‘RIGHT FIRST TIME’

INDEPENDENT REVIEW INTO SOUTHERN HEALTH NHS FOUNDATION TRUST

Executive Summary

1. This independent investigation was set up to consider the circumstances of the deaths of five people between October 2011 and November 2015, which occurred whilst they were under the care of Southern Health NHS Foundation Trust (“SHFT”).

2. The Chair, Nigel Pascoe QC, was appointed in 2019, to undertake a paper-based investigation, to consider the internal and external investigations of those five deaths and the steps recommended or taken to prevent their re-occurrence. This culminated in a written report in February 2020, which made specific recommendations, including the establishment of a*, “limited public investigation that is specific and focussed in nature”.* The purpose was to address and resolve the issues that could not be considered fully on a paper review. Thus, the paper Review and subsequent report became Stage 1.

3. Stage 2 proceeded on the basis of the specific policy areas that had been identified at Stage 1. A Panel of three members was appointed to sit alongside the Chair. They received a wide and diverse body of evidence from service users, carers and family members; SHFT; the CCG; NHSE/I; and independent experts and highly-experienced individuals. The public hearings took place over a seven-week period.

4. The Panel understand and respect the decision of the five families who participated at Stage 1, not to participate at Stage 2. The Panel’s unanimous view was that it was, and remains, in the wider public interest for Stage 2 to proceed.

5. The Panel’s focus at Stage 2 has been on: where SHFT were in 2019, where SHFT are today in 2021 (two years later), and where SHFT should be, with a view to future reform and improvement.

6. The Panel have, on the evidence received, formed their own independent views and conclusions on these key questions and the evidence received. They have then proceeded to make 39 Recommendations and 9 Learning Points on the policy issues of complaints handling, communication and liaison, independent investigatory structures, action plans and supervisory structures with the CCG. They also cover the 'additional themes' identified by the Panel. These are intended to move forward a process of constructive and necessary reform.

7. In conclusion, the Panel have formed the view that, in the last two years, there has been evidence of improvement by SHFT towards increased engagement with service users, carers and family members. But these changes have not been universal in their impact and the evidence, taken as a whole, suggests that they have not always happened to the standards expected, or in some cases, at all.

8. Therefore, the Panel is driven to conclude that there is a real need for continuing systematic and practical reform in SHFT, to fill significant gaps and resolve difficult issues.

9. The Panel have concluded that SHFT has some way to go in its journey to address all of the policy areas in the terms of reference if it has a chance of meeting the fundamental need to 'get it right first time', every time.

10. The Panel has identified good work in progress in SHFT and thus it has rejected wholesale and undiluted attacks made on SHFT. However, there is a necessity for further strategic and practical change, in order for there to be far-reaching and consistent reform which is in the greater public good. The proof of good intentions will be their successful implementation.

Recommendations

The Panel has set out below its Recommendations and Learning Points.

Complaints Handling

Complaints Handling Policy, Procedure and Process

1. 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 and paid and unpaid carers, including family members. 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.

2. 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.

3. 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.

4. 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.

5. SHFT should re-develop its Complaints Handling leaflet so that it 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.

Response to Complaints

6. 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.

Support for Complainants

7. SHFT should ensure that all complaints which go through its complaints handling process have access to advocacy services where required. SHFT should be alert to the importance of perceived independence of representation. Therefore, it should look to Third Sector organisations to facilitate access to advocacy services, or signpost their availability to complainants. This should be co-ordinated so as to be part of the complaints handling process.

Communication, Liaison and 'Care for the Carer'

Culture, Attitudes and Duty of Candour

8. 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 acknowledges 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.

Communication and Liaison with Service Users, Carers and Family Members

9. 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 recruitment processes should include good and effective communication skills criteria for all roles at every level of the organisation.

Communication and Liaison with Carers

10. SHFT should develop a Carers 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 Carers Communication Plan, which must be underpinned by relevant training.

11. SHFT should ensure all staff are 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.

12. SHFT should set up regular localised drop-in sessions and groups for carers (as well as virtual sessions for remote carers), to provide support and advice in order to meet local needs. These sessions and groups should include ongoing peer support.

Support for Service Users, Carers and Family Members

13. SHFT should strengthen 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.

Information Sharing

14. SHFT should pay due regard to the 7th and 8th principles of the UK Caldicott Guardian Council in (i) recognising the importance of the duty to share information being as important as the duty to protect patient confidentiality and (ii) ensuring that service users are informed about how their confidential information is used. 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.

Communication between Primary and Secondary Care and Internal Communications

15. 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.

Measuring Impact

16. SHFT must make swifter progress in developing the Patient Experience Dashboard to ensure that it is able to triangulate data and information effectively. It 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.

Investigations

Incident Investigation Policy, Procedure and Processes

17. SHFT should adopt the Patient Safety Response Incident Framework and National Standards for Patient Safety Investigations (published by NHSE/I in March 2020) for reporting and monitoring processes, when they are introduced nationally.

18. It is recommended that future NHS patient safety frameworks for Serious Incidents should acknowledge and incorporate the different needs of patient groups, such as those with physical and/or mental health conditions and/or learning disabilities and including the unique context in which the incident took place.

Independence

19. 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. 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.

20. 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.

Support for Service Users, Carers and Family Members during the SI Investigation Process

21. 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.

Investigation Officers

22. 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.

23. SHFT should develop a more extensive Investigation Officer training programme, to include a shadowing and assessment process. Service users, family members, 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.

Investigation Reports

24. 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.

25. 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.

Sharing Learning

26. 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.

Feedback

27. SHFT should have in place, as a priority, a mechanism for capturing the views and 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.

Monitoring and Quality Assurance

28. SHFT should improve the quality of the Initial Management Assessments 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.

29. 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 confidentiality laws.

30. 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 quantitive analysis of all incidents, but it should also reflect a thorough qualitative analysis to identify the relevant themes of current errors and future themes for learning.

Medical Examiner

31. SHFT should recognise, implement and develop the role of the Medical Examiner, in line with forthcoming national legislation and guidance.

Patient Safety

32. 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.

33. 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.

Supervisory Structures

34. The CCG should monitor its contract with SHFT with demonstrable rigour and patent independence.

35. The establishment of the newly formed Integrated Care System provides an opportunity to strength the service delivered by the shared specialist Mental Health and Learning

Disability Team. Therefore, the team should be acknowledged and embedded in the ICS in the next 12 months.

Action Plans

36. 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.

37. SHFT should introduce a Board-level monitoring system for action plans and the 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.

Just Culture and Accountability

38. 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.

Leadership, Succession and Strategy Planning

39. 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.

Learning Points

Complaints Handling

1. SHFT should avoid terms such as ‘upheld’ or ‘not upheld’ in all complaint investigation reports and response letters.

Communication, Liaison and ‘Care for the Carer’

2. 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.

3. 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.

4. 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.

Investigations

5. SHFT should consider the use of recognised mediation services to resolve outstanding issues with families who have disengaged within the last two years.

6. 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.

Action Plans

7. 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 place, they should be provided with regular updates on the implementation of the action plan.

Quality Improvement

8. 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 projects and SHFT's journey of improvement.

Leadership, Succession and Strategy Planning

9. SHFT should increase its annual and quarterly reporting by committees and divisions. The reporting should be more accessible to the public it serves.

Conclusions

1. The Panel appointed to conduct the Stage 2 Review into Southern Health NHS Foundation Trust have found a mixed picture.

2. In the last two years, there has been a welcome move towards increased engagement with service users, carers and family members. There have been Quality Improvement projects, co-production work, regular invitations for service users, carers and family members to present at Board meetings, amongst other improvements, which are identified in this Report. Whilst this is admirable progress, there is absolutely no room for complacency.

3. Why not? The bottom line is that those changes have not been universal in their impact. The Panel heard examples from individual service users and carers which suggested that change has not happened to the standards expected, or in some cases, at all.

4. Further, on the evidence, the Panel is driven to conclude there is a real need for continuing systematic and practical reform in SHFT. There are still significant gaps to be filled and some difficult unresolved issues. These are matters of concern.

5. Faced with that reality, the Panel have made 39 recommendations and 9 practical learning points for SHFT, the CCG and wider NHS to consider. These are intended to move forward a process of constructive and necessary reform.

6. The Panel have concluded that SHFT has some way to go on its journey to address all of the policy areas in the Terms of Reference. The 'gold standard' and areas of improvement that participants identified have not yet been achieved. There is still a fundamental need to get it right first time, every time.

7. The Panel have been able to identify good work in progress and a real commitment from a number of SHFT participants across the organisation. In that respect, the Panel has rejected wholesale any undiluted attacks made on SHFT.

8. But in the last analysis, the Panel is certain that further strategic and practical change is necessary in the greater public good and they consider that the present management does recognise the need for reform. The proof of good intentions will be their successful implementation.

Chair: Nigel Pascoe QC

Panel Members:

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