussions, including debate around introducing more formalised and bolstered service and professional governance structures, stronger clinical involvement, and leadership in the delivery of the strategy will be central to the enacting of this strategy, regardless of organisational form. Embedding a culture of accountability will be critical to this.

Engagement with clinical staff has been a key element of the approach to the development of the strategy, but key to the successful implementation of it will be their support and ownership of the recommendations. As such, along with greater Board and management focus, consideration will be made of the requirement to have clinical staff lead the planning and implementation of the proposed changes, sitting on, and driving key governance and oversight groups set up to deliver the resulting transformation programme.

Our Clinical Reference Group has representatives from senior clinical staff within the Trust whilst the Mental Health Alliance Clinical Reference Group, has commissioner and GP representatives on in addition. These two groups should be used as the central clinical voice to oversee the implementation of the strategy and be the interface to the wider local clinical community.

Culture

'the combination of organisational inspiration and purpose, motives and beliefs of individuals, and the norms and patterns of interactions of groups, which provides the meaning to drive leaders' and employees' behaviours and results'
Hay group organisational culture model

[58] Clinica MJ 1998; 317, 61

A significant proportion of feedback from our staff cited a lack of vision, cultural issues and difficult working environment as contributory factors to the need to change. This has been associated with the issues around standards and quality of service provision in certain parts of the Trust, but has also led to dissatisfaction with the way the Trust has been run, and staff recruitment and retention issues.

A fundamental shift in the culture of our organisation, to put patients at the centre of everything that we do, will be critical to the success of this transformation. This will start by proactively involving Service Users, Families, Carers and staff in the design, development and implementation of the transformation. In addition, our culture will require a shift in emphasis to clinical leadership and earned autonomy, which will require sharper systems of accountability. In this way, our staff will feel empowered to make positive changes and do their jobs, but at the same time, there will be an atmosphere of accountability that is constructive and supports the delivery of high quality, safe services.

However, the culture of an organisation is not changed overnight, and neither will the delivery of a new clinical strategy guarantee this. A number of the priorities described in this chapter will help to improve the culture of the organisation, and other key techniques to help when embarking on cultural change include:

- *Changing structure and process:* Decentralising operations within a clear framework, increasing autonomy and reviewing spans of control can lead to behavioural changes in leadership which can subsequently foster positive behavioural and cultural change in staff too.
- *People:* Bringing in new leadership or people at all levels with a different perspective, skill set and capability can lead to behavioral and performance changes that, in turn, can affect new ways of thinking and culture change.
- *Incentives*: Incentives affect behavior and performance and attract new resources and capabilities, which can lead to culture change. Incentives should look to improve job and service satisfaction.
- *Changing and enforcement:* Learning from the past, including mistakes, and use the lessons learned to change is vital. This includes holding people accountable for performance in an appropriate manner. These actions or emphases will help to shape new behaviours that will create a culture of learning and achievement.

The tools for transformation: a Quality Improvement Methodology and resource to support transformation

The tools to transform: Quality Improvement Methodology

High performing NHS organisations are increasingly adopting new ways of working around the concept of continuous improvement, Lean or Quality Improvement (QI). This will provide an approach and a methodology that will underpin our transformation and equip us to be better able to implement change.

There is no one single QI methodology that is recommended for a Mental Health trust and currently a number of different approaches are used in the NHS. Most of the well-known methodologies have evolved from industry and can trace their DNA to the Toyota Production System (TPS). In recent years these methodologies have been refined to use in healthcare but most can be further adapted and customised to use in Mental Health settings.
Our next step will be to decide what quality improvement methodology is right for us. We will do this by involving service users, families and carers and other stakeholders in a process to identify the best option for the needs of our organisation. This will underpin **our** way of doing things, and become an embedded approach to ongoing improvement.

The resource to transform

The delivery of this strategy will require full board and senior management support; an investment of both time and money by the organisation to design and build the most effective, suitable and affordable model for delivery; and an investment in the skills required to ensure its successful delivery at a good pace.

The scale of this transformation will require focus around a specific programme of work, that has its own Programme Board (as a committee of the Board) led by a senior responsible owner (SRO) who is accountable for delivery of programme outcomes and realisation of benefits. The Board will responsible for coordinating all projects and work streams that form part of that programme. In order to deliver this, the development of a Strategy Implementation Team, led by an Executive Director will provide the resource required to support teams to implement the strategy. This will be a pragmatic resource that supports managers and clinicians to deliver the transformation. In addition to this, operational managers and clinicians will need to be released from some of their current commitments and have appropriate support to implement change.

The Strategy Implementation Team will:

- Provide strategic oversight and challenge;
- Maintain a central information hub (to facilitate clear and transparent reporting of progress);
- Manage the programme governance framework;
- Establish and maintain agreed corporate systems and standards for programme and project management;
- Provide support for a culture of continuous improvement, and
- Align resources to strategic effort.

Evidence suggests that as many as 70% of all programmes fail to realise the main benefits they set out to deliver and fail because they over-focus on activity, suffer mission creep, avoid tackling behaviours that hinder change, or were simply not clear from the outset about the purpose of the programme. We will therefore ensure that the management and realisation of benefits is core to how we organise and support the programmes of work.

It will be the responsibility of the programme board to ensure at a detailed level that:

- For every benefit to be achieved by the programme it is clear who has ownership of the benefit, what outcome is required to derive that benefit and what activity and outputs will lead to this;
- For every activity and output, it is clear how it contributes to the delivery of expected benefits; and
- Performance towards benefits realisation is monitored and remedial action taken where necessary, integrating this work with risk and issue management.

All programmes will require the input of supporting functions. In some areas this function may require a dedicated project or work-stream as part of the programme, in others there may be only a need for finite tasks, information or guidance. Communications and engagement matters will be assigned to a communications and engagement work-stream, with others such as workforce, finance, estates and information also forming part of the programme.

System wide vision and strong partnerships

Our services operate in a much wider system that includes other health providers, social services, community-based support and the voluntary sector. We cannot work in isolation in delivering this transformation. We are committed to working in collaboration with our commissioners, other providers (including General Practice) and the voluntary sector to drive positive change.

It will be critical that our services are mapped onto local delivery systems including primary care and general community care to link completely with these services and provide joined up care around the needs of the person. We will work closely with Local Delivery Systems to ensure that local delivery is at the heart of the services that we provide.

We currently provide Mental Health and Learning Disabilities services to five different CCGs, two different local authorities and NHS England. A number of the changes that this strategy is proposing will require

the alignment and agreement of our commissioners. We are committed to working closely with commissioners to take this strategy forwards.

As a wider system of health, care and the voluntary sector we need to work together to agree a coherent vision and strategy for Mental Health and Learning Disabilities on a system wide basis. A Mental Health Alliance for Hampshire and the Isle of Wight has been set up as part of the Hampshire and Isle of Wight STP, which brings together the relevant commissioners and providers from across the NHS, Local Government and voluntary sector. The Alliance should be instrumental in shaping a shared strategy across Hampshire and the Isle of Wight spanning health, social care and voluntary sector organisations, Service Users, Carers and Families.

Workforce and talent

A risk to the implementation of this transformation is the availability of the right workforce. We will develop a robust workforce strategy that will underpin the delivery of the transformation of Mental Health and Learning Disabilities services. This will also inform the wider Hampshire and Isle of Wight workforce strategy, which is working across organisations in Hampshire and the Isle of Wight to ensure there is a sustainable quality workforce for the delivery of services.

A critical success factor in building for the future is attracting and retaining the right staff. In order to ensure that the services delivered are fit for purpose, understanding the number, skills and capabilities of the workforce is critical. A detailed level of profiling, including skill base and mix will inform recruitment, and training needs across the Trust.

There is a nationwide shortage of registered mental health nurses, and as a result we will need to think flexibly and creatively about how to deliver care. This may mean the development of new roles as services evolve.

As well as recruitment of staff, the retention of staff is critical, particularly in the light of the attention there has been on the Trust. We will ensure that the Trust is an attractive place to work, through demonstrating that staff are valued and supported, and providing development opportunities.

Finance and other enablers

Finance

Key to the considerations of the deliverability of the strategy will be the financial sustainability of the model proposed both now and in the future, and the cost of implementation.

A more detailed assessment of the cost of the service model is still to be made and will need to form part of a larger assessment of the costs and benefits of implementing the strategy. This will also need to consider the system wide savings that could be made from implementing this strategy that could be used to fund any additional costs (or one-off transition costs). Such savings are likely to include avoiding admissions, reduction in the use of out-of-area beds and fewer attendances at A&E (of Service Users who should have otherwise been seen in the community). We will continue to involve commissioners in the co-production and detailed design process of the model, and seek approval for our proposals where appropriate. We will seek support from NHS Improvement to set up the transformation programme of work.

Technology

The delivery of this transformation must be supported by a robust approach to information technology. Our vision for technology and informatics recognises the critical role of technology in enabling the delivery of high quality services including putting Service Users at the centre of information and technology; enabling integrated seamless care via information sharing; facilitating efficient ways of

working; and establishing an information-led culture which encourages transparency and improvement of services.[59]

Other areas where technology could support the successful implementation of the strategy include:

Data sharing between organisations	Sharing pertinent data and information with primary care services, other provider organisations, and the wider health and care community including the third sector will facilitate the provision of integrated care. We have some data sharing mechanisms in place, such as protocols with Acute Providers to obtain patient identifiable A&E and emergency admission data - but further work is needed to ensure this integrated clinical intelligence is fully utilised across all relevant pathways. In addition, clinicians have access to the Hampshire Health Record (HHR) which integrates Primary Care, Secondary Care and Community Care data across physical and mental health pathways. Better use of this tool would ensure the benefits of a shared clinical record are fully recognised in all appropriate clinical interactions.
Access Points and Technological Solutions	Telephony systems which incorporate live directories of services and allow warm transfers between call handlers, clinical staff and other external services, can be of great benefit when managing service performance in Access Points. They enhance the experience for the caller, including Service Users in distress, by better managing the flow of calls, avoiding answerphones and being put on hold for long periods, and losing connection during transfers. Use of a wide range of communication methods, including email, web chat, text messaging, etc. can increase engagement and improve communication with Service Users, Carers and other partners, and will be explored as part of this transformation.
Supporting efficient ways of working	Ensuring that staff have access to technology that supports more efficient ways of working, which reduces the amount of time away from direct clinical care is a key enabler of improving services. This includes implementing clinical applications that support mobile and agile working, and reduces the administrative burden on clinicians. This will enable services to be more responsive to Service Users.

Information based organisation

In order to deliver high quality services and improve the consistency and effectiveness of care delivered, access to robust data, including outcomes, performance and clinical data is critical. Quick access to accurate, live data which is comprehensive yet easy to navigate is critical to the delivery of effective and safe services.

A systematic and robust use of outcomes data is critical to driving improvement. We will support teams to record and interpret outcomes data to inform learning cycles. This will be underpinned by a robust understanding of the underlying clinical data – i.e. who the Trust is caring for (stratification of patients), how they are doing this (operational data), and with what result (outcomes and feedback.) This will allow outcomes measures to be evaluated and compared to ensure that services are working in the best way possible. Sufficient granularity of clinical data will ensure that resource can be deployed as effectively as possible around pathways and the needs of Service Users.

The introduction of Tableau performance software, has greatly enhanced the ability to use both operational and clinical data in a timely manner in order to drive performance and improvement. As the Information Team continues to enhance the system, it is critical that as well as performance data, outcomes data and clinical data is made available, and that a culture of analysis and interpretation of data is fostered in the organisation.

In order to drive out variation of clinical care between teams and understand the quality of services provided, the organisation will need to make better use of benchmarked and weighted data. These can be

[59] Informatics and Technology Strategy Refresh for 2015/16, SHFT, March 2015

used as a starting point in improvement programmes to discover where and why variation occurs. The Trust Tableau system does contain weighted data, in the form of performance reports, but the use of these for the purposes of improvement has been limited in the organisation and will need to increase to ensure the strategy can be implemented.

Estates

The configuration of the estate in which care and treatment is provided can have a great effect on the experience of Service Users. A fit for purpose configuration and design can lighten the burden on staff and therefore enhance care both in the community and inpatient settings.

The environment in which care is provided needs to:

- Be safe, healthy, comfortable and therapeutic, to ensure high quality of care can be delivered which is centred on the needs of the Service User.
- Be in the best locations to maximise accessibility.
- Be able to support activities for Service Users, this includes occupational therapy and education activities for inpatients.
- Provide an environment which preserves privacy and dignity of patients in the care environment.
- Take the needs of staff and visitors into account in order to provide them with a pleasant working environment
- Allow for separation of groups based on gender, vulnerability, ability, and acuity.
- Be designed and maintained in collaboration with services users, Carers, and staff. Good communication between estate and ward staff is key to ensuring this happens.

Whilst the statements above may be somewhat obvious they are not always easy to implement and this strategy provides an opportunity to make more strategic decisions around environment and estate to follow the services. The service need should drive the configuration of the care environment rather than the existing estate dictating the delivery of clinical services.

Communications

A key enabler of change is communication. Our approach to communication could be amalgamated within a broader engagement programme or the Service User, Families, Carer and staff inclusion strategy, but in either scenario, the amount of communication required to successfully deliver this strategy is not underestimated.

We need to build on the positive momentum and communication and engagement that went into developing the strategy as this will be even more important when moving to implementing change.
We will develop a communications strategy that takes a systematised approach to keeping the various groups of stakeholders informed, including defining the communication channels and the frequency of communication with different stakeholders, according to their needs. We will ensure the smooth implementation of the strategy via open and transparent communication with staff, service users, their families and carers and other stakeholders.

8 Next Steps

In taking forward this Strategy, we have identified a number of important initial next steps that are required to progress the programme and ensure that it progresses at pace. Further details of these are currently being planned including clearly defined objectives, success criteria and milestones. We have outlined a number of our initial next steps below:

1. **We will determine with Service Users, Families and Carers how we will best work in partnership to deliver the transformation.**

   Our first step will be to work with service users, families and carers to define how best we will work together to co-develop services. This will be led by one of our Executive Directors. It is critical that this is progressed first, as we require service user, family and carer inclusion to the next steps that follow in designing our transformation.

2. **We will identify the right Quality Improvement Methodology for our organisation**

   We will convene a task and finish group including service users, carers and other stakeholders that will identify the methodology for quality improvement that we will use. This group work at pace to explore the options so that we can procure the methodology as quickly as possible to enable us to move to implementation.

3. **We set up the programme required to deliver our transformation**

   We will establish the infrastructure required to support our transformation including securing the resource to support the implementation of the strategy, and ensuring that clinicians and managers are freed up to deliver the transformation. This team will set up a programme structure and associated governance structure to take the work forwards including establishing work streams with clear accountability and action plans to drive the pace of change, at the same time ensuring that this is pragmatic and agile.

4. **We will develop an Organisational Development plan that will support our transformation**

   We will work to develop an Organisational Development plan at pace that will support the delivery of the cultural change required to deliver our ambitions. This will include clarifying the planning cycle, developing levels of empowerment within the organisation including a how authority will be devolved, and accountability sharpened, and how performance will be measured to support this.

5. **We will invest in developing our senior clinical leadership through a leadership training programme**

   Our clinical leaders are crucial to the success of this strategy, and as such an immediate next step will be to identify and invest in procuring leadership training for our senior clinical leaders to ensure that they are equipped with the necessary skills to lead our transformation.

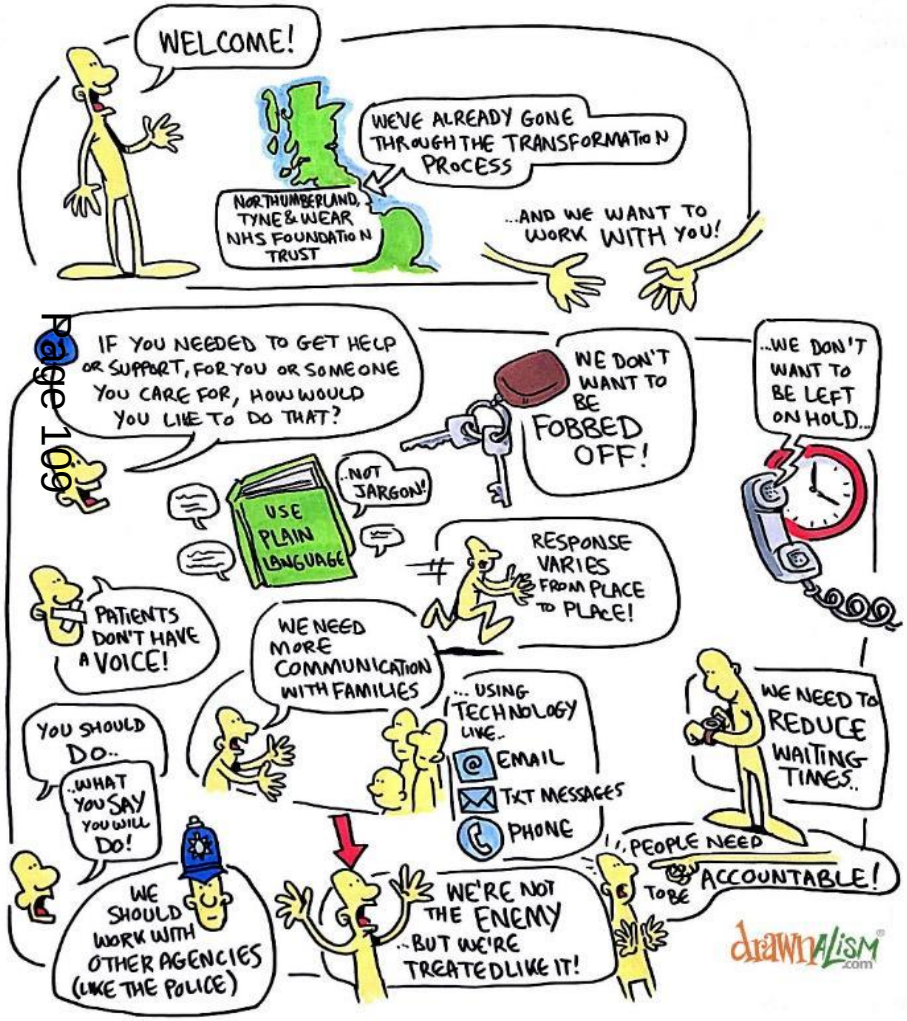
   Full detailed plans are being developed that will enable the implementation of this strategy at pace.

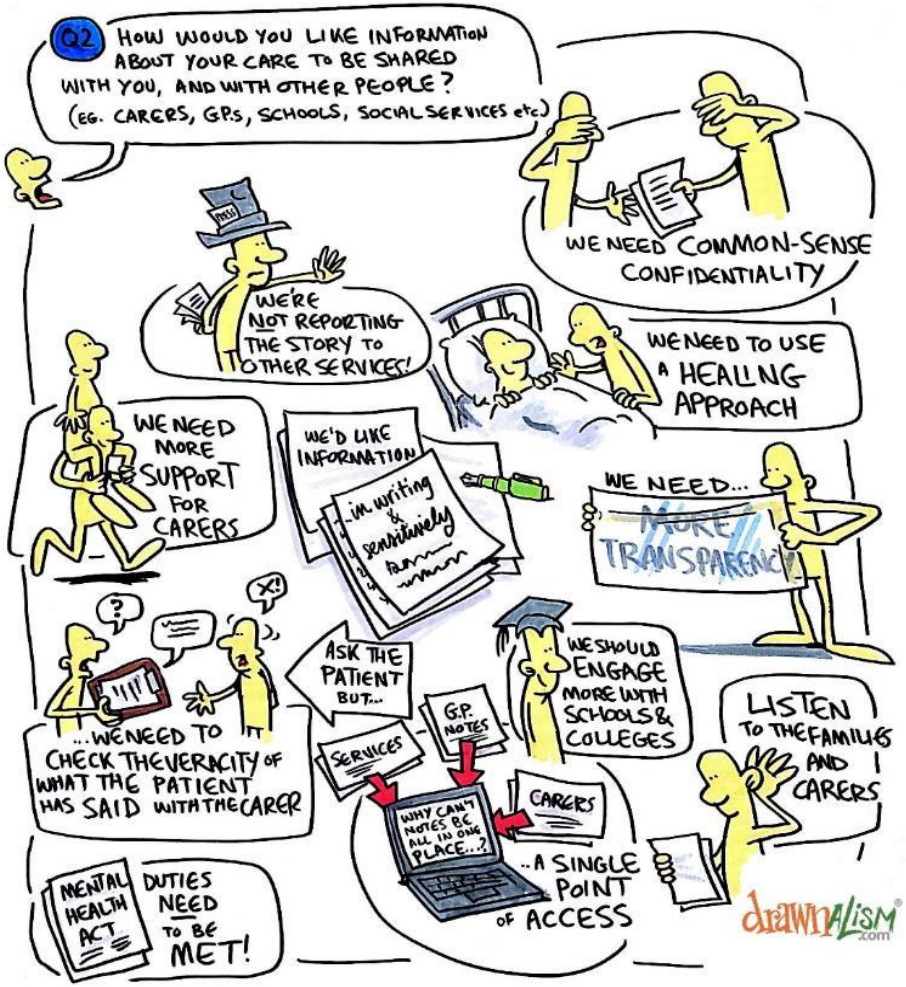
9 Appendices

Appendix 1: Service User, Carer, and Families Feedback

Mental Health Service User, Carer, and Families Feedback

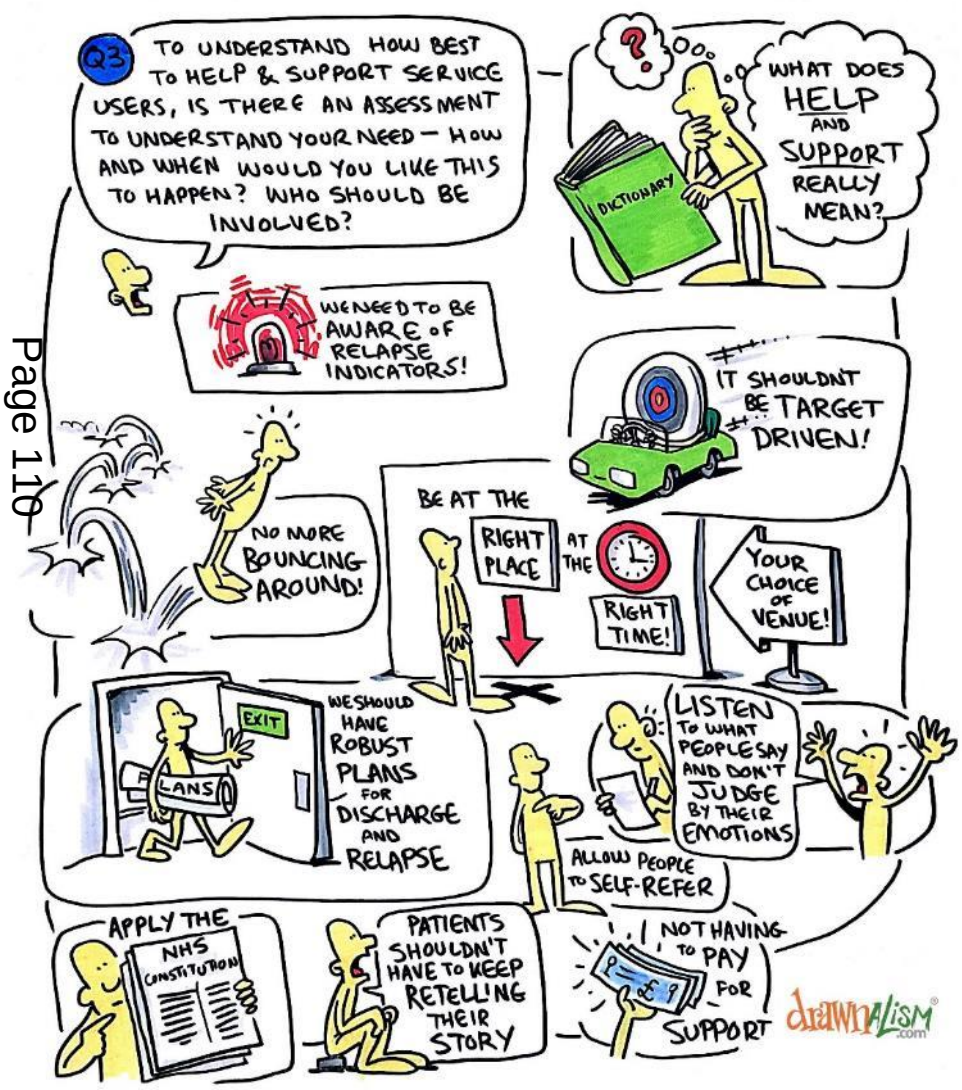
Lysses House Hotel, Farnham, Thursday 17th November 2016

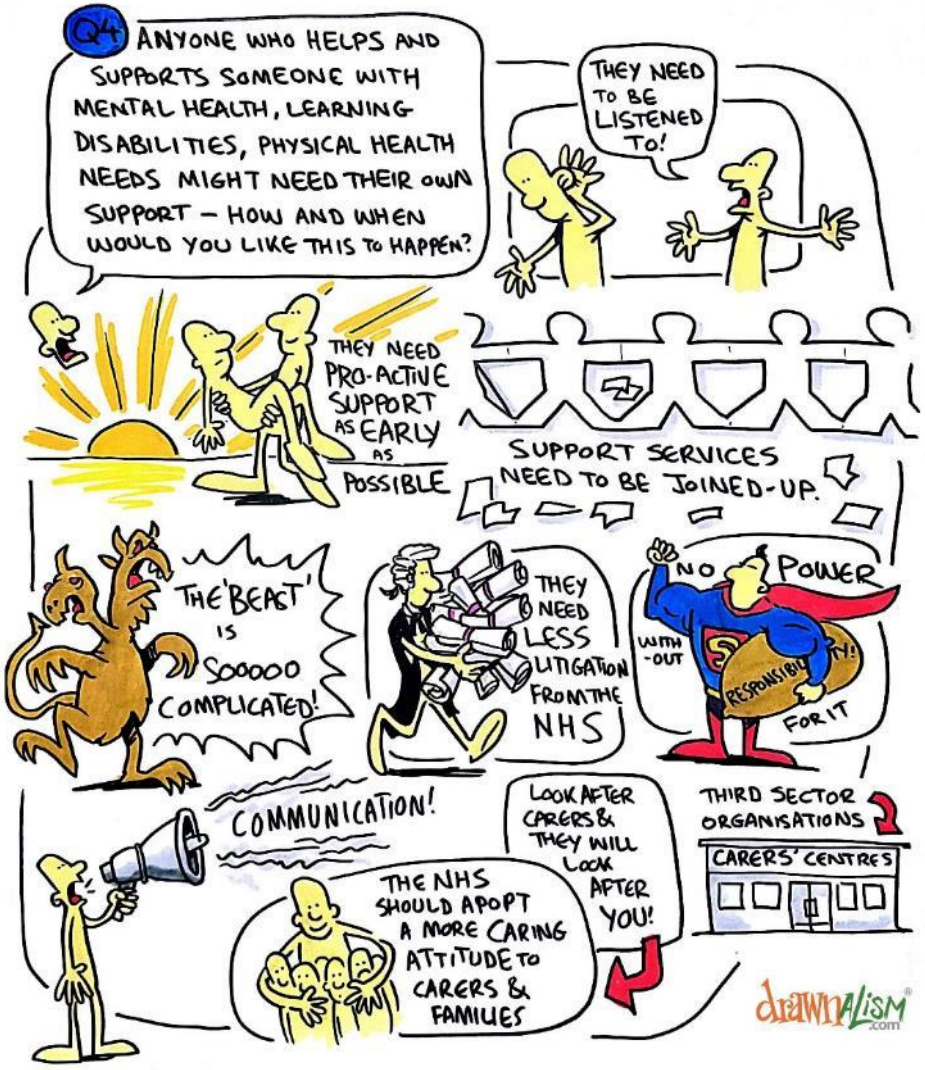




Mental Health Service User, Carer, and Families Feedback

Lysses House Hotel, Farnham, Thursday 17th November 2016





Mental Health Service User, Carer, and Families Feedback

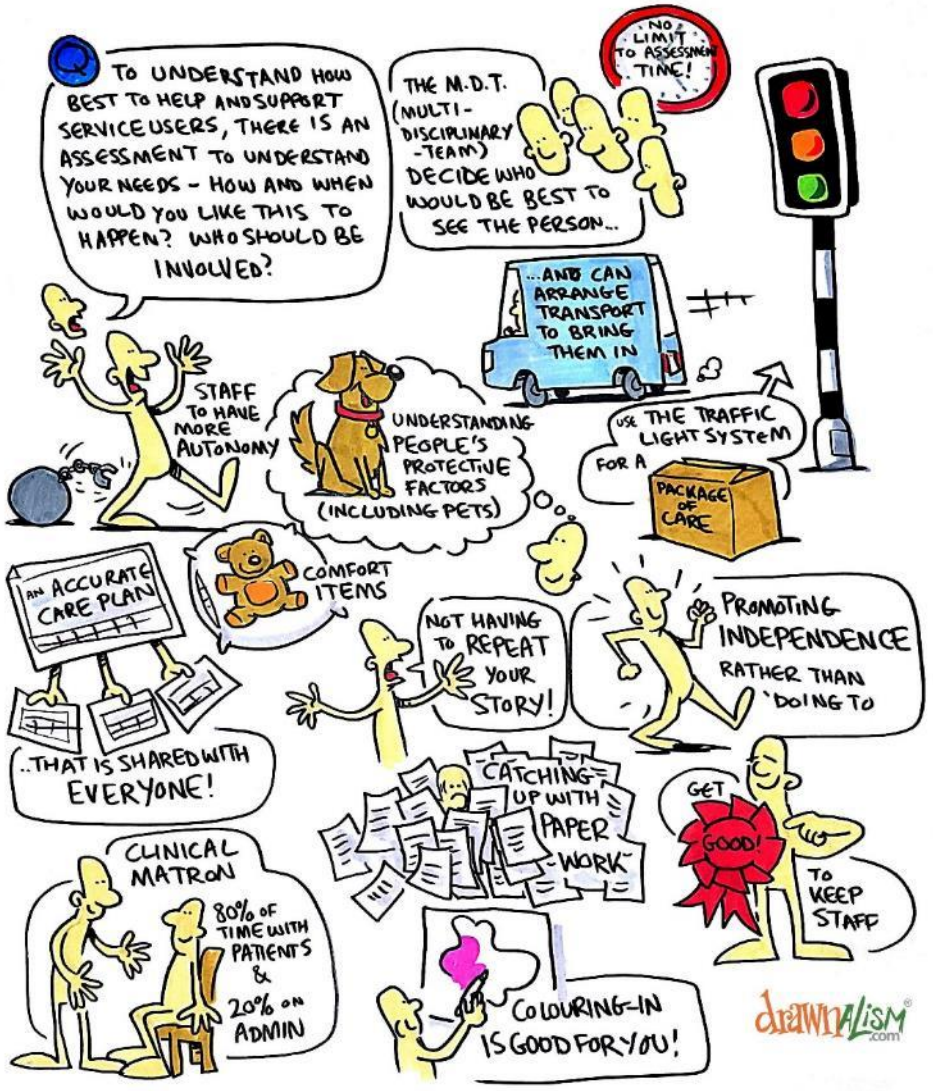
Lysses House Hotel, Farnham, Thursday 17th November 2016

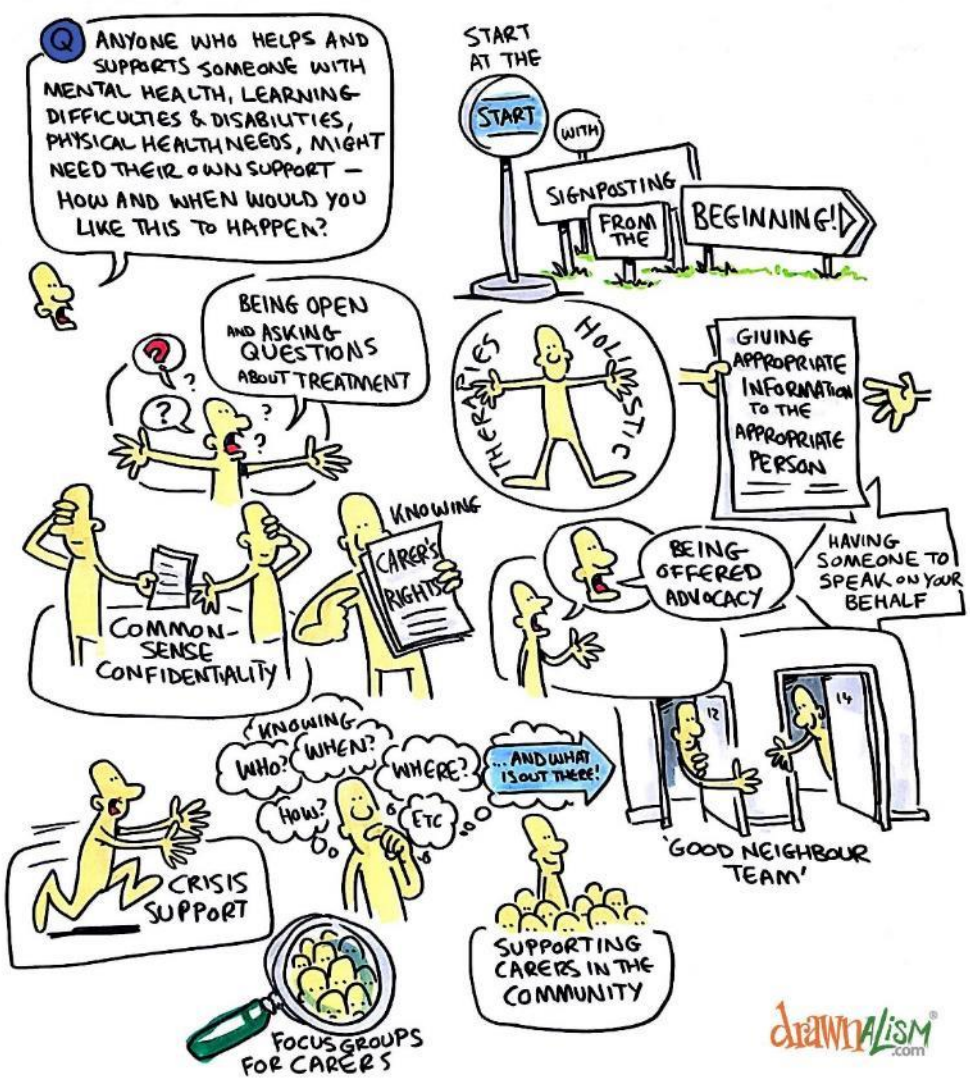
Mental Health Service User, Carer, and Families Feedback

Weybrook Park Golf Club, Basingstoke, Friday 18th November 2016

Mental Health Service User, Carer, and Families Feedback

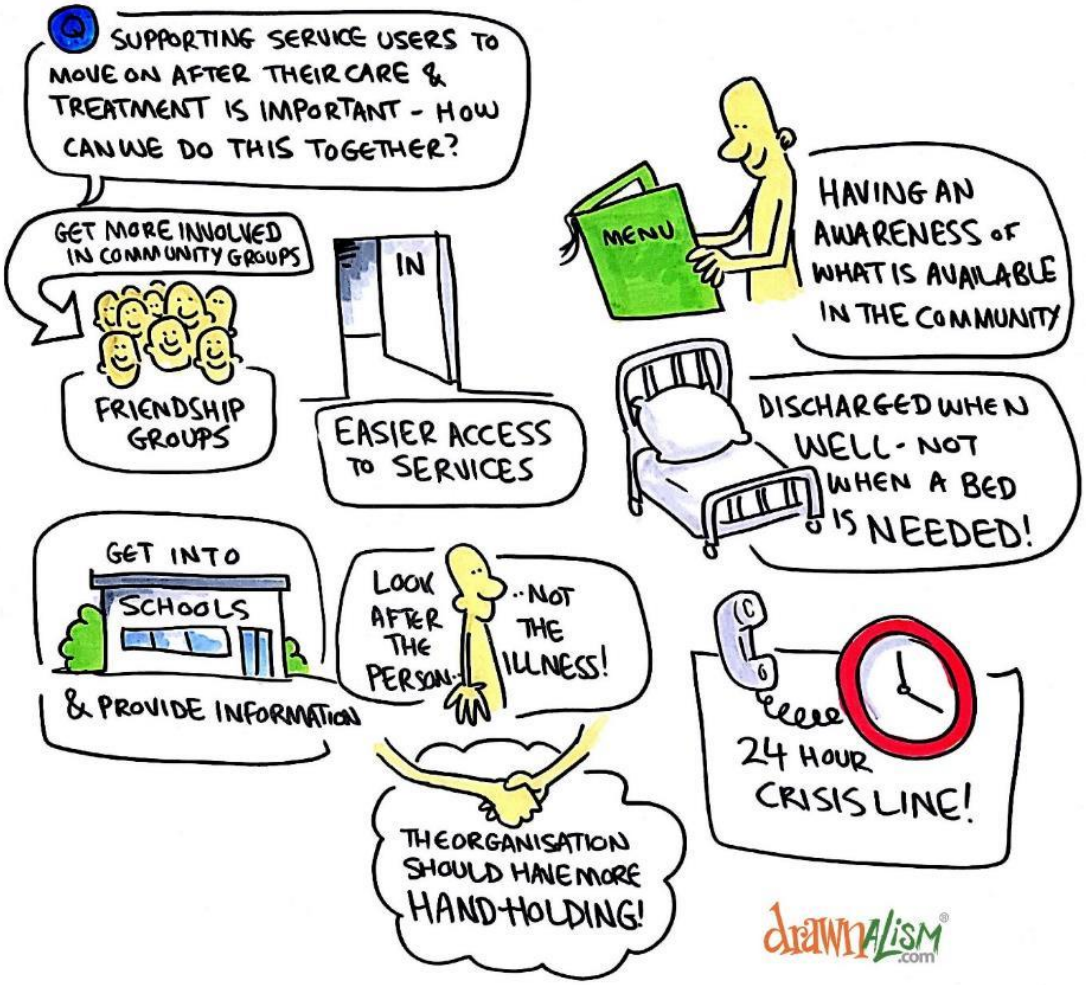
Weybrook Park Golf Club, Basingstoke, Friday 18th November 2016





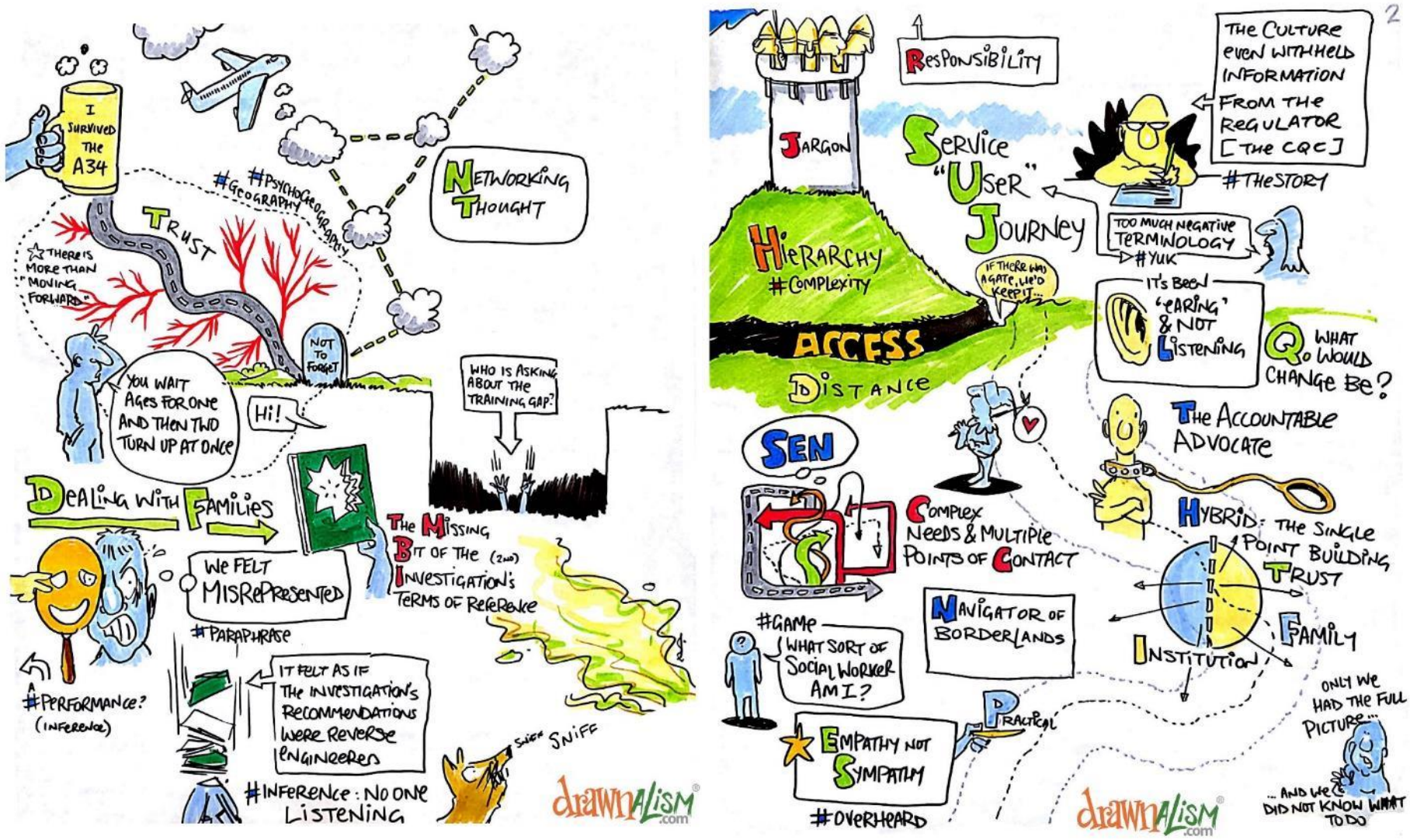
Mental Health Service User, Carer, and Families Feedback

Weybrook Park Golf Club, Basingstoke, Friday 18th November 2016



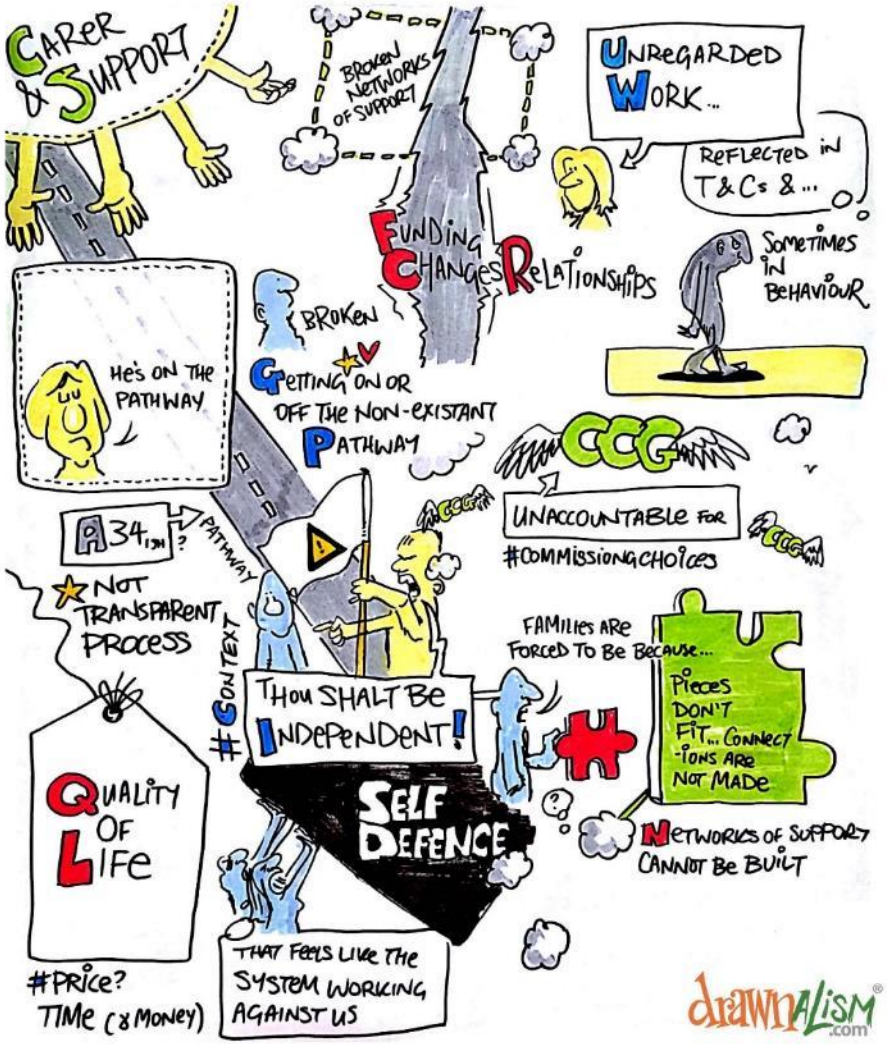
Mental Health Service User, Carer, and Families Feedback

Great Western Park Community Centre, Didcot, Wednesday 23rd November 2016



Mental Health Service User, Carer, and Families Feedback

Great Western Park Community Centre, Didcot, Wednesday 23rd November 2016

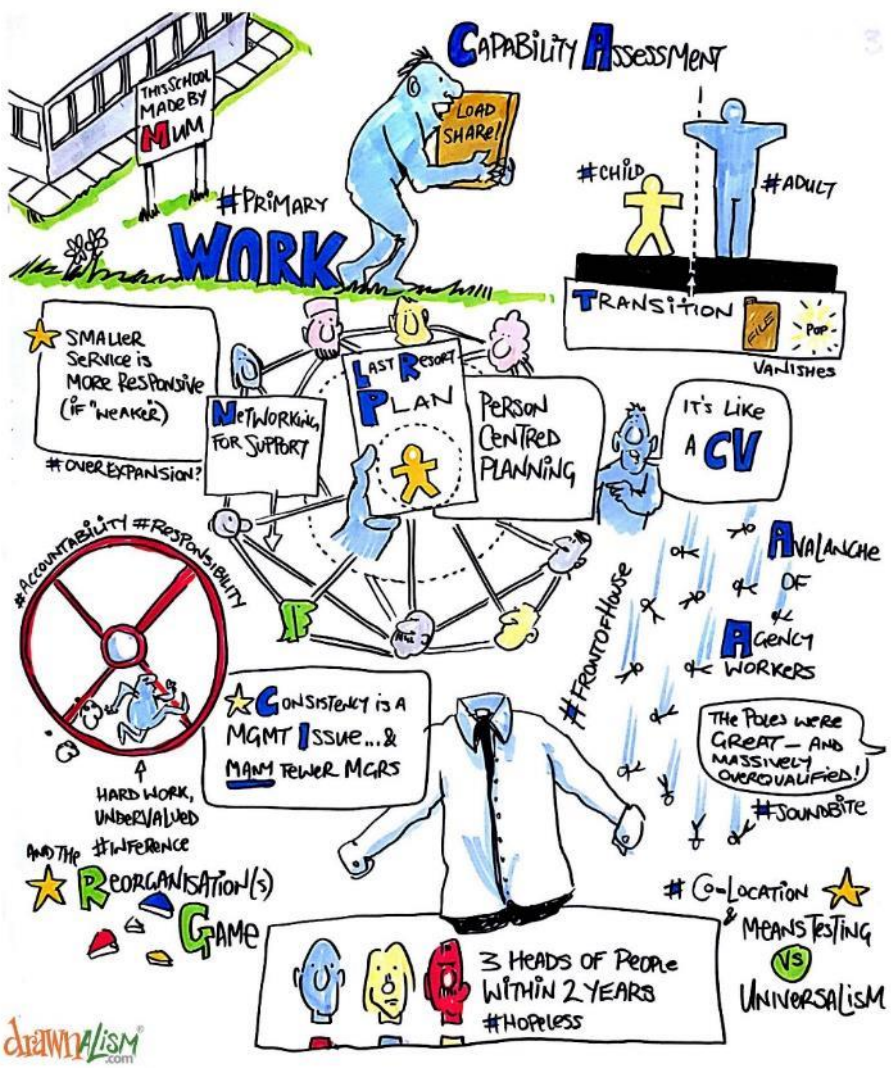


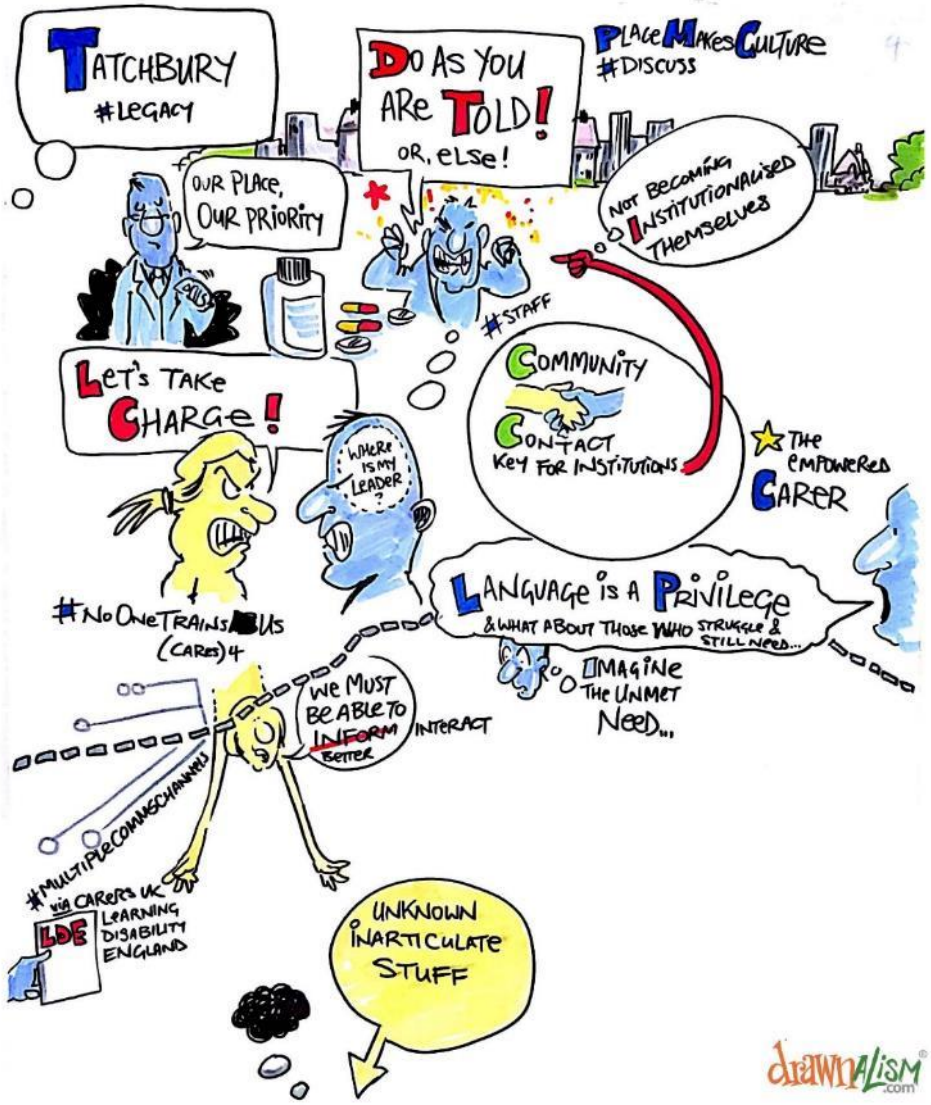
Mental Health Service User, Carer, and Families Feedback

Shirley Freemantle Community Centre, Southampton, Thursday 24th November 2016

Mental Health Service User, Carer, and Families Feedback

Shirley Freemantle Community Centre, Southampton, Thursday 24th November 2016





Appendix 2: Expert Reference Group

Expert Reference Group
Membership

NAME	POSITION
Geraldine Strathdee	National Clinical Lead, Mental Health Intelligence Network PHE Specialist Adviser on Population Mental Health, Integrated Care and Prevention Hon. Consultant Psychiatrist, Oxleas NHSFT Visiting Professor, Integrated Mental Health Programme, UCL Partners Patron, Positive Practice Collaborative
Carole Kaplan	Clinical Lead for Clinical Services Programme Director Transformation Programme, Northumberland Tyne and Wear NHS Foundation Trust
Tim Kendall	Psychiatrist & Current National Clinical Director
Dominic Slowie	GP & NHSE Professional Advisor, Learning Disability
Julie Hankin	Nottingham Medical Director & Vanguard: MCP Former CQC National
Professor Paul French	Associate Director (Greater Manchester West NHS Mental Health Trust) Clinical Lead (Greater Manchester Lancashire and South Cumbria) Strategic Clinical Network Regional Clinical Lead (N.W. EIP, NHSE) North Honorary Professor Institute of Psychology Health and Society, (University of Liverpool)
Emma Tiffin	GP, East of England, Vanguard
Esther Cohen-Tovee	Lead IAPT Psychologist, NTW & Chair BPS Clinical Faculty
Mark Trewin	Bradford Integrated Care Service and Vanguard Service Manager Mental Health Principal Social Worker (Adult and Community Department, City of Bradford Metropolitan District Council)
Stephen Firn	Clinician & CEO expertise for Integrated Mental Health and Community Providers and Specialised Commissioning
Alan Worthington	User/Carer Representative, National Expert Advocate
David Fearnley	Medical Director (Mersey Care NHS Foundation Trust) Associate National Clinical Director for Secure Mental Health (NHS England) Chair of Adult Secure Clinical Reference Group (NHS England)
Rafik Hamaizia	Care Quality Commission, Committee Member at NICE, CEO at JTI, Expert by Experience Lead at Cygnet, NHS England
Professor Harold Pincus	USA Integrated Care Expert
Helen Wood	CEO, MHT and Primary Care Strategy Expert
Chris Nas	Dutch Outcomes Measurement Expert
Professor Pat McGorry	CYP Expert, Australia

Expert Reference Group
Terms of Reference

Key Responsibilities (Duties)

The Expert Group will have an advisory role, with direct access to the Trust Board Chair and Chief Executive. The key role of the Expert Reference Group will be to:

- Provide advice to the clinical services strategy programme to ensure that the models developed are consistent with wider system thinking
- Review and test the emerging thinking and strategy, highlighting risks and issues requiring action.

This will be through a combination of proactive engagement to share insight and experience, and providing advice and views on the clinical service strategy in response to requests from the Programme.

Mode of Working

It is not expected that the Expert Group will hold regular meetings, but will work virtually and through establishing a strong network co-ordinated by the Expert Group chair, with meetings convened as required.

Requests to the Expert Working Group will be co-ordinated through the Clinical Service Strategy Programme Management Office, with leadership provided the Programme Clinical Lead, Dr Carole Kaplan.

The Chair of the Expert Working Group, and other members may be invited to attend key forums through the course of the work.

Reporting Arrangements

The Expert Reference Group will work in an advisory capacity to the Trust Board and Programme Steering Group. It will be overseen by the Southern Health Medical Director and the Clinical Services Strategy Clinical Lead.

Conduct of work

Any meetings of the Expert Reference Group that are required will be supported with an agenda and papers distributed in advance of the meeting.

Requests for advice will be co-ordinated by the Clinical Services Strategy Clinical Lead, Dr Carole Kaplan who will agree the timeline for responses with the Expert Group Chair.

Appendix 3: Care Cluster Groups

Care Clustering
(Mental Health Clustering Booklet, V5.0, 2016/17, NHS England)

Introduction

The Mental Health currencies have been mandated for use since April 2012. For most provider and commissioning organisations completeness and accuracy of cluster allocations is now a key concern and a great deal of audit/assurance work is being undertaken. This manual is not intended to replace face-to-face training sessions, but to provide clinicians with all the information needed to accurately use the model.

What is a Cluster?

In this context a cluster is a global description of a group of people with similar characteristics as identified from a holistic assessment and then rated using the Mental Health Clustering Tool (MHCT). The clusters allow for a degree of variation in the combination and severity of rated needs. However, as the clusters are statistically underpinned, definite patterns in the MHCT ratings exist for each of them. These ranges are indicated by the colour coded grids (Appendix 3) and are supplemented by the contextual information on the left hand side of each page, which is particularly useful when reviewing the appropriateness of previous cluster allocations.

When should I cluster someone?

People's needs change over time, and over the course of their treatment. A payment system for mental healthcare must reflect the differing levels of input that are provided throughout changing and unpredictable episodes of care. In order to achieve this, it is essential that people are not only assessed and clustered at the point of referral, but also re-assessed and re-clustered periodically. In practice this will equate to assessing and clustering people at:

- The end of the initial assessment (typically within 2 contacts).
- All planned CPA or other formal care reviews.
- Any other point where a significant change in planned care is deemed necessary (e.g. unplanned reviews, urgent admissions etc.)

Organisations should ensure there is clarity about who is responsible for clustering, particularly when more than one professional is involved.

How do I Cluster someone who is newly referred?

As organisations use different IT systems, the exact procedures will vary from provider to provider. However all providers will follow these basic steps:

Step 1: Based on the information you have gathered during your routine screening/assessment process, rate the individual's identified needs using the Mental Health Clustering Tool - Version 5.0 (Appendix 1).

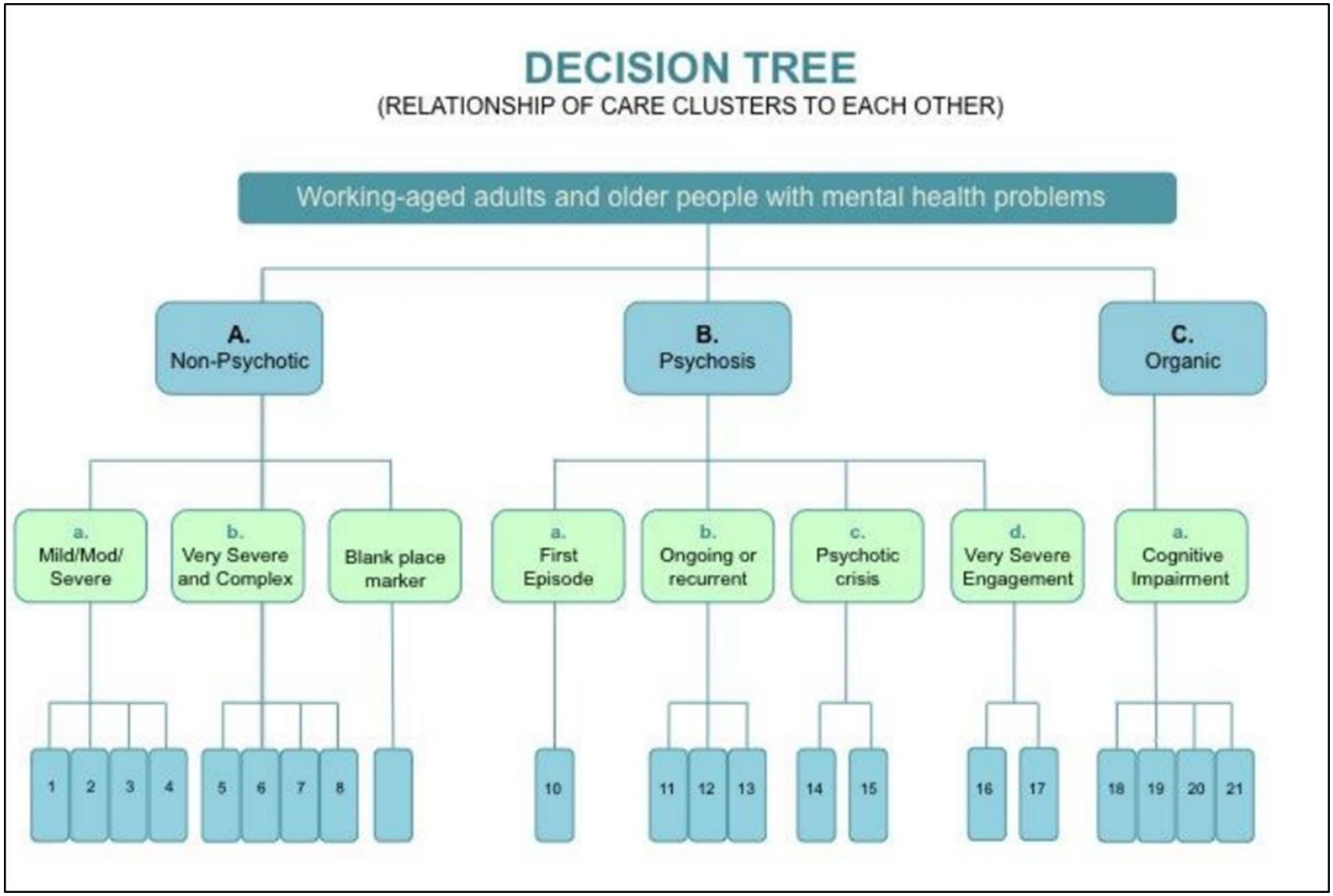
Step 2: Use the Decision Tree (Appendix 2) to decide if the presenting needs are non-psychotic, psychotic or organic in origin. Then decide which of the next level of headings is most accurate. This will have narrowed down the list of clusters that are likely to describe the person's needs.

Step 3: Look at the rating grids (Appendix 3) to decide which one is the most appropriate by using the colour-coded key.

- Start with the Red ratings. These indicate the type and level of need which must be apparent in order to be a member of this cluster. If the ratings do not match, try another cluster.
- Next, consider the Orange ratings. These represent expected ratings. You may allocate a person to a cluster if the orange ratings do not exactly match the coloured grids. However, this reflects a "weaker fit" to that cluster.

Care Clustering

(Mental Health Clustering Booklet, V5.0, 2016/17, NHS England)



Appendix 4: NHS Benchmarking data

Inpatient and Community Mental Health Benchmarking, November 2016 (weighted data)

NHS Benchmarking data

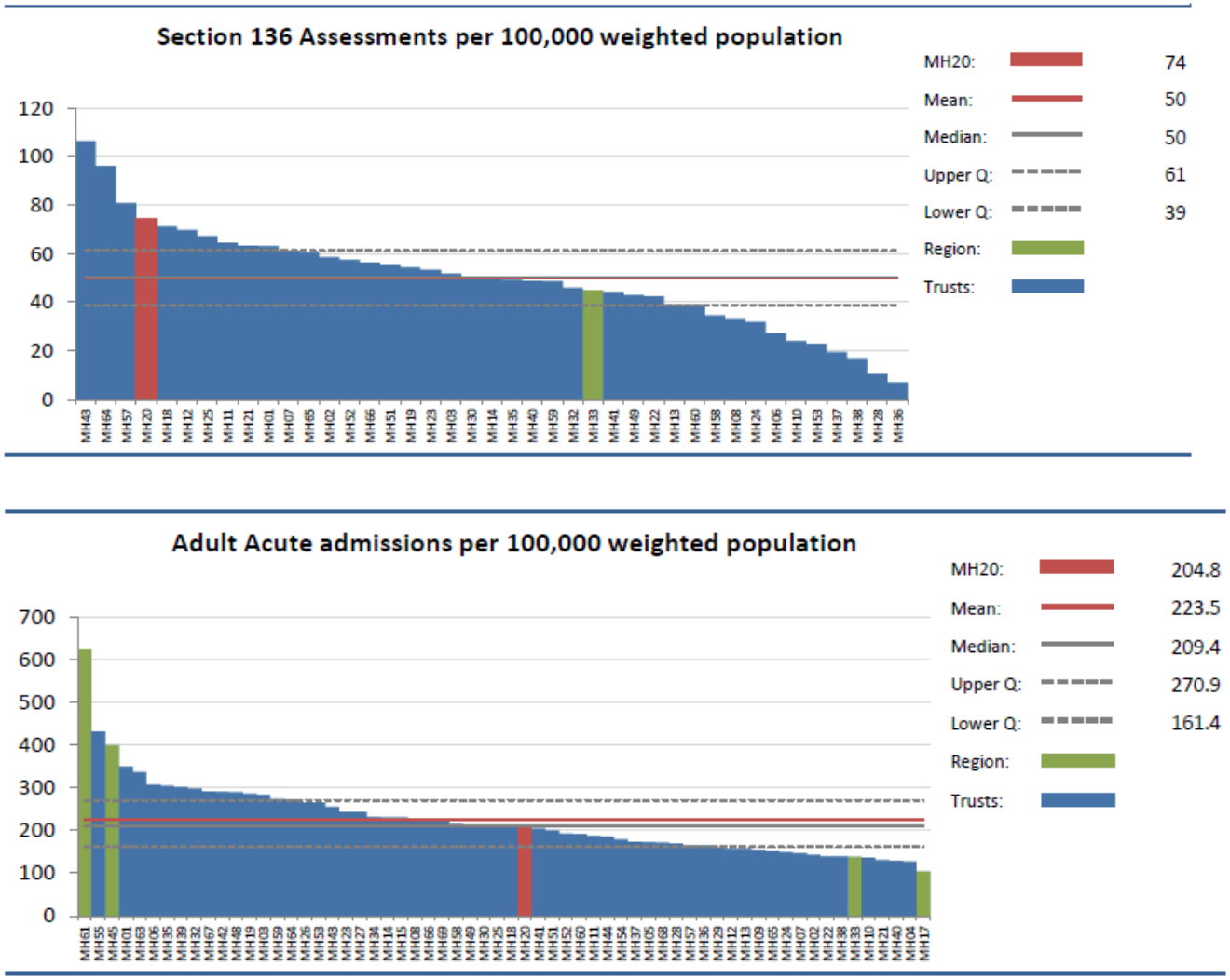
Benchmarking Network

This report summarises the main findings from the 2016 benchmarking process that has taken place across NHS mental health services.

Southern Health NHS FT is named MH20 on the charts.

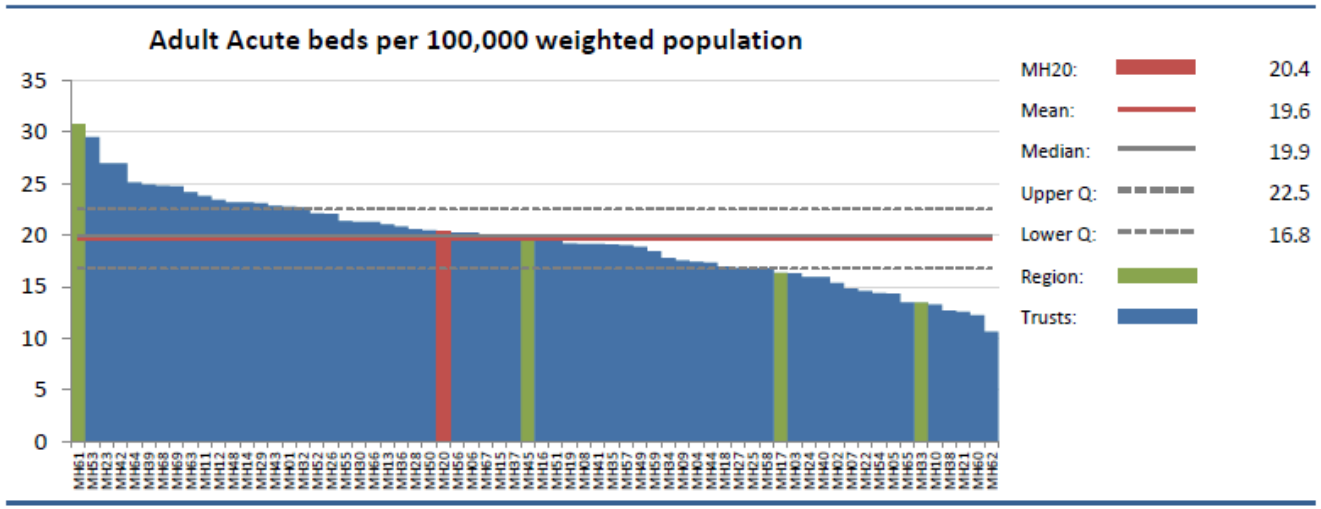
The charts on the following pages are a selection from a full pack of NHS Benchmarking Information that is available from the Trust.

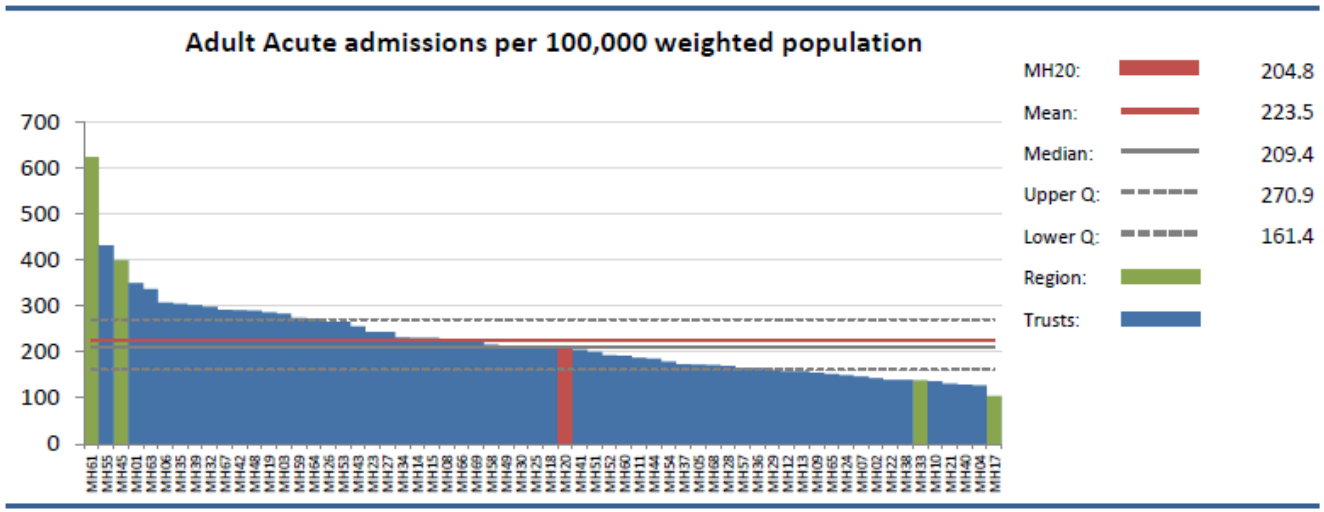
NHS Benchmarking data: Section 136 and Acute admissions per 100,000 weighted population



Source: NHS Benchmarking Data - NHS Benchmarking Network, Inpatient and Community Mental Health Benchmarking, November 2016

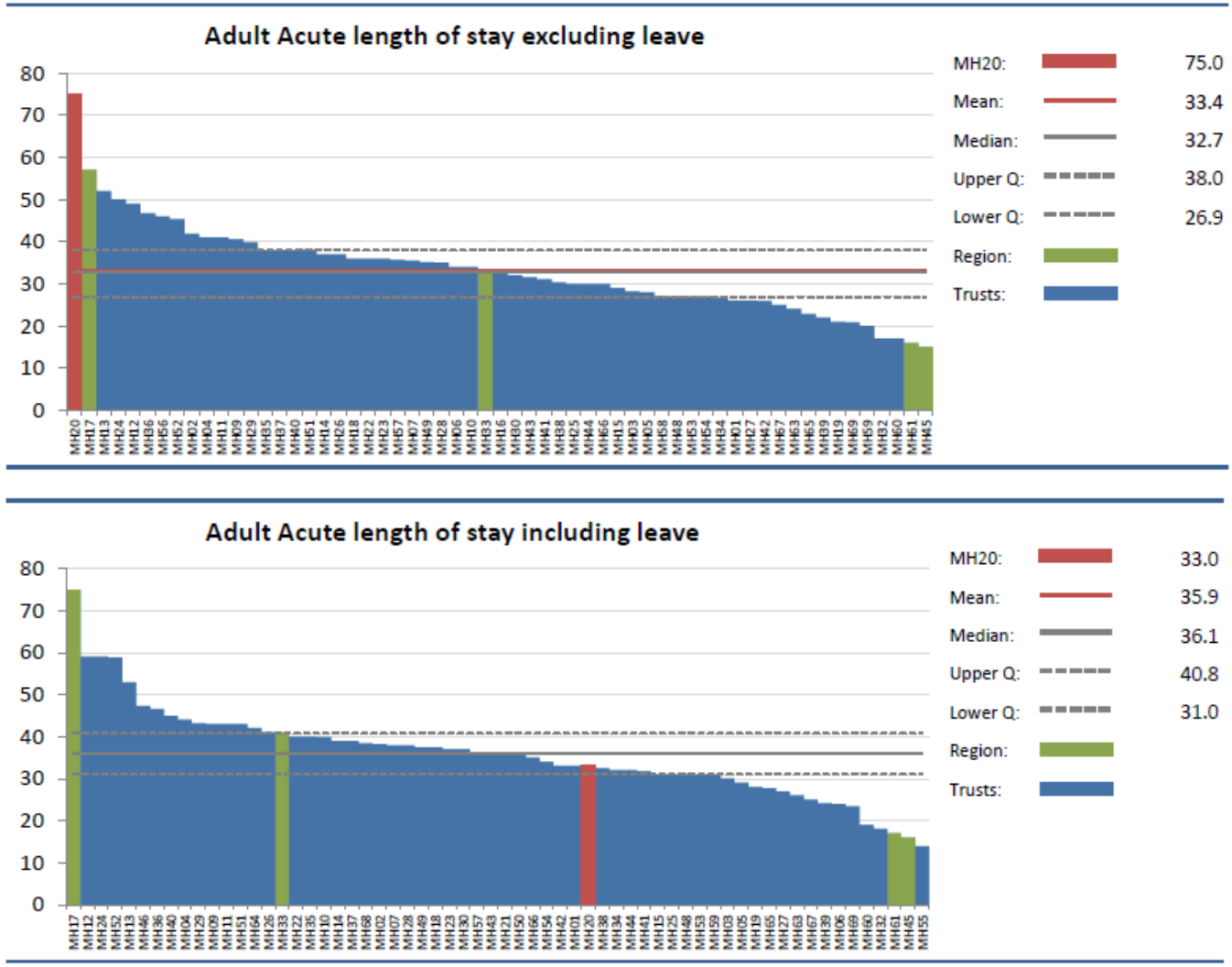
NHS Benchmarking data: Adult beds/admissions per 100,000 weighted population





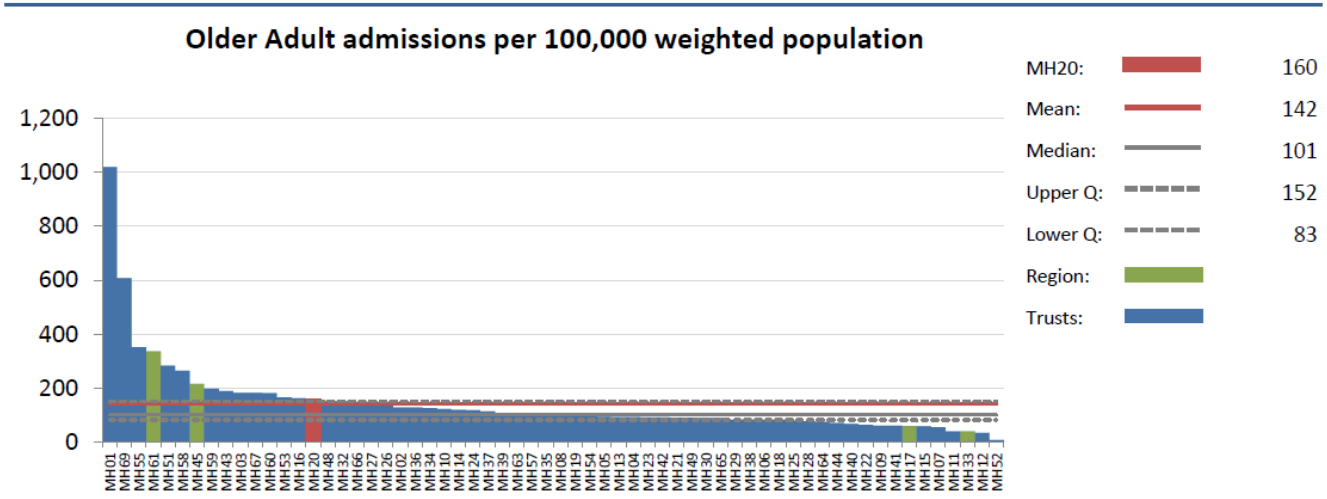
Source: NHS Benchmarking Data - NHS Benchmarking Network, Inpatient and Community Mental Health Benchmarking, November 2016

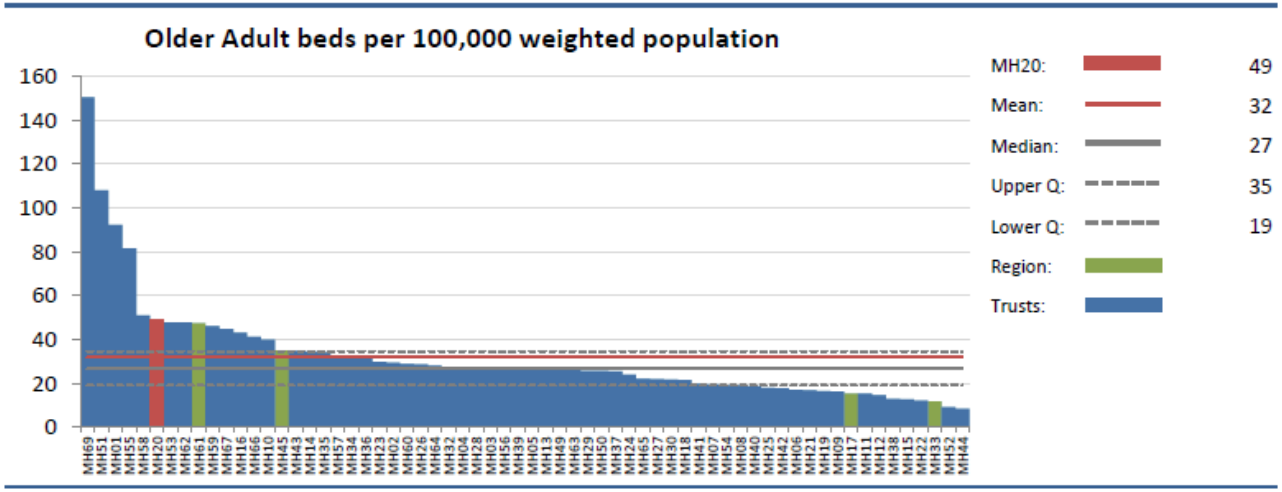
NHS Benchmarking data: Adult Length of stay



Source: NHS Benchmarking Data - NHS Benchmarking Network, Inpatient and Community Mental Health Benchmarking, November 2016

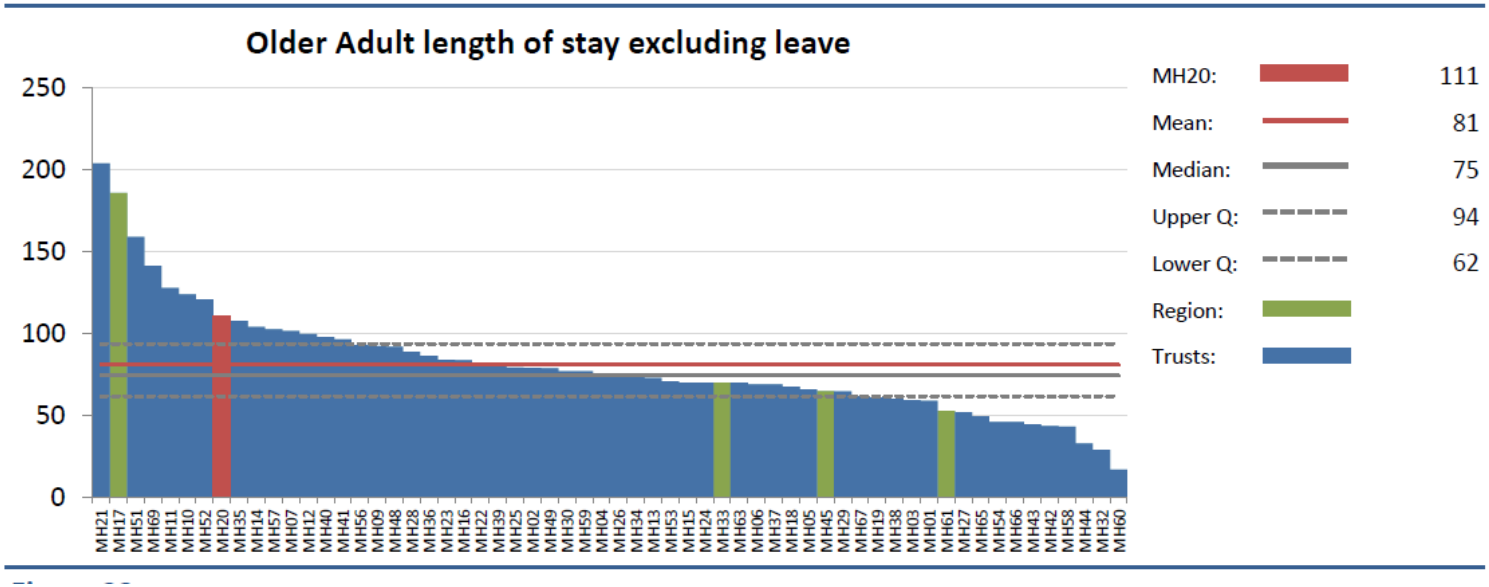
NHS Benchmarking data: Older Adults beds and admissions per 100,000 weighted population





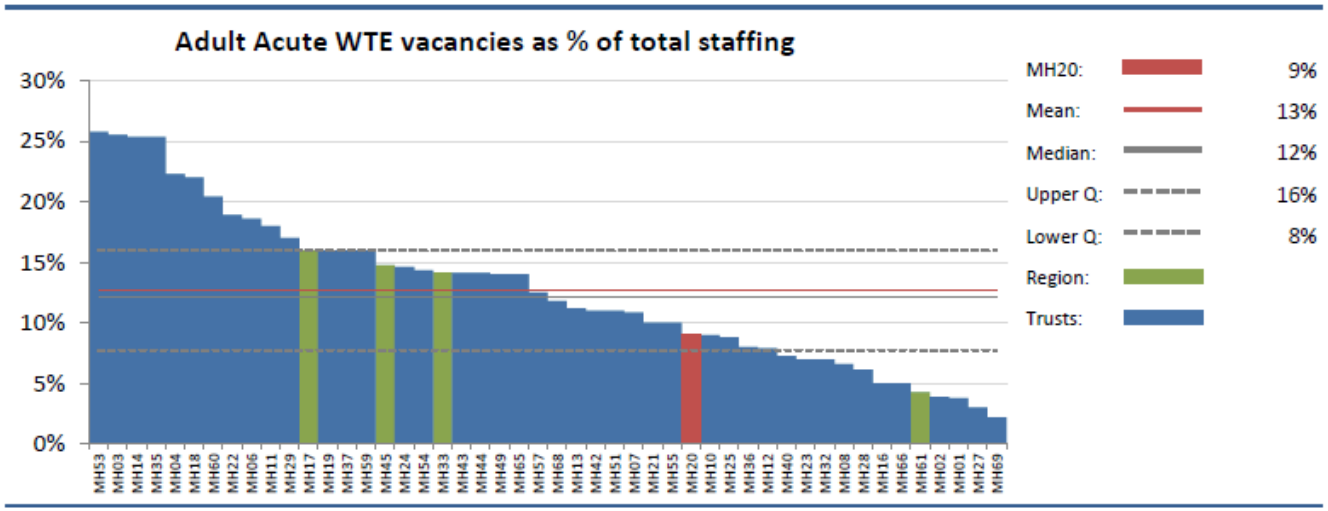
Source: NHS Benchmarking Data - NHS Benchmarking Network, Inpatient and Community Mental Health Benchmarking, November 2016

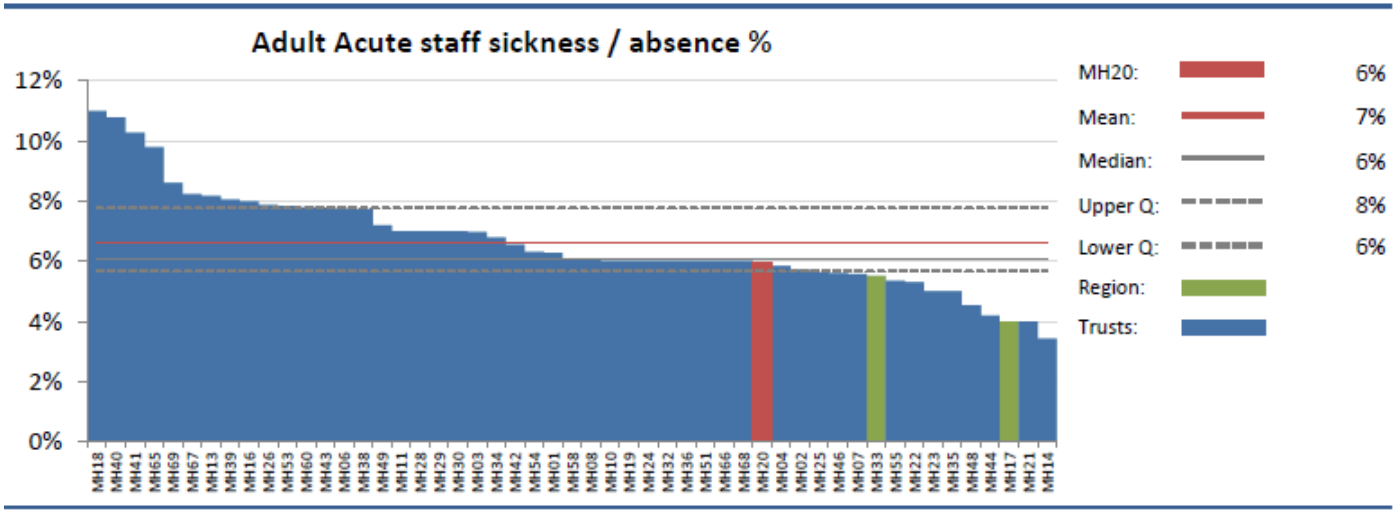
NHS Benchmarking data: Older Adults Length of stay



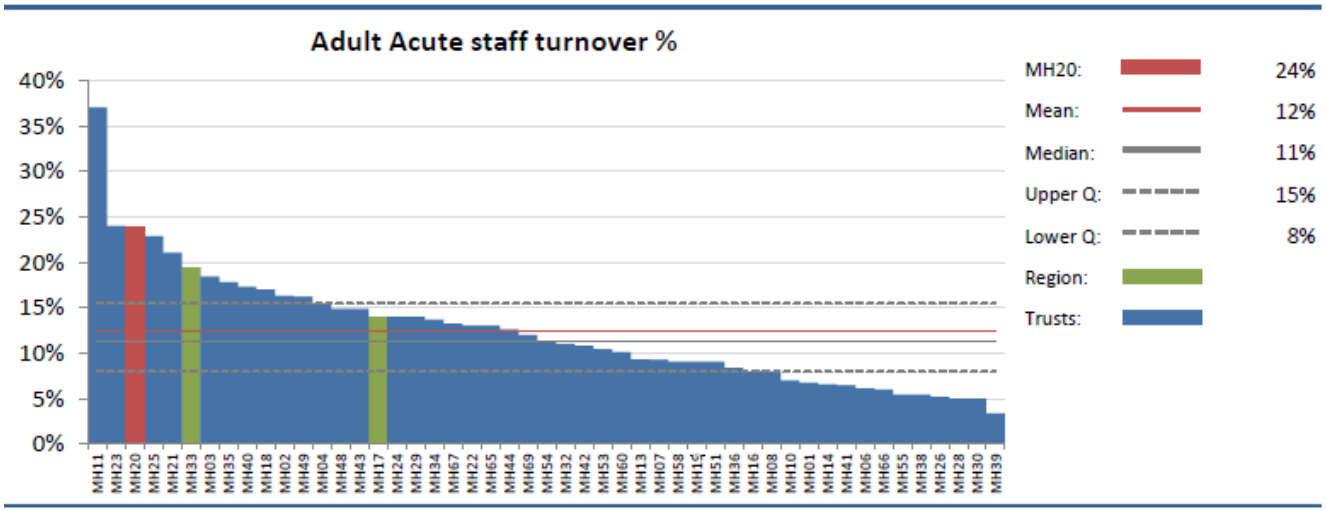
Source: NHS Benchmarking Data - NHS Benchmarking Network, Inpatient and Community Mental Health Benchmarking, November 2016

NHS Benchmarking data: Workforce metrics





NHS Benchmarking data: Workforce metrics



Source: NHS Benchmarking Data - NHS Benchmarking Network, Inpatient and Community Mental Health Benchmarking, November 2016

Source: NHS Benchmarking Data - NHS Benchmarking Network, Inpatient and Community Mental Health Benchmarking, November 2016

Source: NHS Benchmarking Data - NHS Benchmarking Network, Inpatient and Community Mental Health Benchmarking, November 2016

HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Adult Social Care Select Committee
Date of Meeting:	20 June 2017
Report Title:	Proposals to Develop or Vary Services
Report From:	Director of Transformation & Governance

Contact: 01962 847336 / members.services@hants.gov.uk

1. Summary and Purpose

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

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

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

1.4. This Report is presented to the Committee in 3 parts:

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

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

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

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

Items for Action

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

Context

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

2.2 A stroke is a serious life-threatening medical condition that occurs when the blood supply to part of the brain is cut off. Because of this, strokes are a medical emergency and urgent treatment is essential[1].

Background

2.3 Six Clinical Commissioning Groups in Surrey have led a review of how stroke services are provided across Surrey in order to deliver services that meet the South East Coast Stroke Services Specification, and to enhance care in the region. Services in West Surrey form one of three stroke systems across Surrey County.

2.4 Following a period of engagement, agreement of a proposed stroke service model for West Surrey, and assurance from NHS England, Guildford and Waverley CCG and North West Surrey CCG undertook a consultation on these services from 6 February to 30 April 2017.

2.5 The consultation was held for a period of 12 weeks, and a number of events were held in affected areas of North and East Hampshire to discuss the

[1] http://www.nhs.uk/conditions/Stroke/Pages/Introduction.aspx

proposals with the public and stakeholders. Details of these events were circulated to members of the HASC.

2.6 The outcomes of the consultation are currently being analysed by the NHS Transformation Unit, and will be summarised in a public report to be considered by the West Surrey Stroke System Committees in Common in July 2017.

Proposal

2.7 A paper detailing the background to the stroke review, engagement to date, consultation activities and next steps is attached as Appendix One. The full stroke consultation document is attached for the Committee's information as Appendix Two, in order to provide a fuller overview of the proposals.

2.8 Historically, three hospitals in West Surrey have provided some specialist stroke care; Frimley Park (Camberley), Royal Surrey County (Guildford), and St Peter's (Chertsey). Of these, only Frimley Park currently has a full hyperacute stroke unit and a separate acute stroke unit. The other two sites have combined hyperacute and acute stroke care units.

2.9 The CCGs are proposing a service model where there would be two larger hyperacute units providing highly specialist care at Frimley Park and St Peter's Hospital. This is because these two sites scored highest in options appraisals for specialist stroke services. Resultantly, there would be no specialist stroke care provided at Royal Surrey Hospital if the proposals were agreed.

2.10 It should be noted that the three hospitals in West Surrey support the CCG's proposals. Currently, there is an interim stroke provision arrangement in place across West Surrey where the Royal Surrey Hospital does not receive patients suspected of suffering a stroke, due to staff vacancies in the multi-disciplinary stroke team.

Impact on Hampshire

2.11 Historically, patients suspected of having a stroke in some parts of North East and South East Hampshire would be conveyed by ambulance to either Frimley Park Hospital on the Surrey / Hampshire border, or Royal Surrey County Hospital in Guildford. Therefore the Committee is a statutory consultee in this potential substantial change in service, as a small number of the Hampshire population may be impacted by the proposals.

2.13 Representatives of North East Hampshire and Farnham CCG and South Eastern Hampshire CCG will be present at the meeting to discuss further the

impact of the proposals on Hampshire residents. The majority of the population of Hampshire will not be affected by these proposals, as the hyperacute stroke unit provided by Hampshire Hospitals NHS Foundation Trust is unaffected by these proposals.

Recommendations

2.14 That Members:

a. Determine whether the proposals for stoke services in West Surrey constitute a substantial change in service for the Hampshire population.

b. Request that the outcomes of the consultation and final proposals for stroke services be considered at the 21 September 2017 meeting.

c. Request any further information required on this issue.

CORPORATE OR LEGAL INFORMATION:

Links to the Corporate Strategy

A. Hampshire safer and more secure for all:	yes
Corporate Improvement plan link number (if appropriate):	
B. Maximising well-being:	yes
Corporate Improvement plan link number (if appropriate):	
C. Enhancing our quality of place:	yes
Corporate Improvement plan link number (if appropriate):	

Section 100 D – Local Government Act 1972 – background documents

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

Document	Location
None	

IMPACT ASSESSMENTS:

1. Equalities Impact Assessment:

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

2. Impact on Crime and Disorder:

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

3. Climate Change:

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

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

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

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

Appendix One

Guildford and Waverley Clinical Commissioning Group

Hampshire Health and Adult Social Care Select Committee

20th June 2017

West Surrey Stroke System – Next Steps

Purpose of the report: Scrutiny of Services

To explain the process followed by Surrey's six CCGs to review stroke care and steer providers to develop proposals that meet the requirements within the Stroke Service Specification.

To explain the steps taken to consult the public regarding these proposals.

To summarise the next steps to be taken by Guildford and Waverley and North West Surrey CCGs with regard to the commissioning of stroke care in West Surrey.

1. Background

1.1 Every year just over 2,000 people are admitted to the following three hospitals in West Surrey and diagnosed as having had a stroke:

- Frimley Park Hospital in Frimley near Camberley
- Royal Surrey County Hospital in Guildford[2]
- St. Peter's Hospital in Chertsey

1.2 This number is likely to rise because the population is aging. Most of these people go to hospital then move on to use community rehabilitation services. Getting fast effective treatment can save lives and prevent long-term disability.

1.3 Following the publication of national guidelines, between late 2014 and late 2015, Surrey's six CCGs were requested by the South East Coast Clinical Senate to review how stroke care is provided to their population. The Surrey Stroke Review examined whether local stroke services met the criteria for providing good stroke care. The Surrey Stroke Review collected feedback from local people, clinicians,

[2] The Royal Surrey County Hospital is not currently receiving patients suspected of suffering a stroke. Patients are being taken to either Frimley Park Hospital or St Peter's Hospital under interim arrangements. A proportion of these patients are being transferred to the RSCH following the hyper-acute period for acute stroke and rehabilitation care during this interim period.

voluntary and community groups, a panel of national experts and other stakeholders. Data was compiled about the number of people using stroke services and the quality of the services provided. The Review found that services could be enhanced to provide better care and to meet the South East Coast Stroke Services Specification. A review of key success factors was undertaken by the South East Coast Clinical Senate.

1.4 All CCGs in Surrey assigned delegated committees of their Governing Bodies to oversee the next steps. These CCG Committees in Common gave the three health systems in Surrey (East, West and Surrey / Hampshire borders) an opportunity to propose how they would deliver the South East Coast Stroke Services Specification, which was based on the national stroke specification. In June 2016, each system submitted a proposal about how to improve stroke services locally and the CCGs have given systems feedback about areas that need further development. These were further refined and final submissions were made in October 2016 for the CiC to consider these updated proposals and plan next steps.

1.5 The outcome of the Surrey Stroke Services Review was a recognised need to further enhance stroke services. The CCG Collaborative used a structured process to achieve the recommendations of the Review, which involved working with hospitals and community health and care organisations to plan the best way of implementing an evidence-based specification for stroke services.

1.6 Systems put forward proposals to deliver a holistic pathway of care from the time people have a stroke through to six months after discharge from hospital. This includes care in hospital as well as in the community.

1.7 Based on population numbers and hospital capacity, the Surrey Stroke Review examined evidence about having one, two or three hyperacute stroke units (HASUs) located in different parts of Surrey as part of a whole pathway of care. The CCG Committees in Common asked local health and care systems to work together to propose where HASUs might be best located and how they would integrate with the wider pathway of care. An outline of the stroke pathway was provided at the November 2015 Surrey Wellbeing and Health Scrutiny Board meeting.

1.8 Each of the acute trusts that may house a HASU was asked to facilitate the development of plans to meet the South East Coast Stroke Services Specification, working closely with others in the local health system. The three systems are:

- East system: SASH and Epsom (supported by Surrey Downs and East Surrey CCGs)
- **West system: St Peter's (part of ASPH) and RSCH (supported by Guildford and Waverley and North West Surrey CCGs)**
- Surrey and Hampshire borders system: Frimley (supported by Surrey Heath and North East Hampshire and Farnham CCGs)

1.9 In June/July 2016, the systems submitted proposals for a full stroke pathway of care. An assurance panel made up of national and local experts, including clinicians, the Stroke Association, service user and carer representatives, Royal College members, NHS England, Health Education England, CCG stakeholders and others reviewed the proposals using pre-set assurance criteria.

1.10 The CCG Stroke Committees in Common examined the proposals and the expert feedback in July 2016. They decided that progress had been made in each system but there was more work to do to make sure that the proposals were feasible and offered the best quality and value services for local people. Each system further developed their proposals over the coming months with engagement from partners and local service users.

1.11 On 13 December 2016 the CiC unanimously affirmed the 3 HASU/ ASU model and recognised the need for different timescales to achieve it in the 3 different areas; it agreed that the Collaborative should monitor delivery. The CiC acknowledged that there will be different transitional models in the interim until the final model is achieved.

1.12 NHS Guildford and Waverley CCG and NHS North West Surrey CCG agreed that they were ready to carry out a public consultation on the proposed service model for West Surrey following assurance from NHS England.

1.13 The proposals put forward for public consultation are explained on the CCG's website[3], and the consultation document is attached as Appendix Two.

2. Engagement

2.1 In line with good practice and to meet the legislative requirements set out in the Health and Social Care Act of 2012 (sections 13Q, 14Z2 and 242) and the four tests outlined in the Mandate from the Government to NHS England, public and service user involvement needs to be an integral part of any service change process. The Surrey CCG Collaborative recognised that engagement should be early and continue through all stages using a broad range of engagement activities.

2.2 Early engagement in 2015 informed the development of the plans that were consulted on in West Surrey. As part of the Surrey Stroke Review, the public, service users and carers and other stakeholders were asked to share their views regarding the relative importance of different aspects of stroke care, from prevention through acute care and into rehabilitation and life after stroke. Three public meetings were held in September 2015, an online and paper survey was completed by more than 300 people, a database of more than 200 people and organisations was developed to receive updates and service users, carers and service user organisations were involved in events to shape the specification that systems responded to. The Stroke Association was part of the assurance panel helping to review and shape proposals.

[3] http://www.guildfordandwaverleyccg.nhs.uk/index.aspx

2.3 A stakeholder event was organised by NHS North West Surrey CCG and NHS Guildford and Waverley CCG in August 2016 to highlight the emerging plans for West Surrey and to gain feedback on how best to engage the local communities during a consultation period. Suggestions included attending existing meetings; holding events in accessible venues; making materials accessible. All suggestions were incorporated into the planning of the consultation.

2.4 Building on this early engagement work, a plan was developed for the public consultation. This proposed a timeline as follows:

- December 2016: NHS England assurance process (CCGs need to fulfil the terms of the Mandate from Government)
- 6 February 2017 –30 April 2017: public consultation
- 4 July 2017 – West Surrey Stroke System Committees in Common meeting in public to consider outcomes of consultation and make decisions regarding next steps
- 4 September 2017 – Surrey County Council Adults and Health Select Committee
- 2 October 2017: potential commencement date of service changes

3. Public consultation

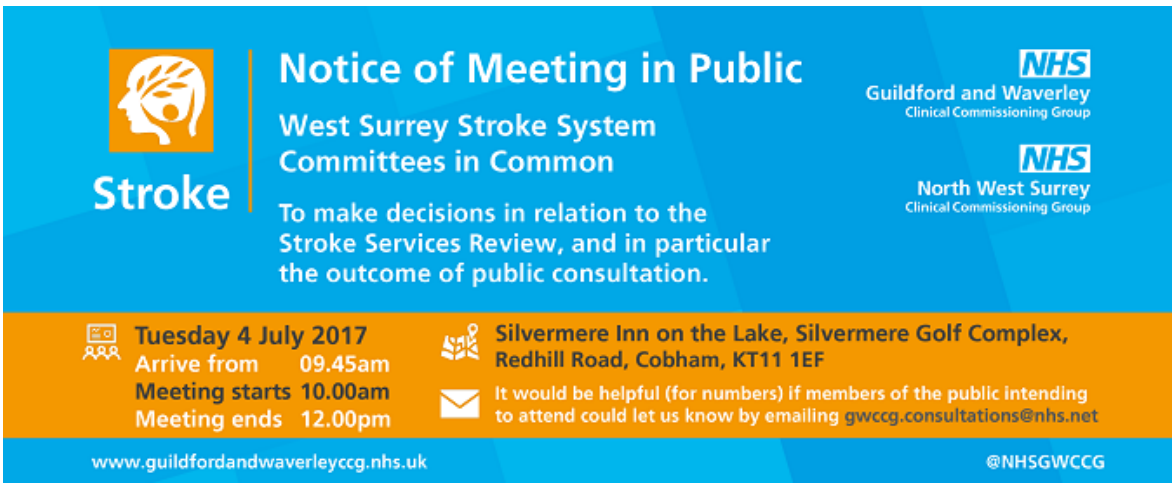
3.1 A series of pre-consultation engagement activities were carried out prior to 6 February 2017 in order to publicise and discuss the upcoming public consultation. See Appendix 1.

3.2 The CCGs consulted the public via a wide range of pre-organised public meetings held in various locations across West Surrey and through targeted attendance at specific service user group meetings. See Appendix 2.

3.3 The consultation closed at midnight on 30 April 2017. All feedback from meetings, events, emails and letters to the CCG has been submitted to an organisation called The NHS Transformation Unit (TU). It has been commissioned to analyse the feedback from the public consultation and to write a public-facing report. It is completely independent of the two CCGs carrying out the consultation and the providers of stroke care in West Surrey.

4. Next steps

4.1 The West Surrey Stroke System Committees in Common will meet in public on Tuesday 4 July 2017 to consider the outcomes of the consultation and make decisions regarding the future model of stroke care in West Surrey. The meeting is open to the public and key stakeholders will be invited e.g. Healthwatch Surrey. Details are as follows:



4.2 It is aimed to implement any changes to stroke services that may arise from the decisions to be taken at the above meeting by 2 October 2017. Mobilisation of any changes will require a comprehensive communications and engagement plan.

Contact: Liz Patroe, Head of Partnership & Engagement
Contact details: l.patroe@nhs.net
Website: www.guildfordandwaverleyccg.nhs.uk
Stroke Consultation webpage

Appendix 1: Pre-consultation engagement activities

Activity (Type)	Activity Description (Free text)	Due Date
Event - Patient & Public	Stakeholder Afternoon Consultation Event - Godalming	26-Jan-17
Interview - Newspaper	Stroke Briefing Meeting – with Surrey Advertiser (failed to attend), Haslemere Herald (attended) and Eagle Radio (attended) - to explain plans and encourage publicity via their media (online, print, radio).	24-Jan-17
Meeting	Disability Alliance South West Surrey Meeting	11-Jan-17
Meeting	Healthwatch Surrey	10-Jan-17
Meeting	CCG - Patient & Public Engagement Group discussion	03-Jan-17
Meeting	Meeting with Patient Participation Group Chairs for Cranleigh, Haslemere, Wonersh and Chiddingfold surgeries - Haslemere Hospital	21-Dec-16
Meeting	CCG - Patient Participation Group Chairs Meeting	08-Dec-16
Meeting	Older Persons Network South West Surrey Meeting	07-Dec-16
Meeting	Meeting with Julia Potts, Leader of Waverley Borough Council	29-Nov-16

Appendix 2: Consultation activities

Type of event	Details	Date
Meeting	TALK Surrey - Ashford	24-Apr-17
Meeting	Meeting convened by Lead Councillor of East Hants District Council	20-Apr-17
Event - Provider	Meeting convened by the Royal Surrey County Hospital NHS Foundation Trust for members and governors - CCG presented	19-Apr-17
Meeting	TALK Surrey - Knaphill	13-Apr-17
Meeting	North West Surrey Valuing People Group - talk about stroke plans	10-Apr-17
Event - Patient & Public	Ashford Hospital - Drop in Session (day)	10-Apr-17
Event - Patient & Public	Manned Stand at Ashford Hospital to publicise evening consultation events for Stroke	10-Apr-17
Event - Patient & Public	Staines - Evening Stakeholder, Patient and Public Consultation Event	05-Apr-17
Event - Public	Manned stand at VASWS Annual Conference	04-Apr-17
Meeting	TALK Group - Guildford (morning group)	28-Mar-17
Event - Patient & Public	Haslemere - Evening Stakeholder, Patient and Public Consultation Event	28-Mar-17
Event - Patient & Public	Milford Hospital Drop in Session (day)	27-Mar-17
Event - Public	Cranleigh Medical Centre - Drop-In Session	22-Mar-17
Event - Public	Woking - Evening Stakeholder Consultation Event	21-Mar-17
Meeting	Meeting with Haslemere Town Councillors and Town Mayor	16-Mar-17
Meeting	South West Surrey Valuing People Group - talk about stroke plans	16-Mar-17
Event - Patient & Public	Liphook - Evening Stakeholder, Public and Patient Consultation Event	15-Mar-17
Meeting	TALK Surrey - Walton	13-Mar-17
Meeting	TALK Surrey - Ashford Group	08-Mar-17
Meeting	TALK Surrey - Guildford (afternoon group)	07-Mar-17

Type of event	Details	Date
Event - Patient & Public	Guildford - Evening Stakeholder, Patient and Public Consultation Event	07-Mar-17
Event - Patient & Public	Ashford - Evening Stakeholder, Patient and Public Consultation Event	02-Mar-17
Forum - Public	Presentation to audience attending Heart Health event run by the Royal Surrey County Hospital NHS Foundation Trust on stroke plans and consultation	23-Feb-17
Event - Patient & Public	Manned Stand at the Royal Surrey County Hospital NHS Foundation Trust to publicise evening consultation events for Stroke	23-Feb-17
Event - Patient & Public	Godalming - Evening Stakeholder/ Public and Patient Event	20-Feb-17
Event - Patient & Public	Find out about Stroke Services - Staines Shopping Centre	17-Feb-17
Meeting	Attendance at Wellbeing & Health Scrutiny Board	17-Feb-17
Event - Patient & Public	Haslemere Hospital - Drop in Session (day)	14-Feb-17

Improving Stroke Care in West Surrey

SHARE YOUR VIEWS

Public consultation 6 February to 30 April 2017

Guildford and Waverley Clinical Commissioning Group

North West Surrey Clinical Commissioning Group

Contents

This document describes plans to improve future stroke care in West Surrey in good faith so as to inform, engage and consult with the public about their impact and scope for improvement.

We can provide other versions of this document such as Easy Read, Braille or other languages. Please email gwccg.consultations@nhs.net or call 01483 405468 to request a different version.

Introduction

Stroke is the fourth single leading cause of death and one of the largest causes of disability in the UK[1]. Over a third of stroke survivors in the UK are dependent on others; of those, one in five is cared for by family and/or friends.

Between April 2015 and March 2016, just over 700 people in Guildford, Waverley and North West Surrey had a stroke[2].

Over the past two years, the NHS in Surrey has been working with local people and health and care professionals to plan ways to improve stroke care. We have compared stroke services across Surrey to national standards and clinical guidelines. We have talked to patients, carers, clinicians and national experts, including the Stroke Association. This helped us understand what is working well and where change is needed.

Stroke care is better in some parts of the UK than in Surrey. The NHS in West Surrey has therefore developed plans to improve stroke services in this part of the county. By improving services, we can prevent more people from dying or being disabled after a stroke.

Which organisations are involved?

NHS Guildford & Waverley Clinical Commissioning Group (CCG) is leading this consultation across West Surrey in partnership with NHS North West Surrey CCG. These organisations plan and buy healthcare to meet the needs of local people.

These CCGs have worked closely with the following local organisations that provide stroke services, in order to review the current service and develop these plans:

- Ashford and St Peter's Hospitals NHS Foundation Trust
- Frimley Health NHS Foundation Trust
- Royal Surrey County Hospital NHS Foundation Trust
- The Stroke Association and other local stroke voluntary groups
- Virgin Care Services Limited

Why have changes been planned?

CCGs must ensure local health care is high quality and safe for patients who need it. We consider that stroke care needs to change because of the following findings:

- Rates of death and disability following stroke are higher in Surrey compared with some parts of England and Wales.
- There is evidence which proves better health outcomes - that is reduced death rates and disability - can be achieved with a new model of stroke care.
- There are not enough specialised stroke staff to provide services safely in every hospital.

[1] State of the Nation Stroke Statistics, The Stroke Association, January 2017, https://www.stroke.org.uk/sites/default/files/state_of_the_nation_2017_final_1.pdf

[2] Sentinel Stroke National Audit Programme, April 2015 to March 2016, CCG data for Guildford & Waverley, North West Surrey and Surrey Heath CCGs https://www.strokeaudit.org/results/national-results.aspx

- Our specialists need to see and treat more people with stroke to obtain the experience they need to keep their skills up to date.

Is this about cost-cutting?

This is not about saving money, but about investing more money in the whole care pathway. Stroke can have devastating impacts on patients, carers and their families; we want to achieve better outcomes for all and plan to devote more funding towards this.

How can I find out more?

The public consultation starts on 6 February 2017 and ends on 30 April 2017 and we have organised a number of opportunities for you to meet clinical specialists to find out more:

- Evening events
- Drop-in daytime sessions

Please see page 26 for a list of dates and venues.

As well as this booklet, a shorter summary has been produced. These will be posted to a wide variety of stakeholders including community groups, parish councils and voluntary organisations at the start of the consultation. They will also be made available in places such as libraries, GP practices and health centres.

If you would like to receive printed copies of this booklet or the summary please email gwccg.consultations@nhs.net with your address or call the CCG on 01483 405468.

How can I share my views?

We welcome your feedback about how we could improve stroke services further. A questionnaire is available for you to complete **by hand or online**. You are encouraged to feedback using this questionnaire. There is space for you to write freely with your comments.

- Go to our website. See full web address below[3]. The survey can be linked to from there.
- Tear or print off the questionnaire at the back of this booklet and complete by hand. Use extra blank pages if you would like. You can then post this free to:

FREEPOST
NHS G&W CCG

We look forward very much to hearing from you.

Dr David Eyre-Brook
Chair
NHS Guildford & Waverley CCG

Dr Charlotte Canniff
Chair
NHS North West Surrey CCG

[3] http://www.guildfordandwaverleyccg.nhs.uk/page1.aspx?p=20

What local people told us was important

In 2014 and 2015, the NHS across Surrey worked with the Stroke Association, service user groups, clinicians and other partners to review stroke care.

We collected information about the quality of current services, learnt from national experts and research and talked to health and care professionals about the best way forward.

350 members of the public and people using services told us what good care means for them and what we should focus on to improve stroke services.

The following aspects of stroke care were identified as being very important by over 70% of respondents:

- Being in a hospital with the most experienced doctors and nurses, even if the hospital is a little further away
- Having access to treatment seven days a week
- Being better supported after leaving hospital
- Having a medical review six months following a stroke

By comparison, the same people said the following aspects of stroke care were less important to them:

- Being in the hospital nearest to where I live
- Staying in hospital until I am fully able to support myself
- Having a helpline for stroke care
- Having professionals visiting me at home for more than two months following a stroke

Feedback from national experts

Taking into account that death rates after stroke are higher in West Surrey than other areas of the country, we asked a national panel of experts for their recommendations about the best way to provide stroke services in hospital.

After looking at all the evidence and hearing the views of local people and clinicians, the national expert panel recommended that specialist stroke care should be provided at three hospitals throughout all of Surrey. This would include East Surrey Hospital (outside the scope of this document).

This specialist care should include a hyperacute stroke unit (intensive care given during the first three days after a stroke) alongside an acute stroke unit (care given after the first three days and usually up to about seven days). This would mean enough specialist staff would be available to provide seamless and continuous care during the first stages of someone's care.

Why we are proposing changes to how stroke services are provided in West Surrey

More people die or suffer severe disability in Surrey following a stroke compared to many other parts of the country

We want to make sure local residents have access to the best care to save lives and reduce disability

Local people and staff have told us there need to be smoother transitions between services

People still require support after they leave hospital and they do not feel that this is adequate at the moment

Services in different parts of West Surrey vary

We want to make sure that wherever people live, they have access to the same good quality care, with the best possible outcomes

Specialist stroke units need to see between 500 and 1,500 people with a stroke every year so that staff keep up their skills

Most hospitals in West Surrey do not see this many people with a stroke each year; we need to consolidate so fewer hospitals care for a larger number of people

There are not enough specially trained and highly experienced staff to offer stroke services in every acute hospital in West Surrey

There is a shortage of specialist stroke doctors, nurses and therapists throughout England

Services are not all meeting best practice standards

Providing better care for more people suffering a stroke would save lives and reduce levels of disability

Summary of our plans

Based on the evidence from places that have centralised stroke care such as London and Manchester, we have developed plans to improve health outcomes and patient and carer experience.

We want to ensure that we have considered these plans from all angles and we want to hear from you about whether we could improve them further.

1. **We want to improve hospital care for patients by consolidating specialist stroke services at two hospital sites in West Surrey. This would enable seven day stroke specialist care to be provided, which is known to improve outcomes.**

   The following hospitals have been chosen to provide this care:

   - Frimley Park Hospital in Camberley
   - St. Peter's Hospital in Chertsey

   Under these plans specialist stroke care will no longer be provided at:

   - Royal Surrey County Hospital in Guildford

2. **We want to improve specialist stroke rehabilitation for patients who do not need to stay in the acute hospital but who are not quite well enough to go home. Changing how this is provided will enable patients to receive more intensive therapy, according to their needs, and therefore go home earlier.**

   In order to make best use of specialist skills, we want to consolidate the number of hospitals providing this specialist care at Farnham Hospital with other possible options including Ashford Hospital, Milford Community Hospital and Woking Community Hospital.

   Further consultation and planning is required to settle on the most suitable base from the three above and your views through this consultation are welcomed.

3. **We want to improve community-based rehabilitation services so that patients and carers feel better supported when they return to their own home.**

   - Increase the number of people able to return home sooner with stroke specialist rehabilitation. This is known as Early Supported Discharge or ESD
   - Increase the number of people able to access psychology services
   - Ensure that everyone who has a stroke has a review 6 months afterwards
   - Develop and support initiatives aimed at preventing stroke

Equality analysis

Clinical Commissioning Groups have a duty to reduce health inequalities experienced by their populations.

All service change plans must be assessed and analysed with respect to their potential impact on individuals with any of the nine protected equality characteristics defined under the Equality Act 2010.

- Age
- Disability
- Ethnicity
- Gender
- Gender reassignment
- Marriage & civil partnership
- Religion & beliefs
- Pregnancy & maternity
- Sexual orientation

Impacts may be positive, negative or neutral (no impact at all).

In addition to these equality groups, the CCGs assess the impact of plans on

- Carers
- Particular geographical locations and areas of deprivation

Findings

An equality analysis of these plans was carried out in December 2016.

All people in West Surrey will have access to the best pathway of stroke care recommended by experts. Overall, the plans will have a positive impact on the majority of equality groups and a neutral impact on the remainder. No equality group will experience a negative impact.

However, it is fully recognised that carers, family members and friends in some parts of West Surrey would need to travel further to visit a friend or relative. This would have most impact on those who are completely reliant on public transport because of the potential financial implications of finding alternative transport.

Through consultation we will need to ensure we fully understand the impact on this group to ensure they are not significantly disadvantaged by these plans.

To read the full equality analysis, go to www.guildfordandwaverleyccg.nhs.uk and click on Stroke Consultation.

What should happen when you have a stroke?

What is a stroke?

A stroke is caused when the blood supply to the brain is interrupted usually due to the following:

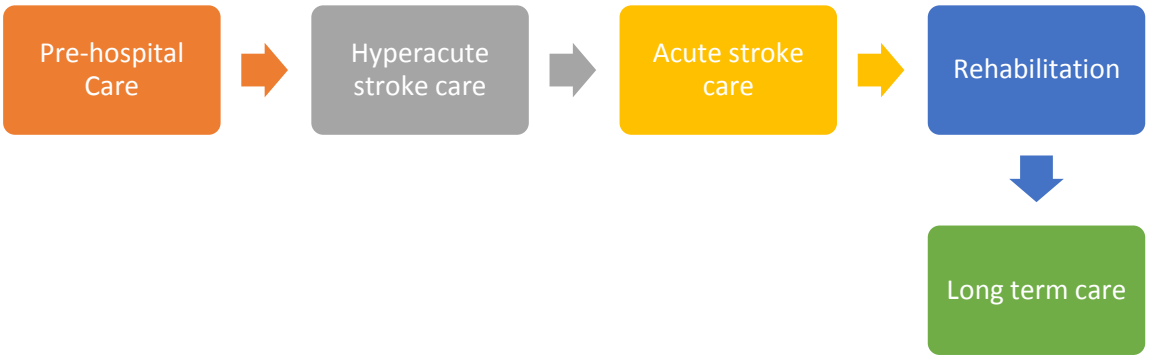
- a blood vessel is blocked by a clot
- a blood vessel bursts causing a bleed

This cuts off the supply of oxygen and nutrients, which can damage the brain tissue. The effects of a stroke depend on which part of the brain is injured and how severely it is affected.

The type of treatment needed depends on the type of stroke, but everyone who has a stroke benefits from receiving care in a hospital with stroke specialist staff followed by stroke specialist rehabilitation and support in the community if needed.

Best practice stroke care

When someone has a stroke, they have a 'pathway' of care to support their recovery. This is illustrated below in the flow diagram and explained in the narrative below.



Getting to hospital

People do best if they receive care in a specialist hospital unit immediately after having a stroke; life-saving treatments such as clot busting drugs need to be given within two hours of a stroke. occurring. The first step in the pathway is therefore getting to hospital, which is usually by ambulance with trained paramedics **monitoring patients and pre-alerting the specialist hospital** to enable potential stroke patients to be met on arrival by a member of the stroke team

Not all patients suspected of suffering a stroke will be diagnosed with stroke; but all of these patients should be taken to a hyperacute stroke unit for diagnosis (see next section).

Immediate care in hospital

Evidence shows that good quality stroke care when people arrive at hospital is the most important contributor to survival. The first four hours of care is critical.

Patients should be cared for in a **hyperacute stroke unit (HASU).** A high-performing HASU would be expected to have highly trained doctors, nurses and therapists and specialised equipment to provide high quality stroke care **24 hours a day, 7 days a week**.

People might stay in a HASU for about three days, though this will vary based on individual needs.

Follow on care in hospital

After about three days in a hyperacute stroke unit, some people might be ready to go home.

However, many people need a few extra days in hospital where they are cared for by specialist staff. This would be less intensive care than their initial treatment but would still take place in an acute hospital. This is referred to as **acute stroke unit care**.

Usually people stay in these units for about seven days after having a stroke. The exact number of days people stay depends on their individual needs. The preferred location for an acute stroke unit would be in the same hospital as the hyperacute unit, as this provides continuity of care and enables better use of staff resources.

Care in the community

After people leave specialist hospitals, they might need further in-hospital rehabilitation, which could either be provided in a community hospital or co-located with the acute stroke unit.

Some people return home with **'early supported discharge' (ESD).** These people leave hospital as early as possible and get ongoing help at home for around six weeks provided by a specially trained team. This type of intensive, specialist rehabilitation carried out as early as possible in the familiar setting of a patient's own home has been shown to improve overall recovery from stroke.

Some people obtain help with changes to their home, like installing handrails. People may have physiotherapy or speech and language therapy. As well as these NHS services, there are a wide variety of voluntary groups providing exercise sessions, social groups and other support.

Long term care

Stroke survivors and their carers should be enabled to live a full life in the community, building up over the medium and long term. On-going therapies should be provided to ensure maximum recovery.

Carers of stroke survivors should be provided with a named point of contact for stroke information, written information about the stroke survivor's diagnosis and a personal care plan together with sufficient practical training to enable them to provide care.

After six months everyone should have a review to see how they are getting on and to ensure the right care is being provided.

Transient Ischaemic Attacks

Transient Ischemic Attacks (TIAs) are often referred to as mini-strokes. The risk of a stroke is high following a TIA – approximately four to ten per cent of patients who have a TIA will go on to have a stroke within seven days.

Specific TIA services provide rapid diagnostic assessment and access to specialist care for high risk patients thereby lowering the risk of a subsequent stroke. Such services benefit from being based in a highly specialist stroke centre.

Current services

Currently, three hospitals in West Surrey provide some specialist stroke care, to patients living in Surrey and surrounding counties:

CURRENT	Frimley Park Hospital	Royal Surrey County Hospital	St. Peter's Hospital
Location	Camberley	Guildford	Chertsey
Stroke care provision	Full hyperacute stroke unit and a separate acute stroke unit	Combined hyperacute and acute stroke care.	Combined hyperacute and acute stroke care
Number of patients cared for who have been diagnosed with a stroke[4]	540	342	520

Full hyperacute care

Full hyperacute care, covering the first three days is not currently available in all three hospitals.

We want to ensure all our patients can benefit from this intensive stroke care.

Number of patients

The national recommendation, endorsed by the National Clinical Director for Stroke, is that there **should ideally be a critical mass of at least 500 stroke patient admissions per year for each unit**. The table above shows that this is not currently happening. Whilst this does not mean that current services are not good, we know that they can be improved and, importantly, they need to be sustained in the future.

This has been identified as the scale which makes a hyperacute stroke service clinically sustainable, to maintain specialist expertise and to ensure good clinical outcomes.

Not all our hospitals are seeing enough patients to maintain this expertise.

[4] Stroke Sentinel National Audit Programme, Annual Results Portfolio, March 2015 to April 2016 https://www.strokeaudit.org/results/Clinical-audit/Regional-Results.aspx

Staff

With a 40% vacancy rate for stroke consultants across the country, there are insufficient specialists for all of three hospitals in Surrey to be able to provide the very best stroke care.

We want to attract the very best stroke specialists to work in Surrey and we can only achieve this if our hospitals can offer a range of specialist training and development opportunities.

Seven day care

There are variations in whether the hospitals are meeting best practice standards, such as:

- Whether people are assessed quickly by a specialist stroke doctor and
- Whether people receive the recommended amount of therapy to help them recover

Increasing access to care **seven days a week** is a major improvement programme across the NHS as we know this improves care and how well patients recover. For specialist services like stroke, access to the right specialist staff and treatments seven days a week is proven to be a crucial element in a patient's recovery.

TIA Service

All three hospitals currently provide TIA clinics. Future guidance, which will come into operation in September 2017, states that all suspected TIAs should be treated as urgent and seen within 24 hours.

As with stroke, rapid access to diagnostic equipment and the right specialist staff seven days a week is required.

Summary

We need to consolidate services in two hospitals across West Surrey (in line with recommendations from the panel of national experts) so that each hospital providing stroke care is seeing at least 500 people with strokes each year and is able to recruit the highly qualified stroke specialist staff required to care for people who have a stroke or a TIA.

Our plans to improve stroke care in hospital

We want to improve immediate hospital care by having **two larger hyperacute stroke units** providing highly specialist care at:

- Frimley Park Hospital in Camberley
- St Peter's Hospital in Chertsey

After the first three days, if needed, people would continue their care in **acute stroke care units at the same hospitals** with access to specialist doctors, nurses and therapists. This is usually for a further period of up to seven days.

In other words, the plan is for Frimley Park Hospital and St Peter's Hospital to have hyperacute and acute stroke units located on the same site.

Similarly, TIA clinics would be provided at Frimley Park Hospital and St Peter's Hospital.

There would be no specialist stroke care or TIA clinics at the Royal Surrey County Hospital under these plans.

Why are we proposing these two hospitals?

We consider that Frimley Park Hospital and St Peter's Hospital are the best option for hyperacute stroke units because they build on the good services already in place and offer the best access to specialist stroke services for our population.

Frimley Park Hospital

Frimley Park Hospital is a major hospital serving the west of Surrey and the borders of Hampshire. It already offers all specialist stroke services so there is no reason to change the good work happening here and the outcomes are being achieved.

St Peter's Hospital

It is important to understand that St Peter's Hospital and the Royal Surrey County Hospital worked together to consider and recommend which site overall would be best for stroke services.

Both sites already met important criteria regarding travel times for ambulances. This means that patients throughout the catchment area would be able to get to either hospital within the time required for stroke patients to receive the recommended clinical care processes such as clot-busting drugs.

Both hospitals examined different criteria that are important to care delivery. Each option was scored from 1 to 5 according to how well they met these criteria.

The scoring was done by specialist stroke doctors, nurses, therapists, managers and other senior staff from Royal Surrey County Hospital and St Peter's Hospital in May 2016.

Criterion	Weighting (%)	Criterion	Weighting (%)	Criterion	Weighting (%)
Opportunity to provide the best quality services	20%	Good access and transport links	15%	Cost and affordability	18%
Fits well with broader strategic vision	19%	Availability of staff	15%	Practical deliverability & timescale	13%

Outcome

Using this structured process, both Royal Surrey County Hospital and St Peter's Hospital could both be considered safe, viable options based on staffing and set up costs. However, St Peter's Hospital scored higher overall as the best site for a hyperacute stroke unit because:

a) **St Peter's Hospital already offers many services that need to be provided alongside specialist stroke care.**

   These 'co-dependencies' include interventional cardiology, vascular and interventional radiology services. These services are not all available at Royal Surrey County Hospital.

b) **A panel of national experts recommended that units should be located where the largest proportion of people would have to travel the least.**

   There is a large population living in North West Surrey. If the hyperacute stroke unit was at Royal Surrey County Hospital, a larger proportion of people would need to travel a greater distance.

c) **A larger number of older people live nearer to St Peter's Hospital[5].**

   Older people are at greater risk of having a stroke, so it makes sense to have the most specialist hospital care nearest to the largest population of older people.

For these reasons, our recommended plan is to provide specialist stroke services at St Peter's Hospital rather than Royal Surrey County Hospital. This decision was reinforced and supported by national clinical experts.

[5] July 2015 Health Profiles state there are 38,000 people aged 65yrs and older in Guildford & Waverley CCG and 59,000 in North West Surrey CCG

How will these changes improve things?

Acute hospital stroke units will be big enough to give the best care, which will save lives and reduce disability

- **Specialist units mean patients have access to life-saving treatments and specialist care immediately they arrive at hospital.**
- **Having two hospitals in West Surrey offering specialist stroke care is an improvement because units have to be big enough to support (a) the right number of stroke specialists and (b) a critical mass of stroke patients to allow clinicians to develop their expertise and skills.**

40% of all stroke consultant posts nationally are vacant.

There is simply not enough specialist staff to deliver high quality stroke services in each hospital seven days a week, even with unlimited resources.

Both hospitals planned to offer a hyperacute stroke unit would have up to six specialist stroke doctors, which is an increase on what is currently available. A larger, specialist service offers more opportunities for clinicians to build skills and knowledge as well as providing essential professional support in what is a complex, high risk environment. It also makes the service more resilient, which in turn benefits patients.

- **Having the right number of specialist stroke staff means stroke patients can be seen every day.**

  Currently, if you are admitted with a stroke on a Friday afternoon you may not see a specialist stroke consultant until Monday morning because the existing stroke units are too small and don't have enough specialist doctors.

  Providing specialist care seven days a week is an important improvement programme across the NHS, and is particularly important for specialist services such as stroke. With services available seven days per week, care plans can be reviewed more regularly to reflect changes in condition and meet health needs.

  Providing specialist input seven days per week will result in fewer deaths and less disability, as has been clearly evidenced elsewhere.

- **Locating acute stroke units in the same hospitals with a hyperacute stroke unit would mean that people will not need to move hospitals.**

  They can continue receiving care and rehabilitation from the same team of stroke specialists. Consolidating services in this manner also means that there is a critical mass of specialist staff able to provide a more robust service.

What does this mean for you?

Everyone in West Surrey who is suspected of suffering a stroke would go to either Frimley Park Hospital or St Peter's Hospital for all their immediate specialist stroke care, as described below.

People from Guildford, Waverley and part of South East Hampshire who would usually go to Royal Surrey County Hospital would notice a change in where they receive specialist stroke services. They would go to another hospital as follows:

a) People nearest to St. Peter's Hospital, mainly those in the Guildford area, would receive all their specialist stroke care at St Peter's Hospital.

b) People nearest to Frimley Park Hospital, mainly those in the Waverley area and parts of South Eastern Hampshire, would receive all their specialist stroke care at Frimley Park Hospital.

Some people may live in Guildford borough but be closer to Frimley Park Hospital so they would receive all their specialist stroke care at Frimley Park Hospital.

People from North West Surrey who would usually go to St Peter's Hospital won't notice any change in where they receive specialist stroke services.

People from Farnham and nearby areas who would usually go to Frimley Park Hospital won't notice any change in where they receive specialist stroke services.

All these people would receive specialist care in the same hospital up to about seven days, depending on their individual needs

Travel Times

Ambulances

South East Coast Ambulance Service has confirmed they can travel to either Frimley Park Hospital or St. Peter's Hospital from both the Guildford and Waverley areas and North West Surrey within the time required for stroke patients to receive the recommended clinical care processes.

South Central Ambulance Service has also advised us that they can transport stroke patients in villages close to the border with Surrey to Frimley Park Hospital in the time required for recommended care processes to be carried out.

These care processes include receiving a CT scan and, if clinically indicated, receiving a clot-busting drug, a procedure known as thrombolysis.

Clinical guidelines state that these diagnostic and treatment processes should be completed within 2 hours of a 999 call being made. What is most important to overall health outcomes following a stroke is that this treatment is provided within two hours of a stroke taking place.

The time it takes an ambulance to get to hospital is clearly a contributing factor, but so is quicker access to specialist staff and care on arrival at hospital.

Pre-Alerts

Paramedics are trained to administer pre-hospital care and to pre-alert the hospital so that the patient is met by the stroke specialist team on arrival rather than going through A&E departments.

Although for some people it will take longer than at present to get to hospital, travelling directly to a specialist centre means quicker access overall to life saving treatment.

We consider that slightly longer travel times, which will affect some people, are outweighed by the benefits of being treated in a specialist centre by the right, highly skilled staff.

Visitors

We do recognise that family and friends are vital in supporting the recovery of people who have had a stroke. They may have further to travel to visit them than they do now to the Royal Surrey County Hospital. Increasing the number of patients who go home with Early Supported Discharge teams, which these plans may enable, should reduce this travel burden overall.

As CCGs, our primary responsibility is to secure the best health care outcomes for the population we serve and we believe that these plans will reduce deaths and levels of disability following stroke, based on experience elsewhere where services have been consolidated in this manner.

Possible advantages and disadvantages of plans to consolidate stroke services in two hospitals in West Surrey

Situation	Possible advantages	Possible disadvantages
Current services: Some stroke services at Frimley Park, Royal Surrey County and St Peter's Hospitals	• If stroke services were at Royal Surrey County Hospital, it may be quicker for people from the Guildford and Waverley areas and their visitors to get to hospital	• Not enough staff at each hospital to provide safe high quality services at all locations. • Stroke units are not big enough to see the required number of patients to meet clinical guidelines and ensure staff keep their skills up to date to provide the best care
Proposed improvement: Hyperacute and acute stroke units at Frimley Park and St Peter's Hospitals. No stroke services at Royal Surrey County Hospital	• Rates of survival after stroke should improve • Fewer people should have serious disability after stroke • Bigger hyperacute stroke units will mean all the right staff and equipment are on hand to treat people quickly • Meets national quality standards • No need to transfer between hospitals i.e. from hyperacute stroke care to acute stroke care, when most unwell • Frimley Park and St Peter's hospitals have all the related clinical services that need to be provided alongside stroke services e.g. vascular service • Supports access to specialist care seven days/week • Fits in with what local people have said they would be prepared to do i.e. travel further for highly specialised care • Fits with the outcome from the options appraisal that clinicians and managers at Royal Surrey County Hospital and St Peter's Hospital carried out	• Some people will have to travel further to get to a specialist stroke unit for their immediate care. • Some visitors will have to travel further to visit relatives and friends

You may think of other consideration or solutions.
See page 30 to find out how you can let us know.

Our plans to improve stroke care in the community

Current services

At the moment, there is wide variation in the care that people who have suffered a stroke receive after leaving hospital in West Surrey.

We want to improve stroke care in the community so people have access to good follow on care no matter where they live.

Planned improvements

- Provide **specialist stroke rehabilitation** services at two hospitals.
- Have an **early supported discharge (ESD) team as part of the hospital team** to help people go home more quickly where appropriate and feel supported
- Make **psychological therapies** more available to help people cope after a stroke
- Assign a **Stroke Care Navigator** to help coordinate care, make transitions between services easier and be a link for people and their carers after hospital
- Offer everyone **reviews** six weeks and six months after hospital discharge
- Provide good information about what makes people more likely to have a stroke and **how to prevent stroke**
- **Signpost** people who have had a stroke and their visitors to information about the services and support available

Rehabilitation in hospital

All people who suffer a stroke require some form of stroke specialist rehabilitation to recover as well as they possibly can. Some people get better more quickly with the help of rehabilitation in hospital, whilst the majority of people would be better rehabilitated in their own home.

Currently, people in West Surrey who require rehabilitation in hospital are usually transferred from the acute hospital looking after them to one of four hospitals:

- Ashford Hospital
- Farnham Hospital
- Milford Community Hospital
- Woking Community Hospital

We want to consolidate the number of hospitals providing this specialist care at Farnham Hospital with other possible options including Ashford Hospital, Milford Community Hospital and Woking Community Hospital.

Further consultation and planning is required to settle on the most suitable base from the three above and your views through this consultation are welcomed.

We want to ensure there are enough staff with specialist stroke rehabilitation skills to provide the level and intensity required to reduce the impact of stroke-related disability. This can only be achieved if we concentrate specialist staff in two hospitals rather than four sites.

Early Supported Discharge

Evidence shows that people who receive specialist rehabilitation at home in familiar settings are able to live more independently than those who have all their rehabilitation in hospital.

Currently, only a quarter of patients are able to go home early with this specialist support and rehabilitation in place. We estimate that up to half of people who have a stroke could leave hospital earlier with Early Supported Discharge (ESD). Our plans seek to increase availability of ESD for more people at the intensity required.

Each hospital with specialist stroke units will provide an Early Supported Discharge team of nurses, therapists and social care staff who link with hospital teams to help people leave hospital earlier. They would provide intensive rehabilitation at home for around six weeks.

This improvement will help people get better faster, increasing people's independence and quality of life.

Transition between services

A Stroke Navigator will be introduced to act as a single point of contact for families to signpost appropriate services following discharge home. Once discharged from acute care, patients will be contacted by their Navigator to check that they understand agreed next steps and identify ongoing needs to ensure the best possible recovery.

This includes linking patients and carers to appropriate voluntary and community services, social services and NHS services.

Support and advice

Each hospital has worked with service users and carers to plan a Stroke Survivors Passport.

The passport will keep clear and up-to-date records of treatment and support available throughout rehabilitation. It will encourage the use of monthly goal setting targets which can be referred to by those professionals helping the patient in their recovery.

Reviews

People told us that they experienced a sudden reduction in support and care following discharge from care. This was described as a 'cliff-edge'.

We propose that every person who has a stroke will be offered a medical review at six weeks and again at six months after discharge. This will mean that people's needs can be assessed and they can be signposted to useful and supportive services.

How will these changes improve things?

Our plans respond to what local people said was most important. They would like to:

- Spend fewer days in hospital
- Have better access to stroke rehabilitation specialists, such as occupational therapists and psychologists
- Be better supported after the initial acute phase of their stroke and when they leave hospital
- Know what services are available and be supported to access it

Everyone in West Surrey will have better access to high quality stroke specialist rehabilitation whether they go straight home or via a community hospital

There will be a more streamlined pathway of care overall

- Up to half of people could be discharged home early from specialist stroke units. This is an increase compared to now
- More people will stay fewer days in hospital
- More people will be cared for by rehabilitation teams with enough staff with the right specialist skills e.g. physiotherapists, occupational therapists, speech and language therapists and psychologists
- Carers and family members will have one team to liaise with during rehabilitation, so there will be more continuity and less duplication

What does this mean for you?

Overall, these changes will mean more services will be available in the community, such as psychology, and services will be more joined-up.

The main change that people may want to comment about is the location of in-hospital stroke specialist rehabilitation services.

For people living around Farnham there would be no changes to the location of in-hospital rehabilitation, which would continue to be offered at Farnham Hospital.

We are still exploring options for people living in Guildford, Waverley and North West Surrey.

We want to consolidate specialist resources in fewer community hospitals to ensure patients requiring in-hospital specialist stroke rehabilitation receive this to the intensity required to maximise recovery.

As well as Farnham Hospital, other possible options include:

- Woking Community Hospital
- Milford Community Hospital
- Ashford Hospital

Please complete the survey at the end to let us know your views on these sites.

The decision regarding this will be based on where we can best consolidate specialist resources.

We recognise that some visitors may need to travel further to visit people receiving rehabilitation in hospital, depending upon where these services are concentrated. However, having increased access to teams with specialist stroke skills should mean that people can go home earlier and visitors would need to travel on fewer days overall.

Summary of plans to improve stroke care

	Care in hospital		Follow on care / community	
	What happens now	***Proposed change***	***What happens now***	***Proposed change***
Farnham area	Specialist care at Frimley Park Hospital	**No major change:** Specialist care at Frimley Park Hospital	Early supported discharge linked to Frimley Park Hospital In-hospital rehabilitation at Farnham Hospital	**No major change:** Early supported discharge team linked to Frimley Park Hospital In-hospital rehabilitation at Farnham Hospital.
Waverley area **Parts of South Eastern Hampshire**	Specialist care at Royal Surrey County Hospital	**Location change:** Specialist care at Frimley Park Hospital	Early supported discharge available through adult community services team In-hospital rehabilitation at Milford Community Hospital or Woking Community Hospital	**Location change:** Early supported discharge team linked to Frimley Park Hospital In-hospital rehabilitation at Farnham Hospital with other possible options including Ashford Hospital, Milford Community Hospital and Woking Community Hospital.
Guildford area	Specialist care at Royal Surrey County Hospital	**Location change:** Specialist care at St Peter's Hospital	Early supported discharge available through adult community services team In-hospital rehabilitation at Milford Community Hospital or Woking Community Hospital	**Location change:** Early supported discharge team linked to St Peter's Hospital In-hospital rehabilitation at Farnham Hospital with other possible options including Ashford Hospital, Milford Community Hospital and Woking Community Hospital.
North West Surrey area	Specialist care at St Peter's Hospital	**No major change:** Specialist care at St Peter's Hospital	Early supported discharge available through community team. In-hospital rehabilitation at Ashford Hospital or Woking Hospital	**Location change:** Early supported discharge linked to St Peter's Hospital. In-hospital rehabilitation at Farnham Hospital with other possible options including Ashford Hospital, Milford Community Hospital and Woking Community Hospital.

Ways to get involved and find out more

We want to know what you think about these plans to improve stroke services before we make decisions about next steps.

Everyone affected by these proposed changes is invited to find out more and let us know their views.

Share your views by midnight on Sunday 30 April 2017.

Read about the proposed changes

Visit the dedicated Stroke Consultation webpage at www.guildfordandwaverleyccg.nhs.uk

Come and speak with us

You are welcome to come to one of our planned events. Daytime and evening events are being run throughout the consultation period.

See the next page for a calendar of events. No prior booking is required but if you require arrangements to help you participate e.g. a British Sign Language interpreter, please do contact us in advance so we can arrange this for you. See contact details below.

Invite us to speak with your group

As well as the pre-planned events, we would be delighted to attend any interested community groups e.g. stroke support groups, disability alliance meetings. Please get in touch so that this can be arranged, using the contact details below.

Send us your feedback

Online Survey

www.surveymonkey.co.uk/r/strokeconsultationwestsurrey

Postal Survey

Tear off the survey at the back of this booklet, complete by hand and post free to:

FREEPOST
NHS G&W CCG

Email

gwccg.consultations@nhs.net

Events

We will be holding a range of different events at different times of day and evening to explain more about the plans and ensure you know how you can provide feedback.

There is no need to register for any of the events in advance. No prior booking is required but if you require arrangements to help you participate e.g. a British Sign Language interpreter, please do contact us in advance so we can arrange this for you:

Email: gwccg.consultations@nhs.net **Telephone:** 01483 405450.

EVENING EVENTS

Date	Time	Venue
Monday 20th February	7pm to 9pm	Godalming Masonic Hall, Godalming
Thursday 2nd March	7pm to 9pm	Education Centre, Ashford Hospital, Ashford
Tuesday 7th March	7pm to 9pm	Glass Room, GLive, Guildford
Wednesday 15th March	7pm to 9pm	Millennium Hall, Liphook
Tuesday 21st March	7pm to 9pm	Goldwater Lodge, Woking
Tuesday 28th March	7.30pm to 9.30pm	Haslemere Hall, Haslemere
Wednesday 5th April	7pm to 9pm	Hythe Centre, Staines

DAYTIME DROP-IN SESSIONS

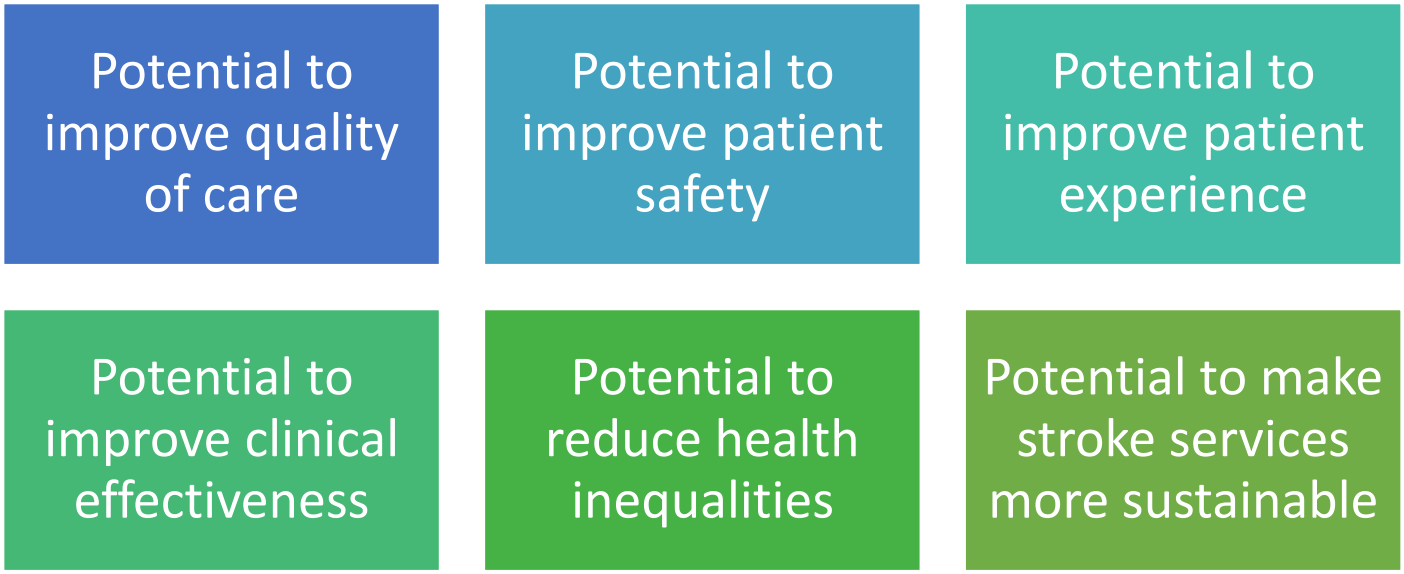
Date	Time	Venue
Thursday 23rd February	10am to 12pm	Level B, Royal Surrey County Hospital
Tuesday 28th February	2pm to 4pm	Haslemere Hospital
Friday 17th March	2pm to 4pm	Room 3, Postgraduate Education Centre, St Peter's Hospital
Wednesday 22nd March	10am to 12pm	Cranleigh Medical Centre
Monday 27th March	2pm to 4pm	Milford Community Hospital
Monday 10th April	2.15pm to 4pm	Room 3, Education Centre, Ashford Hospital

Please check our website in case there are any changes to these arrangements or extra events are added.

What happens after the consultation has ended?

After 30th April 2017, all the feedback we have received will be compiled and considered by the clinical commissioning groups (CCGs) alongside the clinical evidence that has informed this review.

The CCGs will use the following criteria to ensure that the changes described above will offer an improved stroke care service overall compared to the current arrangements:



In addition, the CCGs will feed back how they intend to address any comments and concerns that people raise.

Guildford and Waverley CCG and North West Surrey CCG will meet together in public to report back on the consultation and make this decision.

It is expected that this public meeting will take place in June or July 2017.

Details will be made available as soon as possible on our website at www.guildfordandwaverleyccg.nhs.uk or you can telephone Guildford & Waverley CCG to find out on 01483 405450.

Map of West Surrey showing acute trusts and community hospitals

Reports that have informed these plans

The following reports can all be accessed from our website:

- Stroke Pathway Project Report, Healthwatch Surrey (2012)
- Surrey Stroke Review report on engagement activity (2014)
- 6 month review commissioning pack, South East Coast Strategic Clinical Networks (2014)
- Life after Stroke commissioning pack, South East Coast Strategic Clinical Networks (2014)
- Stroke Service Specification, South East Coast Strategic Clinical Networks (2015)
- Stroke and TIA Quality Core Standards, South East Clinical Networks (2016)

Have your say

We want to understand the impact of these plans on patients and carers so that we can improve things further. You will find a survey starting on the next page (page 30).

Please let us know what you think about our plans to improve stroke care **by midnight on the 30th April 2017**.

Complete the survey online at: www.surveymonkey.co.uk/r/strokeconsultationwestsurrey

You can also access this survey via our website

Or you can complete it by hand – turn to the next page to start. Please use additional paper if you want to write more. Once completed, post it free to:

FREEPOST
NHS G&W CCG

Survey: Stroke Consultation West Surrey

Q1. Do you agree or disagree with the following statements?

STATEMENT	Strongly agree	Agree	Disagree	Strongly disagree
Access to seven day specialist stroke services should be provided at Frimley Park Hospital and St Peter's Hospital to enable more people to survive a stroke and minimise risk of disability				
Please explain further if you would like to:				

STATEMENT	Strongly agree	Agree	Disagree	Strongly disagree
Seven day clinics for transient ischaemic attacks (TIA) should be provided at Frimley Park Hospital and St Peter's Hospital as part of the specialist stroke service				
Please explain further if you would like to:				

STATEMENT	Strongly agree	Agree	Disagree	Strongly disagree
The reason for concentrating in-patient stroke specialist rehabilitation services in fewer hospitals in West Surrey is justified and supported				
Please explain further if you would like to:				

Q2. How could the plan for seven day hyperacute and acute stroke care at Frimley Park Hospital and St Peter's Hospital be improved?

Q3. Please let us know your thoughts on the potential choices for where in-hospital specialist stroke rehabilitation could be provided?

Q4. What comments do you have about these plans overall?

Finally a little about you …

Please tell us a few details about yourself. You do not have to complete this but it does help us ensure we have a wide range of views.

Q5. Have you had a stroke or do you care for someone who has had a stroke? Yes❒ No ❒

Q6. What age group are you in?

Under 18 ❒ 18 to 24 ❒ 25 to 44 ❒ 45 to 64 ❒ 65 to 74 ❒ 75 to 84 ❒ 85+ ❒

Q7. What is your gender?

Male ❒ Female ❒

Q8. What is your ethnic group?

a. White

English/Welsh/Scottish/Northern Irish/British Irish ❒

Gypsy / Roma / Traveller ❒ Any other White background ❒

b. Mixed / multiple ethnic groups

White and Black Caribbean ❒ White and Asian ❒

White and Black African ❒ Any other Mixed / multiple ethnic background ❒

c. Black / African / Caribbean / Black British

African ❒ Caribbean ❒ Any other Black / African / Caribbean background ❒

d. Asian / Asian British

Indian ❒ Bangladeshi ❒ Pakistani ❒ Chinese ❒ Nepalese ❒

Any other Asian background ❒

e. Any other ❒ Please describe: _____

Q9. Do you have a disability[6]? Please tick all that apply

No disability ❒ Physical impairment ❒ Sensory impairment ❒

Mental health condition ❒ Long-standing illness or health condition ❒

Learning disability ❒

Other (please specify): _____

Q10. Are you a carer? Yes ❒ No ❒

Q11. In which area do you live? Please tick

Guildford ❒ Waverley ❒ Woking ❒ Weybridge & Chertsey ❒

Staines ❒ Farnham ❒ East Hampshire ❒

[6] The Equality Act 2010 considers a person to be disabled if they have "a mental or physical impairment that has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities."

Agenda Item 11

HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Adult Social Care Select (Overview and Scrutiny) Committee (HASC)
Date of meeting:	20 June 2017
Report Title:	Work Programme
Report From:	Director of Transformation and Governance

Contact: 01962 847336 / members.services@hants.gov.uk

1. Purpose of Report

1.1 To consider the Committee's forthcoming work programme.

RECOMMENDED

That Members consider and approve the work programme.

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

Topic	Issue	Link to Health and Wellbeing Strategy	Lead organisation	Status	20 June 2017	21 July 2017	21 September 2017
Proposals to Vary Health Services in Hampshire - *to consider proposals from the NHS or providers of health services to vary health services provided to people living in the area of the Committee, and to subsequently monitor such variations. This includes those items determined to be a 'substantial' change in service.*							
Andover Hospital Minor Injuries Unit	Temporary variation of opening hours due to staff absence and vacancies	Living Well Healthier Communities	Hampshire Hospitals NHS FT	Updates on temporary variation heard at June and September 2016 mtgs. Update: to be reviewed once full operating hours are reached	Further update **(E)**		
Antelope House PICU	Urgent temporary closure of 10 beds due to concerns on safe staffing	Living Well	Southern Health NHS FT	Item heard July 16. Item on reopening heard March 17. Update on staffing to be received in 6 months' time.			Update to be considered **(E)**
Dorset Clinical	Dorset CCG are	Starting Well	Dorset CCG /	First Joint HOSC			

Topic	Issue	Link to Health and Wellbeing Strategy	Lead organisation	Status	20 June 2017	21 July 2017	21 September 2017
Services review **(SC)**	leading a Clinical Services review across the County which is likely to impact on the population of Hampshire crossing the border to access services.	Living Well Ageing Well Healthier Communities	West Hampshire CCG	meeting held July 2015, CCG delayed consultation until 2016. Last meeting Feb 17 to discuss consultation response.	Verbal update to be received once next meeting has been held. **(M)**		
Friarsgate Surgery, Winchester	Monitoring actions post-closure of Kings Worthy branch surgery	Starting Well Living Well Ageing Well Healthier Communities	West Hants CCG Friarsgate Practice (Local Members Cllr Porter and Tod)	Committee considered March 17. Further information requested to be circulated to Members			
North and Mid Hampshire clinical services review **(SC)**	Management of change and emerging pattern of services across sites	Starting Well Living Well Ageing Well Healthier Communities	HHFT / West Hants CCG / North Hants CCG / NHS England	Monitoring proposals for future of hospital services in north and mid Hampshire since Jan 14. Latest update indicated whole system review to report in Jan 17 as			

Topic	Issue	Link to Health and Wellbeing Strategy	Lead organisation	Status	20 June 2017	21 July 2017	21 September 2017
				part of STP. Status: to next appear once options are available.			
West Surrey Stroke Services	Review of stroke services	Living Well Ageing Well	NE and SE Hampshire CCGs	To be considered once the consultation has closed	**(M)**		
Issues relating to the planning, provision and/or operation of health services – *to receive information on issues that may impact upon how health services are planned, provided or operated in the area of the Committee.*							
Care Quality Commission inspections of NHS Trusts serving the population of Hampshire	To hear the final reports of the CQC, and any recommended actions for monitoring.	Starting Well Living Well Ageing Well Healthier Communities	Care Quality Commission	To await notification on inspection and contribute as necessary.	Southern Health **(M)**	PHT update on progress **(M)**	
Mazars report reviewing deaths of people with a learning disability or mental health problem in	Review and recommendations made to Southern Health, commissioners and national	n/a	NHS England Southern Health NHS FT	Issue heard and reviewed extensively at 9 February meeting. Agreed to monitor and review again in six months'	Update **(M)**		

Topic	Issue	Link to Health and Wellbeing Strategy	Lead organisation	Status	20 June 2017	21 July 2017	21 September 2017
contact with Southern Health April 2011 to March 2015	bodies on reviews of deaths in care of the Trust		West Hants CCG CQC/Monitor	time September 2016 update. Chairman agreed to monitor in interim, next update in summer 17.			
Sustainability and Transformation Plans: one for Hampshire & IOW, other for Frimley	To subject to ongoing scrutiny the strategic plans covering the Hampshire area	Starting Well Living Well Ageing Well Healthier Communities	STPs	H&IOW considered Jan 17, Frimley March 17 H&IOW: next considered July Frimley: next considered Sept		H&IOW STP **(M)**	Frimley **(M)**
Transforming Care Partnership	To consider the implementation of the TCP locally	Living Well	SHIP 8 CCGs	Considered Plan and proposals for Cypress ward Jan 17, to receive quarterly information updates	Quarterly update to be received **(E)**		
Overview / Pre-Decision Scrutiny – *to consider items due for decision by the relevant Executive Member, and scrutiny topics for further consideration on the work programme*							

Topic	Issue	Link to Health and Wellbeing Strategy	Lead organisation	Status	20 June 2017	21 July 2017	21 September 2017
Budget	To consider the revenue and capital programme budgets for the Adults' Health and Care dept	Starting Well Living Well Ageing Well Healthier Communities	HCC Adults' Health and Care (Adult Services and Public Health)	Considered annually in advance of Council in February Transformation to 2019 proposals to be considered Sept 17.			Transformation to 2019 to be considered **(M)**
Scrutiny Review - *to scrutinise priority areas agreed by the Committee.*							
STP scrutiny	To form a working group reviewing the STPs for Hampshire	Starting Well Living Well Ageing Well Healthier Communities	STP leads All NHS organisations	TBC			
Real-time Scrutiny - *to scrutinise light-touch items agreed by the Committee, through working groups or items at formal meetings.*							
Adult Safeguarding	Regular performance monitoring of adult	Living Well Healthier Communities	Hampshire County Council Adult Services	For an annual update to come before the Committee.			

Topic	Issue	Link to Health and Wellbeing Strategy	Lead organisation	Status	20 June 2017	21 July 2017	21 September 2017
	safeguarding in Hampshire			Next update due November 17.			
Ambulance performance	To review ambulance performance following referral of issues from system resilience groups.	Living well	South Central Ambulance Service South East Coast Ambulance Service	Item heard at June meeting, agreed to hold annual updates and receive quarterly data. Next update Summer 2017 – likely to be July.		Performance update **(E)**	
Public Health	To undertake pre-decision scrutiny and policy review of areas relating to the Public Health portfolio.	Starting Well Living Well Ageing Well Healthier Communities	HCC Public Health	Breastfeeding model of delivery considered March 2016. 0-5 services to be reviewed when timely – to include child dental health Items for consideration to be agreed as part of 2017/18 work programme			

Key

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

CORPORATE OR LEGAL INFORMATION:

Links to the Corporate Strategy

Hampshire safer and more secure for all:	yes
Corporate Improvement plan link number (if appropriate):	
Maximising well-being:	yes
Corporate Improvement plan link number (if appropriate):	
Enhancing our quality of place:	yes
Corporate Improvement plan link number (if appropriate):	

Section 100 D - Local Government Act 1972 - background documents

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

Document	Location
None	

IMPACT ASSESSMENTS:

1. Equality Duty

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

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

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

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

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

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

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

2. Impact on Crime and Disorder:

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

3. Climate Change:

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

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

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

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