

Update report for Hampshire HASC
March 2023

Stage 2 Independent Investigation Report: *'Right First Time'*

Progress report: March 2023

1. The table below summarises the work done by the Trust to implement the recommendations of the Stage 2 Independent Investigation Report. The table describes the actions taken since the report was considered at the HASC meeting in November 2022. Progress is monitored by the Southern Health NHS Foundation Trust Board and its Quality Safety Committee.

These assurance processes commenced during March 2022 and evidence against each recommendation has been considered by the Quality Governance leads in both the Integrated Care System (ICS) and NHS England's (NHSE) South East Office. The ICS developed a clear governance process for reviewing Trust progress, which was shared and signed off by NHSE. The ICS and NHSE reviewed the progress made at an extraordinary meeting on 31 October 2022. **At this meeting, it was noted that all of the recommendations had either been 'fully completed' or were 'on track/ongoing.'**

Of the 37 recommendations, 12 (32%) have been fully completed and 25 (68%) are on track. It is important to note that the 'on track' recommendations cannot be fully completed due to the nature of the recommendation and the need for ongoing monitoring to ensure that the actions continue to be embedded in practice.

The ongoing monitoring will be part of the Trust's business as usual and continue to be monitored by the ICS. This will be reviewed on a 6 monthly basis.

2. **The committee is asked to consider this Progress Report and to note that themes from the Stage 2 Independent Investigation Report will, as appropriate, be worked into the Trust's regular cycle of reporting to the HASC.**

Recommendations		Progress since November 2022
R1	SHFT's Complaints, Concerns and Compliments Policy and Procedure documents should be urgently reviewed and reformed. They should be combined into a single document . The policy should prioritise service users, family members and carers. SHFT should work with these groups to co-produce it. It must be clear, straightforward and in an easily understood format. All members of staff must undertake mandatory training on the new Policy and Procedure.	<p>The updated policy and procedure, which was approved in February 2022, is now business as usual. This is monitored via quarterly reporting to the Trust Quality & Safety Committee.</p> <p>The Trust has been a pilot site for the new complaints standards issued by the Parliamentary and Health Service Ombudsman (PHSO). The pilot started in summer 2021 and finished in November 2022, after which a report was submitted to the PHSO for evaluation.</p> <p>The Trust received the draft evaluation report in February 2023 - at the time of writing, the content of the report was confidential and embargoed.</p>
R2 Completed	SHFT should clarify what complaints management system is actually in place in the organisation, whether this is centralised or locally managed, and further go on to ensure the system is publicised and shared in clear language with staff, service users, family members and carers.	<p>Responses from the Q3 2022/23 complaint satisfaction surveys have demonstrated that people find the new process more straightforward and easier to understand:</p> <ul style="list-style-type: none"> • <i>'the new system is so simple'</i> • <i>'clear and simple process'</i> • <i>'thank you for making the process better'</i> • <i>'the new timelines are so much better'</i> • <i>'I like the fact there are so many ways to make a complaint now'</i> • <i>'I really did feel safe to raise my concern'</i>.
R3 Completed	SHFT should clarify and define the role of PALS and if proceeding with it, co-design and co-produce a strategy and implementation plan for its development throughout the organisation. The service must be accessible, supportive and responsive to service user and carer needs.	Our Carer and Patient Support Hub Team are now well established and continue to review and improve the service in response to feedback from service users and carers – see R12 below.

<p>R4</p>	<p>SHFT should urgently implement a process to monitor the quality of the investigation of complaints, complaint reports and responses and the impact of recommendations from complaints. That system should test the extent to which outcomes and judgments are evidence-based, objective and fair.</p>	<p>The quarterly Complaints Review Panel is now well established with membership from Healthwatch, the ICS, service users, carers and staff. The latest Complaint Review Panel took place on 23 February 2023.</p> <p>The group included external representation from the Integrated Care Board Quality Team and Healthwatch. The group reviewed the Trust's current complaint literature, including the complaint leaflet and poster. Feedback was also requested around the newly published process maps for staff, designed as guidance documents for managing early resolution cases and full investigation complaints. All documents are published on the staff portal. The feedback shared was all positive. An idea was raised about including QR codes on the documents and this will be taken forward by the Trust Survey Lead who was at the meeting. The codes will be added ready for the next print run. A representative also joined the group from the Parliamentary and Health Service Ombudsman to provide an update on the complaint standards work they are undertaking. They confirmed that training will be provided to NHS staff which will include bite-size sessions, in person training in a classroom setting, online learning, and self-led packages. The training available will include early resolution, complaint investigations and response letter writing.</p> <p>It was agreed that complaint satisfaction survey results for the year, will be presented to the next review panel meeting, as well as the work being done to raise the profile of positive feedback within the Trust. The satisfaction results will include staff feedback regarding undertaking complaint investigations, and how staff found interactions about being named in feedback.</p> <p>The new complaint satisfaction survey has been in use since 1 April 2022. The survey questions align with the proposed Parliamentary and Health Service Ombudsman complaint standards. The Complaints and Patient Experience Manager and Trust Survey Lead co-produced the</p>
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		<p>new Trust survey with service users, patients, and carers to ensure this was more accessible.</p> <p>In Q3 2022/23, the Trust received 47 responses to the survey regarding first contact with the Complaints Team and 90 responses to feedback on the complaints and concerns process. Overall responses have been positive - the majority of people stated they felt safe to raise their complaint or concern and they were not worried that their clinical care would be negatively affected by raising a concern or complaint.</p>
R5	<p>SHFT should re-develop its Complaints Handling leaflet that reflects the complaints process, outlines expectations and timelines for service users, family members and carers. It must be co-designed and co-produced with these groups. The documents should be widely available to all in paper and digital format.</p>	<p>This action has been completed but, as part of continuous improvement, the Complaints Review Panel will review the current complaint literature, including the complaint leaflet and poster at their next meeting. Feedback will also be requested regarding the newly published process maps for managing early resolution cases and full investigation complaints (closer look cases).</p>
R6	<p>During the investigation of complaints, SHFT should offer the opportunity for face-to-face meetings as a matter of course. These meetings should provide the time to discuss with complainants about how they wish their complaint to be handled and a timeframe for a response, should be agreed. SHFT should maintain communication with the complainant throughout, with a full explanation for any delays.</p>	<p>Our routine practice includes earlier intervention by our clinical teams, dialogue directly with people to understand their preferences for resolution and putting these in place, regular keeping in touch during the response and improving the way we communicate our findings.</p> <p>This is monitored via the complaint satisfaction survey links to which are shared with every complaint response.</p>
R7 Completed	<p>SHFT should ensure that all complainants that go through its complaints handling process, have access to advocacy services where required. SHFT should be alert to the importance of perceived independence of</p>	<p>This is now business as usual - we have identified local advocacy services and actively promote them through our website and via the Carers and Patient Support Hub.</p>

	<p>representation. Therefore, it should look to Third sector organisations that it can facilitate access or signpost their availability for complainants. This should be co-ordinated so as to be part of the complaints handling process.</p>	
R8	<p>There is a vital and continuing need for SHFT to re-build trust and confidence with the population it serves. To achieve this end SHFT should continue its move away from a past unresponsive culture and defensive language. Today, SHFT acknowledge the need to balance accountability and responsibility by ensuring that it meets the Duty of Candour and admits its mistakes. To achieve this, SHFT needs to ensure all staff are trained and understand the Duty of Candour and take a positive pro-active approach in all future engagement with families, carers, and service users, to ensure that their needs are met.</p>	<p>This is embedded into our processes and promoted in staff training and in practice. Our Investigating Officers and Family Liaison Officers openly engage with families when they are part of an investigation and check that service leads have shared information openly and honestly.</p>
R9	<p>SHFT should co-produce with service users, carers and family members, a Communications Strategy to identify a 'road map' for improving communications. This should include, but is not limited to, mandatory training on communication across the whole of SHFT, including improving internal communications and the development of a protocol setting out how SHFT will provide support to its service users, carers and family members. It should create specific roles to provide this support. SHFT</p>	<p>This is being embedded into Trust processes and we continue to co-produce more effective communication channels with service users, carers and family members.</p> <p>The Trust is committed to listening to feedback received by those that use our services and their friends, families and those that matter to them. The Trust has increased the number of ways that people can give feedback and opportunities to share their experience.</p> <p>Our People in Partnership Commitment details our commitment to working together with service users, patients, families and carers so that they have a say in their care and treatment and help us to improve.</p>

	<p>recruitment processes should include good and effective communication skills criteria for all roles at every level of the organisation.</p>	<p>This Commitment was reviewed during 2022 with a series of task and finish groups established with representatives from our Working in Partnership Committee, Carers, Families and Friends Group, Governors, Voluntary Sector, Charitable Organisations and Partners. A consultation draft of the refreshed strategy was then produced for wider consultation and comment.</p> <p>The draft document was circulated to more than 1500 people, was shared widely on social media and a survey was also available for people to complete.</p> <p>We took all the feedback into account and made the necessary amendments to the strategy which was approved by the Quality & Safety Committee in January 2023.</p>
<p>R10 Completed</p>	<p>SHFT should develop a Carer's Strategy, in which the aims and actions are understood and are to be articulated by carers, working together with staff. As a minimum, these actions should be reviewed annually at a large-scale event with carers at the centre. In future, carers must have the opportunity to articulate their needs and the actions needed to address them. Part of this process should be the enhancement and wider use of the Carer's Communication Plan, which must be underpinned by relevant training.</p>	<p>As stated above, our recently updated People in Partnership Commitment details our commitment to working together with service users, patients, families and carers so that they have a say in their care and treatment and help us to improve.</p> <p>The use of Carers Communication Plans is continuously monitored by the Carers, Family and Friends group as well as the Patient Experience and Caring Group on a quarterly basis.</p> <p>The percentage of carers with a carers' communication plan has improved month on month from 56% in February 2022 to 77% in February 2023 - demonstrating the impact of our Triangle of Care training and delivery of our strategy.</p> <p>Insights (our performance data system) is currently launching a caseload view for individual clinicians to rapidly check whether carers' communication plans are in place or due for review (as well as care</p>

		plans, risks assessments etc). This can be easily amalgamated up to service, divisional and Trust level.
R11	SHFT should ensure all staff are all rapidly trained to understand the Triangle of Care and that these principles are clearly communicated across SHFT to all staff to ensure greater awareness. The Quality Improvement methodology should be used to measure the impact of the Triangle of Care.	<p>The Triangle of Care is one of the approaches the Trust has for supporting carers.</p> <p>Triangle of Care training is ongoing and available weekly for all staff. 17 Carers Leads and 14 nurses/practice development nurses have been trained to facilitate the training. The face-to-face Healthcare Support Worker induction includes Triangle of Care training and has been delivered since November 2022. This ensures buy-in from all delegates and provides them with the skills and knowledge going forward into their new careers.</p> <p>Feedback from delegates is always positive for both the content and the delivery of the course. Face to face training is available to all teams across Southern Health and has been delivered by request.</p> <p>Further training about working with carers has been undertaken in the form of Forum Theatre – Think Carer workshops and Carers Rights training delivered by Hampshire Carers Together on Carers Rights Day.</p> <p>The Trust achieved Star 1 Triangle of Care Accreditation in December 2021. The self-assessments for Star 2 have been completed and are currently being reviewed prior to submission to the Carers Trust.</p> <p>The introduction of Esther coaching will further enhance and reinforce the Triangle of Care principles. Esther Improvement Coaches are specially trained dedicated members of staff who support the development of other staff to create a culture of continuous improvement to ensure person-centred care. User involvement is integral to the model, building a network around the patient including family, friends, and key staff.</p>

<p>R12 Completed</p>	<p>SHFT should set up regular localised drop-in sessions and groups for carers and remote carers, which provides support and advice to meet local needs, to include ongoing peer support.</p>	<p>We currently have six active Carers & Patients Support Hubs with a further six in development at various locations across Hampshire. We also have dates arranged for six drop-in clinics in 2023.</p> <p>For the remainder of 2023, the Carers & Patients Support Team aims to focus more on community settings as, over the last 12 months, there has been more success in community settings, rather than our clinical settings. By focusing more on the community, we will create a wider network of people who will be aware of our service, who will know where they can go when they need support.</p> <p>We have a number of carers groups across the Trust, as well as supporting external groups. Most recently, the Trust has funded and supported the setting up of a BAME carers group in Southampton.</p> <p>Another example is our six-weekly Family and Friends Forum which takes place for our forensic families. Each forum has an education session, followed by time for 'getting to know' each other.</p> <p>The Carers and Patients Support Hub has sent out information regarding what we offer to all libraries run by Hampshire County Council, to support us to reach more people in the community.</p>
<p>R13</p>	<p>The Panel recommends that SHFT strengthens its links with the local Hampshire Healthwatch, to ensure that the voices of service users, family members and carers are heard locally. This relationship should be formalised and monitored through a quarterly feedback session between SHFT and Hampshire Healthwatch, with a written report that is publicly available.</p>	<p>The Trust continues to link with the local Hampshire Healthwatch groups in a variety of meetings and forums, including their membership of the Trust's Complaints Review Panel.</p>

R14	SHFT should pay due regard to the 7th principle and 8th principle of the UK Caldicott Guardian Council in recognising the importance of the duty to share information being as important as the duty to protect patient confidentiality . Through training, supervision and support, staff need to be empowered to apply these principles in everyday practice and SHFT should be transparent about how it does so.	The Trust already promotes the importance of both principles, and they are included with our Triangle of Care work and information governance (IG) training. IG training is completed annually by every member of staff which ensures the principles are embedded into practice.
R15	SHFT should seek to improve both the quality of the handover and the sharing of information between clinicians involved in patient care, to include nursing, medical, therapy and pharmacy staff. This should extend, where relevant, to all care settings, including, SHFT and General Practices across its divisions.	<p>Improvements in internal communication continue to be embedded with developments to our electronic clinical record system and ensuring dedicated time for handovers.</p> <p>Additionally, in February 2023 we improved access to primary care records for our community and mental health staff. A link from RiO to primary care records within England has been implemented using GP Connect, a national solution. This enables staff to directly access their patients' primary care records in real-time without needing to log in to another system or search for their patient. These records include consultations, problems, medications, referrals, immunisations, administrative items, clinical items, and observations.</p> <p>External communications also continue to improve with more collaborative working with our partners across Hampshire and the Isle of Wight. This will continue to strengthen over the next 12 months as the Fusion Project progresses to bring together mental health, community and learning disability services across Hampshire and the Isle of Wight.</p>
R16	SHFT must make swifter progress in developing the Patient Experience Dashboard to ensure that it is able to triangulate data and information effectively. It	The Patient Experience dashboard is in place and presented at the Quality and Safety Committee on a quarterly basis as part of our business-as-usual quality monitoring.

	should consider using the data from the Triangle of Care processes to inform this Dashboard. It should also implement specific audits of carer feedback at a local level.	The Trust has increased the number of ways that people can give feedback and opportunities to share their experience. This is reported to the Working in Partnership Committee and the Patient Experience and Caring group as part of our business-as-usual reporting.
R17	SHFT should adopt the Patient Safety Response Incident Framework and National Standards for Patient Safety Investigations (published by NHSE in March 2020) for reporting and monitoring processes, when they are introduced nationally.	In line with the national roll-out, the Trust Patient Safety Response Incident Framework (PSIRF) Implementation Team are currently working through phase two 'Diagnostic and Discover' within the project plan where a gap analysis is being completed to compare current processes of incident and complaints management against the PSIRF standards. It is estimated that phase two will be completed by 31 March 2023.
R18	It is recommended that future NHS patient safety frameworks for Serious Incidents should acknowledge and incorporate the different needs of patient groups , such as physical health, mental health and learning disability and the unique context in which the incident took place.	<p>Phase three 'Governance and Quality Monitoring' also began on 1 February 2023. In this phase, the Trust will be reviewing a range of data from the previous two years to create the incident profile and begin conversations on the governance processes for learning response decision making in preparation for drafting the PSIRF Plan and Policy. The draft plan and policy will be going to the Quality Safety Committee in July 2023.</p> <p>Communications have started with staff, patients, families and carers by attending meetings/forums to introduce PSIRF as well creating e-booklets for staff to refer too.</p> <p>Following the Trust gaining accreditation from the Royal College of Psychiatrists' Serious Incident Review Accreditation Network (SIRAN) in October 2021, we successfully passed their mid-term review in February 2023.</p>
R19	SHFT should provide a clear and transparent definition of ' independence ' and an open and accessible explanation about its processes for ensuring its investigations are 'independent'.	This is now business as usual - patients and families are provided with a clear explanation of our approach to independence and a letter confirming this is sent to the family prior to investigation.

	The definition and explanation should be available to service users, carers and family members and staff. SHFT should also set out criteria which indicate when an independent and external investigation in respect of a Serious Incident will be conducted and who, or which organisation, will commission it.	
R20	In the case of an enquiry into a Serious Incident that requires an external independent investigation, there should be a fully independent and experienced Chair , the background and qualities of whom should be specific to the facts of the case subject to investigation.	This is current practice. The Trust in conjunction with NHS England will commission fully independent reviews where appropriate.
R21	Following a Serious Incident, SHFT should ensure that families, carers and service users, with limited resources, can access external legal advice, support, or advocacy services , as required. Due to potential conflicts of interests, SHFT should not fund such support services directly, but should explore options with local solicitor firms and Third sector or not-for-profit organisations, to facilitate access or signpost their availability.	This is now business as usual with the Carers and Patients Hubs and Family Liaison Officers sign-posting families and carers to the available support.
R22 Completed	The job description for SHFT's Investigation Officer role should include specific qualities required for that post. The minimum qualities should include integrity, objectivity and honesty .	Completed
R23	SHFT should develop a more extensive Investigation Officer training programme, which includes a shadowing and assessment process. Service users, family members,	In line with the national roll-out, the Trust Patient Safety Response Incident Framework (PSIRF) Implementation Team are reviewing training requirements and we have started to enrol staff in courses

	carers and clinical staff should be involved in the development of this programme. It should include, but is not limited to, regular refresher training, a structured process for appraisals, a continuous professional development plan and reflective practice. This will ensure continuous quality improvement in the centralised investigations team.	available online through the Healthcare Safety Investigation Branch (HSIB).
R24	SHFT should urgently change and improve the Ulysses template for investigation reports to ensure that all completed investigation reports are accessible, readable, have SMART recommendations and demonstrate analysis of the contributory and Human Factors.	This was updated and has now been fully embedded into business as usual. Further improvements will be made over the next 12 months as part of our Patient Safety Response Incident Framework (PSIRF) implementation plan.
R25 Completed	All completed investigation reports in SHFT should explicitly and separately document the details of family and carer involvement in the investigation, in compliance with any data protection and confidentiality issues or laws.	This is current practice and is a requirement for the completion of investigation reports.
R26 Completed	SHFT must share learning more widely throughout the whole organisation and ensure that staff have ready access to it. The Trust should ensure staff attend learning events to inform their practice.	This is an area that the Trust will always be working to continuously improve. Recent improvements include the establishment of Quality Improvement Oversight Groups, bringing clinicians and managers together across divisions within service lines to share learning and deliver Trust-wide quality improvement. These groups take feedback from serious incidents, complaints, surveys, inspections and performance data to inform the priorities.
R27	SHFT should have in place, as a priority, a mechanism for capturing the views and	The Family Liaison Officer (FLO) feedback form, which was co-produced with families, is now embedded within our process. Any feedback

	<p>feedback of the service user, family member and carer about the entire SI investigation process. This should be monitored at regular intervals for learning purposes and should be shared with the central investigations team and the Board.</p>	<p>received is included in the quarterly report presented to the Families, Carers and Friends Involvement Group and the Patient Experience, Engagement and Caring Group.</p> <p>The survey for those family members and carers involved in the investigation process is currently being finalised following feedback and will be in place by the end of March 2023.</p>
R28	<p>SHFT should improve the quality of the Initial Management Assessments (IMAs) that are provided to the 48-hour Review Panel to ensure that the decision-making process for the type of investigation required is robust, rigorous and timely. This should be done through a systematic training model and quality assurance mechanisms should be put in place</p>	<p>The initial redesign of the Trust's incident review panel processes was completed in March 2022. Further improvements have been implemented during 2022/23 with the separation of 48hour panels (now called Corporate Incident Review Panels) and mortality review panels.</p> <p>This will be continuously reviewed and improved as we work with the local Medical Examiners (ME) to implement their new processes.</p>
R29 Completed	<p>SHFT should produce a quarterly and annual Serious Incidents Report, which should provide a mechanism for quality assurance. It should be presented to the Board and available to the general public, in compliance with data protection and laws.</p>	<p>This is current practice and reports are presented at the Trust Quality and Safety Committee and reported annually through the Trust Quality Account.</p>
R30 Completed	<p>The SHFT Board and the Quality and Safety Committee should receive more information on the degree of avoidable harm and the lessons learnt, through regular reporting. Thereafter, that information should be discussed by the Board and shared through the Quality Account and Annual Report and with the general public, in compliance with data protection and confidentiality laws. It should address not only the quantitative</p>	<p>This is current practice with quarterly serious incident reports and learning from deaths reports presented to the Quality and Safety Committee and summarised annually in the Quality Account and Annual Report, as part of our business-as-usual reporting.</p> <p>The Trust is also currently updating the Integrated Performance Report to have a clearer focus on Outcomes, with metrics mapped under the headings of Patient Experience, Outcomes, Access, Quality & Safety, and Value. This will allow the Board greater visibility of the high-level</p>

	analysis of all incidents, but it should also reflect a thorough qualitative analysis to identify the relevant themes of current error and future themes for learning.	metrics across these differing outcome domains, to better target areas for improvement and learning.
R31	SHFT should recognise, implement and develop the role of the Medical Examiner, in line with forthcoming national legislation and guidance.	We continue to work closely with the Medical Examiners at UHSFT, HHFT and PHU to support the roll out of the national programme.
R32 Completed	SHFT should examine the potential of expanding and bringing together the Patient Safety Specialists into a team, led by a Director of Patient Safety, from the Executive level.	This is in place - the Trust has a group of Patient Safety Clinical Leads (introduced in 2019), embedded within our clinical divisions, who report into the Patient Safety Specialist and are led by the Deputy Director of Nursing – Quality Assurance & Safety.
R33 Completed	SHFT should develop a co-produced Patient Safety Plan , which includes a long-term strategy for the recruitment of Patient Safety Specialists and Patient Safety Partners and a commitment to continuous improvement.	As described in R17/18 above, the draft PSIRF plan and policy will be going to the Quality Safety Committee in July 2023 in line with the national roll-out of the new framework. Although delayed due to COVID-19, following the publication of the Patient Safety Partner’s job description, the Trust commenced recruitment into these roles with support from the Families, Carers and Friends Involvement Group. Sixteen patient safety partners have been recruited to date and it is anticipated that the induction programme for the partners will commence March 2023.
R36	All Action Plans that are created by SHFT, at any level of the organisation, should include a deadline and the name of an individual(s) and their role, who is responsible for taking forward the action indicated. They must be monitored to ensure they have been implemented and shared for learning.	The standardised action plan template, which was developed for Trust-wide and divisional improvement plans, has been implemented to ensure actions are outcome focused.
R37	SHFT should introduce a Board-level monitoring system for action plans and the	This is in place as part of business-as-usual reporting - the Learning from Events Forum provides a key role in ensuring actions of

	<p>implementation of recommendations made during investigations. That process should require tangible evidence to be provided of actions of improvement and learning. That process should be documented and reported on regularly.</p>	<p>improvement are undertaken and learning is shared widely across the organisation. This is attended by Patient Safety Leads. Themes from this and our serious incident reporting also are considered by the Quality and Safety Committee and the Board where appropriate.</p> <p>Trust level quality improvement programmes are also taken forward for further development through the Quality Improvement Oversight Group and sub-groups, and progress on delivery of their priorities is overseen through the Finance and Performance Committee with a regular milestone report part of the standard committee agenda.</p>
R38	<p>SHFT should adopt the NHS Just Culture Guide and put in place an implementation plan to ensure its uptake through its ongoing organisational development and staff training programme. It should ensure that it is well placed within the SHFT recruitment strategy and within all induction programmes for all staff, to particularly include substantive and locum medical staff.</p>	<p>We have developed a Just Culture Implementation Plan, in line with the NHS Just Culture Guide, ensuring it is embedded in all our people processes. This is an area for continuous improvement.</p>
R39	<p>SHFT should work to ensure that the membership of its sub-committees and its Staff Governors is increased and diversified, so that it better represents the population it serves. It should work with its Governors to do so. This should form part of a long term strategy and the impact of it should be measured, monitored and reported on through formalised structured processes.</p>	<p>Work has continued since the appointment of our Associate Director of Diversity and Inclusion. In March, we will be launching our Reverse Mentoring programme.</p> <p>The programme will be focused on Mentors whose personal characteristics identify with marginalised and minoritised groups in our workforce. This includes those from a Black, Asian and minority ethnic background, the LGBTQ community, those with a disability and long-term health condition, carers and over 50s.</p> <p>Mentees will be sought from the Board of Directors, Senior Leaders and decision makers across the organisation.</p>

Learning Points		
L1	SHFT should avoid terms such as 'upheld' or 'not upheld' in all complaint investigation reports and response letters.	We ceased this practice in late 2019 / early 2020.
L2	SHFT should consider more effective mechanisms to respond to the immediate needs of carers. That could include a possible helpline or other technical aid in order to lead to a practical response	Our Carers and Patients Support Hubs are in place and the work of the team is continuing to expand to meet the needs of carers.
L3	SHFT should work harder to ensure that compassion and respect is reflected in every verbal, written response and communication it has with service users, carers and family members.	As described in R1/2 above, the Trust has undertaken a pilot with the Parliamentary and Health Service Ombudsman (PHSO) which included monitoring and evaluating quality of communication with services, families and carers regarding complaints and investigations. The draft evaluation report has been received and is currently being reviewed.
L4	SHFT should take a 'team around the family' approach to providing support to families and carers and actively recognise that carers and families are often valuable sources of information and they may be involved in providing care and also in need of support.	We have several families and carers groups in place and continue to introduce more across Hampshire in response to need. As described in R12 above, the Carers and Patients Support Hubs are in place to provide specific support to individuals, and we will be focusing on outreach sessions in the community during 2023.
L5	SHFT should consider the use of recognised mediation services to resolve outstanding issues with families who have disengaged within the last two years.	The Trust has appropriate mechanisms in place. The Trust will always consider independent support and encourage advocacy.
L6	SHFT should review its 'Being Open' Policy to ensure that it is fit for purpose and actively promote it to staff, service users, carers and family members, in digital and paper formats.	Our policy has been reviewed and updated in co-production with patients, carers and families. This has been implemented and embedded into our processes and promoted in staff training and in practice.
L7	SHFT should involve service users, family members and carers in the writing of action plans across all investigations. Where requested and the appropriate consent is in	This is current practice. We offer this opportunity within our current processes.

	place, they should be provided with regular updates on the implementation of the action plan.	
L8	SHFT should ensure that staff members and volunteers across all levels of the organisation and a diverse range of service users, carers and family members are part of the Quality Improvement (QI) projects and SHFT's journey of improvement.	During 2022/23 we have continued with our approach to involving service users, carers, family members and staff in QI projects and have run a number of workshops with the people who use our services at the centre of the sessions.
L9	SHFT should, overall, increase its annual and quarterly reporting by committees and divisions to be accessible to the public it serves.	A review of guidance and good practice has been undertaken and agenda frameworks for Committees and the Board have been amended accordingly.

Note: Recommendations 34 and 35 relate to the Clinical Commissioning Group and Integrated Care System so have not been included in this table.

3. Further information

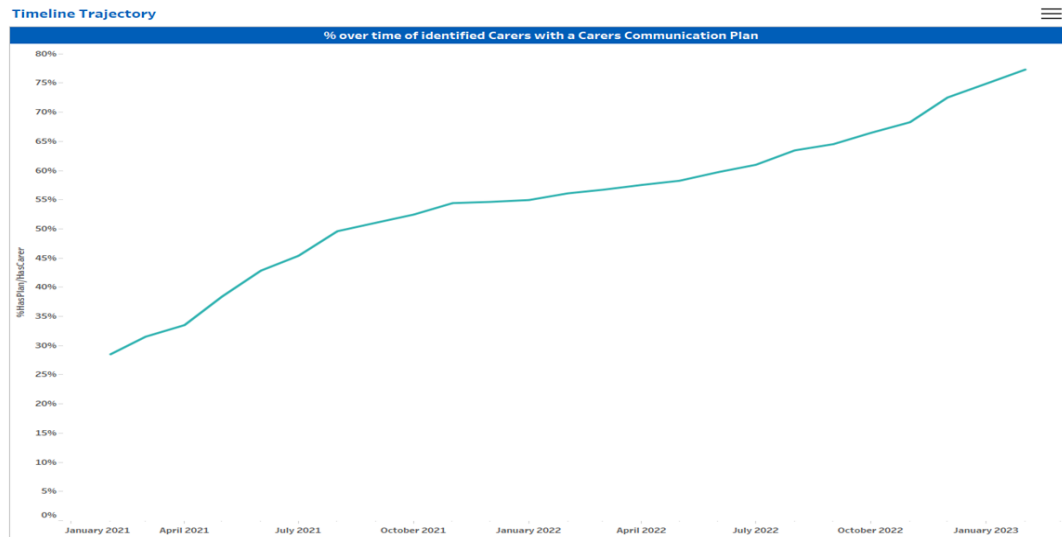
- 3.1** The full report (including an Easy Read version) and the Trust's public statement (issued on the day of publication), can be found on the Trust website here: <https://www.southernhealth.nhs.uk/about-us/news-and-views/second-stage-review-southern-health-published-today>
- 3.2** Additional information, including the Terms of Reference for the review, can be found on the NHSE website here: <https://www.england.nhs.uk/south-east/publications/ind-invest-reports/southern-health/>

Appendix 1: Outcomes/Impact Report for HASC (for Stage 2 Independent Investigation Report)

Carers and Families

We have carers support leads or carers champions in most of our services. This has improved the experience for our carers and compliance with carers' communications plans has increased. In many areas the number of complaints has decreased or, with the support of the carers lead, been resolved more quickly.

Increased compliance with Carers' Communications Plans



Feedback from carers, showing the impact of a Carers Lead role:

Carer Feedback 1

"I was recommended to contact Ben by my husband's mental health nurse, as I was struggling with coping with my role as a Carer and its effect on my life. I didn't know what to expect when I first met up with Ben, I thought that he was going to help me understand my responsibilities as my husband's Carer and explain what more I should be doing to support his mental health

issues. However, Ben immediately clarified that these sessions were to support me and to explore how I was dealing with the impact of the experience. On hearing that this was the purpose of our sessions, I burst into tears! To have this opportunity was such a huge relief as it has provided me with the space to express my feelings, fears, and thoughts about how I would manage my own life in my new role as a Carer. Ben's non-judgemental approach has allowed me to talk openly and share the whole range of emotions that I had been experiencing. He also provided me with some valuable information and insight into the various support networks and resources that are available for me to access.

Ben also challenged me on my pre-conceived ideas about my own self-worth and value. He helped me to see that I still mattered, and I didn't have to sacrifice my own life to care for my husband. Ben encouraged me to re-assess my caring relationship with my husband so that we were both clear about what I would be doing, but also what I couldn't do, in my role as his Carer.

From attending my sessions with Ben, I have gained a greater understanding of how my mental wellbeing is of equal importance to my husband's recovery. I learnt that it was not my role to 'fix' my husband's mental health issues or to become a mental health expert. This was a real turning point for me as I had been struggling with how I would cope with this. Ben encouraged me to think through a plan and set some goals that would improve my life and move us both forward. By the end of our sessions, I had taken some actions to achieve these goals - this was a very important development for me and restored my belief that I can still take control of my life.

I would like to thank Ben for all the support he has given me and to strongly advocate the provision of this service to Carers. It is so important for carers to be given the opportunity and space to consider their own wellbeing and recognise that they also deserve time and support. In doing so carers can learn and develop a new purpose to their lives."

Carer feedback 2 (11.07.22)

"We're very grateful as a family for the amazing support we're receiving from you all, it definitely has made a difference."

Carer feedback 3 (10.07.22)

"Thank you for all that you have done, your support has been fantastic. Your Carers Support role is as important as every other at Anchor House."

Carer feedback 4 (19.07.22)

"Your advice about the Triangle of Care helped me to understand that I could have a valuable input with my husband's treatment under the CMHT. Having the opportunity to have someone to talk to is really helpful."

Carer feedback 5 (22.08.22)

“You've done a really good job and equipped me with the tools should I need them to help my daughter. Thanks so much again for your help in what has been a difficult time for us as a family. It really has made a difference...please continue the excellent work!”

Example of Co-production with Carers

Carers' experiences of hospital discharge has remained a topic of interest for NHS England nationwide for the past decade. There are multiple articles, reports and commentaries on the processes and practices involved in hospital discharge and the inclusion of carers. With funding from NHS England, our project aimed to explore carers' experiences of hospital discharge from Adult Mental Health (AMH) and Forensic services at Southern Health.

Three carers led the project, as project leads, with the support of Southern Health's Carers Strategy Project Officer (project manager). The project was user-led and co-produced throughout. The project was developed through three phases: desktop research, carers' survey and interviews, and staff interviews. The final report has recently been completed and the findings and key recommendations will be presented by the carers to the Board in March.

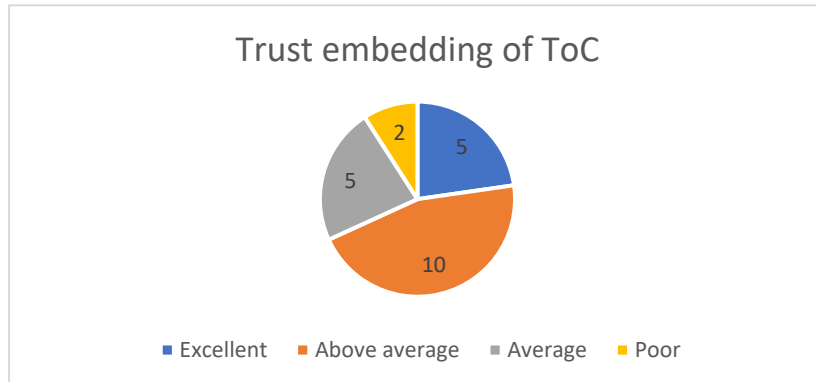
Staff Carers Network

Our Trust has established a staff carers network which has proved to be a great support for our staff. One staff member commented:

“I have been a part of the Staff Carers Together support group since it started. Initially I wasn't a carer for my husband, but the confidential group gave me confidence to know that if I had any questions or concerns I could raise them and that I wasn't the only person in this situation. Now I am a carer and just knowing that there are others within Southern Health in similar situations is very reassuring. Having a member of HR on our meetings means queries can be raised in an informal way and answer something that maybe you hadn't even thought about. The best gift we can all give to people is our time, compassion, and kindness and that is what the Staff Carers Together group provides.”

A survey was conducted with the carers leads to ensure that they were supported to undertake these roles. In particular, responses to two questions show the progress the Trust is making.

How do you feel the Trust is doing, in terms of embedding Triangle of Care?



How do you feel the Trust is doing, to improve the culture of working together with carers, families and friends?



Carer and Patient Support Hub

Examples of how we are making a difference:

- A lady was upset as she still had a temporary death certificate for her husband who passed away in March. We managed find out and signpost her to an organisation who was able to help immediately.
- An inpatient commented *“It’s great to see an impartial team coming in to support the patients away from the wards, I’m very grateful for you coming and listening to my concerns today”*.
- We supported someone who had followed countless leads getting someone to listen to her and failed. We met in the library for a coffee and listened to her story. She felt confident that we were going to open doors that were currently closed to her. After attending a PPG meeting on her behalf, we were able to successfully take her enquiries forward.
- A lady from another outreach clinic was embarrassed and worried about asking for a refund from her husband’s Care Home since his passing a few weeks ago. We contacted the Care Home on her behalf and arranged for her to have £1,000 refunded.

Feedback on service and accessibility

We received 95 responses in Q1 (an increase of 18% from Q4) and 43% of people stated they heard about the Hub from others and 50% of people stated they saw information about the Hub via posters, leaflets, and business cards.

88% of people found it easy to contact the team but 6% of people stated that they didn’t find it easy, as no one is available after 5.00pm. (The Carers & Patient Support Hub is currently covered from 8.00am until 5.00pm, however users are able to leave a voicemail and send us an email which will be dealt with the next working day).

80% of people felt safe to talk to the Hub. Out of 19 people that stated they didn’t feel safe, 13 people left comments that they were worried about whether it would affect their care. The Carers and Patient Support Hub always reassures people that their feedback will not affect their clinical care.

There were two main themes from the free text:

- **Communications** (i.e. examples of what you can help with and face to face drop in's)
The Carers & Patient Support Hub now has 10 clinics across Hampshire, and is in the process of setting up a social media page to help advertise these further. We also make sure that services advertise our drop-in clinics to their carers and patients.
- **Time** (e.g. have an evening drop in as "I don't finished work until 6pm everyday and why does it close at 5pm - there is no one available to discuss an issue I had)
The Carers & Patient Support Hub is currently covered from 8.00am until 5.00pm, however users are able to leave a voicemail and send us an email which will be dealt with the next working day.

Complaints & Patient Experience

Below is some feedback on Southern Health's complaints process. Responses from the Q3 2022/23 complaint satisfaction surveys have demonstrated that people find the new process more straightforward and easier to understand:

- *"The new system is so simple"*
- *"Clear and simple process"*
- *"Thank you for making the process better"*
- *"The new timelines are so much better"*
- *"I like the fact there are so many ways to make a complaint now"*
- *"I really did feel safe to raise my concern".*

ENDS.