

'RIGHT FIRST TIME'

INDEPENDENT REVIEW INTO **SOUTHERN HEALTH NHS FOUNDATION TRUST**

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Chair: Nigel Pascoe QC

Panel Members:

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Professor Hilary McCallion CBE

Priscilla McGuire

9 September 2021

PART 1: Introduction

1. In July 2019, I began an investigation into Southern Health NHS Foundation Trust (“SHFT”). I had been invited to consider the circumstances of the deaths of a number of adults between 2011 and 2015. At the beginning of my final report in February 2020, I expressed, as I do again, my profound sympathy for what has happened and the devastation that the family members of those individuals experienced. As it happens, I also understand the feelings which arise from the untimely death of a beloved family member.
2. Meeting the families concerned, I understood their very considerable dissatisfaction with the care given to their family members leading up to their death. It was coupled with real anger at the treatment given to relatives, both before and after their death. Their anger was palpable. It had to be addressed.
3. However, I recognised at the same time, as a matter of common humanity, that many health professionals would have had deep feelings of concern of their own. Many also welcomed reforms to prevent the repetition of errors. As always, there were two sides to the story, polarised as it had become, and sadly, how in part it has remained.
4. By the end of the Stage 1 investigation, I was absolutely clear that I had two choices. I could recommend, on top of all of the recent investigations into SHFT, an even larger scale process along the lines of the Hillsborough Inquiry. That would take at least a year to set up and would go on for many months, even years. I was sure that reform was paramount and necessary and by taking that course, constructive change of some existing policy areas would be further delayed. Of course, at that point none of us knew of the existence of COVID-19 and the even greater delays that would have resulted.
5. Alternatively, I could recommend a much more focused and shorter public investigation, which concentrated, mainly, on what had failed at SHFT, with a view to promoting constructive reform far earlier. There was no doubt in my mind that that was the right course, bearing in mind all of the evidence that I had heard from the families, SHFT and West Hampshire Clinical Commissioning Group (“the CCG”). For the sooner that real change and improvements are made in Hampshire, in the wider public interest, the

better. Nevertheless, family members would have preferred that I had opted for a much wider investigation. I do understand and respect their view.

6. As part of my decision, it was necessary to decide which issues should be investigated in the public arena. As I looked at the evidence, without doubt, at the top of my list in policy terms, was the need to ensure that a completely independent investigative system was in place. Why? So that never again would families feel that they had not been heard or had been subjected to sub-standard investigations. That concern and desire was shared by the Panel members appointed at Stage 2. So, a strong and distinguished body of independent evidence was called at Stage 2, to make suggestions as to the design and shape of such a process. In addition to this topic, I also recommended a number of specific policy areas be examined in public and these were included in the terms of reference for Stage 2.
7. The process for a public investigation provided an opportunity for the family members to repeat or develop their own constructive suggestions for reform, if they wanted to do so. The intention was not for them to have to relive their tragic and traumatic experiences, rather, it was to allow them to speak out for future families to ensure that their own experiences would not be repeated. It also allowed other service users to take part. From the beginning, it was stressed that the process would be investigative and not accusatorial. It would never become a witch-hunt.
8. After the Stage 1 report was published, there were discussions and disagreements between the family members and those who commissioned this investigation. Without doubt, that was a painful and difficult period. Ultimately, the families decided not to participate and on 29 January 2021, they issued a press release which was widely reported, making their position clear.
9. The Panel replied in sympathetic terms. Some of that response needs to be set out here to explain the Panel's clear view that the investigative hearing should proceed, notwithstanding the absence of the families.

“As a Panel we recognise that no investigation will ever be able to fully recognise the pain of losing a loved one. We also recognise that the past cannot be undone. However, we want to ensure that the mistakes of the past are not repeated.”

To that end, this panel shares the sentiment of the families, that the ‘true witness to whether the Trust has indeed mended its ways lies not with the five families who have brought about this hearing but with the current and most recent users of the service and their family and carer network’.

That is why the investigation is not limited to the experiences of the five families, but it goes wider and seeks to hear evidence from other service users and families. As a panel we also share the families’ ambition for lessons to be learnt from their experiences.

The panel are therefore united in the view that there is a greater public interest in considering the current policies and procedures in place....”.

10. In correspondence dated 19 February 2021, the families also rejected the invitation of the Panel to reconsider their decision not to take part.
11. As Chair, I decided not to make any comments on the reasons given by the families for deciding not to participate. That remains my position. I simply asked at the outset of the hearings that the Panel be permitted to get on with its task and to be judged accordingly.
12. This public investigation has continued to appreciate the position of the five families, but it has also been conscious of the other service users, carers and families who gave evidence before it and of its duty towards future families, carers and service users. Unexpectedly, it was also necessary to call out the serious and very unpleasant intimidation of a Trust employee during the period of proceedings.
13. Thus, the Panel has sought to recognise the wider public interest in conducting Stage 2 and the need to see the issues being investigated from all sides. It has looked carefully at the need for constructive reform in the recommendations and learning points made. But I have been clear throughout that neither I, nor the Panel members, are anybody’s creature or mouthpiece.
14. I want to stress that the Panel have remained conscious of the need to try to move this fraught position forwards towards some degree of resolution. As part of that, we have suggested that SHFT should consider the possible use of mediation services to resolve

outstanding issues with families. That may apply to the five families, even if that seems a remote prospect at this moment in time.

15. Lastly, I need to address the issue of COVID-19. An intolerable burden has been placed on an overloaded National Health Service, whose members have had to struggle with their own stresses and acute pressures. That is a fact and it cannot be divorced from the way this investigative hearing has proceeded.
16. On one level, the acute emergency situation gave SHFT the opportunity to make progress on some of the issues identified in the Stage 1 report, before Stage 2 began. Indeed, it would have been quite extraordinary if SHFT had not taken account of the criticisms which I had made, given their acceptance of all of my recommendations. So, one underlying issue for this Panel has been to consider just how far they have come in implementing real reform in the past two years.
17. However, where participants have explained to the Panel that there has been delay due to COVID-19 and thus a shift in priorities, understandably, that has been taken into account in our conclusions.
18. On a second level, the delay has further emphasised the absolute need to set-up a practical and constructive investigative process; in the words of a number of witnesses, 'to get it right first time'. This Report seeks to promote that aim.
19. A further consequence of COVID-19 has been the restrictions on meeting in person. A decision was taken early on that the hearings would proceed remotely by way of Teams.
20. I would like to thank every member of the Panel for their absolute dedication and immense commitment, and to recognise fully that their experience has been invaluable during this independent investigation.
21. Finally, I would like to thank the Panel Secretary, Alice Scott, for her immense contribution to the entire process, including its huge administrative burden. In that process she has demonstrated professional skills and integrity of the very highest order.

Nigel Pascoe QC Chair of the Investigative Panel.

Reading the Report

22. Part 5A of this report considers **where SHFT were** in each of the areas being investigated. This includes a summary of the findings of Nigel Pascoe QC at Stage 1, which was the position SHFT were in approximately two years ago, in 2019 and prior to that, and the evidence received during Stage 2. Where relevant, this will also include evidence on the additional themes identified.
23. Part 5B considers **where SHFT are today** in each of the areas being investigated and the additional themes. The answer to this question has been informed by the evidence the Panel have received during the Stage 2 process, in particular from SHFT, the CCG, NHS England and NHS Improvement (“NHSE/|”), service users, family members and carers.
24. Some of the evidence that was provided by service users, carers and family members pre-dated the Stage 1 report and, where appropriate, the Panel have made this clear, or not included it in this report. The focus has been on the evidence that was most relevant to the Stage 2 terms of reference.
25. Part 5C considers **where progress still needs to be made by SHFT** and any other relevant body or organisation. In reaching these views, the Panel have given particular consideration to the evidence of service users, carers, experts and other independent individuals, with relevant experience and insight on best practice and on ‘getting it right first time’. The Panel has sought to reconcile the evidence it has received in a way that is consistent with the public interest and its terms of reference.
26. In Part 6 the Panel has set out its **Recommendations** for each topic area, which the Panel expects to be implemented and actioned in a prompt and timely manner by those to whom the recommendation is directed.
27. Following the recommendations, the Panel had suggested **Learning Points**, which they would strongly encourage SHFT, or the relevant organisation, to implement and action in a prompt and timely manner.

PART 2: Stage 2 Terms of Reference

1. The two stages of this Review were commissioned by NHSE/I.
2. The Stage 1 report identified a number of thematic issues which could not be determined fully on paper. Thus, Nigel Pascoe QC recommended a limited public investigation to determine those issues in a specific and focused way.
3. A Panel were appointed for Stage 2, to sit alongside the Chair, to investigate and address the key concerns identified at Stage 1. This included evaluating and commenting on SHFT's progress to date; identifying where SHFT or another relevant organisation have not gone far enough in implementing reform; making recommendations for learning and, if appropriate, where accountability for its recommendations should lie at an individual organisational level. The purpose of Stage 1 and 2 was not to name or hold individuals personally responsible for any identified failings.
4. The key concerns identified to be considered at Stage 2 were:
 - a) The implementation of a robust, efficient and effective complaints handling procedure at SHFT.
 - b) The structures and procedures now in place at SHFT for communication and liaison with patients' families, both during a patient's life and afterwards.
 - c) The establishment of a totally independent, robust investigative structure and process to conduct transparent and fair investigations into serious accidents, deaths and complaints at SHFT.
 - d) The supervision structure that has been in place since 2011 by the Clinical Commissioning Group (who shall provide the relevant evidence) and how it has been exercised towards SHFT in relation to complaints and investigations, and of any planned changes in the light of public concerns.
 - e) How the outcome of sub-paragraphs (a) and (d) above might be extrapolated across the NHS in England.
 - f) The extent to which recommendations from previous investigations referred to in the Stage 1 report have been developed, implemented and monitored by SHFT, including in its Action Plans and by providing illustrations of effective Action Plans in the recent past, and whether areas for further improvement have been identified and actioned.

5. Following Stage 1, the five families who had participated, contacted NHSE/I with a view to seeking to include further specific aims and terms of reference which they wanted to achieve during Stage 2. Regrettably, it was not possible to reach agreement and on 29 January 2021, the families withdrew their consent to participate in Stage 2.
6. The Panel expressed their considerable regret at the decision of the families to withdraw. However, the Panel were unanimous in their view that the decision of the families should not detract from the other very important aims of Stage 2, which are in the wider public interest. In reaching this view, the Panel bore in mind the interests of future service users, carers and family members and the potential of any recommendations to improve the current policy areas being investigated.
7. The Panel acknowledges that a consequence of proceeding without the five families is that they have been unable to address part of their terms of reference for Stage 2. However, the Panel viewed the terms of reference as a whole and considered the wider public interest encompassed by them and the evidence that could be provided by service users, other families and carers.
8. It is strongly hoped that SHFT, the Clinical Commissioning Group, and NHSE/I, will commit to the aim of ensuring that the recommendations and learning points that the Panel have identified at Stage 2 are implemented promptly and learnt from by all concerned.
9. The Panel were not concerned at Stage 2 of the wider Review, with further investigating the specific facts of any of the cases considered in Stage 1 or to consider any new cases.

PART 3: A Summary of the Evidence

1. The public hearings for Stage 2 took place over a seven-week period and the Panel sat for a total of 23 days.
2. The Panel received documentary evidence and heard oral evidence from an array of individuals and organisations both in the lead-up to, and during, the Stage 2 investigation. All of the evidence received was full, comprehensive and directly informed the Panel's recommendations and conclusions set out in this Report. The Panel is grateful for all of the evidence that was provided and acknowledges the time and, in some cases, the deep emotional response arising from the decision to revisit traumatic events in order to participate.
3. In response to the Panel's request, they received a significant amount of documentary and oral evidence from SHFT. In some instances, randomised samples were provided and the evidence was confined to the period of 2018/2019 to March/April 2021, for reasons of proportionality and resource limitations.
4. The Panel's views, recommendations and conclusions, were all formed on the basis of the evidence they received from the participants in this Review.
5. The Panel's views are in addition to the recommendations. The Panel has chosen to express views on evidence, but the cardinal features of this Report are the Recommendations and Learning Points.
6. At the Panel's invitation, detailed and comprehensive written statements were provided by some existing staff at SHFT, who also attended to give oral evidence. At the Panel's request, additional current staff members and volunteers also attended to answer the Panel's specific questions in order to fulfil their terms of reference.
7. The Panel received written statements from members of the CCG on the topics of supervisory structures, complaints handling and investigations. At the Panel's invitation, other staff members of the CCG also attended to answer their specific questions.
8. At the Panel's invitation, regional and national staff members of NHSE/I attended the oral hearings to answer their questions on the topics being considered.

9. The Panel received invaluable, insightful, and, at times, distressing, evidence from service users, carers and family members of SHFT, on their experience of the topics being considered. They provided both short and long written statements, some with documents in support, and attended the hearings to answer the Panel's questions. They all did so with diligence, courage and good intentions and the Panel would like to thank them for doing so. All of those who attended provided constructive and helpful suggestions as to where SHFT and the CCG could improve in future, in order to ensure, in the words of a number of witnesses, that they are 'getting it right first time' for the population they serve. The Panel trusts that those that came forward will see some of their suggestions in the recommendations and learning points in this Report.
10. The Panel invited evidence from other individuals, organisations and independent experts, that it deemed directly relevant and necessary to provide wider insight into the topics being considered. The Panel is very grateful to all of those who attended to answer their questions, some of whom attended at short notice. The Panel considered evidence from Healthwatch Hampshire, the national Healthcare Safety Investigation Branch, the Parliamentary and Health Service Ombudsman, current and retired members of the judiciary, experts and individuals with experience in investigations, the Care Quality Commission ("CQC") and experienced academics. This is a non-exhaustive list.
11. The insight and experience that the Panel gained from the independent experts and individuals it heard from, has, in part, directly informed some of their recommendations; their contribution was thus, invaluable to this investigation.
12. Finally, the Panel would like to express its thanks to all of the participants who gave evidence, and particularly to those who did so at short notice.
13. During Stage 2, from the evidence received, the Panel identified some themes which were additional to those in their terms of reference, but inextricably linked to them. Some of the themes are linked to the extrapolation of learning across the wider NHS. Therefore, these will also be included in this Report and they are:
- **'Care for the Carer'¹**
 - **A psychologically and emotionally safe environment for service users, carers, family members and staff**

¹ There is significant overlap between this and the topic of 'communication and liaison'.

- **Just culture and accountability**
- **Leadership and succession and strategy planning**
- **Wider National Reporting**

14. Furthermore, the Panel received a great body of evidence in regards to SHFT's approach to, and journey of, quality improvement. This permeates all of the topic areas in the terms of reference and some of the additional themes identified above. Therefore, it is only right that this evidence is also set out separately in the Report.

15. Finally, it should be made crystal clear that the Panel's recommendations and conclusions in this Report arose from the evidence with which they were presented.

PART 4: 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.

PART 5A: Where were SHFT?

1. This section will set out some of the key findings of the Chair at Stage 1, which were informed by the evidence received covering the period of 2012 to 2019 and a selection of the evidence received about where SHFT were, received at Stage 2.
2. The question of where SHFT were was summarised well by the **Chair** of SHFT, who has been in post since July 2017, and said that when she arrived, “the organisation felt very distressed and the Governors had gone through a period of radical change and were feeling bruised and the Governor body had been split”. She described how staff would remove their lanyard with the ‘Southern Health’ name on it before they left work, or when working in the community. She said SHFT made a conscious decision not to put good news stories out, because it would have caused offence and distress.²

Quality Improvement

A. Where were SHFT?

Evidence at Stage 1

3. The evidence at Stage 1 was that NHSE/I had, between 2017 to 2019, approved and funded, a ‘buddying support’ programme and quality improvement (“QI”) methodology with Cumbria, Northumberland Tyne and Wear Foundation Trust to support the internal quality improvement transformation at SHFT. Further, that SHFT received regular ad-hoc advice and support from NHSE/I to identify how best to initiate and roll out a Trust-wide quality improvement methodology.³
4. Furthermore, the evidence was that the QI projects had been used to improve co-production with carers and family members and that it had been used to identify issues and proposals for improvement in the complaints processes.

Evidence at Stage 2

² Evidence of Chair of SHFT, 16 April 2021

³ Stage 1 Report, 20 February 2020

5. The Panel were told that the SHFT Board established a QI Programme Board to oversee and drive forward their plans to improve their services through QI methodology. The Board is chaired by the Chief Medical Officer and has a broad membership including staff, carers and service users.⁴
6. The **Chief Medical Officer** stated that the adoption of the QI methodology was instigated by the family group who instigated this Review. He said, in his personal view, he would have wanted to have a single methodology for QI in the organisation, but that they opted for the Virginia Mason methodology, which is slightly different from the Institute for Healthcare Improvement in Boston. However, they are using the same principles of cultural change from Boston.⁵
7. He said that the history and culture in the organisation five to six years ago meant that teams were defensive and were using tick boxes to show improvement, which does not lead to change. He said that in the last 18 months to two years, with the help of NHSE/I, they had developed and utilised controlled charts in their reports to give an example of where things are changing and learnt to focus less on assurance and more on continuous improvement.⁶
8. He described how some staff resisted the introduction of QI methodology to SHFT and asked, 'is this just another fad?'. However, he said that quite a few consultants came on the training and they saw "epiphanies happen after day three...". He attributed this to "understanding that your perception isn't always right, especially of the service users and families, who don't often have the opportunity to sit with clinicians for one week and challenge them".⁷
9. In regard to where they were two years ago in the QI journey, the **Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement** said, "two years ago, we were just at the start of our real transformation programme and starting the launch and partnership work with Cumbria, Northumberland Tyne and Wear, who we partnered with. They have been running a QI programme for the last ten to 15 years, so

⁴ Statement of Head of Patient and Public Engagement and Experience at SHFT, 2 February 2021

⁵ Evidence of Chief Medical Officer of SHFT, 12 April 2021

⁶ Ibid

⁷ Ibid

they are very experienced and it is embedded. It was a new approach for us, we had a lot to learn, it was a very different way of doing things, which is all about the human side of change. It was about starting psychologically safe teams, that felt ready and able, with support and coaching and improvement science skills, to deliver improvement”.⁸

10. The **Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement** said SHFT’s priority during the first year was to train 60 people in the organisation to ‘certified leader level’ of the QI methodology, which is a four month in-depth course, including five days theory, a viva to pass and they have to run, with a coach, a small QI project for four months, then deliver and facilitate a one week rapid improvement week. She said that when they started, “this was a new and different way of working and in the first cohort we had a lot of emotions in the room and fear, I use that word, as when I joined the organisation, I sensed and felt the fear. But, for people to actively listen and work together to improve and have ideas, if you start with fear, people are closed and we saw that play out early on in our improvement journey”.⁹

11. The Panel heard from a **Non-Executive Director and Chairman of the Audit, Risk and Assurance Committee**, who joined SHFT in July 2017 and said, “the Board and Committee papers in 2017 were pages of words, it was all in there, but the presentation wasn’t particularly brilliant and the vast majority of the papers dealt with the past... there was a lot of the ‘what’ and not the ‘why’ or ‘how we change’ within the papers. Once you got out and visited there was a lot of good things going on”. He said, “at the start, there were lots of things I couldn’t get hold of, understand and there was so much backward-looking data, not information”.¹⁰

⁸ Evidence of Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement at SHFT, 29 March 2021

⁹ Ibid

¹⁰ Evidence of Non-Executive Director and Chairman of the Audit, Risk and Assurance Committee at SHFT, 13 April 2021

Complaints Handling

A. Where were SHFT?

12. At the conclusion of Stage 1, Nigel Pascoe QC identified a *'systemic culture of delay'* in the handling of complaints within SHFT. Furthermore, he concluded that he was *'disappointed to learn that Complaint Handling within SHFT has not yet received full rigorous scrutiny and improvement. I understand there is some work being done with some objective improvements'* and he said that *'it should be a priority for SHFT as it goes forward to a better place'*.¹¹

Evidence at Stage 1

13. The conclusions at Stage 1 were informed by the experiences of the family members who participated and were supported by the evidence available. In general, the evidence showed that it was commonplace for a complainant to make multiple complaints on the same issue, because SHFT failed to deal with them in the first instance. Furthermore, the investigations by external agencies identified that complaints and questions were either not fully answered or not satisfactorily answered. Two of those external agencies recommended an overhaul of the complaints handling process in SHFT, including an explanation as to, *'how improvements in complaints handling have and, will be, monitored'*.¹²

14. Specific recommendations for SHFT in a January 2017 report, included: *'respond to complaints in one document and the time frame should be agreed with the family... improved communications and involvement of the people making complaints... there should be one person at SHFT who deals with the person who made the complaint... SHFT should look at a range of training... the time it takes to respond to complaints needs to be shortened'*.¹³

15. Moreover, the evidence showed that some of the communications by SHFT with complainants were *'insensitive and inappropriate'*.¹⁴

Evidence at Stage 2

¹¹ Stage 1 Report, 20 February 2020

¹² Parliamentary and Health Ombudsman Report, 2016

¹³ Investigation Report by Ideas4Use, January 2017

¹⁴ Stage 1 Report, 20 February 2020

16. A part of the evidence received at Stage 2 was historic but it is set out to provide context.

17. In January 2016, following an inspection, the CQC reported on SHFT's complaints handling:

'... some letters did not answer all of the concerns that had been raised by the complainant. Some reports into the investigation of complaints were superficial and appeared rushed and not challenging. Most of the action plans were poor, incomplete and did not identify actions, learning or change of practice. There was some evidence of learning from complaints in some clinical teams but this was not widespread across the teams inspected'.

The CQC made specific recommendations of action SHFT should take to *'Ensure SHFT is able to capture, understand and develop a culture which supports positive patient experience every day for every patient'*.¹⁵

18. Thus SHFT carried out a thematic review of the complaints process between April to June 2016, which highlighted, *'inconsistencies in how the complaints process was applied across SHFT'*.¹⁶ The review found that, *'21% of patients and service users stated that they may be prevented from speaking up as they worry that care would be even worse as an outcome'* and *'26% of patients and service users indicated that they were unsure who they should go to if they had concerns about their care'*.¹⁷

19. Furthermore, the thematic review found that the *'Ulysses system for logging and tracking complaints is managed inconsistently'* and *'the length of the complaints process was variable and ranged from 24 to 153 days'*.¹⁸

20. Notably, the thematic review records that one service user said, *'the only complaint I have ever made resulted in a response from the CEO that did not address any of the key points in the agreed Complaint Plan and remained unresolved a year later when my son,*

¹⁵ Statement of Deputy Director of Nursing at SHFT, 2 February 2021

¹⁶ Ibid

¹⁷ Complaints, Compliments & Concerns: A Thematic Peer Review, June 2016

¹⁸ Ibid

the subject of the complaint, died. Absolutely shocking behaviour and demonstrating total contempt'.¹⁹

21. In January 2017, SHFT invited the Quality Governance team from Calderdale & Huddersfield NHS Foundation Trust to conduct a peer review, where further improvements were identified. An action plan was put in place, overseen by the Patient Experience, Engagement and Caring Group, which reported to the SHFT Board and Quality and Safety Committee.

22. In December 2018, over a three month period, SHFT carried out an analysis of the complaints process and in March 2019, a Rapid Process Improvement Workshop took place. This involved complainants, staff from the Complaints & Patient Experience Team, commissioners and staff in SHFT. SHFT define this as a, "turning point in our understanding of the issues".²⁰

23. From this experience, SHFT identified four priority areas:

- (1) Improving initial contact, including response times for complaints increasing to 40 days for a 'standard' complaint (60 days for a 'complex complaint');
- (2) Establishment of an Investigating Officer role, within a Central Investigation Team aligned with the Serious Incident investigation process, who is independent of the services where the complaint is made and with specialist expertise in investigating complaints;
- (3) Outcomes and learning, including contact to be made with the complainant once actions are completed; and
- (4) The importance of communication skills during a complaint.²¹

24. However, some of these priority areas were later modified or superseded, for example, SHFT opted not to implement a Central Investigation Team for the resolution and investigation of complaints, but for them to be dealt with at local level in divisions, with oversight from the Central Complaints & Patient Experience Team.²²

¹⁹ Ibid

²⁰ Statement of Director of Nursing at SHFT, 2 February 2021

²¹ Ibid

²² Ibid

25. The top three themes for complaints in SHFT (care received, communication and attitude of staff) are the same top themes that were present in 2014/15.²³ The **Director of Nursing and Allied Health Professionals (AHP)** was asked what is being done to address these themes and said, “prior to the (QI projects), we had not listened, or we thought we had but we didn’t really hear. We didn’t analyse information effectively, which made us draw wrong conclusions and sometimes the actions were put in place and we didn’t actually solve the issues”.²⁴
26. A Governor in SHFT since 2016 and **Lead Governor** since 2020 said, “just after 2016, we had the Council of Governors looking at the performance report on complaints and the only thing shown to us was how quick they were undertaken and when I asked about the outcomes, trends, what we were doing wrong and could learn, I did not receive a satisfactory answer... I was told to comment on it and I did and it went back into the ‘Southern Health ether’ and I never heard back”.²⁵
27. He said that in 2016, the quality of engagement with families and service users in the complaints handling process was, “nowhere near where it should have been for whatever reason and clearly not good enough”.²⁶
28. He said that, “in 2017... there were some complainants which were, very understandably, in a place where it was difficult to get anywhere. There are some vexatious complainants, I don’t include families who lost loved ones, and I don’t think you could ever get to an agreement with them, there is still evidence of that going on”.²⁷
29. A **Non-Executive Director and the Chair of the Audit, Assurance & Risk Committee**, who joined SHFT in 2017, said in regard to complaints, that “in 2017, there was little evidence of a clear strategy or plan... there was a published strategy, but... strategies only work if the management team knows what they’re doing and how it fits in across the organisation”.²⁸

²³ Evidence of Acting Director of Quality and Nursing at West Hampshire Clinical Commissioning Group, 5 March 2021

²⁴ Evidence of Director of Nursing and AHP, 9 March 2021

²⁵ Evidence of Lead Governor, 30 March 2021

²⁶ Ibid

²⁷ Ibid

²⁸ Evidence of Non-Executive Director and the Chair of the Audit, Assurance & Risk Committee, 13 April 2021

30. A **carer** who complained in 2017 said he received a prompt response, the Consultant met with him and it was a very personal response, which is described as helpful and said there were practical steps to move forward. In 2018, he had an issue communicating with a consultant and was told to contact the GP, so he raised a verbal concern with SHFT, but not a formal complaint as he said he gave up. He said he had wanted to help to prevent a crisis but was told that he could only get help if a crisis happens.²⁹

31. The Panel heard from another **carer** with experience of making complaints in 2011 and 2020 and he said that when he first complained in 2011 the complaint would go to the Chief Executive and you would get a letter from him or the Director of Nursing.³⁰

²⁹ Evidence of carer, 31 March 2021

³⁰ Evidence of carer, 6 April 2021

Communication, Liaison and 'Care for the Carer'

A. Where were SHFT?

32. At Stage 1, Nigel Pascoe QC identified *'disturbing insensitivity and a serious lack of proper communication with family members'* and, at times, there was, *'unacceptable delay'* in providing reports and investigations to family members.³¹

Evidence at Stage 1

33. The evidence showed there was a significant gap, in particular, between SHFT and carers. For example, carers' assessments were absent and support for carers was lacking.³²

34. In 2015, SHFT stated in correspondence that it had identified the need for improvement in carers' assessments and for the inclusion of families and carers in the involvement of the care of the patient.

35. Furthermore, the evidence showed that in multiple cases, at different times, there was inappropriate written and verbal communications with family members. This prompted the commissioning of external investigations into these communications. The investigations identified that, *'better communication would have helped'*³³ and *'there should be communication methods and (the) frequency (of them should be) agreed with the patient, family and key contacts'*.³⁴

36. One investigator recommended in 2016: *'(a) dedicated, independent team or specialist family liaison contact, skilled in dealing with bereaved families; advice to be sought from this contact before any meetings with the family; an agenda and key messages for the family should be prepared for these meetings; and a 'neutral colleague' should accompany a Trust officer to 'particularly sensitive meetings' with the family'*.³⁵

37. SHFT said that in December 2016 they introduced and appointed a Family Liaison Officer, who they described as independent of the Investigations Team and who will work

³¹ Stage 1 Report, 20 February 2020

³² Investigation by Clinical Services Director, November 2014

³³ Capsticks investigation, July 2016

³⁴ Root Cause Analysis, March 2016

³⁵ Capsticks Investigation, July 2016

with a family or carer throughout the Complaints or Investigation process. The focus of the role of the Family Liaison Officer was to build better relationships and communicate more effectively to reduce the likelihood of problems arising or the need for a complaint through early intervention.³⁶

38. SHFT averred that work had been done to improve the engagement and involvement of family, carers and the service user in the production of Care Plans, and that this had had positive results. They said there had been recognition of the need, and desire, for a multi-disciplinary approach and continuity across all of the services which had been implemented with success, but that lack of resources had hindered progress at times. Further, SHFT also accepted that their previous structure had led to a lack of confidence and trust and, as a consequence, more serious harm.³⁷

39. SHFT began to introduce the 'Triangle of Care' in 2018. The Triangle of Care is defined by the Carers' Trust as: *'A therapeutic alliance between service user, staff member and carer that promotes safety, supports recovery and sustains wellbeing.'*³⁸ The Triangle of Care recognises the importance of collaboration across three key stakeholders in the care of the service user: the service user, staff and carers. The aim of the Triangle of Care is to better identify, recognise, communicate with, engage and support carers. There are six core principles:

- 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 regarding 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 is available.³⁹

³⁶ Stage 1 Report, 20 February 2020

³⁷ Ibid

³⁸ <https://carers.org/resources/all-resources/72-triangle-of-care-membership-scheme-in-england>

³⁹ Statement of Head of Patient and Public Engagement and Experience at SHFT, 2 February 2021

40. The Triangle of Care includes an accreditation process. The accreditation process requires self-assessments to be completed for each ward or team in every service across SHFT over the course of three years.⁴⁰

41. However, problems were identified in the implementation of the principles and training when service users withheld consent. Thus it was recommended internally that SHFT improve on this.

42. Nigel Pascoe QC was told that a carer could only request patient records through a Subject Access Request, but that the Trust have been working on the issues of consent that attach to such requests. He said that, *'this should be given very careful consideration, but that should not lead to further serious delay'*.⁴¹

Evidence at Stage 2

43. The statement of the **Head of Patient and Public Engagement and Experience** referred to the Mazars Report in December 2015, highlighting the *'variable, and sometimes inadequate, involvement of families and carers in the treatment and care of their loved ones, and in the investigation of adverse events'* and stating that it was raised by families in individual work with SHFT between 2017 and 2019.⁴²

44. During the period of 2017 to 2018, SHFT averred that they:

- Co-produced the Carers' Charter & Principles;
- Identified the implementation of the Triangle of Care as a priority;
- Implemented the Quality Improvement programme;
- Appointed an expert by experience to the Quality Improvement Team and a Head of Patient and Public Engagement and Experience; and
- Published its Experience, Involvement and Partnership Strategy 2018-2022".⁴³

45. The Experience, Involvement and Partnership Strategy 2018-2022 sets out SHFT's commitment to working in partnership with people who use their services, carers and families. It was developed in consultation with staff, service users, carers, families and

⁴⁰ Ibid

⁴¹ Stage 1 Report, 20 February 2020

⁴² Statement of Head of Patient and Public Engagement and Experience at SHFT, 2 February 2021

⁴³ Ibid. The Panel have not had sight of all of the documents listed here.

partner organisations. It describes four distinct levels at which SHFT will operate to communicate and involve service users, carers and families (individual, team, local and strategic).⁴⁴

46. A **family member and previous Governor** in SHFT gave evidence to the Panel, in writing and orally, that on 1 February 2018, he, along with representatives of two families whose cases were investigated at Stage 1, presented a paper to the SHFT Board. They suggested that SHFT should establish the Triangle of Care, involving the clinician, service user, family, friends and carers in all healthcare decisions. They described this as “essential to the process of developing an individually tailored care plan solution”. He maintains that this was not implemented and was one of the reasons that in 2019, they presented their paper to West Hampshire Clinical Commissioning Group, but, he said, still nothing changed.⁴⁵

47. SHFT asserted that in 2018 they developed:

- The Carers’ Action Plan;
- Created the role of, and appointed, two Service User Involvement Facilitator, one with a specific focus on carer involvement;
- The Working in Partnership Committee, chaired by a carer and comprising of user, carer and voluntary sector representatives, to oversee the Experience, Involvement and Partnership Strategy.
- A letter was sent from the CEO to all staff highlighting the importance of information sharing with carers.⁴⁶

48. The **Chair of the Working in Partnership Committee** said the purpose of the Working in Partnership Committee can be summarised in four points:

- 1) To be a voice for, and champion of, the interests and perspective of families and friends, users and anyone affected by SHFT’s services;
- 2) To foster good working relationships, communications and cooperation between all organisations involved with people who use or are affected by SHFT’s services;

⁴⁴ Ibid

⁴⁵ Evidence of family member and ex-Governor at SHFT, 14 April 2021

⁴⁶ Statement of Head of Patient and Public Engagement and Experience at SHFT, 2 February 2021

- 3) To support the efforts of SHFT staff and the Board to provide an excellent service, to improve service quality and to have those achievements recognised; and
- 4) To be an instance of co-production at SHFT-wide level, with a focus on the quality improvement of services.

He said the Committee does not have a work plan for the year ahead, but in the report there is a 'moving forward' section which is about what they want to see happen.⁴⁷

49. As part of the Learning from Deaths process, the Working in Partnership Committee conducted a review of investigations that had taken place over the period of 2018 to 2019. Some of the themes for improvement identified are relevant to the topic of communication and liaison:

'Theme: Communication/Transfer of Care Discharge summaries being provided to the GP in a timely manner.'

Repeated Theme – Featured in two quarters of the year.

Improvement: All services working towards discharge summaries becoming electronic by April 2019. Improvement activities in progress'.

'Theme: Systems and process for patient follow-up when a Care Coordinator is on sickness absence leave are not always robust and communicated.'

Repeated theme - Featured in three quarters of the year.

Improvement: Thematic review of the role and responsibilities of the Care Coordinator is underway at Antelope House. This will provide some understanding of why the "Buddy" system for the CCO role is not functioning as well as it should. Improvement activities are to be defined by the Mental Health Quality and Safety Meeting when the review is received'.

'Theme: Communication with Family Development of a 'my safety my crisis plan' with the service user and the family when the level of risk reaches medium and ensuring it is updated when the risk changes.'

Repeated Theme - Featured in all four quarters of the year.

⁴⁷ Evidence of Chair of the Working in Partnership Committee, SHFT, 11 March 2021

Improvement: Roll out of the Triangle of Care throughout Trust which will support the use of family communication plans. Tableau recording of compliance to updating plans within a twelve month period'.⁴⁸

50. In the period of 2019 to 2020, a service users' story was told at a Trust Board Seminar by their family. The service user had sadly taken their own life. It was found that the failure to contact the service user had led to delays in treatment. The main learning from the presentation was recorded as follows:

- *Delay in allocation of Care Co-ordinator led to a lack of support from mental health services for approximately five to six months.*
- *No clear communication method agreed. The patient preferred email communication and would not answer their phone, services continued to try and phone them.*
- *Communication between (the ambulance services) and SHFT.⁴⁹*

51. The **Deputy Director of Nursing** at SHFT spoke of a comment she made during a Quality & Safety Committee meeting in July 2018, where she highlighted that a number of service users had indicated that they were raising their concerns at a number of CCG forums and local delivery groups which SHFT also attended. She said that this feedback referred to the fact that SHFT were quite disconnected from, and not embedded in, the community-based feedback mechanisms that were already in place. This resulted in service users, families and carers raising concerns with health services or local community groups, but the feedback loops were not in place as all of the internal and external mechanisms were separate.⁵⁰

52. A **Service User Involvement Facilitator at SHFT** said, "when I started, I was lucky to get any users to work with me to share their views, as far as they were concerned, the organisation didn't listen". However, it was explained that their role is to talk to, and involve, service users and carers in activities and co-production work across the organisation and gather feedback and views about the organisation.⁵¹

⁴⁸ Quality & Safety Committee ("QSC") Learning from Deaths Report, 2018 - 2019 Q3

⁴⁹ QSC Learning from Deaths Report, 2019 - 2020 Q3b

⁵⁰ Evidence of Deputy Director of Nursing at SHFT, 29 March 2021

⁵¹ Evidence of Service User Involvement Facilitator for Mental Health and Learning Disabilities and Specialist Services and Carer Feedback Lead in SHFT, 18 March 2021

53. The **Service User Involvement Facilitator** said, "...when I joined the organisation (in 2019), patients were not necessarily at the heart of everything that happened... there was a tendency to do the job, move on and not think about the person as a whole".⁵²

54. The **Family Liaison Officer** told the Panel that when she started in July 2019, her caseload was about eight and quickly picked up to 25 and was rising really quickly. She said that by the end of 2019 she realised that she needed some support.⁵³

55. SHFT averred that in 2019 they established:

- The Families, Carers' and Friends Group, to monitor the delivery of the Carers' Action Plan and advise staff on issues affecting families and carers;
- The Triangle of Care training;
- The People and Partnership Commitment was published (previously the Experience, Involvement and Partnership Strategy); and
- A letter was sent to all staff by the Caldicott Guardian and CMO to provide clarity on the seventh Caldicott Principle.⁵⁴

56. The **Head of Patient and Public Engagement and Experience** told the Panel that the Triangle of Care is a framework to focus staff on working with carers and families. It has been rolled out in adult health mental health services and has been designed around that, but SHFT decided to roll it out into physical health too. She said that they have carers delivering the training, but the training is not mandatory, as SHFT want to encourage staff to realise how important it is.⁵⁵

57. SHFT state that they have developed dedicated carer awareness training aligned to the Triangle of Care, which is available to all staff in SHFT and is designed to increase staff knowledge of key principles and instil best practice that can be adopted in their teams. It covers the importance of listening, informing, involving and supporting carers and the benefits this brings to service users. The training also covers information sharing and how carers can remain involved or listened to, even in the absence of consent to share.⁵⁶

⁵² Ibid

⁵³ Evidence of Family Liaison Officer, SHFT, 30 March 2021

⁵⁴ Statement of Head of Patient and Public Engagement and Experience at SHFT, 2 February 2021

⁵⁵ Evidence of Head of Patient and Public Engagement and Experience at SHFT 10 March 2021

⁵⁶ Statement of Head of Patient and Public Engagement and Experience at SHFT, 2 February 2021

58. Furthermore, it is asserted by SHFT that during 2018 to 2020, Learning Disability services developed an easy read Service User and Carer Engagement Strategy and that service users, carers and families were involved in the development and ongoing review of the Strategy.⁵⁷
59. It is declared that the Carers' Action Plan adopts the Triangle of Care Principles and best practice and sets out SHFT's overarching approach to improving communication and liaison with the carers and family members of people using their services. It is averred that the Carers' Action Plan was co-produced with carers and staff and responds to the findings and recommendations of previous reviews.⁵⁸
60. In regard to community engagement and partnership, the **Head of Patient and Public Engagement and Experience** said that when she joined, in the summer of 2018, there were pockets of good examples, but not a consistent approach. She wanted to enable staff to embrace engagement and involvement and the value of working in partnership with voluntary organisations and to work alongside them.⁵⁹
61. A **Consultant Psychiatrist** in SHFT, who was also the Clinical Services Director in SHFT between 2013 - 2016 and the Divisional Medical Director between 2019 - 2020, said, "... SHFT went through a stage some years ago where staff felt worried about doing the right thing... they were afraid of doing the wrong thing and ended up doing the worst thing by not communicating...".⁶⁰
62. The Panel heard from the current **Lead Governor, Chair and appointed Governor for Carers Together**, who has been in the former role since July 2020 and the latter role since 2016. He said that in 2016 there was, "a pretty toxic atmosphere in SHFT and a breakdown of the relationships between Governors, the Board and within the Board itself; behaviours across all groups was appalling... I think patients and families must have been left wondering what was going on. In all the years I had worked in the public sector, this was the most dysfunctional organisation I had ever come across".⁶¹

⁵⁷ Ibid

⁵⁸ Ibid

⁵⁹ Evidence of Head of Patient and Public Engagement and Experience at SHFT 10 March 2021

⁶⁰ Evidence of Consultant Psychiatrist in SHFT, 10 March 2021

⁶¹ Lead Governor, Chair and appointed Governor for Carers Together, SHFT, 30 March 2021

63. Furthermore, the **Lead Governor** said that when he started and went to a committee meeting, they were not allowed to say anything until briefly at the end and just listened. He said that in 2016 there was a lack of Non-Executive Directors being able to do their job properly, as they had no connection to the Executives and some were behaving as Executives or operational managers. He recalled being in a queue getting lunch (at SHFT) and hearing a senior member of staff say, “don’t tell the Governors anything”, he said that you would not hear that now.⁶²

64. He said, in regard to internal communications with the Council of Governors in 2016, it was “pretty much zero... I would find out what was going on in SHFT on TV, online or in the papers”.⁶³

65. He stated that in 2017 there were two committees for Governors set up: Members Engagement Group and a Patient Experience and Engagement Group. He said they tried hard to talk to people, but he did not think it had gone very well.⁶⁴

⁶² Ibid

⁶³ Ibid

⁶⁴ Ibid. Later he referred to the membership group meeting between 2016 to 2018.

Investigations

A. Where were SHFT?

Evidence at Stage 1

66. During Stage 1, Nigel Pascoe QC received Critical Incident Review reports and investigation reports, both undertaken internally in SHFT and externally. The Critical Incident Review in one case showed that there had been a lack of evidence in support of professional decision-making, as to the assessment of risk.⁶⁵

67. The investigations that were done internally highlighted a number of problems. These were just a few of them: families were not included in the investigations and their views were not included in the reports; reports were never provided to family members; no details of the implementation of recommendations or actions were given in the report or to family members afterwards and one investigation found that the tone and approach adopted by SHFT appeared defensive.⁶⁶

68. In more than one instance SHFT commissioned Capsticks to conduct external investigations; they were a firm of solicitors that were used by SHFT as their own legal advisors at the time the investigations were conducted. Nigel Pascoe QC commented at Stage 1, *'perception was particularly important... perceived independence was crucial... it is difficult for a family member or detached member of the public to see this as a wholly independent report'*.⁶⁷

69. The suggestion of the need for independent investigators at SHFT was referenced in internal investigations completed by SHFT in 2018 and by external investigators in 2016⁶⁸ and 2017.⁶⁹ Therefore Nigel Pascoe QC found that, *'the families (following a serious incident or death) could not have trust and confidence in the investigative systems and processes in place or adopted will be robust and independent and perceived to be so'*.⁷⁰

⁶⁵ Critical Incident Review, November 2012

⁶⁶ Clinical Services Director Report, November 2014

⁶⁷ Stage 1 Report, 20 February 2020

⁶⁸ Capsticks Investigation, 2016

⁶⁹ Ideas4Use Report, January 2017

⁷⁰ Stage 1 Report, 20 February 2020

70. SHFT averred at Stage 1 that the Serious Incident (“SI”) and Mortality Investigative processes that were implemented by SHFT in 2015 were robust and truly embedded in their systems and training; the notification functions and monitoring reduced the risk of delays and ensured compliance. Thus, where it would have once been a clinician carrying out the investigations in addition to their busy practice, now there were dedicated investigation officers and panels, who are all trained and qualified to be carrying out the work. Therefore, if these deaths were to occur today, they said, qualified and skilled individuals would carry out the investigation process without the extraordinary and unacceptable delays that these families faced.⁷¹

71. Nigel Pascoe QC concluded at Stage 1 that, *‘delay in the proper investigation of all these cases has been both serious and unjust’*.⁷²

Evidence at Stage 2

72. SHFT’s **Deputy Medical Director** gave evidence to the Panel and said that her initial involvement in SHFT’s investigative system and processes began in 2015/2016, in response to the Mazars Report and SHFT created a specific role of Associate Medical Director, to provide oversight to developing a robust system of incident investigations. She said that prior to 2015 they had SI Investigations done by clinicians on top of their day job and there were deficits in that arrangement.⁷³

73. She said that in 2016, it was not uncommon for clinicians to wonder why they had to spend time, or be involved in investigations or report them and it was not uncommon for her to hear ‘I have a day job, to look after patients’.⁷⁴

74. The **Clinical Director of the South-West Division** said that when she first started in 1997, it was very clear that doctors did not routinely report patient safety incidents in the same numbers as nurses and AHP. She believes that this reflects their training and that it is a national problem where people don’t see their seniors do it. But, she said, nurses report regularly and are conscious of Ulysses (the risk management system).⁷⁵

⁷¹ Ibid

⁷² Ibid

⁷³ Evidence of Deputy Medical Director at SHFT, 1 April 2021

⁷⁴ Ibid

⁷⁵ Evidence of Clinical Director of the South-West Division, SHFT, 1 April 2021.

75. In the **Deputy Medical Director's** written statement, she set out the key changes that SHFT have implemented through their Mortality and SI Action Plan (these will be analysed further in Part 5B of the Report):

- The introduction of the 48-hour Review Panel to determine the grading of the incident and the level of investigation required;
- The creation of a dedicated central investigation team to ensure that investigations are undertaken independently of the clinical teams;
- The development and implementation of a two day training programme for staff undertaking SI investigations to ensure only appropriately skilled investigators undertook this work;
- Evidence of Improvement Panels established in June 2016. Chaired by a Clinical Director (Chief Medical Officer, Director of Nursing & AHP, or one of their deputies). Clinical teams present evidence of the changes made as a consequence of the findings of the serious incident investigation for the most SIs (those with an impact category of 4 and 5); and
- The establishment and appointment from December 2016 of the Family Liaison Officer role to provide support to families following the death of a loved one and during the subsequent investigation and inquest process.⁷⁶

76. The **Deputy Medical Director** at SHFT said "...since 2016, we have commissioned thematic reviews of all our SI Investigations every six months, in arrears, and now have seven reports, which are a detailed analysis spanning 2016 to 2019... that is a very valuable resource", but she recognised that its focus is on output.⁷⁷

77. The **Deputy Director of Patient Safety in NHSE/I, Dr Fogarty** said the first national policy on 'Learning from Deaths' was published in 2017 and it imposed a number of expectations on every Trust in the country to undertake mortality reviews. This includes Trusts being required to identify patients who died within, or under, the remit of the care of an individual organisation and to undertake a case record review, to identify problems in care and the themes of the problems, to identify opportunities for improvement and then initiate, and carry out, the improvement activity. The policy requires that to be

⁷⁶ Statement of Deputy Medical Director, 2 February 2021

⁷⁷ Evidence of Deputy Medical Director at SHFT, 1 April 2021

undertaken in certain circumstances and more generally on a sampling basis. He said he would not have expected this to have been done by Trusts before this policy was in place in 2017. He said the previous reviews that had been done were not done on a structured or systemic basis and that the Learning from Deaths process systematised and structured those processes across all trusts and mandated it in some circumstances.⁷⁸

78. The **Deputy Medical Director** has chaired the Learning from Events Forum in SHFT since 2016. She told the Panel about its evolution from a mortality committee, focussed on compliance, getting processes right and where every death was looked at; to a Serious Incident and Mortality Committee in 2018, once they had begun to understand adverse events in mental health deaths in terms of mortality. From 2019, they saw the Committee's role was to extract learning from all events so, it became a Learning from Events Committee/Forum.⁷⁹

79. She said that prior to 2019, the grading system for SIs was taken from the NRLS guidance but it does not include the actual harm suffered by the individual. So, in 2019, SHFT introduced a two dimensional matrix approach to grading, firstly, to capture the acts of omission or commission by the organisation and report it, but for their own purposes, they also capture the actual level of harm suffered by the individual. She said this allows them to direct their improvement efforts.⁸⁰

80. The **Deputy Director of Nursing** spoke of the role of the Evidence of Improvement Panels, she said they were brought in as part of SHFT's reconfiguration of the investigation process and governance structure in 2016. Therefore, for the more serious incidents, that meet the 'Serious Incident' definition, following an investigation, there is an Evidence of Improvement Panel. This is for the team to come back after six months later to talk about what they had learnt, what they had done differently and what changes had been made, so they could be tested and some family members have come to the panel discussions, if they want to.⁸¹

⁷⁸ Evidence of Deputy Director of Patient Safety in NHSE/I, Dr Fogarty 20 April 2021. He is one of two Deputy Directors of Patient Safety in NHSE; he is the Deputy Director of Patient Safety (Policy and Strategy) and there is also a Deputy Director of Patient Safety (Insight).

⁷⁹ Evidence of Deputy Medical Director at SHFT, 1 April 2021

⁸⁰ Ibid

⁸¹ Evidence of Deputy Director of Nursing, SHFT, 29 March 2021

81. The Panel acknowledges the CQC findings following their inspection in October 2018:

'There was a comprehensive serious incident reporting and investigation process in place and a culture of detailed examination and challenge over serious incidents and deaths. The appointment of a family liaison officer was a positive step in supporting family involvement in investigations'.⁸²

⁸² Southern Health NHS Foundation Trust, Inspection Report, CQC, 3 October 2018:
<https://api.cqc.org.uk/public/v1/reports/101eb61f-a20a-4221-8066-808a904b411e?20210117122254>

Supervisory Structures

A. Where were SHFT?

Evidence from Stage 1

82. During Stage 1, Nigel Pascoe QC received evidence which suggested that the funding system between the the CCG and SHFT, '*lacked coordination and leadership*' and that there had been a failure by the CCG to require the development of care plans and risk assessments for specific patients and deep concerns had been raised about the commissioning of services.⁸³

Evidence from Stage 2

83. A **Senior Quality Manager in West Hampshire CCG** said that until 2016, "our supervisory function was probably not so good, our relationship was not so good, but everything that happened during 2015 to 2017... improved the relationship we have and I find the relationship we have with them is very good... its collaborative and supportive". She said her philosophy is to support SHFT and described how since 2015 to 2017, SHFT has been open and honest with the CCG, they are willing and encouraging them to be included in anything they do.⁸⁴

84. The **Acting Director of Quality & Nursing in West Hampshire CCG** said that in his opinion the management of contracts with Trusts can lead to an adversarial approach. From 2013, the CCG had taken on an assurance role with SHFT which duplicated internal assurance and governance processes the providers have and he added that, it is difficult to add value to those processes. Further, he said that, before 2015 it was almost unheard of for a CCG to be on an internal Trust meeting with access to papers.⁸⁵

85. He said that the service user's voice was heard in the CCG through a feedback programme called 'learning from service users' between 2016 to 2019, but said, where they need to get to is really listening to their population.⁸⁶

⁸³ Stage 1 Report, 20 February 2020

⁸⁴ Evidence of Senior Quality Manager in West Hampshire CCG, 5 March 2021

⁸⁵ Evidence of Acting Director of Quality & Nursing in West Hampshire CCG, 5 March 2021

⁸⁶ Ibid

86. The Panel heard from the **Interim Director of Nursing and Quality for North Hampshire, South-East Hampshire, Fareham, Gosport and Isle of Wight CCG** and her substantive role is the Deputy Director of Quality and Nursing in the Isle of Wight. She has held roles in CCGs since 2013 and took a career break between 2015 to 2017 then returned to her role in 2017. She said, “I saw a change (in SHFT) when I returned (in 2017), in terms of transparency and willingness to change... our relationships have been well built over the years. We still have work to do, but everyone is around the table at our Hampshire & Isle of Wight Quality Board, we have worked to build our relationships with our providers since 2017, and SHFT are a consistent attendee at those Boards”. She said that as the lead commissioner, they have always had engagement through SI Panels and communications regarding contractual support and engagement. She commented that they have a way to go, but said it is a significant improvement since 2013.⁸⁷

87. The **Director of Quality and Board Nurse for West Hampshire CCG**, who has been in post since 2017, said, “I think the structures within SHFT (in 2017), didn’t lend itself to some of the integrated working and improvement we wanted to do. I think there were people within SHFT, many of whom are still there, who at that period were feeling quite battered and bruised... (as a result) it presented itself sometimes as quite closed and a little defensive, which is not there now...”. She said that some of the responsibility for that needed to sit with the CCG too, as she was not sure that the way the CCG and other commissioners were conducting their communications with SHFT in 2017 were helpful. She said it could be quite confrontational and accusatory and that will never get the best result for service users.⁸⁸

88. She said that people were saying things needed to improve when she arrived in 2017 and that this had been highlighted in an external Serious Incident Audit in 2016/17 which identified three ‘Important Action Points’ and specifically found, ‘*a Lack of communication between Safeguarding and Quality Team in respect of the implications of individual cases*’ and ‘*No local Serious Incidents procedures in place and no process map to identify actions required within set timescales.*’ She believed that the actions identified in that audit had been completed.⁸⁹

⁸⁷ Evidence of Interim Director of Nursing and Quality for North Hampshire, South-East Hampshire, Fareham, Gosport and Isle of Wight CCG, 14 April 2021

⁸⁸ Evidence of Director of Quality and Board Nurse for West Hampshire CCG, 15 April 2021

⁸⁹ TIAA, NHS West Hampshire Clinical Commissioning Group, Review of Quality Governance (including SIRIs), 2016/17

89. Since 1 April 2013, the CCG has led monthly Clinical Quality Review Meetings (“CQRM”) with SHFT to review the contractual requirements and quality of services provided.⁹⁰ The meetings are attended by representatives from all of the CCGs who are locally commissioning services and by representatives from SHFT. Service users are invited to attend to give their story or experience. Furthermore, it has been annually agreed with SHFT that metrics and narrative are to be reported at the CQRM and the CCG are to be provided with the End-User Surveys from the complaints process within SHFT.⁹¹
90. It was averred that in 2014/2015 it was agreed that SHFT would submit more regular and in-depth information to the CCG, and that this was updated to include more targeted and enhanced narrative elements in the quarterly reports in 2015/2016, 2017/2018 and 2018/2019.⁹²
91. It was stated that in November 2015, the CCG began attending SHFT’s internal peer review process (this was later formalised in the contract).⁹³
92. Further, between July 2016 to October 2018, in response to a CQC inspection, a Quality Oversight Committee was formed, with the CCG represented. The committee received the thematic review SHFT had and the findings of the peer review. Following this, they requested further assurance around the quality of complaint responses and the implementation of the Duty of Candour guidance in April 2017.⁹⁴
93. It is averred on behalf of the CCG that, since 2016 they have moved away from a primarily assurance focus to a more partnership approach with SHFT, supporting quality improvement within teams. Further, that the CCG is carrying out its contractual functions more effectively by assessing and supporting the quality of services by engaging with SHFT’s own internal assurance function (focussing on collectively doing it once).⁹⁵

⁹⁰ Statement of Acting Director of Quality and Nursing, West Hampshire CCG, 16 February 2021 – there has been a change to this arrangement since February 2020, due to the COVID-19-19 pandemic, which is explored further in Part 5B.

⁹¹ Ibid

⁹² Ibid

⁹³ Ibid

⁹⁴ Ibid

⁹⁵ Ibid

94. The **Acting Director of Quality & Nursing in West Hampshire CCG** said that from 2013 to 2015 there were multiple concerns about the quality of investigations at SHFT, but since then, there has been training of Investigating Officers in SHFT and a dedicated pool. In regards to the CCG's supervision of SHFT in dealing with SIs, he said that whilst the supervision was there, it did not go far enough and was not thorough enough.⁹⁶
95. The **Interim Director of Nursing and Quality for North Hampshire, South-East Hampshire, Fareham, Gosport and Isle of Wight CCG** said when West Hampshire CCG took over from the previous primary care trust (in 2013), there was a backlog of 250 SIs, that had not been submitted and closed and a big bit of work needed to be undertaken to understand it.⁹⁷
96. She said that in 2015, the quality and standard of the SI reports was poor, but that it probably was across other providers too, and incident and safety reports were variable across the patch from each provider. She said that work was put, with providers and they went further with SHFT.⁹⁸
97. Then, in 2017, she said there was "significant improvement in their report writing... (and) if there was a SI we were lead commissioner, we would have the overall decision, as to whether it was a thorough investigation". She described a turning point when they introduced a 'Serious Incident Checklist' which set out what they expected to have in each SI report and she said that ensured there was consistency and a focus from staff".⁹⁹
98. She said that "from 2017 we have seen improvements... we have to be vigilant and can't take things for granted; we have to continue to improve, to provide an objective view and make sure we work on our relationships with our providers, so we get openness and transparency, not a transactional relationship".¹⁰⁰
99. The **Regional Medical Director for NHSE/I for the South East Region, Dr Lewis** said, "my direct experience in NHS England dates back to 2015, when I was (Regional Medical Director for the old South Region for specialist commissioning for NHSE) and I wouldn't go as far as to say (the CCG and NHSE/I) never met, but the two processes were quite

⁹⁶ Evidence of Acting Director of Quality & Nursing in West Hampshire CCG, 5 March 2021

⁹⁷ Interim Director of Nursing and Quality for North Hampshire, South-East Hampshire, Fareham, Gosport and Isle of Wight CCG, 14 April 2021

⁹⁸ Ibid

⁹⁹ Ibid

¹⁰⁰ Ibid

separate, with separate contracts. We did combine forces with CCGs at provider level around our quality surveillance work. But my experience of that was more in the acute sector, rather than community and mental health services...”.¹⁰¹ In 2015, Dr Lewis was not the Regional Medical Director for NHS Improvement.

¹⁰¹ Evidence of Regional Medical Director for NHSE/I for the South East Region, Dr Lewis, 6 April 2021

Action Plans

A. Where were SHFT?

Evidence from Stage 1

100. During Stage 1, Nigel Pascoe QC found evidence that action plans that been produced by SHFT following external investigations into complaints, for example by the PHSO,¹⁰² and in SI investigations conducted externally,¹⁰³ but it was not clear if the actions had been implemented or not, and if so, to what extent. There was also evidence of action plans lacking deadlines for implementation following Critical Incident Reviews. Furthermore, there were complaints and evidence of the same issues arising again and again, with the strong implication that action plans had not been followed.¹⁰⁴

101. Thus, Nigel Pascoe QC stated in the Stage 1 Report, *'feedback and learning mechanisms must be set up to ensure recommendations are implemented promptly and effectively... to avoid the very real risk of further injustices occurring for patients and families'*.¹⁰⁵

Evidence from Stage 2

102. The **Chief Medical Officer** at SHFT said, "we have, historically, seen action plans being very specific, for example, asking people to read or implement a policy, but that does not change behaviour".¹⁰⁶

¹⁰² Ombudsman Report, 2016

¹⁰³ HASCAS Draft Report, 2016

¹⁰⁴ Stage 1 Report, 20 February 2020

¹⁰⁵ Ibid

¹⁰⁶ Evidence of Chief Medical Officer at SHFT, 12 April 2021

A Psychologically and Emotionally Safe Environment for staff, service users, carers and families

A. Where were SHFT?

103. The topic of a psychologically and emotionally safe environment for service users, carers, family members and staff, was one that developed over the course of the Stage 2 Review from the evidence that was received from all of the participants. It is a deeply important and significant issue, particularly following the effects of the COVID-19 pandemic on staff working in the NHS.

104. Therefore, the Panel formed the view that this topic should be considered separately and, in addition to, the topics set out in its terms of reference. Essentially it permeates all of the topics and issues the Panel have been considering and some of the evidence discussed above is also relevant to this topic and it should be read as a whole.

Evidence from Stage 2

105. The **Deputy Director of Nursing** who joined SHFT in 2013 said that when she joined the teams were quite closed. For example, she described how she visited some units who said that she had not booked an appointment to see them and she believes that was because they were fearful of why she was there and had experienced being blamed when things went wrong. She said that when they informed staff that they were going to take a new approach, work together and actively listen, people did not feel in a psychologically safe place to accept some of it. She explained that they saw that play out in the early days, where there was lots of anxiety at the start of improvement week and emotion on both side: service users had tried to tell their story and it had not been heard, so there was scepticism, but she described how there was an unlocking in the way people thought on both sides.

106. She described that between 2015 to 2017, the structures were quite siloed so patient safety and experience were disconnected.¹⁰⁷

107. The Panel heard from the **Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement** she said, “historically, from my personal

¹⁰⁷ Evidence of Deputy Director of Nursing at SHFT, 29 March 2021

observations, when I joined seven and a half years ago, there was a very different approach to change. Many teams were quite fearful. There was a very clear focus on process and policy and I think if you had asked our staff how they felt at the time, many of them were fearful they'd be blamed, as opposed to supported to improve change. Improvement is all about behaviours and co-production as a core element of what we do every day and seven and a half years ago that was not how I observed people practice on daily basis".¹⁰⁸

108. The **Clinical Medical Officer**, who joined SHFT in April 2018 said, "when I started at SHFT, I recognised the level of fear in the organisation was very significant due to their history and prosecutions; clinicians were very concerned about making decisions that might go wrong or lead to a risky or poor outcome".¹⁰⁹

109. A **service user**, who made a complaint to SHFT between 2017 to 2019, said, "the de-valuing, not hearing, fobbing off and ultimately the silencing of myself, resulting in deep psychological and emotional harm, and in my case, giving rise to a heightening of my physical symptoms... I feel that I have no cause to trust SHFT".¹¹⁰

¹⁰⁸ Ibid

¹⁰⁹ Evidence of Chief Medical Officer of SHFT, 12 April 2021

¹¹⁰ Evidence of a service user, 4 March 2021

Just Culture and Accountability

A. Where were SHFT?

110. The topic of a culture that is 'just', balanced with one that promotes accountability, was one that developed over the course of the Stage 2 Review and will be considered at length in Part 5C of this Report, in regard to where SHFT should be focussing its improvement efforts to develop such a culture. Once again, this topic pervades all of the topics and issues the Panel have been considering. Therefore, the Panel formed the view that this topic should be considered separately and in addition to the topics set out in its terms of reference.

Evidence from Stage 2

111. The **Director of Workforce, Organisational Development and Communications**, who has been in post for three years, said, "a psychologically safe culture is where we don't take immediate action against individuals, but try and work through a situation. What tended to happen previously, was action was taken and that creates a fear culture, so people don't want to report, take steps to improve, don't take the leadership positions and don't want to do things that are right and when I came in, I felt there was a fear and lack confidence in the organisation".¹¹¹

112. The **Director of Nursing and AHP** expressed that she does not believe that SHFT had a safety culture in place and said there were individuals who felt blamed and it left deep scars in some cases.¹¹²

¹¹¹ Evidence of Director of Workforce, Organisational Development and Communications at SHFT, 19 April 2021

¹¹² Evidence of Director of Nursing and AHPs, SHFT, 9 March 2021

Leadership, Succession and Strategy Planning

A. Where were SHFT?

113. The topic of leadership, succession and strategy planning is one that has arisen out of the evidence the Panel have received during Stage 2. It is exceptionally important for this topic to be addressed by SHFT, which is why it has been separated from the others, and where they are now on this and where they should be, will be addressed in Part 5B and 5C.

Evidence from Stage 1

114. At Stage 1, Mr Pascoe found that '*at significant and important times, leadership was sadly lacking and too often that contributed to a systemic culture of delay*'.¹¹³

¹¹³ Stage 1 Report, 20 February 2020

PART 5B: Where are SHFT now?

Introduction

1. The Panel received an extensive body of evidence, in writing and orally, as to where SHFT are now, from staff members of SHFT and the CCG, NHSE/I and service users, carers and family members.
2. The Panel considered all of the evidence submitted, however, not all of it will appear in this section of the Report. This is because it was either not relevant to the terms of reference, or it was repeated by other witnesses. Furthermore, it has always been important to the Chair and the Panel members, that this Report remains accessible to the general public, thus, to avoid an unnecessarily lengthy report, the evidence has been summarised and the Panel took an independent and proportionate approach to what should be included.
3. It must be recognised that the views of the groups and individuals who gave evidence, are, at times, inconsistent with one another and the Panel acknowledges that, in some instances, it has not received both sides of the story, as it were. However, the Panel has listened to these accounts, taken on board the evidence received and formed their own objective and independent views, where it has been possible to do so.
4. The Panel asked the **Chief Executive of SHFT** whether he wished to challenge any of the statements made by participants during the hearings, and he said that, except for one which raised a safeguarding issue and would be addressed separately, “the experiences as presented, although some are historic, are by those who have been witnesses and I respect that”.¹¹⁴
5. The Panel sought to ask the majority of the participants ‘What has changed in SHFT over the past two years?’, and where this was asked, their answers have been incorporated into this part of the Report, whether favourable or not.
6. The Panel has recognised throughout the Stage 2 Review, and continues to do so, the enormous and far-reaching effects that the COVID-19 pandemic has had on the NHS

¹¹⁴ Evidence of Chief Executive of SHFT, 16 April 2021

more widely, and SHFT are not immune to that. In assessing 'where SHFT are now', the Panel has continued to bear this in mind and set out its views accordingly.

7. The Panel acknowledges and records the fact that SHFT divided into five divisions on 1 April 2019. These are geographically centred and each division has a Clinical Director and Medical Director, who are responsible for the quality of care and services. There is a Divisional Director of Nursing (who also has quality responsibilities) and Divisional Director of Operations in each division, together they lead the division. The four roles are, collectively, a Board, and there is also a Head of Nursing and AHP and Head of Operations within that. They all meet monthly and represent the division to the SHFT Board and vice-versa. In the South-West Hampshire Divisional Board, there is a Divisional Director of Nursing, Divisional Director of Operations, a Clinical Director and a Medical Director, who is a psychiatrist.¹¹⁵

8. The Panel received a statement and heard evidence from the Chief Executive of SHFT, who has been in post since June 2020 (although appointed in March 2020), therefore, the Panel acknowledge that he has been in-post for a relatively short period of time in relation to the timing of this Review. He held a previous substantive role as Chief Executive at Dorset NHS Foundation Healthcare Trust for seven years.

9. In evidence the **Chief Executive** referred to the families that had been involved in Stage 1 and said, "from the families' experience, SHFT has genuinely learnt and used the events and what happened around them, as the platform from which we brought about significant improvement and against which we continue to measure what we're doing in trying to do the best we can do. We can, should and will never, forget what has gone wrong, but there is a need for a line to be drawn as we continue to provide services today and want to provide the best services in the future. So it is very important that whilst we do not forget what has happened and continue to learn from it, it is important that we are judged on where we are and what we will be doing in terms of improvement in the future and the markers in terms of how good we are in providing services to the population we serve. The progress is on the back of learning from what has happened and whilst it will never compensate for what has happened for the families, they can at least see that as a consequence of what happened, SHFT has generally learnt, is moving on, and is not

¹¹⁵ Evidence of Clinical Director South West Hampshire Division, Deputy Chair of the Learning from Events Forum, at SHFT, 1 April 2021

in any way pretending to be perfect. We do many things really well, but still make mistakes and, when we do, I hope we deal with them in a much better way”.¹¹⁶

10. The **Chief Executive** expressed how it is clear from the Stage 1 Report that beyond the initial tragedies, there was the subsequent actions and inactions in the way things were dealt with and he said, “in that respect, we must be better”. He also said, “... SHFT does apologise unreservedly for the errors, mistakes and distress caused by those incidents. The fact those events happened and the way SHFT responded is a source of profound regret for all of the SHFT Board and is something I know staff in the organisation have taken very personally as well”.¹¹⁷

11. The **Quality & Safety Committee Chair at SHFT** also said, “the memory of those loved ones is a strong impetus to improve things”.¹¹⁸

12. The **Chief Executive** set out in summary, in his written statement, where he believed the new Board and Senior Leadership Team are today and said that they “demonstrate an absolute determination:

- To be open, transparent and as engaged with people who use services, their carers and families;
- To make the experience of users, carers and families central to all that SHFT does;
- To be grounded in SHFT’s values;
- For culture to be the central platform for building better services and demonstrating it through behaviours, to always do what is right;
- To develop effective governance and to build assurance of quality of services, of culture, of doing the right things, in the right way”.¹¹⁹

13. In oral testimony, the **Chief Executive** defined SHFT’s values as: “culture, just, fair and engaging”. In approaching these values, he said, SHFT has “tried to do it properly and at the heart of that is how we engage clinicians and the hearts and minds of those who deliver our services and that we build into that, the patients and families, who are the

¹¹⁶ Evidence of Chief Executive of SHFT, 16 April 2021

¹¹⁷ Ibid

¹¹⁸ Evidence of Quality & Safety Committee Chair, SHFT, 9 March 2021

¹¹⁹ Statement of Chief Executive of SHFT, 2 February 2021

source of much of the knowledge we have, but also the first point of contact in establishing how we resolve issues”.¹²⁰

14. The **Chief Executive** was asked by the Panel about engaging clinicians’ hearts and minds. He said, “there are 6000 staff in the organisation and for the vast majority of them their minds and hearts are in the right place; but people do make mistakes and get things wrong and sometimes there are problems with the hearts and minds, but it’s a small number of people at any one time... and if people are not prepared to be doing the right thing, or have the wrong attitude, it has to be dealt with in appropriate ways”.¹²¹
15. He provided an example of this: “... what matters to me is that an elderly person relates to their District Nurse and they might not know they belong to SHFT, but they know the nurse and appreciates what they do; then the challenge for us is to make that nurse feel this organisation supports them and they’re proud to be in it”.¹²²
16. The **Chief Executive** gave an appraisal of where he believes SHFT are today: “I think this is a good organisation and as good as any I have worked in. There are pockets which are absolutely, truly outstanding and there are pockets where it is, at times, marginal that we can provide the service we want to and a whole range within there. Overall, this is a good organisation and one I am proud of”.¹²³
17. The Panel heard from the **Chair** of SHFT, who has been in post since July 2017 and said the biggest change in the last two years has been, “a change in culture”.¹²⁴
18. She said this change has been “driven by the work done with our staff to look at the vision values of the organisation”, which are, “patients and people first; partnerships; and respect”. She said that the values had been produced through the Head of Patient and Public Engagement and Experience’s carers’ groups and the Governors.¹²⁵
19. The **Chair** said that to be sure that everyone is treated with respect and to treat others with respect, “we have to have people speaking up when they’re not spoken to with

¹²⁰ Evidence of Chief Executive of SHFT, 16 April 2021

¹²¹ Ibid

¹²² Ibid

¹²³ Ibid

¹²⁴ Evidence of Chair of SHFT, 16 April 2021

¹²⁵ Ibid

respect and feeling confident that the organisation is behind them when they do speak-up...”.¹²⁶

20. The **Chair** set out the three areas where she believed there had been progress made within the last two years. She acknowledged these are “very staff-focused”:

- QI programme. The Chair is trained in the QI model and said it was a good opportunity to come together at all levels and she learnt a lot from the staff.
- Recruitment of high-quality senior clinicians to leadership roles in the new organisation. She highlighted the new divisions and said this had two benefits. Firstly, they can see people around them who understand the work they do and ensure they get the right support and supervision with it. Secondly, people working in the organisation can identify with people to develop aspirations for themselves to become a leader for the future”.
- People and organisational development. She said they are engaged with (their) staff on working on the culture they work within in their teams.¹²⁷

21. The **Chair** said that she no longer thinks staff members would “remove their lanyard before they left work (out of shame) ... they feel proud of the services they offer”. When asked by the Panel what she would take from this organisation, she said, “I would take a lot of the staff, and I would like to take their courage... and their commitment to be better and constantly learn, it really takes your breath away sometimes...”.¹²⁸

22. She spoke, as Chair of SHFT, of what the organisation has been through in the last four years and said, “we have been through... a Health and Safety Executive prosecution, two CQC inspections, Mr Pascoe’s first report and now this enquiry, in just under four years; and to try and keep an organisation motivated, excited and enthralled, dealing with these things and moving forward confidently and being able to shake off the feelings of gloom I experienced when I first came here, I can’t tell you the energy it takes and the energy it gives you”.¹²⁹

¹²⁶ Ibid

¹²⁷ Ibid

¹²⁸ Ibid

¹²⁹ Ibid

23. The Panel acknowledges and records the fact that in January 2020 (following an inspection in October 2019), SHFT was rated 'good' by the CQC in four out of the five areas.¹³⁰ This is a very positive and encouraging achievement. This was an improvement from October 2018, when SHFT was rated as 'Requires Improvement'.
24. The Panel heard from the **National Clinical Director for Mental Health in NHSE, Professor Kendall**,¹³¹ who provides advice and direction at a national level for the development of services in mental health and is responsible for obtaining the finances to do so. Incidentally, he has also had some direct involvement with SHFT since 2016, including with the families involved at Stage 1.
25. When asked where SHFT are today, **Professor Kendall** said, "I rely on the CQC judgment as to how good a Trust is... SHFT are improving, but they have been in a difficult place... with complaints, serious incidents, patient safety and in other areas, such as out-of-area placements... but that is not true across the board and in some secure care facilities, they have done some very good things". He also spoke generally of the national "chronic underfunding of mental health services".¹³²
26. Furthermore, the NHS Annual Staff Survey results for the years 2018 to 2020 do show an incremental improvement in staff saying they would recommend SHFT as a place to work, with 66% saying yes in 2020 (59% in 2018) and in staff saying that they would be happy with the standard of care provided by SHFT if a friend or relative needed treatment, with 74% saying yes in 2020 (66% in 2018). However, there was a decrease of 4.11% of staff saying they were satisfied with the extent to which SHFT values their work, to 49% in 2020. These results are, however, caveated and must be read with the knowledge that, the response rate in 2020 was 41.2%.
27. The **Chief Executive** said, "... staff have to feel good, valued and safe, to bring about change and to deal with things when they go wrong... we are trying to be the best employer and we are still a long way from that and we dropped a couple of percent this year (in the NHS Annual Staff Survey), but we are still up there with the national average. But, understanding how staff feel and why they feel a certain way towards their services,

¹³⁰ SHFT was rated 'Requires Improvement' in the effectiveness of services and in specific services: mental health crisis services and health-based places of safety and wards for older people with mental health problems

¹³¹ Evidence of National Clinical Director for Mental Health in NHSE, Professor Kendall, 29 April 2021

¹³²

work and the organisation, is to me, the fundamental underpinning of everything we do around delivery of service and quality”.¹³³

28. The Panel heard from a **carer** who gave his own personal experience and said, “individuals don’t stay in SHFT... one Care Coordinator stayed for just ten months then went to another local Trust”.¹³⁴

29. A **family member** developed this in their evidence and said, “I don’t want anyone fired, I don’t want it to happen again, but I know the reason it has happened is because of collective incompetence, which has to be because of how they’re organised, as all the people I have dealt with have been lovely, caring people, this is the twist of it”. He said, “I haven’t met anyone who hasn’t tried to get things right”.¹³⁵

30. The Panel also heard from a **family member and carer** who said, “I accept SHFT has managed to get to a ‘Good’ rating by the CQC, but it doesn’t mean that what worries people is dealt with”.¹³⁶

31. Finally, the **Chair of the Working in Partnership Committee** said “I do feel SHFT has moved forward... that is reflected in the CQC rating... but ‘Good’ is not perfect is it”.¹³⁷

Assurance

32. The **Chief Executive of SHFT** said that, “in light of the Stage 1 Review, we put in place proper assurances, to try and have the means to prevent things going wrong, or mistakes, or where there are mistakes, they’re quickly learnt from and we are continuing to improve”.¹³⁸

33. The **Chair** spoke of the work being done by the Governors as being “crucial to the success of the organisation... we are proud to have the Governors we have today and they provide the link between us and the community”. She also acknowledged that they could use them a lot more.¹³⁹

¹³³ Evidence of Chief Executive of SHFT, 16 April 2021

¹³⁴ Evidence of a carer, 6 April 2021

¹³⁵ Evidence of a family member, 14 April 2021

¹³⁶ Evidence of a family member and carer, 9 March 2021

¹³⁷ Evidence of Chair of the Working in Partnership Committee at SHFT, 11 March 2021

¹³⁸ Evidence of Chief Executive of SHFT, 16 April 2021

¹³⁹ Evidence of Chair of SHFT, 16 April 2021

34. This topic is considered further below, in the section on 'Leadership, strategy and succession planning'.

Quality Improvement

B. Where are SHFT now?

35. The Panel acknowledges that SHFT have committed to, and developed, a Quality Improvement (QI) methodology approach to improvement. This was referenced during Stage 1 and some of that background is set out in Part 5A of this Report. The Panel received extensive evidence at Stage 2 from SHFT as to their ‘continuous journey of improvement’.
36. The evidence from SHFT is that it has implemented the methodology from the Virginia Mason Institute, in addition, to the Institute for Healthcare Improvement’s (IHI) Model for Improvement. By way of background, the methodology of the Virginia Mason Institute is about engagement and is believed to work when the support and direction from senior leadership is consistent and clear. The key pillars are: respect, continuous improvement and improving the flows of health care; which are all underpinned by the objective of creating value, as defined by the patient.¹⁴⁰
37. The IHI uses the Model for Improvement as a framework for improvement work. The idea behind it is to accelerate improvement. It is developed from the Plan-Do-Study-Act (PDSA) cycles and from that, asking: what change can be made that will result in improvement; how will we know that a change is an improvement; and what are we trying to accomplish?¹⁴¹
38. SHFT referred in oral evidence to the ‘Life QI’ programme, which is used by other NHS Trusts and Foundation Trusts, who have, or are, implementing the QI methodology and it is used as an organisation-wide system to collate and track QI projects, to communicate with the project team and provide a method of reporting and analysing the impact and success, or otherwise, of projects, across the organisation and to collect this data and share it more widely.
39. The **Chief Executive** provided his perspective: “no one Quality Improvement programme methodology has all of the answers. There is something common in those

¹⁴⁰ <https://www.virginiamasoninstitute.org/about/our-approach/>

¹⁴¹ <http://www.ihf.org/resources/Pages/HowtoImprove/default.aspx>

organisations that have been the most successful and that is, they have taken a long-time and had continuity of leadership to come through”.¹⁴²

40. The **Chief Executive** reflected on his approach when he was Chief Executive in Dorset Healthcare NHS Foundation Trust and said that they did not have a formal QI methodology approach when he joined and before being rated as ‘Outstanding’ (from ‘Special Measures’) by the CQC; and their approach to quality was to, “get people to feel good about what they’re doing, proud of their work, keen to improve and provide the best services”.¹⁴³

41. He said, “my general impression is that there are some really good people in QI, we have good linkages for learning and validation... and we have services that are doing really well and are exemplars but they haven’t followed the formal QI approach”. Therefore, in his view, “it’s a question of how it all comes together, it doesn’t all have to be in a formal QI programme, but how you amplify the best and highlight those that are really good, is the challenge”.¹⁴⁴

42. The QI Programme is executive-led and the Medical Director is the lead, with the Chair of the Board and the Board members as Certified Leaders; and they report to the SHFT Board at every meeting. The **Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement** is responsible for delivering the QI Strategy and said, “this is not just about projects, but it’s about how the organisation uses insight, information and improvement; how we learn from incidents, how we create a just and open culture around safety culture, so we can learn and improve...”.¹⁴⁵

43. She said, “over the last 2 to 3 years, we have seen a very different approach to improvement... the QI perspective changed how we thought about improvement, and a core principle is that you do not try to improve anything without involving the people who use those services... when you have a workshop, you identify a problem... you build a quality improvement team consisting of people who use the service and staff that deliver it”. She believes she has formally presented to the SHFT Board once a year.¹⁴⁶

¹⁴² Evidence of Chief Executive of SHFT, 16 April 2021

¹⁴³ Ibid

¹⁴⁴ Ibid

¹⁴⁵ Evidence of Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement at SHFT, 29 March 2021

¹⁴⁶ Ibid

44. In terms of where SHFT are in their QI journey today, the **Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement** said they have a five year strategy for their QI approach: which is to have 60 certified leaders, 600 staff trained in improvement science and 6000 staff involved. She said these numbers are based on the size of the organisation and their capacity. She explained that their ambition is to keep six QI coaches and to run one certified training course per year. She said, in terms of training and involving staff, they are only in year three of the five year strategy, so if they stopped now, there is a risk they would not reach the point of sustainability in five years. She said they currently have about 111 certified leaders and 200 staff trained. She said they are on target for their five year delivery.¹⁴⁷
45. The Panel were told that a number of Board members had undertaken the training themselves, both Executives and Non-Executives. As this project was launched with Cumbria, Northumberland, Tyne and Wear, they returned after one year and reported that, “with such good whole-Board-engagement in the strategy, (SHFT) were highly likely to be able to continue to transform in this way”.¹⁴⁸
46. The COVID-19 pandemic has had an effect on SHFT’s progress of their QI Strategy. The **Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement** said that there had had to be a postponement of the Rapid Improvement approach overall, including for the Serious Incident Investigation Process. This has been postponed to June 2021. She acknowledged that, in terms of progressing with the strategy in the last eighteen months, “I think we need to do more...”.¹⁴⁹ The **Chief Medical Officer** said they had wanted to “shift to forward-looking quality improvement” at the start of 2020, but it has been delayed due to COVID-19.¹⁵⁰
47. However, the **Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement** said they were intending to relaunch the programme in April 2021, with partial devolvement to the divisions and less centralised control and to activate the 111 certified leaders in the services to provide a coaching system, with the leaders delivering the training locally. The central team will continue to support the start-up, the measurement and the workshop and monitor it for 30, 60 and 90 day cycles. Then, at 90 days, they will decide if they need to still oversee it centrally or can devolve

¹⁴⁷ Ibid

¹⁴⁸ Ibid

¹⁴⁹ Ibid

¹⁵⁰ Evidence of Chief Medical Officer, 12 April 2021

oversight, as it's become 'business as usual' and people are not talking about it as a 'project', but there has been a mind shift to 'this is the new way we work'. This has been approved by the Board, with substantial budget for that model.¹⁵¹

48. In terms of monitoring improvement, the **Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement** said, "some project measurements were not as strong as they could have been", so, they have been exploring a system called 'Life QI', which SHFT does not currently have, and she said it is part of their 2021-2022 strategy to strengthen the measurement of their work.¹⁵²

49. In regard to how learning is shared internally at SHFT, she said that she attends the Quality & Safety Committee meetings and reports there. She also chairs the Patient Safety Group, which is the control, assurance and planning part of the QI Programme.

50. In terms of wider learning, the Panel were told that SHFT have held a number of QI conferences and had international speakers and that the Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement was awarded the Florence Nightingale Scholarship to Sweden and from there, learnt more about how they approach improvement at a population health level.¹⁵³

51. The **Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement** said SHFT share their learning through regional and national improvement teams and programmes.¹⁵⁴

52. The Panel were provided with examples of some of the QI projects that have taken place in SHFT and some of the learning from them. Some will be set out here, but this is not an exhaustive list:

- The **Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement** said that their longest-running project, which is in fact part of a national programme and not instigated by SHFT, is to reduce the level of violence and aggression on acute mental health wards and introduce a more therapeutic environment. She said, "... we didn't see a reduction in the number of

¹⁵¹ Evidence of Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement at SHFT, 29 March 2021

¹⁵² Ibid

¹⁵³ Ibid

¹⁵⁴ Ibid

incidents, which is what we first anticipated, but we saw a reduction in the level of harm, length of stay and delay in discharges, through a more therapeutic approach, rather than a restrictive approach. For the patient, this meant a shorter, bespoke admission, with clear reasons and goals for admission, no delays on discharge; and, over time we've seen an improved retention of staff on the ward, a reduction in complaints and concerns and better outcomes for users, but that has taken eighteen months to see that outcome...".¹⁵⁵

- She said they have done a number of improvement and transformation projects, particularly in primary mental health care, but acknowledged that they could do more.¹⁵⁶
- The **Chief Medical Officer** spoke about a project to reduce out-of-area beds in mental health services. He said that the results have been maintained and implemented for more than one year and that they have reduced out-of-area placements to almost zero and that they are one of the few Trusts to do so. He said this massively improves quality and safety.¹⁵⁷

53. As to how SHFT decides on its QI projects, the **Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement** was asked specifically about whether it would be appropriate to use the methodology to address the three top themes that arise in complaints. She said that their decision would depend on whether a quality improvement intervention is the right one for that specific issue.¹⁵⁸

54. In regard to who the 'service user' is in the co-production of a project, the **Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement** said, "we have two experts by experience in the QI Team who are trained and we talk to them to ask what is appropriate to have... they are always clear that we don't want (the co-production) to be a tick box exercise, it has to be real".¹⁵⁹

55. The **Regional Medical Director for NHSE/I for the South East Region, Dr Lewis**, gave his view to the Panel on QI methodology in general, not specifically in SHFT, and said, "... I think a tool is only as good as the people using it and when it comes to QI, I

¹⁵⁵ Ibid

¹⁵⁶ Ibid

¹⁵⁷ Evidence of Chief Medical Officer at SHFT, 12 April 2021

¹⁵⁸ Evidence of Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement at SHFT, 29 March 2021

¹⁵⁹ Ibid

think it is about communication: honesty, humility, openness, the cultural approach and attitude of the people using it and recognising existing shortcomings and working to address those, so any tools used are a useful framework to base those conversations and approaches”.¹⁶⁰

56. When asked if this is working in SHFT, **Dr Lewis** said, he would “cautiously say yes” as the reports coming through to him were not drawing SHFT to his attention, or that of others. But he said, “it is difficult to attribute the effect to the cause”. His role, as he described it is to, “... support others to drive (QI), I’m the critical friend, asking the questions and presenting the information”.¹⁶¹

57. He said that “one of the powers of the ‘getting it right first time’ approach, is that nobody wants to be below average and if you present providers with their own data and they’re below the average, in general, people will aim to improve in order to ensure the next time the data is run they their position is more favourable. I think the majority of clinicians don’t go to work to preside over a service that isn’t in the upper-quartile of performance”.¹⁶²

58. The Panel heard from a **family member and previous Governor at SHFT** who said he does not consider that SHFT has continuous feedback and improvement.¹⁶³

59. The other service users, carers and family members who presented evidence to the Panel had not heard of the QI programme or methodology and had not been invited to attend QI project workshops or Rapid Improvement Workshops with SHFT.

60. The **Chief Medical Officer** was asked how long it would take to embed this approach and how they would sustain it and he said, “many organisations have two to three years of input and then revert back and are not utilising the methodology... we’re two years in and we’re very aware that three years is still young”. He referred to the Swedish system where they have been in it for twenty years and it took them ten years to embed it.¹⁶⁴

61. In his assessment, the COVID-19 pandemic has “created empowerment in some of the teams, but it hasn’t kept the momentum we would have had otherwise”. Thus, in

¹⁶⁰ Evidence of the Regional Medical Director for NHSE/I for the South East Region, Dr Lewis, 6 April 2021

¹⁶¹ Ibid

¹⁶² Ibid

¹⁶³ Evidence of a family member and previous Governor at SHFT, 14 April 2021

¹⁶⁴ Evidence of Chief Medical Officer of SHFT, 12 April 2021

response to this, he said he has recommended to the Board that there be an independent external expert coach, to work with the Board and to create Integrated Care System QI hubs too, to move SHFT forward.¹⁶⁵

62. From the **Chief Executive's** point of view, "the next stage, is to evaluate, collectively, where we are; talk openly about it and whether we adopt a methodology further, or whether we take a blended approach and how we tie-it in with research and audit and to agree our next steps. Our ambition over the next six months is to draw that debate together and see it evolve in a natural way so it brings people's commitment to it".¹⁶⁶

Panel's views on where SHFT are now on Quality Improvement

- The Panel is pleased SHFT has begun its QI journey and it is satisfied that there has been a number of successful QI projects, with co-production. SHFT is evidently spending time and working hard on this and it should be commended.
- There are also positive signs that SHFT is looking outside of their organisation and outside the UK to learn about QI. The Panel acknowledges they have gone the extra mile by adopting and merging two models for QI.
- Some of the QI projects lined up to take place over the last 12 to 18 months have been delayed due to COVID-19, but should be revived now the situation is improving.
- The QI Strategy and Procedure 2019-2024 and Quality Improvement Programme (documenting projects implemented and in progress), do not set-out a clear plan with outcomes and information about the impact of the projects. There is a lack of evidence showing the mechanisms SHFT has in place to monitor and measure impact following a QI project. Currently, SHFT is not able to identify whether actions are taken at local level and if they are, if they will lead to sustained change and improvement. This must be addressed.
- The Panel have formed the overall view that SHFT is very early on in its QI journey and there are improvements that they need to make in order to be successful in this approach.

¹⁶⁵ Ibid

¹⁶⁶ Evidence of Chief Executive at SHFT, 16 April 2021

Complaints Handling

B. Where are SHFT now?

Introduction

63. The Panel were informed that SHFT had reviewed and amended their 'Complaints Concerns and Compliments Policy and Procedure' documents¹⁶⁷ in July 2020, but it was decided that the amendments would be paused, to allow for further feedback and the roll-out of the Parliamentary Health Service Ombudsman ("the PHSO") NHS Complaints Standards Framework 2020 ("the Framework"). Therefore, the review date has been extended to June 2021.¹⁶⁸ The Framework is currently being tested in pilot sites during 2021 and the aim is that it will be introduced across the NHS in 2022. SHFT are one of the pilot sites.¹⁶⁹

64. The Framework provides a model complaints handling procedure and guidance, setting out how organisations providing NHS services should approach complaints handling.

65. In brief it describes an '*effective complaint handling system*' in the NHS as one that should, '*welcome complaints in a positive way... giving fair and accountable responses and being thorough and fair... and promoting a just and learning culture*'.¹⁷⁰

66. The PHSO provides some examples of good practice in complaints handling that are taken from some of the NHS Trusts that were visited as part of their 'Making Complaints Count' Report.¹⁷¹ In summary, they are:

- Proactive engagement;¹⁷²
- Embracing online feedback;

¹⁶⁷ Complaints, Concerns and Compliments Procedure SH NCP 11 (issued September 2018) and Complaints, Concerns and Compliments Policy SH NCP 10 (issued September 2018)

¹⁶⁸ Statement of Deputy Director of Nursing of SHFT, 2 February 2021

¹⁶⁹ Evidence of Chief Executive of SHFT, 16 April 2021

¹⁷⁰ NHS Complaint Standards, Summary of Expectations, Pilot Spring 2021, Parliamentary and Health Service Ombudsman

¹⁷¹ Making Complaints Count: Supporting Complaints Handling in the NHS and UK Government Departments, PHSO, 15 July 2020

¹⁷² Macclesfield District General Hospital have a PALS Outreach Service and involves staff from the Customer Care Team, going out to hospital wards and departments to speak with patients, relatives and carers about their experiences

- A regular panel meeting with senior staff that puts complaints at the heart of governance;¹⁷³
- Adopting a just and learning culture; and
- Early and direct engagement.

67. The Framework includes a 'Draft Guide' for ensuring that there is a relationship between the organisation and their local, independent NHS Complaints Advocacy Service, which is free, independent, impartial and funded by local authorities.

68. It is acknowledged that the CQC found in January 2020 that, *'the Trust treated concerns and complaints seriously. The organisation investigated concerns and complaints and shared lessons learned with staff. Patients were included in the investigation of their complaint'*. However, they also observed overall that in regard to wider improvements, *'the Trust had not yet made all of the improvement that we identified needed to be made at the last inspection in older people and crisis services'*.¹⁷⁴

69. Further, the NHS Annual Staff Survey results for SHFT to the question, *'my organisation acts on concerns raised by patients/service users'* have improved from 2016, where 70% said 'yes', to 80% in 2020. The results, however, must be read with the knowledge that the response rate in 2020 was 41.2%.

70. A number of participants were asked where SHFT are now, compared to two years ago, in regard to complaints handling. Some of those responses are set out here.

71. The **Chief Executive of SHFT** said there has been, "continuous improvement in the way we have dealt with complaints and concerns and it has moved on significantly. SHFT have tried to do it in the right way by engaging complainants, staff and engaging QI methodologies, to try and bring about the best standards possible". He said SHFT's Policy is fit for purpose compared to most. However, he acknowledged that it is still evolving and improving.¹⁷⁵

¹⁷³ Newcastle-Upon-Tyne Hospitals NHS Foundation Trust set up a monthly panel to scrutinise a range of formal complaints and review any resulting actions and procedural changes, with the Patient Relations Team presenting quantitative data and the opportunity to flag delays or bottlenecks in the process and discuss cases referred to the PHSO; recommendations are shared and it allows senior leaders to oversee what feedback and complaints data says about the service and the action being taken to learn

¹⁷⁴ Southern Health NHS Foundation Trust, Inspection Report, CQC, January 2020:

<https://api.cqc.org.uk/public/v1/reports/3bfd1da5-1a89-47cf-8011-1c6ab96495eb?20210114105252>

¹⁷⁵ Evidence of Chief Executive of SHFT, 16 April 2021

72. The **Director of Nursing and AHP** said that there had been improvements in the complaints system in the last two years, but recognised that there were more to be made, specifically, the quality of responses and timeliness needs to improve.¹⁷⁶
73. The **Quality & Safety Committee Chair and a Non-Executive Director**, who joined in late 2017, said, “we have improved our policy, ability and approach... we have had QI and patients contribute to that, and we came to a more sensitive, immediate and inclusive approach to our management of complaints and concerns”. However, he said there are some elements which do need to be improved and acknowledged that less than half of complainants believe the organisation will change following their complaint which had to be turned-around.¹⁷⁷
74. A **Lead Governor** at SHFT spoke of the one week QI workshop, which involved staff, carers and service users and stakeholders in the same room and led to suggestions and significant recommendations for change. He said, “if I compare that with before, it’s a totally different world in terms of the way complaints are dealt with”. However, he also acknowledged that they have a way to go on complaints and said that not all of the areas coming out of the QI report have been implemented, a view, he says is reflected by the Board too.¹⁷⁸
75. He said that there have been a number of reports on complaints handling in SHFT brought to the Council of Governors and they were not happy with some, so asked SHFT for another report in the next cycle of meetings, to look at the plan and to see if SHFT can show that they can support a person to prevent a concern becoming a complaint and that it has caught up with its set targets. He said they are monitoring it closely. He expanded upon this: “the holy grail for me is that the best way to deal with them is to try to stop the complaint before it happens, so get the processes right... to try to minimise complaints by getting this right first time”.¹⁷⁹
76. The **Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement** said in the last six to twelve months, “we have moved from trying to put everything through a formal process, to an earlier resolution where there’s a concern, even if it means the Head of Nursing or Divisional Director of Nursing trying to resolve

¹⁷⁶ Evidence of Director of Nursing and Allied Health Professionals at SHFT, 9 March 2021

¹⁷⁷ Evidence of Quality & Safety Committee Chair and Non-Executive Director, SHFT, 9 March 2021

¹⁷⁸ Evidence of Lead Governor, 30 March 2021

¹⁷⁹ Ibid

the issue as quick as we can; that is where we want to be: resolving issues when they first happen”.¹⁸⁰

77. In regard to the local CCG’s view on where SHFT are today, the **West Hampshire CCG Senior Quality Manager** said that in October 2020, they invited the SHFT complaints team to give a presentation on their progress of improvement and found they had changed their approach and although things couldn’t progress as quickly as they would have liked, they still had plans in place.¹⁸¹

78. The **Chair of Hampshire Healthwatch, Ann Smith**, who was appointed in 2019 said she hoped that SHFT are on a trajectory to change. She commented that, “the only evidence I have of that is their change of focus on managing complaints, which I found very enlightening, but they are only words, and I’ve not seen action yet...”.¹⁸²

79. However, a **family member**, who complained to SHFT in 2019 and had also been a Governor at SHFT between April 2012 to July 2016, rated SHFT a “1 or 2 out of 10” in terms of its handling of complaints. Nevertheless, he gave his own experience, which was, overall, positive: “I took my complaint... through the system and they didn’t off-load me to the PHSO, all credit to the new Board...”.¹⁸³

80. He described how the main problems his family had were “failings in commissioning”. He said that he approached senior managers who listened and tried to make things happen, but said that they did not happen. Therefore, he went to the Board and the Chair and a Non-Executive Director took up responsibility for reviewing the case. He said “I wanted the Board to monitor performance, which they did diligently and were very supportive”.¹⁸⁴ For reasons that will not be explored further in this Report, the involvement of the Board stopped and the family member was directed to the PHSO if he remained unsatisfied.

81. A **family member and carer**, who has current experience of SHFT’s complaint processes, said staff do not follow or know about the policies in place for complaints or the Duty of Candour. She said, “if you have three people to care for, you don’t have time

¹⁸⁰ Evidence of Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement at SHFT, 29 March 2021

¹⁸¹ Evidence of West Hampshire CCG Senior Quality Manager, 5 March 2021

¹⁸² Evidence of Chair of Hampshire Healthwatch, Ann Smith, 6 April 2021

¹⁸³ Evidence of family member, 14 April 2021

¹⁸⁴ Ibid

to write out a huge complaint, you just want someone to put something right, so you want to raise a concern. It's in the policies, but it's not followed". She believes "people do not want complaints and take them personally, so if you raise anything, you are labelled".¹⁸⁵

82. The same **family member and carer** said, "if your question is answered, you feel a lot happier".¹⁸⁶

83. A **service user** said that she was told she did not need to record her complaint and when she asked would what happen if the issue arose again, she was told by the manager that "she would remember it in her own head".¹⁸⁷

The Complaints Handling process in SHFT

Quality Improvement in the Complaints Handling process

84. The consistent suggestion by SHFT was that the improvements in the complaints handling process have stemmed from the QI process, implemented in December 2018. A three month project took place between December 2018 to March 2019. It included analysis of twelve months of data, staff involvement, observing practice and reviewing a number of complaints.

85. During March 2019, a five day Rapid Process Improvement Workshop was undertaken. It involved complainants, staff from the Complaints & Patient Experience Team, commissioners and other staff across SHFT involved in managing complaints.¹⁸⁸ From the workshop, 140 improvement ideas were generated with four priority areas for improvement agreed: first contact/accessibility, investigation officer role, outcomes and learning, and communication.¹⁸⁹ Key actions were identified, some of which are listed below. The Project Lead was to monitor it and escalate any barriers to the Executive sponsors and report to the Quality Improvement Programme Board:

- *Emphasis on the first point of contact - "No Decision About Me, Without Me" - addressing "Power dynamics" and ensuring an "Adult-to-adult approach*

¹⁸⁵ Evidence of a family member and carer, 9 March 2021

¹⁸⁶ Ibid

¹⁸⁷ Evidence of a service user, 15 April 2021

¹⁸⁸ SHFT Annual Complaints Report 2019/20

¹⁸⁹ Ibid

respecting mutual views, knowledge and experience”. The first contact point should be with the Case Handler and for them to “Journey with the complainant through the process to the outcome, making it a personalised and compassionate approach”.

- *Achieve local resolution where possible.*
- *Agree desired outcomes and timescales with the complainant as soon as possible and record to ensure expectations are met.*
- *Establish a dedicated central management investigation team aligned with the serious incident investigation process, improving the quality and consistency of investigation reports.*
- *Complainant to choose who they would like their response letter to come from.*
- *Full investigation report to be sent to the complainant, with a covering letter and meeting with them to be offered.*
- *Complaint information posters and leaflets to be reviewed and updated to make them more accessible.*¹⁹⁰

86. The Panel did not hear from any service users, carers or family members who had been involved in this QI Workshop, thus could not assess how effective this was as a mechanism for ensuring their voices were heard in the development of the Complaints Concerns and Compliments Policy and Procedure documents. The Panel acknowledges that the direct evidence received from service users, carers and family members in this Review was limited to those who came forward to participate and was a small proportion of the population that SHFT serves.

87. The SHFT Annual Complaints Report 2019/20 states that, *‘since the QI (workshop) has taken place, the Complaints and Patient Experience team have worked on a 62-point action plan, of which 94% of the actions have been completed’*, but it does not say which actions these are or how, if at all, their impact is measured once implemented.

¹⁹⁰ Ibid

The involvement of service users, carers and family members in the Complaints Concerns and Compliments Policy and Procedure in SHFT

88. The **Director of Nursing & AHP** said that the Working in Partnership Committee had helped them to review their Complaints, Concerns and Compliments Policy and that the Group has members from a “range of voluntary sectors... and individuals with carer roles”. Further, she said that Healthwatch and SHFT’s Service User Facilitators, have provided input into the development of their feedback surveys. She said that there are, as of March 2021, 150 Carer Leads across SHFT and Carer Links, who have been carers. She acknowledged they needed to develop this further and said they were in the process of recruiting Peer Support Workers.¹⁹¹

89. The **Head of Patient and Public Involvement and Patient Experience** said they have two Service User Facilitators who, “encourage more involvement and offer support”, for example, if someone is sharing their story, with the Board or another committee. She said, “it is for staff to understand what is needed, so that we are a welcoming organisation. We have guidance on this as it is our bread and butter”.¹⁹²

Local resolution of concerns and complaints

90. The evidence received from SHFT, overall, suggested that their intention is, where possible, to resolve concerns at source; resolving them quickly where they can, and negotiating with complainants, who may be service users, carers or families, and responding to them in a timely manner. However, if the concern cannot be resolved, then it becomes a formal complaint and it will be investigated within the service that the complaint originates from. The ownership of the complaints process lies with the Divisional Director of Nursing and Chief Nurse and there is also a dedicated, centralised Complaints and Patient Experience Team that oversees the complaints process (but does not investigate complaints). This contrasts with the centralised Serious Incident Investigation Team, which does investigate SIs and will be studied later in this Report.

91. The SHFT Annual Complaints Report 2019/20 states the decision not to have a centralised complaints investigation team was taken due to ‘*Financial implications*’,

¹⁹¹ Evidence of Director of Nursing & AHP at SHFT, 9 March 2021

¹⁹² Evidence of Head of Patient and Public Involvement and Patient Experience at SHFT, 10 March 2021

however, the **Director of Nursing and AHP** said, "...the reason why that wasn't taken forward wasn't due to funding, but it was felt the investigating role should be held closer to the divisional team and not a separate investigating team".¹⁹³ The **Deputy Director of Nursing** echoed this: "we have learnt that ownership from divisional teams, particularly clinical leadership teams is important... a more removed complaints team could take ownership from the clinical teams".¹⁹⁴

92. The local approach to managing and resolving complaints is supported by the **Chief Executive** who said, "fundamentally, complaints are part of the experience of a patient and family and it should be part of the discussion... we should be picking it up close to where it happens and if there is a good relationship close to the service point then its best dealt with there...". He said, "... if you separate them rigidly, people don't learn... if staff close to the patient are involved in understanding why the patient or family is upset, concerned, or complaining, then if they're looking at why that is, they are more likely to understand why that attitude is the issue or it's not an issue, or why the communications are problematic or not. The ownership is fundamentally about connecting it, making it part of someone's care and not seeing it as an administrative process, as that is where complaints get really bad, particularly because of the time it takes for them to be resolved".¹⁹⁵

93. The Panel understands that SHFT can receive complaints through two routes: to the Complaints and Patient Experience Team or directly to the service or ward that is the subject of the complaint. The Panel were told in oral evidence that the current timeframe for acknowledging a complaint is 24 to 48 hours and for resolving a complaint it is ten days.

94. However, the SHFT Annual Complaints Report 2019/20, states that, '*During 2019/20 SHFT set its internal target to have all final response letters sent within a 40 working-day timescale for a standard complaint, and 60 working days for a complex complaint*'. This is clearly contrasting to the oral evidence stated above.

¹⁹³ Evidence of Director of Nursing and AHPs of SHFT, 9 March 2021

¹⁹⁴ Evidence of Deputy Director of Nursing of SHFT, 4 March 2021

¹⁹⁵ Evidence of Chief Executive of SHFT, 16 April 2021

95. Regardless of the route it is received, SHFT's evidence is that the following process should take place:

- 1) An automatic email acknowledgment is sent from the Complaints and Patient Experience Team (if the complaint is received by them by email).
- 2) The Complaints and Patient Experience Team Administrator, or the service subject to complaint, or clinician, will log it on Ulysses and the Divisional Leadership Team and the Complaints and Patient Experience Advisor will be notified (by the end of day 1).
- 3) The division will identify a Commissioning Manager to make contact with the complainant, who makes contact within 24 to 48 hours of the referral, to agree a local resolution if it is a concern, or the terms of reference for the complaint investigation.
 - If it is straightforward, it should be remedied straightaway at source and resolved on the ground.
 - The Divisional Directors of Nursing & AHPs, will ensure that contact is made with all complainants by telephone within 24 to 48 hours to discuss their concern.
- 4) An Investigating Officer in the division is appointed by the Commissioning Manager to undertake the investigation and the division notify the Complaints and Patient Experience Team of the agreed way forward via Ulysses (by the end of day 2).
- 5) By the end of day 6, the Investigating Officer should have completed the template report, in line with the terms of reference. The Investigation Report should be submitted to the Commissioning Manager for review and uploaded to Ulysses.
 - Investigating Officers are expected to maintain regular contact with complainants to keep them updated about the progress of their complaint.
- 6) By the end of day 8, the Commissioning Manager should have reviewed and approved the Investigation Report. The Final Response Letter is drafted by the Commissioning Manager, to accompany the Report and both are uploaded to Ulysses.
 - The Commissioning Manager should notify the Complaints and Patient Experience Team that the action has been completed.
- 7) By the end of day 10, the Complaints and Patient Experience Advisor should have proof-read the Response Letter and Investigation Report and will decide if the Chief Executive's approval is needed; otherwise, the Complaints and Patient Experience

Team Administrator will send the response and Report to the complainant. The case will be closed and the Advisor will be notified and they notify the division.

8) It is then for the division to add agreed actions to the case on Ulysses and they should be marked as complete by the division once delivered.

96. The **Director of Nursing & AHP** is responsible for the Complaints and Patient Experience Team, assuring and overseeing the process. She said, “we do have a centralised process, where every Monday our Complaints Team speak to the Divisional Director of Nursing & AHPs in the division... that is followed-up by me and (the Deputy Director of Nursing) and Customer Experience Complaints Manager who speak every Tuesday to the centralised Complaints & Patient Experience Team and brings in the divisional members as and when required”. She said that they will discuss any concerns about the progress of complaints.¹⁹⁶

97. The **Deputy Director of Nursing** set out in her written statement the purpose of the Complaints and Patient Experience Team, which is to:

- Drive towards the implementation of the new ten-day process.
- Assure the quality of the complaints handling process, and to escalate if it is not being handled properly.
- Support and advise the Investigating Officers in handling complaints, which can include bespoke training and “buddy support”.
- When appropriate, raise concerns about the handling of the complaint with the Divisional Director of Nursing & AHPs.
- Where concerns remain, they make the Chief Executive aware.¹⁹⁷

98. The Panel received a sample of the End-User Feedback Surveys, which stated the following in response to the question: ‘How easy was it to make a complaint?’:

‘Not easy, convoluted, initially sent concern to (...), poor response. Then signposted to complaints... the IO and other chap who contacted him were very helpful, understood his feedback, supported and took his views’.

“Not very, did not know where to get any information’. (February 2021)

¹⁹⁶ Evidence of Director of Nursing & AHPs, SHFT, 9 March 2021

¹⁹⁷ Statement of Deputy Director of Nursing, 2 February 2021

'The process was a lot easier than anticipated, open and honest'.

'Not very, did not know where to get any information. CPN then passed on the e-mail address. Throughout care have never been advised where or how to raise any concerns'. (February 2021)

A centralised approach to resolving complaints

99. SHFT has opted not to implement a centralised investigation team for complaints. This is despite the fact that as part of the Rapid Improvement Workshop, "It was agreed that the complaints process would benefit from dedicated Investigating Officer roles, in line with our serious incident process"¹⁹⁸ and the **Deputy Director of Nursing** acknowledged that it was something it was felt would be helpful, but said that, it had been reviewed and was not put in place.¹⁹⁹

100. The Panel heard from the **Clinical Director for the South-West Hampshire Division** where, in her division, they have trialled a different way of dealing with complaints. Their process is to put the complaint through their Director of Nursing and they deal with them in two weeks. She described how the Lead Investigating Officer said complex complaints could be done by the central Investigating Officers if they went through her. As a result of this pilot, she said "(only) one complaint is outside the timeline, (and that is) due to its complexity".²⁰⁰

101. The local resolution approach was not spoken of favourably by service users, carers and family members who provided evidence to the Panel of their experiences.

102. A **family member and carer**, who has current experience of SHFT's complaints handling process, said, "only concerns should be dealt with at the grassroots level. If a complaint is dealt with there, you will never get through the process correctly". She expressed that she had had a better experience making a complaint to SHFT when the process was centralised, although this was some years ago: "they listened to the concern, talked to you, treated you with dignity and respect, checked they had the right

¹⁹⁸ SHFT Annual Complaints Report 2019/20

¹⁹⁹ Evidence of Deputy Director of Nursing, SHFT, 4 March 2021

²⁰⁰ Evidence of Clinical Director for the South-West Hampshire Division, SHFT, 1 April 2021

message and set out what they thought would solve the problem, which you could agree or disagree with, then it was investigated effectively and efficiently”. She said, “you didn’t get the feeling they were going locally, you never got backlash for making the complaint and the care was not reduced... it was just pleasant and helpful”. She described how she bought them flowers. However, she said, “it has all changed and nothing is taken on-board anymore, they used to be so efficient and effective, they were great, that has all been completely lost”.²⁰¹

103. A **carer** who had made a complaint to SHFT in 2011 and in 2020, said, “when I first complained in 2011, the complaint would go to the CEO and you would get a letter from him or the Director of Nursing. Recently it goes to the division you’re complaining about, not the main Board... I asked for copies (of the statement I made) to go to the main Board, but they don’t reply or engage... the main Executive Director Board should be more directly involved in complaints to make sure they’re followed through”. In his view, the person who investigates should keep tabs on whether the recommendations are being carried out, as often the local teams don’t carry them out. He said, “ours was brushed under the carpet”.²⁰²

104. He described how he believes, “a degree of independence is needed: if a complaint is about the division, you don’t really want it investigated by the people in that division, sometimes it can be helpful, if it is a clinical matter, to go down the medical direction, then you’d think you’d be successful, but often it isn’t because it isn’t carried out. So, what you’re looking for, is for the main Board or the central team, to look into it and oversee it...”. He said, “where we are, in adult mental health care, is that the service didn’t get better, it got worse, as investigations were pushed into divisions and away from the main Board, that is, I think, the problem”.²⁰³

Patient Advice and Liaison Service (“PALS”) in SHFT

105. The SHFT Annual Complaints Report 2019/20 says that SHFT will, ‘*significantly improve the timeliness of our responses alongside improving the tone and quality by:*

- *Offering dedicated complaints/local resolution training to staff.*

²⁰¹ Evidence of a family member and carer, 9 March 2021

²⁰² Evidence of a carer (for his son), 6 April 2021

²⁰³ Ibid

- *Developing our approach to local resolution to include building a business case for a dedicated PALS.*
- *Benchmarking with other similar Trusts.*
- *Embedding a culture of early resolution.*
- *Working with divisions regarding ownership and working with complainants’.*

106. Therefore, SHFT should be judged against the improvements that they committed to making. However, the Panel received significantly contrasting and inconsistent evidence regarding a PALS in SHFT, therefore, this evidence is set out in summary below.

107. The Panel were told by the **Head of Patient and Public Involvement and Patient Experience**²⁰⁴ and **Quality & Safety Committee Chair**,²⁰⁵ that there is no centralised PALS team at SHFT (emphasis added), which was attributed to the fact that there are too many sites spread over a wide area. The **Head of Patient and Public Involvement and Patient Experience** said, “I’m working on developing a ‘Patient and Carers Support Service’ and we are co-producing a model... the feedback is to not call it a ‘PALS service’ and not to have it in clinical settings; we have ambitions to have it in community settings, so we can encourage people to come and share experiences and concerns without going down the formal complaint route”.²⁰⁶

108. However, the **Director of Nursing & AHP**,²⁰⁷ **Deputy Chair/Lay member of the Working in Partnership Committee**²⁰⁸ and **Chief Executive of SHFT**²⁰⁹ gave contrasting evidence.

109. The **Chief Executive** said, “the PALS function is provided in different ways in SHFT: in some parts there is a strong service, mainly where there is a significant site...”. He said, “we are looking to strengthen PALS. That is complementary to the Family Liaison Officer (FLO)... there will be a more core team to engage with families around complaints”.²¹⁰

²⁰⁴ Evidence of Head of Patient and Public Involvement and Patient Experience at SHFT, 10 March 2021

²⁰⁵ Evidence of Quality & Safety Committee Chair at SHFT, 9 March 2021

²⁰⁶ Evidence of Head of Patient and Public Involvement and Patient Experience at SHFT, 10 March 2021

²⁰⁷ Evidence of Director of Nursing & AHPs at SHFT, 9 March 2021

²⁰⁸ Evidence of Deputy Chair/Lay member of the Working in Partnership Committee at SHFT, 17 March 2021

²⁰⁹ Evidence of Chief Executive of SHFT, 16 April 2021

²¹⁰ Ibid

110. The **Director of Nursing & AHP** said there is a “dedicated complaints team and a PALS function, which picks up 185 enquiries per year... a couple of individuals would be sat in hospitals... to be visible and we’re looking to develop that side”.²¹¹ She said that due to COVID-19, the PALS support has been withdrawn from hospitals to reduce footfall but it remains available through email and telephone currently.²¹²
111. The **Deputy Chair/Lay member of the Working in Partnership Committee** spoke of PALS being developed and acknowledged that it has to be accessible at local level. He said, it could be accessible by telephone or internet, but it must not be assumed that everyone has internet access.²¹³
112. The **Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement** said they would like a formal PALS and it is being developed.²¹⁴

Investigation Officers (for complaints)

113. SHFT’s evidence is that the options available for who will investigate a complaint are: a trained investigator from within the service; a trained investigator from a different team; or an external investigator from another organisation. Further, that complex complaints, which involve a Serious Incident, will be referred to SHFT’s centralised Serious Incident Investigation Team for investigation, based on the complexity and wishes of the complainant.²¹⁵
114. The Panel were told that the Investigation Officer training is two days.
115. As to the role of the Investigation Officer, if a complaint is raised about an individual, the **Deputy Director of Nursing** said, she would expect them to: “first talk to the complainant to understand what had been raised and the circumstances; following that, I would expect the person about whom it was made would be notified and appropriate support given to them. The Investigation Officer... will meet the complainant to discuss the terms of reference and ask the clinician what happened to understand it from their

²¹¹ Evidence of Director of Nursing & AHP at SHFT, 9 March 2021

²¹² Ibid, provided during the fact-checking exercise

²¹³ Evidence of Deputy Chair/Lay member of the Working in Partnership Committee at SHFT, 17 March 2021

²¹⁴ Evidence of Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement at SHFT, 29 March 2021

²¹⁵ Statement of Deputy Director of Nursing at SHFT, 2 February 2021

point of view... review the clinical notes... the clinician's line manager would be aware and there is a mechanism to record the names of people who have had complaints made against them".²¹⁶

Independence in investigating complaints

116. The Panel were given evidence from a number of participants as to the process that would follow if the complainant wanted someone outside of the service, team or division, to investigate their complaint, or if it covers more than one service or team (emphasis added). SHFT's evidence was that it can go to an Investigation Officer outside of the division or an individual in a corporate role, and the process would be as follows:

- 1) A commissioning manager will make contact with the complainant within 24 to 48 hours to agree terms of reference.
- 2) An Investigation Officer will investigate the complaint and are expected to maintain regular contact with complainants to keep them updated.
- 3) The Commissioning Manager approves the investigation report and drafts the response letter to the complainant.
- 4) The team provides a level of independent scrutiny to ensure that the complaint response addresses all of the issues raised in a transparent and empathetic way.
- 5) If the response to a complaint is sent to the Chief Executive (as it has been deemed necessary to do so), it will be approved by the Chief Executive.
- 6) Complaint responses will normally be copied to all staff involved, and the complaint will be discussed with them, so that they know what has been said about them in the response, and they are engaged in the learning.
- 7) The approved final version of the complaint investigation report will be sent with a covering letter to the person who has raised the complaint.
- 8) A meeting with the Commissioning Manager, or a suitable representative from the relevant service, is also offered as a matter of course.

117. The **Deputy Director of Nursing** said there have been examples of a complainant asking for independence in the appointment of the Investigating Officer, which they have

²¹⁶ Evidence of Deputy Director of Nursing at SHFT, 4 March 2021

considered and someone from a different division or in a corporate role has taken on the investigation.²¹⁷

118. She also said that there have been examples of SHFT going to another external organisation to carry out the investigation at the request of the complainant, or sometimes, of their own initiative, for example, for a medical review. However, she could not give an example of an external investigator reviewing a complaint.²¹⁸

119. The **Chief Executive** acknowledged that, "... where the person close to (a complaint) maybe isn't the best person to deal with it, then a judgment has to be made to take a step-back... and sometimes you have to have someone completely separate to do it". Further, he said that there is "is a place for separate independent investigation of events, depending on the proportionality of it and there is a place for formality and the importance of the PHSO".²¹⁹

120. In the reporting period in 2019/20, eight complaints were referred to the PHSO.²²⁰

Panel's Views on where SHFT are now: complaints handling process, policy and procedure

- The Panel have reviewed the Complaints Concerns and Compliments Policy SH NCP 10 and Complaints Concerns and Compliments Procedure SH NCP 11 and note that the contents are inconsistent with the evidence that was given both orally and in the written statements submitted by SHFT during this Review. For example, the times for SHFT to acknowledge a complaint do not correspond. It is understood that these are due for review again in June 2021 and that a new complaints handling policy is imminent. However, these documents are available to the public on the SHFT website and presumably also accessed by staff who may be conducting investigations into complaints. Therefore, this inconsistency is unhelpful and misleading.
- The Panel acknowledges that SHFT's new Policy and Procedure documents will incorporate the (PHSO) Framework and that they are part of the pilot scheme for this new model, which are positive and encouraging steps forward, however, the results of this are yet to be seen.

²¹⁷ Evidence of Deputy Director of Nursing at SHFT, 4 March 2021

²¹⁸ Ibid

²¹⁹ Evidence of Chief Executive of SHFT, 16 April 2021

²²⁰ SHFT Annual Complaints Report 2019/20

Panel's Views on where SHFT are now: complaints handling process, policy and procedure continued...

- The current SHFT Policy and Procedure documents do not state when a complaint will be investigated externally.
- Furthermore, the Policy and Procedure documents do not provide a definition of a 'complex complaint', which would be sufficient to pass the complaint to a different team or division, or prompt the involvement of the FLO to provide support.
- The target audience for the Policy and Procedure document is stated as: '*staff of Southern Health NHS Foundation Trust, Non-Executive Directors, Volunteers, Governors and Contractors.*' Therefore, they are not intended to be read or used by service users, carers or family members, who are, arguably, their target audience. In fact, the Panel heard evidence that these groups were not expected to read or know the Policy. Thus, it would appear, that there is no document provided for service users, carers or family members, that outlines exactly what they can expect from the complaint process, the 'service standards', or their rights as a complainant.
- Furthermore, the Panel observed that the Policy and Procedure documents and Complaints Leaflet are not straightforward in terms of layout and the language used.
- The Panel is not satisfied that the information provided on SHFT's website for how to raise a complaint or concern is sufficiently informative and clear for service users, carers and family members. Furthermore, it is not clear how those groups can access the Policy and Procedure if they do not have digital access. Information on complaints must be widely available to everyone and not just in a digital format. The website guidance for complaints does not refer to, or signpost people to, the complaints Policy or Procedure documents. At the time of writing, June 2021, the link to the 'Complaints Leaflet' does not work.
- The Panel is not satisfied that the process set out in the Policy and Procedure documents is always followed. This was demonstrated by evidence from some of the participants in this Review and the documented feedback in the End-User Feedback Surveys. In particular, the evidence of complainants having to make repeated complaints to get something to happen and complaints being re-opened, shows that the system is not working for the complainant and SHFT are not getting it right first time.

Panel's Views on where SHFT are now: complaints handling process, policy and procedure continued...

Local resolution of complaints

- SHFT have implemented a process for managing complaints at a local divisional level and have opted not to adopt the proposal that arose from the QI project, for a centralised complaint investigation team (which would mirror that in place for Serious Incidents). This is understood to be an attempt to streamline the process, with the monitoring of complaints taking place at a higher centralised level.
- However, the Panel heard various references to a 'complaints team', a 'customer experience team', a 'centralised complaints team', a 'centralised process', and the development of a 'Patient Advice and Liaison Service (PALS)'. The Panel members were very confused by the interchangeable and, at times, contrasting use of such terms. It would flow from this that it would also be confusing for members of the public who were trying to understand the process. Indeed, this is reflected in some of the evidence they heard and read from service users, family members and carers.
- SHFT have moved away from a procedure where the Chief Executive, or his office, sign-off the responses to complaints and has sight of them. Whilst the Panel recognises some of the benefits of a local resolution to concerns or complaints made at divisional level; it could also be argued that this leads to a 'cleansing', where the Chief Executive only has sight of the most complex complaints or where there are breaches of response deadlines. This could lead to the Board or senior management having a limited understanding of the reality of what is happening on the ground in the divisions, or there being a divergence between what they are told and what is in fact happening.
- Furthermore, the move towards divisions managing their own complaints results in the quality and approach taken being dependent upon the management style in that division, or service, from which the complaint has originated. The Panel is not persuaded by the evidence that there are sufficient assurance processes in place which are systematically applied to ensure there is quality and parity across the organisation when it comes to the managing of complaints. A lack of a co-ordinated response ultimately means that there is inconsistency between the divisions as to the quality of the process and response.

'Concerns' and 'Complaints'

121. In the evidence received from all of the participants at Stage 2, there were various and, at times, interchangeable, references to 'concerns' on the one hand, and 'complaints' on the other. There was also evidence received from SHFT, some of which was inconsistent, as to how these two scenarios should be addressed and resolved.
122. By way of an overview, in the period of 2019 to 2020, SHFT received 232 'complaints' and 1113 'concerns'. SHFT's evidence is that *'the Complaints and Patient Experience Team have spent time educating staff on what should be recorded as a concern, which has led to an increase in those being reported'*.²²¹
123. The **Chief Executive** was keen to point out that the division of 'complaints' and 'concerns', is not at all helpful and said that in his view concerns and complaints are not separate or different, but are part of a continuum; thus, most complaints arise from not dealing with concerns at source. He said, "concerns can be complaints and it is important that you take the themes and learning from them and don't disregard them, it is not a way of avoiding complaints; but the way we resolve issues is by engaging directly with families and complainants at the outset and then more often than not, they're satisfied and get the information, understanding or changes they want". In his words: "a concern is a complaint in making".²²²
124. The **Chief Executive** gave a recent example of a family's 'concern' about an elderly person's end of life care being dealt with quickly, not as a formal complaint, which would have taken longer to resolve. He said, "the first response was for a clinician to talk with the family and understand from their perspective what needed to be done and they engaged with a consultant straightaway and were happy with what was provided".²²³
125. In terms of the process for 'concerns', the Panel were told that a 'concern' that is received through the Complaints & Patient Experience Team and fits the criteria for a 'concern' could be linked to the division to be dealt with. If the 'concern' is reported directly to the clinical team, or if it is received directly to the clinical team, it will be logged on Ulysses with the actions taken and the dashboard shows the open 'concerns' and

²²¹ SHFT Annual Complaints Report 2019/20

²²² Evidence of Chief Executive at SHFT, 16 April 2021

²²³ Ibid

incomplete actions.²²⁴ They are shared in local governance meetings and the Complaints & Patient Experience Team analyse them for emerging themes.

126. A **Community Mental Health Team Manager** at SHFT was able to share her experience and opined that ‘concerns’ and ‘complaints’ are two categories and said they are looked at in the same way, but the complaint has an official complaint response, which is fully investigated, whereas they try to resolve a concern at local level first before going through complaint process.²²⁵

127. She said that, in her experience, they respond within three days to a concern and ten days to a complaint. She said, generally, a complaint would go to another team to investigate, as we would have already looked into it at the concern level.²²⁶

128. The Panel received a sample of the End-User Feedback Surveys for the period 2019 to 2021, and one stated, *‘there were plenty of opportunities for my concerns to have been addressed in the month leading up to my letter of complaint...I felt I had no option but to write a formal letter of complaint’*.

Panel’s Views on where SHFT are now: ‘complaints’ and ‘concerns’

- The Panel is not persuaded, on the evidence received, that SHFT are sufficiently clear and consistent in the language and messaging they use to define a ‘complaint’ or a ‘concern’ and the different processes that will be followed depending on which one it is. For example, the Complaints Leaflet and current Policy and Procedure documents do not clarify the difference or describe the process.
- The Panel’s view is that the intermittent and inconsistent use of the two terms is not helpful and it is not clear to the Panel when or why SHFT converts a ‘concern’ into a ‘complaint’, and whether it is investigated by the same team or service if it becomes a complaint. Therefore, it is not satisfied that there is enough information available to service users, families and carers to enable them to understand the difference between the two.
- The Panel is alarmed by the fact that the evidence does not point to SHFT seeing ‘concerns’ as warnings. The lack of learning that is taken from the ‘concerns’ is explored further below.

²²⁴ Evidence of Deputy Director of Nursing at SHFT, 4 March 2021

²²⁵ Evidence of Community Mental Health Team Manager at SHFT, 31 March 2021

²²⁶ Ibid

Responding to Complaints

129. The Panel reviewed a sample of complaint responses covering the period of 2019 to 2021. They were also provided with responses to complaints by some of the service users, carers and family members who came forward at Stage 2.

130. The responsibility for writing a response to a complaint lies with the Investigating Officer at the team level in the divisions.

The contents of complaint responses and investigation reports

131. The **Deputy Director of Nursing** said in her written statement to the Panel that, SHFT has done work to ensure that any report produced is not written in ways which offend, for example, by using standardised conclusions such as “not upheld”, or “sincere apologies”, which implies we offer insincere apologies. She said, “our teams have been liberated by removing the template version of the letter and we have asked them to have personal conversations with service users, families and carers; and they have to create a personal letter to them”.²²⁷ Some of this evidence was contradicted by oral and documentary evidence the Panel received during the Review.

132. The **Director of Nursing & AHPs** acknowledged that the evidence shows that use of the terms: ‘upheld’ and ‘not upheld’ is unhelpful.²²⁸

133. A **Clinical Ward Manager** said that she has had more input and interaction with people raising concerns and been more involved in writing the responses. She said, “I took it to the Patient Experience Team and they asked me to write the letter and at first I was surprised, but I’m used to that now”.²²⁹

134. A **service user** spoke of having to make multiple complaints between 2017 to 2019, following the receipt of a second complaint investigation report and in a letter, he wrote to SHFT, in response to the report, he had to, point out that his complaint had not been dealt with appropriately, in accordance with the relevant SHFT policies and it was extremely unacceptable for him to be treated this way. He described the complaint

²²⁷ Statement of Deputy Director of Nursing at SHFT, 2 February 2021

²²⁸ Evidence of Director of Nursing & AHPs at SHFT, 9 March 2021

²²⁹ Evidence of Clinical Ward Manager, SHFT, 12 April 2021

response as “sub-optima” and said that he did not receive a response to his letter, so he had, “effectively, been silenced”.²³⁰

135. Another **service user** spoke about the automated email response she received when she sent her complaint to SHFT and said, “I feel that the email system... is not fit for purpose”. She has had to make several complaints.²³¹

136. Furthermore, in the End-User Feedback Survey responses sample the Panel were provided with, a comment recorded was: *‘the lack of follow up following the automatic email acknowledging my complaint was a serious error that needs addressing’ (December 2019).*

137. A **service user** had made many complaints to SHFT on the subject of an appalling administrative error which wrongly recorded him as a sex offender, as opposed to a sexual abuse victim. This mistake was not corrected or noticed for a period of two years and he said it caused him to suffer from suicidal thoughts, nightmares, serious relationship problems and violent outbursts.²³²

138. The apology letter that was sent by SHFT to this **service user**, by email, followed a telephone call, he said he was not invited to a meeting. He said that if SHFT had said they would meet him then it would have saved a lot of time. It is evident from the letter that there was a delay in sending it to him as the author apologises for that too. The letter dated 3 January 2020, said: *‘We are sorry that some of the information provided in your tribunal report was incorrect and the distress this has caused you... following the incident we have learnt that when a notes review occurs by a junior member of staff, the supervising senior member of staff will cross reference all risk statements to ensure the information is correct and not paraphrased’.*²³³

139. He graciously accepted this was a “clerical error” but said, “it could have been put right by the approach being very different in the complaints department, but they were very hard to get hold of, they didn’t want to commit themselves, nobody asked me how I felt about it, and I never received, or was offered, counselling”. He said, “mentally, I was in tears, I needed help and someone to speak to, but I got an automated email reply and

²³⁰ Evidence of a service user, 4 March 2021

²³¹ Evidence of a service user, 15 April 2021

²³² Evidence of a service user, 15 April 2021

²³³ Ibid

if I rang, the staff weren't rude but were non-committal... what I wanted was help at the time, a review, and actual people coming up with something positive".²³⁴

140. He ended his evidence by saying, "I feel the complaint system lets the patients down, but there is some good news, because of the way I was treated they moved my mental health treatment to another part of SHFT... and I was awarded a new CPN, who is marvellous". He said, "not everything is bad in SHFT, but not everything is good".²³⁵

141. The Panel reviewed the samples of recent complaint responses SHFT provided, including one that was made in January 2020, which was, in the Panel's view, a clear example of SHFT not getting it right first, or indeed, the second time. Therefore, multiple complaints had to be made and there was significant delay, of over one year, to reach a resolution.

142. The complaint was about the *'Lack of consistent, clear, collaborative and comprehensive communication, care and support (she) had received across the different SHFT (...) Mental Health teams and professionals (she) had contact with over the last twelve months'*. A complaint investigation report was completed which set out the chronology of events as provided by the complainant, which showed that four members of staff were interviewed and states there was a *'Review of clinical notes'*, but no further details as to that review are stated.

143. A meeting was held with the complainant approximately two months after she lodged the complaint. A root cause analysis was carried out which resulted in findings, actions and recommendations. One of the findings was that no contact had been made with the complainant and therefore an assumption was made that they were fit for discharge, without a review. The recommendation was that there should be, *'Involvement in any discharge planning and that crisis and safety plans are in place'*. The action was that, *'The complaint would be shared with the team as learning to ensure all staff are clear that any discharge plan must be discussed with the service user so that a collaborative plan is agreed'*.

144. There was also a finding that the complainant had been offered a meeting, but that she could not commit to attending because she said she was, *'Unwell and not in a good*

²³⁴ Ibid

²³⁵ Ibid

place'. The complaint investigation report records that this led to an outcome of: *'One word against another'* (this is repeated as an outcome more than once).

145. There was also a finding that for eight months, the complainant received no contact from the Community Mental Health Team and the investigator recommends that this *'Needs to be investigated and appropriate action taken'*, but there is no follow-up or further information about what happened next (in the second response, the following year, it says that, *'A dedicated medical secretary lead has been put in place to ensure direct communication occurs between the consultant and a medical secretary with timely action of tasks'*).

146. The outcome of the complaint was sent to the complainant at the end of April 2020. The complaint was re-opened in February 2021 at the complainant's request and a meeting took place. Following the meeting, a personalised letter was sent to the complainant from the Head of Nursing & Quality, which changed the decision so that six of the complaints that had initially been 'partially upheld' or 'not upheld' were then 'upheld'. The Head of Nursing & Quality acknowledged that the phrase *'one word against another'* should not have been used and that the GP and the complainant herself should have been consulted.

147. Furthermore, responses provided by complainants to the End-User Feedback survey samples the Panel received stated:

'I believe the lack of compassion, added to my feelings of anxiety and at times desperation'.

'The response made him distressed/irritated... lacked empathy'.

'He did not like the phrase 'felt that ...' (we should never say this) and he also says that you can demonstrate understanding and compassion in your verbal dialogue using reassuring words – helps – the reference re body language unnecessary. Lacked empathy.' (January 2021)

Assurance and review processes in place for responses to complaints

148. The Panel received evidence about the assurance and review processes in place for responses to complaints. The **Director of Nursing & AHP** said that the responses are monitored for quality by the divisional team and they are all reviewed by the Divisional Director of Nursing, who will often give feedback to people. Additionally, the Director of Nursing and AHP reviews every complaint letter after it is sent and provides feedback to the author in a regular audit process. She said that the CEO also receives copies of the complaint letters that have been sent-out and information every Friday, from the previous ten days and wants to see the letter that came in, reports, meetings and the timeline.²³⁶
149. The **Director of Nursing & AHP** said that, “the quality of the letters we send is improving, but there are still occasions when we do not fully answer questions, or get the appropriate tone”. She also said that a complainant who does not accept the results of an investigation, can add statements to a report in their own words.²³⁷
150. The **Head of Patient and Public Involvement and Patient Experience** said they are constantly reviewing complaints and understand that sometimes letters have been a cause for concern. She said, it is another place where they encourage patients, carers and families to work with them. People in the Patient and Public Engagement and Experience Team review letters and communications and they produced guidance for staff on writing letters, who test it out with people who receive them.²³⁸

Re-opening complaints following a response

151. The **Director of Nursing & AHP** was keen to emphasise that, “if people come back to us, we’re incredibly flexible about going back to review issues... we recognise people need to heal themselves to be ready to deal with the process”.²³⁹
152. She acknowledged that, “in some cases we are not getting it right first time... we know that from re-opened complaints, of which there were 42 in 2019/20 and a number of those were because we hadn’t answered the question required”.²⁴⁰

²³⁶ Evidence of Director of Nursing & AHPs at SHFT, 9 March 2021

²³⁷ Ibid

²³⁸ Evidence of Head of Patient and Public Involvement and Patient Experience at SHFT, 10 March 2021

²³⁹ Evidence of Director of Nursing & AHPs, SHFT, 9 March 2021

²⁴⁰ Ibid

153. A **service user** said that when he challenged the Investigating Officer's report between 2017 to 2019, he was "silenced and met with silence", he "felt they didn't like being challenged" and that he was being punished for it. Further, he said there was "no closure, no resolution" to the queries and questions he raised with SHFT in 2017. He described how it was "very very hard work and damaging" to him and that he thought this was still an area for improvement.²⁴¹

154. A complaint that formed part of the End-User Feedback Survey response samples provided to the Panel showed that a complaint had been re-opened and as a result, it had been open for a period of 81 days in total (at the time of the feedback survey being completed).

Panel's Views on where SHFT are now: responding to complaints

- The Panel received evidence of recent responses to complaints, which demonstrated a lack of sensitivity and empathy.
- Some of the SHFT staff who provided evidence to the Panel acknowledged that the monitoring of the quality of response letters sent out remains an issue. Although SHFT's intention is to move from template responses to 'personal responses', with resolution at divisional level the standard and quality of those letters will vary and may still be inadequate.
- The Panel is not satisfied that there is an effective process for monitoring or quality assuring the responses to complaints that are sent. For example, the evidence did now show that responses to complaints and judgments reached are sampled or moderated to ensure the judgment is fair, evidence-based and, if necessary, modified, before they are sent to the complainant.
- SHFT's Complaint Concerns and Compliments Procedure refers to a 'good complaint response', but does not outline any criteria for determining what constitutes 'good' and/or a thorough and robust investigation.
- The experience quoted of the complainant in January 2020 and February 2021 posed the question to the Panel of whether this is an exceptional case, or whether repeat complaints are commonplace in order to arrive at a fair judgment or outcome. Given that 42 complaints were re-opened in 2019/20 and a number of those were because SHFT had not answered the question required, the implication is that it is arising more than exceptionally.

²⁴¹ Evidence of a service user, 4 March 2021

Panel's Views on where SHFT are now: responding to complaints continued...

- Furthermore, it is evident that the complainant who complained in January 2020 and February 2021 could articulate her objections to the outcome of her first complaint and understood the investigation report. However, there may be other complainants who lack the skills or ability to do so and SHFT's judgment would go unchallenged. Certainly, the Panel saw and heard from service users who suggested this had happened to them and they had effectively given-up.
- The Panel do welcome SHFT's aim of acknowledging complaints within 24 to 48 hours of receipt, but noted that a reoccurring theme amongst those that experienced the complaints process was their distress and frustration at receiving an 'automated email reply'. This arose multiple times in the End-User Feedback Surveys and oral evidence. The Panel encourages SHFT to consider better ways of acknowledging complaints in a sensitive and considered manner, ensuring the complainant at the heart of that solution.
- The Panel was told that investigation reports are shared with the complainant. However, the reports read as management level reports and it was widely accepted that they are complex and often lengthy, the outcomes are difficult to find within the reports and it is not clear what value an entire investigation report provides to the complainant. This view was reinforced by the evidence the Panel received.
- The Panel's view is that the practice and language of 'upholding, partially upholding or not upholding' complaints, outlined in the Complaints Concerns and Compliments Procedure, paragraph 4.2.11, is not sufficiently transparent. Further, it suggests that an *overall* judgment is made about whether or not a complaint is upheld or not, whereas, the investigation reports show that *elements* of complaints can be upheld, not upheld or partially upheld.
- The use of this type of language – 'upheld/not upheld/partially upheld' - has persisted in investigation reports, despite the suggestion from the QI workshop and evidence received from SHFT and the CCG, that it should not be used and the Panel endorses that conclusion. This type of language is not user-friendly and does not demonstrate empathy or sensitivity. Therefore, training must be provided on this and a quality assurance process implemented, to ensure there is consistency in the terms used.

Involvement of the complainant in the resolution of complaints

Engagement

155. The **Chief Executive** spoke about the engagement of the complainant in the resolution of complaints and said there has been a substantial shift from administering a process, to personalising the response and working in partnership with the complainant and that there is significant engagement directly with complainants.²⁴²

156. The **Director of Nursing & AHP** said, “I am 100% confident and I am engaged on a daily basis, that every service user and carer does get that first engagement opportunity to speak to us... then they continue to be involved... they’re not going to be sent the report unless they have been part of developing it”. She said they will accept if the complainant decides not to be involved.²⁴³

157. The Panel were provided with a sample of the End-User Feedback Surveys and records of telephone calls made to complainants to obtain feedback following their complaint between 2019 to 2021. These are just a couple of the responses reviewed:

‘IO said he would contact the service user to go through the findings of the investigation – this did not happen’ (February 2021).

‘Report was made, no response from me was asked for’.

‘Not taking into account my written evidence... the response didn’t address my concerns’.

158. However, in the feedback from an advocate, he said,

‘Very accommodating to the service user’s needs, offered a meeting, response in writing... pleasant experience and the complaint was well investigated... SHFT were open and took on board what had been said, accepted gaps and put measures in place for learning’.

²⁴² Evidence of Chief Executive at SHFT, 16 April 2021

²⁴³ Evidence of Director of Nursing & AHPs at SHFT, 9 March 2021

Complainants input in the terms of reference

159. SHFT's evidence is that the complainant is consulted on the terms of reference for the resolution of the complaint from the start and the **Director of Nursing & AHP** said that the terms of reference will not necessarily be formally written up, but may be verbally agreed with the individual at the time, but, if it is a more complex complaint, then she would expect there to be a more formalised write-up of the terms of reference.²⁴⁴

160. However, the Panel had identified that this was not evidenced by the sample investigation reports they had been provided with. She agreed that there were gaps in some of the samples provided to the Panel and said they would hope not to see this.²⁴⁵

Meeting complainants as part of the response to a complaint

161. The Panel did not hear or receive evidence from SHFT, that the complainant, or staff member, if appropriate, will be offered a meeting during the ten day complaints handling process as a matter of course.

162. A **service user** said she had received letters from SHFT and had phone calls in response to her complaint over the years, with no offer of a meeting. However, the day before she gave evidence to the Panel, she had been visited by an Investigation Officer for a face-to-face meeting.²⁴⁶

163. The **Lead Governor at SHFT** said, "from my experience... it is best to get the service right in the first place, then try to sort it locally, face-to-face with the complainant, rather than something that is too legalistic...".²⁴⁷

164. Further, the **Director of Quality at West Hampshire CCG** said that in her experience, "the best way to resolve (complaints) is face-to-face".²⁴⁸

²⁴⁴ Ibid

²⁴⁵ Ibid

²⁴⁶ Evidence of a service user, 15 April 2021

²⁴⁷ Evidence of Lead Governor at SHFT, 30 March 2021

²⁴⁸ Evidence of Interim Director of Quality at West Hampshire CCG, 14 April 2021

165. In the minutes of the Learning from Events meeting held on 13 February 2020, a monthly update on the 'Themes and learning from complaints' was provided and it was said: *'complainants are distressed and the team are unsure where to direct them'*.

Panel's Views on where SHFT are: the involvement of the complainant in the resolution of complaints

- The evidence is inconsistent in demonstrating that SHFT always discusses with complainants how they wish their complaint to be handled and agrees a timeframe with them. This was raised with SHFT participants and the Panel could not see any evidence, in the sample complaint reports provided, that the terms of reference or timeframes were agreed with complainants at the start of the investigation. The Panel's view is that this must happen every time and should be recorded in the investigation reports in a clear format.
- However, the Panel is reassured that the service user, carer and family voice has been heard through the QI projects; the regular invitation to present at the Board meeting; and the move towards obtaining feedback by telephone. However, it was very clear that SHFT has a way to go to achieve consistent and meaningful engagement.
- The Panel is not satisfied on the evidence received that a complainant is always offered a meeting with the Investigating Officer and/or the service or ward concerned. They consider that they should be given this opportunity every time and it should be recorded in the investigation report (even if they decline the offer).

Delays and timeliness in responding to complaints

166. The issue of responding to complaints in a timely manner permeated the Stage 1 Review and overall, SHFT's evidence at Stage 2 is that the response rate and timeliness in responding to complaints has improved.

167. A **Matron** said, "a few things have changed (in the last two years) ... processes are slicker, for example, complaint investigations are expected to happen on time... there is pressure on investigating staff to process reports on time".²⁴⁹

168. A **Community Mental Health Team Manager** said, "the speed we respond to complaints has improved dramatically; we have to contact the complainant within 24

²⁴⁹ Evidence of Matron, SHFT, 29 March 2021

hours. That is part of the cultural shift. This was bought in fairly recently and is a huge change and it is positive for people, as knowing it has been received within the day, is a huge relief for everyone”.²⁵⁰

169. Furthermore, a **Clinical Ward Manager** who has some experience in dealing with complaints at a local level in her services said, “we are trying to improve how timely we are and I have seen more emails saying ‘we need a response’ and it is spoken about promptly. She described how they try to find a resolution with the complainant and she has more ownership over it. She gave the example of some patients and carers on her ward who raised a concern and said she had been able to liaise with them directly to find out what that concern was, how they wanted it dealt with and their expectations. Then she was able to write her response, log it and SHFT will then close it, follow it up or escalate it.”²⁵¹

170. It is accepted by the Panel that the SHFT Annual Complaints Report 2019/20 records that 100% of formal complaints met the standard of acknowledgement within three working days, an increase of 1.52% from 2018/19.

171. However, the Report goes on to state that of the ‘135 closed cases (between 1/4/2019 - 31/3/2020), 53% of complaints were responded to within the agreed timeframe with the complainant. This shows a 7% improvement when compared to 2018/19... however, it is recognised we are not performing to the level expected... of achieving 90%... this continues to remain on the risk register for SHFT’. SHFT’s plans to address this are, in summary, more training and the promotion of local resolution.²⁵²

172. Furthermore, the **Chief Executive** said in his written statement, “(the) SHFT Board has been unhappy at the pace of change. The causes of the problem are clearly identified, but SHFT has accepted poor response times for too long”.²⁵³ He developed this in oral evidence: “the timeliness of managing complaints, where response times were picked-up as not good enough, was reported to the Quality Board Sub-Committee and clearly identified in the annual report”.²⁵⁴

²⁵⁰ Evidence of Community Mental Health Team Manager at SHFT, 31 March 2021

²⁵¹ Evidence of Clinical Ward Manager, SHFT, 12 April 2021

²⁵² SHFT Annual Complaints Report 2019/20

²⁵³ Statement of Chief Executive, SHFT, 2 February 2021

²⁵⁴ Evidence of Chief Executive, SHFT, 16 April 2021

173. The **Chief Executive** said that in the last six-months there has been a substantial shift in the timeliness of managing complaints and the fundamental issue has been about the ownership of ‘formal/written complaints’ which have been handled differently now SHFT has moved to most concerns being dealt with through early resolution and direct engagement with the complainant.²⁵⁵
174. The Panel were told that the current timeframe for responding to complaints in full is ten days. In his statement, he said, “nearly all complaints are now resolved within twenty working days and most within ten”.²⁵⁶ In oral evidence he said, “virtually all complaints are now dealt within ten working days”. Further, he said, “generally speaking, most issues and complaints don’t require more than ten working days to be sorted... and if we separate it and put it into a complaints process, it becomes overly administrative and bureaucratic”. He said that their current performance will be sustained.²⁵⁷
175. In the **Chief Executive’s** opinion, “it is not appropriate to have extended timescales (for responding to complaints)”. He said, “in our normal lives, none of us would accept that it would be reasonable for it to take twenty working days to respond to something or provide some simple information”.²⁵⁸
176. The **Deputy Director of Nursing** said that all complaints coming up to or breaching the ten-day process, are escalated to the Chief Executive and there is oversight by the Director of Nursing too. She said there is a response process in place to monitor and review those cases are on track and respond to any difficulties and that is conducted by using the performance dashboard, which shows complaints coming through, and holding meetings twice a week.²⁵⁹
177. The Panel asked the **Director of Nursing & AHP** whether their desire to improve timeliness meant that they were compromising on quality and in response. She said, “it is possible to have speed and quality, we owe it to people, it’s important... if we can have 48-hour SIRI Panels, we need the same process for serious complaints... the longer they take, the more people lose confidence and if we’re taking weeks to sort it. We have not put an action in place to prevent someone else going through a similar issue”.²⁶⁰

²⁵⁵ Ibid

²⁵⁶ Statement of Chief Executive at SHFT, 2 February 2021

²⁵⁷ Evidence of Chief Executive at SHFT, 16 April 2021

²⁵⁸ Ibid

²⁵⁹ Evidence of Deputy Director of Nursing at SHFT, 4 March 2021

²⁶⁰ Evidence of the Director of Nursing & AHPs at SHFT, 9 March 2021

178. As to the significant factor causing the delay, it has been widely attributed to a shortage or delay in allocating an Investigating Officer.²⁶¹

179. The Panel were provided with a sample of the End-User Feedback Surveys and records of telephone calls made to complainants to obtain feedback between 2019 to 2021, one of which stated:

'If my complaint had been dealt with in a timely manner and I had not had to chase the complaint up repeatedly and ultimately engage the help of the CCG, then things might have been different. Ultimately this was a discreet complaint about a single incident and required a response that did not need escalating in that manner that it did. However, the lack of follow-up following the automatic email acknowledging my complaint was a serious error that needs addressing'.

180. Furthermore, one of the complaints in the End-User Feedback Survey response samples showed that a complaint had been re-opened and as a result, it had been open for a period of 81 days in total (at the time of the feedback survey being completed).

Panel's Views on where SHFT are now: delays and timeliness in responding to complaints

- The Panel accepts the Chief Executive's evidence that the timeliness of responding to complaints has been a problem for SHFT in the past, but it has been acknowledged and acted upon. However, he confirmed that the changes had only been implemented in the past six months, therefore it is too early to say if they will have a sustained positive impact.
- The Panel acknowledges that SHFT have moved to providing a full response to the complaint within ten days. However, the Panel queries whether that short timeframe allows for proper engagement with the complainant and a high quality investigation and response, which ultimately leads to resolution, learning and improvement. The Panel's view is that through communication and continuous active engagement with the complainant, the timescale for responding should be negotiated and agreed with them and it should allow for flexibility.

²⁶¹ SHFT Annual Complaints Reports in 2018/19 and 2019/20; Divisional Quality and Safety Meeting North and Mid Hampshire minutes of 17 September 2019; Divisional Quality and Safety Meeting South & West Division minutes 19 August 2020

Panel's Views on where SHFT are now: delays and timeliness in responding to complaints continued...

- If there is going to be a delay in responding to the complaint, the complainant must be informed, with the reasons for the delay given promptly. The Panel is not satisfied that this is always happening.
- The Panel emphasises that the aspiration for a prompt response and achieving targets must not lead to the quality of the investigation and response being compromised. The Panel is not satisfied that this balance is always successfully achieved in SHFT.

Actions taken following complaints

181. The Panel were told by the **Director of Nursing & AHP** that action plans are developed from the findings of the complaint investigation and are embedded in their learning, which is then shared with the complainants and they are given the opportunity to be kept informed of the progress in relation to each action point.²⁶²

182. The **Deputy Director of Nursing** said in her written statement that responsibility for the delivery of identified actions in response to complaints is overseen locally and reported into the Ulysses system once complete.²⁶³

183. However, the Panel heard some evidence about how this has been experienced in practice. A **carer** said, "my own experience is, when you put in a complaint, it's investigated and a report is done; but it's not followed-up...". So, "your hopes are raised and then your hopes become dashed".²⁶⁴

184. Furthermore, **the carer** said that, "when my son was discharged, he didn't have a psychiatrist attached to him and we objected to the discharge and told the complaints department we were very unhappy about it, so why didn't they put it on hold until those concerns were addressed? But they didn't, he was discharged without a psychiatrist or psychologist report, SHFT said it should have happened but it didn't. They recommended, after a recent complaint, that he be referred back to secondary health in a new division, but they turned him down, so there are no teeth to the investigation

²⁶² Ibid

²⁶³ Statement of Deputy Director of Nursing at SHFT, 2 February 2021

²⁶⁴ Evidence of a carer, 6 April 2021

results". Further, he said, "the Nursing Director of that division said she hoped we'd have a positive experience, but the difficulty is that the Nursing Director who made the recommendations is no longer with SHFT - she was there for ten months - so we've lost our contact".²⁶⁵

185. The same **carer** described how, "in the early days, it was straight to a psychiatrist and medical director... as time has gone on, it has been left to the divisions to investigate their own complaints and I suppose they were trying to get more actions, but we have still not had the assessment sent out again (since February 2021). The effectiveness of the complaints process just isn't there. We still have the same problems".²⁶⁶

186. The Panel also heard the views of a **family member and previous Governor at SHFT** who said that, "(the NHS) have ten-times more meetings than I have seen elsewhere... in any other business you would have a meeting, agree ten things to do and the manager would ensure they were carried out before the next meeting". He said, "it is not just about processing a complaint, we are after a result: the result should be to identify the problem and implement it and if it is serious, it should be fixed immediately, within days/weeks and one month at the most, with training if needed across SHFT".²⁶⁷

187. The Panel were provided with a sample of the End-User Feedback Surveys and records of telephone calls made to complainants to obtain feedback following their complaint, between 2019 and 2021, some of which are set out below:

'I believe that my recovery to date has to a large extent been due to the strong support network of family and friends I have in my life, but I am left with significant concerns regarding other patients who may not be in as fortunate position as me'.

'The carer said calls to the ward could be hostile after the investigation'.

'How confident are you SHFT has learnt?: zero - not at all. Service users experience with Mental Health has been poor from the start and she does not want to remain under the care. Carer is now providing the care'.

²⁶⁵ Ibid

²⁶⁶ Ibid

²⁶⁷ Evidence of a family member and ex-Governor at SHFT, 14 April 2021

'I feel this is a missed opportunity for SHFT and don't feel any lesson has been learnt or admission of failings acknowledged'.

Panel's Views on where SHFT are now: taking action taken following complaints

- The Panel is not satisfied that there is sufficient evidence of improvement in the implementation of actions plans in order to ensure that there are positive changes in response to complaints. This should be happening at all levels of the organisation, with evidence of local, front line, divisional and strategic changes.
- The feedback received from complainants demonstrates a lack of confidence in SHFT. This is a cause for concern for the Panel. It suggests SHFT still has some way to go in its journey of re-building trust and confidence. SHFT should be actively seeking to improve this.

Culture

188. The Panel heard extensive evidence from all participants about the extent to which there has been a 'culture shift' at SHFT and this permeates all of the topics the Panel was tasked with investigating at Stage 2. It is therefore considered in most topic areas and as a separate, additional theme towards the end of this section of the Report.

189. The culture at SHFT in dealing with complaints was considered at Stage 1 and some of the observations made then, were reflected by the evidence heard at Stage 2, both positively and negatively, as to whether clinicians are still reluctant to address sensitive or difficult issues which may arise in, or from, complaints. The written statement of the **Deputy Director of Nursing** acknowledged that such a reluctance does still exist. She said that during a pilot project in September 2020, they learned that some clinicians lacked confidence to have challenging conversations which sometimes put them off, thus, creating delays and frustration for the complainant and that some people perceived that this was not their job.²⁶⁸

190. During oral evidence, she accepted that staff have found it difficult at times to respond to complaints in a personal way. She said staff are supported, so they feel part of a learning culture, not blame, so they're better equipped to respond in a positive way. She described how this has improved in line with the environment people are working in,

²⁶⁸ Statement of Deputy Director of Nursing at SHFT, 2 February 2021

which is supportive and focussed on a just and learning culture. She also recognised that, “(the person responding) is a person and human too and those factors can sometimes influence the way someone responds to a complaint, which may not be what we want”. She said this is probably more on an individual basis.²⁶⁹

191. In order to reduce this culture of defensiveness, the **Director of Nursing & AHP** said that she has set up a weekly call with the Heads of Nursing and Matrons in SHFT, as an opportunity for discussion. She said they talk about difficult conversations, challenges and needing to feel safe in their environment and that they are trying to embed a safety culture. She acknowledged that they are not there yet as staff have felt blamed and damaged and it takes a long time to build an environment where they stop feeling defensive.²⁷⁰

192. The **Chief Executive** spoke of a “cultural barometer, which provides some benchmarks and are produced with relative frequency; it provides interesting insights, it’s not an absolute measure in itself, but it gives us the questions we need to ask of ourselves”.²⁷¹

193. However, the evidence received from carers who have experienced the culture of SHFT in the complaints handling process was much less positive.

194. A **carer** said, “often the team will recommend you complain, which seems odd, but they suggest it because they’re frustrated with the system and the people on the ground are not supported and often go out on a limb”. He said “I don’t see a cultural change, I see, if anything, more problems as time goes on in the way some complaints are handled and dealt with more by Nursing Directors”. He said, “I get a sense of frustration that the whole Trust doesn’t work efficiently in their staff’s interests and in the interests of the carer and service user”.²⁷²

²⁶⁹ Evidence of Deputy Director of Nursing at SHFT, 4 March 2021

²⁷⁰ Evidence of Director of Nursing & AHPs at SHFT, 9 March 2021

²⁷¹ Evidence of Chief Executive at SHFT, 16 April 2021

²⁷² Evidence of a carer, 6 April 2021

Panel's Views on where SHFT are now: culture of complaints handling

- The Panel heard from the Chief Executive, and other participants, such as the Governors, about the values that SHFT seeks to uphold and implement, and it was averred that there has been an improvement in the culture at SHFT, such that the culture of fear had diminished. However, this was not always supported by the evidence the Panel received from service users and carers, both orally, and in the End-User Feedback Surveys. It was also unclear how SHFT measures this internally, other than through a 'Cultural Barometer'.
- The Panel were particularly struck by the reported lack of respect, sensitivity and empathy that was shown towards a couple of the service users who gave evidence during the handling of their complaints. For example, the response/apology letter that they saw, which was sent to one service user, was unacceptable; the language, tone and contents were completely inappropriate. This suggests there may be a gap between the perception within SHFT that these values are being upheld and the reality, particularly where the evidence implies that the population it serves does not have confidence that SHFT is committed to upholding these values.
- The Panel reviewed the SHFT Annual Complaints Report 2019/20 and observed that some of the examples of improvements made and/or learning, are defensive in approach and do not demonstrate an acceptance of the complaint made.
- SHFT have progressed and improved their culture in complaints handling, but improvements are still required to ensure staff get it right first time, every time.

Themes in complaints and concerns

195. The SHFT Annual Complaints Report 2019/20, shows that the top three themes, which made up 66% of complaints and 59% of concerns are:

- *Clinical care (106 complaints; 324 concerns)*
- *Communication (28 complaints; 200 concerns)*
- *Attitude (20 complaints; 128 concerns)*

196. In the Report, *'the main theme identified is that complainants would like faster resolutions and more empathy for their reasons for raising a concern or complaint. The Complaints and Patient Experience Team continue to work with the divisions ... to avoid any delays in ensuring these concerns are addressed, and to ensure that our*

*complainants feel listened to and valued. However, we recognise that collectively we need to redouble our efforts in this respect’.*²⁷³

197. The **Chief Executive** said, “the themes that come from complaints are the same nationally... if they were easy to fix, they would have been fixed nationally and in SHFT”.²⁷⁴

198. In regard to how the top three common themes in complaints could be reduced, the **Quality & Safety Committee Chair** said he would, “want to see what approaches could drive all three down”. He said, “the Triangle of Care could be the answer to the change in culture” and there needs to be evidence of the measurements of improvement to change.²⁷⁵

199. The **Deputy Director of Nursing** said that she would measure the impact of the learning or improvement on a theme from complaints through clinical time spent by the heads of nursing in clinical settings and that the more time spent in clinical settings, the more they are able to see the learning in action, but it is difficult to document. She said, if they don’t see recurring themes, they are closing the loop and they are seeing the changes through feedback and there being no more complaints on that issue/theme.²⁷⁶

200. In regards to the improvement work in place to improve on the top themes, the **Director of Nursing & AHP** said they are:

- Triangulating feedback;
- Investing in the ‘Elevate’ leadership programme, to provide support and role modelling;
- Encouraging a safety culture; using the cultural wheel, which is a 360-degree team feedback tool;
- Holding QI programmes, in which over 200 services users have been involved and told their stories.²⁷⁷

²⁷³ SHFT Annual Complaints Report 2019/20

²⁷⁴ Evidence of Chief Executive of SHFT, 16 April 2021

²⁷⁵ Evidence of Quality & Safety Committee Chair, SHFT, 9 March 2021

²⁷⁶ Evidence of Deputy Director of Nursing at SHFT, 4 March 2021

²⁷⁷ Evidence of Director of Nursing & AHPs at SHFT, 9 March 2021

201. As a result of these initiatives, she is confident they are listening, understanding better and trying to triangulate information to really understand the issue, the actions to put in place and are more likely to resolve it as they understand the issue.²⁷⁸
202. However, the **Deputy Director of Nursing** did accept that SHFT could improve their reporting to show evidence of the actions being taken in practice to reduce or improve the number of complaints received on certain themes.²⁷⁹
203. There is no thematic review of ‘concerns’ but they are included in the SHFT Annual Complaints Report, which is discussed in local governance meetings and at the Patients Experience Committee.²⁸⁰
204. The Panel were told that the Complaints Manager conducts an overview of themes the Complaints & Patient Experience Team see coming through. The wider themes across the organisation are shared through the divisional governance structures, learning forums and the snapshot governance newsletter, which is shared with clinical staff and the complaints meeting forum. Additionally, the Divisional Directors and Deputy Directors of Nursing meet regularly to discuss complaints.²⁸¹
205. However, the **Acting Director of Quality and Nursing at West Hampshire CCG** told the Panel that the top three themes in the complaints received by SHFT today - care received, communication and attitude of staff - are the same themes that were present in 2014/15.²⁸²

Panel’s Views on where SHFT are now: themes in complaints and concerns

- The Panel is concerned by the CCG’s observations and the fact that SHFT were unable to provide evidence demonstrating that they had focused and improved on the three top reoccurring themes in complaints and concerns since 2014/15. The Panel is not satisfied by the suggestion that because they are also the top themes nationally, that is a valid excuse for allowing them to continue in SHFT.
- The Panel did not see evidence of SHFT taking a strategic approach to improving on the consistent themes or that SHFT are seeking to understand them in the context of their local population, which they should be actively doing.

²⁷⁸ Ibid

²⁷⁹ Evidence of Deputy Director of Nursing at SHFT 4 March 2021

²⁸⁰ Ibid

²⁸¹ Ibid

²⁸² Evidence of Acting Director of Quality and Nursing at West Hampshire CCG, 5 March 2021

Panel's Views on where SHFT are now: themes in complaints and concerns continued...

- Upon reviewing the examples in the SHFT Annual Complaints Report 2019/20 and hearing the evidence from a small sample of service users, carers and family members, the Panel is not persuaded that the move to a local resolution of complaints has reduced the recurrence of these themes and the outcome for complainants. However, it does acknowledge that this approach is in its infancy.
- The problem of defensiveness is evident in the key recurring theme of 'attitude'. Although there is evidence to suggest that this was discussed with Executives and shared with the SHFT Board, it does not demonstrate any progress in resolving this problem or indicate that SHFT conducts regular 'deep dives' into complaint key themes to identify why they persist. This is substantiated by comments service users made to the Panel.
- Furthermore, the evidence did not show that the CCG have encouraged, enabled and driven SHFT to focus and improve on the top three themes, despite recognising that they have been the same since 2014/2015.

Sharing of themes and learning

206. The SHFT Annual Complaints Report 2019/2020 shows the results of the End-User Feedback Surveys: 43% of the complainants who responded did not feel confident SHFT would learn from their complaint.²⁸³ Therefore, the Panel were very keen to hear what mechanisms and methods SHFT has in place for sharing themes and learning from complaints, particularly, in light of the reoccurring top themes.

207. The SHFT Annual Complaints Report 2019/20, acknowledges that '*this is a concern*'. As to how this could be improved, the Report provides an overview, which states that,

- *The Complaints and Patient Experience Team continue working closely with the divisions to promote the benefits of local resolution whilst sharing best practise and learnings from complaints and concerns; and*
- *Will also develop improved methods for openly sharing learning, for example, information on the SHFT website regarding learning taken from complaints, concerns and compliments, more detailed reference in the publicly available Patient*

²⁸³ There were 10 responses to the 119 surveys that were sent out

Insight report, seeking feedback from other Trusts to establish if we can learn from their approach; and

- *All themes and learnings will be triangulated with Serious Incidents and Safeguarding.*

According to the Report, *'this was another action from the recent patient experience audit where it was felt SHFT could improve its triangulation of information/feedback, and a Quality Dashboard is well under the process of development with a draft to be shared with the Quality and Safety Committee in September'*.

208. However, the evidence received from SHFT participants at Stage 2 was, in summary, that there had been an improvement. For example, the Learning from Events forum, it was said, allows for review and learning to be shared across the organisation and actions are acted upon and shared.

209. A **Matron** said that feedback from complaints across the services is, "only shared if relevant... we are a very big Trust and some may not be relevant to in-patients". This is shared through the Director of Nursing & AHP and the **Matron** said, "there are discussions to say if we think its relevant... there is open channels to dispute and agree on how to action outcomes". These are also discussed in Ward Manager meetings and can be escalated up from there.²⁸⁴

210. She also said that feedback received from complaints, concerns and compliments are used by them to improve outcomes and they are promoting a culture with compliments too. She said that they also look at why they get those complaints, where they come from and what they) need to do to improve the service. As they are a new team, she said they look at similar services to see how they are managing their systems.²⁸⁵

211. The **Patient Safety and Quality Facilitator for the Southampton Division** has been in post for nine months and has a key role in sharing learning across SHFT and her division. Said that she attends weekly update meetings with the Heads of Nursing in Southampton, Director of Nursing and the Patient Experience Team, to discuss individual cases and monitor progress. However, she acknowledged that she is not fully

²⁸⁴ Evidence of Matron, SHFT, 29 March 2021

²⁸⁵ Ibid

embedded in the learning and actions coming out of complaints” but does have access to them and she hopes to get more involved in the complaints and concerns process to share learning.²⁸⁶

212. She recognised that they need more emphasis on looking at the themes and clinical care keeps coming up, but they need to look deeper into it to see the individual themes in each concern or complaint.²⁸⁷

213. Non-Executive Directors see the themes emerging from complaints through the Quality and Safety Committee reporting to the Board, there is a Non-Executive Director on the Patient Experience forum and the Patient Experience Team report into the Patient Experience Committee, quarterly.²⁸⁸

214. In terms of sharing learning from and with other Trusts, the **Deputy Director of Nursing** said that this is done through the regional Director of Nursing and as the Divisional Director of Nursing in the South East she would look at the risks and share any learning from a system perspective, but that this is in early development currently. She said there is a learning forum in each locality, quality forum and risk register across the South East.²⁸⁹

Panel’s Views on where SHFT are now: sharing themes and learning from complaints

- The Panel is supportive of the appointment of a Patient Safety and Quality Facilitator in SHFT and the aspirations for her role are positive. However, COVID-19 has slowed down her work, so it is vital that straightaway she becomes embedded in the learning and actions coming out of complaints and is the conduit in the organisation for sharing data. The structures and mechanisms must be in place for her to carry out this role effectively.
- The Panel is concerned about the increasing number of concerns and the limited learning that comes out of them. This must change with improved structures and processes for learning, improvement and the sharing of learning arising from an ongoing analysis of ‘concerns’.
- The Panel’s overall view is that SHFT would benefit from looking outside of the organisation in order to benchmark and to link with other Trusts for opportunities for learning and not to focus just on looking inwards, which the evidence suggests it has tended towards doing.

²⁸⁶ Evidence of the Patient Safety and Quality Facilitator for the Southampton Division at SHFT, 13 April 2021

²⁸⁷ Ibid

²⁸⁸ Director of Nursing & AHPs at SHFT, 9 March 2021

²⁸⁹ Evidence of Deputy Director of Nursing at SHFT, 4 March 2021

Panel's Views on where SHFT are now: sharing themes and learning from complaints continued...

- The Panel is not persuaded that the evidence demonstrates that the learning from complaints is as widespread or as good as it could be. For example, they heard that the feedback from complaints in some wards or services will only be shared if it is deemed “relevant”. However, what amounts to “relevant” is subjective and could lead to gaps in the sharing of information. The Panel’s view is that professionals should be in a position to make this judgment based on the information before them. Therefore, wider dissemination of learning and themes arising from complaints should be implemented.

Governance and assurance

215. It is, in the Panel’s view, vitally important that the governance structures and assurance functions are in place to ensure that SHFT are not only dealing with complaints appropriately, effectively and efficiently; but also, to ensure that there is wider learning from complaints and concerns, which in turn, should be shared across the organisation. This should sit alongside any quality improvement programme that SHFT are implementing.

216. The **Deputy Director of Nursing** said in her written statement and oral evidence that SHFT’s assurance obligations are discharged in the following ways (in summary):

- 1) Thematic reviews;
- 2) Peer reviews;
- 3) QI projects;
- 4) Oversight and reviews of complaints by the Deputy Director of Nursing and the Director of Nursing;
- 5) Data and reporting are shared through the performance structure in each division and with the Board through the Integrated Performance Report;
- 6) Detailed quarterly reports on complaints are considered by the Board Quality & Safety Committee, along with the SHFT Annual Complaints Report;

7) Service-user Led Audits are presented to the Board by the Service User Coordinator and they identify actions taken in response to the issues raised in the independent audits.²⁹⁰

217. The **Chief Executive** commented that, “the Board directly hears about individual experiences, which are often uncomfortable...”. Further, he said that he assures himself that people are living up to SHFT’s values through observations, including, “learning when things go wrong, from the events that gave rise to this enquiry and from what I see in complaints... I have picked up some complaints that are not to my satisfaction, in terms of SHFT values being fulfilled”.²⁹¹

218. The Panel challenged him on SHFT’s response being ‘reactive’ rather than ‘proactive’, and he said, “it is possible to be proactive rather than reactive in assuring the quality of the culture when responding to complaints if you’re looking through them as they come through”.²⁹²

219. Similarly, the **Deputy Director of Nursing** said in her written statement that the role of the Complaints and Patient Experience Team is to assure the quality of the complaints handling process and said they will escalate it if it is not being handled properly, they support and advise the Investigating Officers, when appropriate they raise concerns with the Divisional Director of Nursing & AHP and they may make the Chief Executive aware.²⁹³

220. The line of reporting on the delivery of the Improvement Strategy, set out in the SHFT Annual Complaints Report and the Patient Safety Commitment and the People in Partnership Commitment is through the Quality and Safety Committee (“QSC”), via the Patient Experience, Engagement and Caring Group. This latter Group is led by a Non-Executive Director and a SHFT Carers’ Lead also sits on it, alongside voluntary sector organisations and they meet every two months.

221. The QSC receive a quarterly report from the Complaints and Patient Experience Team (including a description or example of a complaint and how it was handled in each

²⁹⁰ Statement of Deputy Director of Nursing at SHFT, 2 February 2021 and evidence of Deputy Director of Nursing, 4 March 2021

²⁹¹ Evidence of Chief Executive of SHFT, 16 April 2021

²⁹² Ibid

²⁹³ Statement of Deputy Director of Nursing at SHFT, 2 February 2021

report), but this is a high-level snapshot only.²⁹⁴ They also receive the SHFT Annual Complaints Report and the Integrated Performance Report, which are quite process focussed, but there are Executive Performance Groups where the discussion happens. The QSC receive the minutes and Chair's Report from the Patient Experience, Engagement and Caring Group meetings, and they can escalate concerns or issues in relation to quality or feedback from surveys or complaints to the QSC if required.²⁹⁵

222. The **Quality & Safety Committee Chair** said that the QSC receives 10 to 15 complaints and responses per month but that he does not read them personally as he believes it would be, "stepping into the operational and none of us have the background to understand what went on and what would happen if we didn't agree with the response". He said that he can open up certain ones he thinks might need more explanation or analysis at the QSC.²⁹⁶

223. He said that he would like to see more "granularity" in the complaint reports the QSC receive. He agreed there is a lot of focus on process, but said that the SHFT Board are exposed to patient complaints by complainants appearing before them at meetings. He described how there is an image of a patient who took his life and the last CCTV image of him outside the boardroom and said this is a reminder.²⁹⁷

224. In terms of reporting to their commissioners on complaints, the **Deputy Director of Nursing** said this is done formally through the Clinical Quality Review Meetings (CQRM). However, the Panel heard from other participants that this meeting has not been held, save for 'exceptional reporting' since February 2020, due to the COVID-19 pandemic and there was no evidence provided as to when, or indeed if, it would be restarting. She said her experience of working with the CCG as the Divisional Director of Nursing, is that they have been "An integral part, linked with us and been part of our divisional business meetings (inside SHFT), so they're directly hearing the information about complaints".²⁹⁸

225. The **Acting Director of Quality and Nursing at West Hampshire CCG** said he would, from, a personal perspective, like to examine some complaint responses from SHFT, but said he was aware of the statutory responsibilities of the CCG. He said he

²⁹⁴ Evidence of Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement at SHFT, 29 March 2021

²⁹⁵ Evidence of Director of Nursing & AHPs at SHFT, 9 March 2021

²⁹⁶ Evidence of Quality & Safety Committee Chair, SHFT, 9 March 2021

²⁹⁷ Ibid

²⁹⁸ Evidence of Deputy Director of Nursing, 4 March 2021

would expect Non-Executive Directors at SHFT to look at the narrative and dip sample complaints. He said, “I believe dip sampling has happened at SHFT, but would need to check”.²⁹⁹

226. The **Chief Medical Officer** spoke of SHFT’s relationship with NHSE/I. He said “NHSE/I have been a part of our improvement journey and are less involved in the day-to-day management, but investigations and complaints do get escalated to their regional office to be open and transparent”.³⁰⁰

Panel’s Views on where SHFT are now: governance and assurance of complaints handling

- The Panel’s overall impression is that the CCG and the Governors are involved in meetings and discussions that happen within SHFT effectively, which include the topic of complaints. However, the monitoring by the CCG and Governors of the responses to complaints is an area for improvement. With the correct permissions in place, the CCG should play a more active and regular role in monitoring and overseeing the quality of complaint responses (after the complaint has closed).
- The Panel is satisfied that the Board receives regular reports on complaints and that complainants have presented to them. However, the regular reports do not contain the analysis and systematic rigour required for the Board to reach informed conclusions.
- The Director of Nursing & AHP has an ‘oversight role’ for complaints. The Panel’s firm view is that she must be supported by the Complaints and Patient Experience Team to carry out this role effectively and to the standard and quality SHFT should be aiming for. But there is an important question as to whether the Director of Nursing & AHP is sufficiently independent to carry out a quality assurance role if she also manages the process. Thus, a more formalised and objective quality assurance system is needed for complaint investigations.
- The suggestion from service users, carers and family members was that they want the management team, Executives and/or Board to know what is going on with complaints handling on the ground. But the evidence received suggests that any assurance is more likely to happen at ‘informal meetings’ and at the local level.
- The Panel notes that the CCG rely upon, and would expect that, SHFT are “dip-sampling” complaints, but there is no evidence that this happens. In fact, the evidence from SHFT was that the Non-Executive Directors do not do that.

²⁹⁹ Evidence of Acting Director of Quality and Nursing at West Hampshire CCG, 5 March 2021

³⁰⁰ Evidence of Chief Medical Officer at SHFT, 12 April 2021

Support to make a complaint or raise a concern

227. Throughout this Review, the Panel has been concerned about the support and advocacy services in place for service users, carers and family members to raise a complaint or concern with SHFT and were keen to hear evidence from all of the participants on this topic. This includes, how accessible the process, policy and procedures are for complainants and how they are made aware of them.
228. The **Chief Executive** spoke frankly on this topic and said, “I don’t think the public, generally speaking, knows necessarily how to complain or bring issues... I have had the experience myself; I have felt helpless”.³⁰¹
229. The Panel asked specifically about the work being doing within the Older People’s Mental Health Team (“OPMH”) and Learning Disability services, in response to the evidence showing a low number of complaints in these services.³⁰² The **Deputy Director of Nursing** said her team work with (the OPMH Team) closely to get feedback and the Personal Experience Representative works with services users (with a learning disability) to get feedback. However, she acknowledged that SHFT need to continue to work on and improve this area.³⁰³
230. In terms of other potentially vulnerable groups, the **Director of Nursing & AHP** said it is their obligation to make sure people have advocacy and support, if they need translations etc and that SHFT have policies in place to help them; they have voluntary advocacy groups who support people through the process; and SHFT’s complaints team are there to advocate for people.³⁰⁴
231. Furthermore, the **Director of Nursing & AHP**³⁰⁵ and the **Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement**³⁰⁶, said that they have weekly community meetings in every in-patient unit, which are chaired by service users, where they discuss themes, concerns, changes and issues. They said service users can ask for items to be added to the agenda or raise it at the meeting. The

³⁰¹ Evidence of Chief Executive at SHFT, 16 April 2021

³⁰² SHFT Annual Complaints Report 2019/20

³⁰³ Evidence of Deputy Director of Nursing at SHFT, 4 March 2021

³⁰⁴ Evidence of Director of Nursing & AHPs at SHFT, 9 March 2021

³⁰⁵ Ibid

³⁰⁶ Evidence of Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement at SHFT, 29 March 2021

minutes of those meetings are shared weekly with the Divisional Director of Nursing & AHPs, the Service User Facilitator and the Matron.

232. As to the wider improvement work being done in this field, the **Head of Patient and Public Involvement and Patient Experience** said she is working on developing a 'Patient and Carers Support Service' and SHFT are co-producing a model for it. She spoke of this service supporting the role of the Family Liaison Officer ("FLO").³⁰⁷ The **FLO** said that she works to support families who have a complex or serious complaint that is being investigated by an Investigation Officer and the family or patient would benefit from her support. This is a change in her job role from 2016 where previously she could be asked to step-in if there was just a communication problem.³⁰⁸

233. However, the Panel reviewed the Minutes of the Learning from Events meeting held on 13 February 2020, which included a monthly update on the 'themes and learning from complaints':

'The Complaints Policy and Procedure have just been reviewed. As a result, it is no longer an option to refer complainants to the Family Liaison Officer (FLO) because she lacks capacity for additional referrals - this has left a gap which needs to be addressed. Also, the complaints team no longer have capacity to attend 48-hour panels and so as a result do not have an overview of complex complaints. LH confirmed that the work capacity of the FLO is being reviewed at the request of SHFT Board to see if more resource is required.'

234. The evidence from service users and carers in terms of support and advocacy services provided to them during the complaints process was not positive, and was, at times, distressing to hear.

235. Two **service users** were not offered an advocate, one in 2017 to 2019 and one in the last year, who also said that she was called "weird" for wanting her local councillor and friend to accompany her at a meeting and as a result, he didn't attend with her.³⁰⁹

236. A very articulate **carer** said that for people who do not have the confidence or resilience that he has, "it is absolutely horrendous for them... I hope and I am optimistic,

³⁰⁷ Evidence of Head of Patient and Public Involvement and Patient Experience at SHFT, 10 March 2021

³⁰⁸ Evidence of Family Liaison Officer at SHFT, 30 March 2021

³⁰⁹ Evidence of a service user, 4 March 2021 and a service user, 15 April 2021

that some people will want to help, but some people think it's too hard work all of this correspondence, it is very frustrating, difficult and not easy".³¹⁰

237. A **service user** spoke of her own experience of making complaints to SHFT and said, "that is why I have an advocate - I have days when I don't process properly and she will step in - she is for the complaint only, because their process is very anxiety provoking and sometimes, I need to step back from that and let her take over".³¹¹

238. The PHSO has completed its investigation into one complaint in the period of 2019 to 2020; the complaint was upheld. The PHSO found that *'SHFT's complaint response acknowledges the delay in providing access to an Independent Mental Health Advocate (IMHA) and said this was a key learning point'*. However, the PHSO commented that SHFT's response to the complainant provided, *'no details on how it would address the fault and it did not apologise to the complainant for any distress caused by the fault'*.³¹²

239. In response to the PHSO's findings, SHFT set out an action plan, including making an apology within one month for the distress caused by the faults in communicating about their illness and medication, for not offering or arranging an IMHA sooner and within three months, committing to set out an action plan to address the learning points identified with informing patients about IMHA. SHFT claims that *'these actions have been completed'*, but does not provide details as to what has been done.

Panel's Views on where SHFT are now: support to make a complaint or concern

- The Panel is not satisfied as to how information, policies or investigation reports are made accessible to complainants with low levels of literacy, learning disabilities, language barriers, or mental health illnesses, which may make it challenging for them to read and understand the complex and sometimes distressing investigation reports. Additionally, it is not satisfied as to the support that would be available to such a person who wishes to complain or raise a concern.
- Although the Panel is pleased that additional support has been committed to expanding the role of the FLO, the evidence is that this role is not to support complainants, which leaves a gap that has been identified within SHFT and should be filled.

³¹⁰ Evidence of a carer, 6 April 2021

³¹¹ Evidence of a service user, 15 April 2021

³¹² SHFT Annual Complaints Report 2019/20

Feedback from complainants

240. The importance and value of having mechanisms in place for obtaining feedback from complainants cannot be underestimated. However, in an organisation such as SHFT, with a high-number of service users with mental health problems and learning disabilities, the methods they employ to go about gathering such feedback are particularly significant and important. There is some overlap with the evidence heard on this topic in regard to complaints and on the topic of communication and liaison.

241. The **Director of Nursing & AHP** said, “our wish is to be a listening organisation and to welcome feedback”.³¹³

242. SHFT avers that it sends ‘*Satisfaction Surveys out monthly, approximately two weeks after the response letter has been issued. They are either sent out electronically with a link to the on-line survey, or via post, depending on the previously established preferences of the complainant*’.³¹⁴ In 2019 to 2020, 119 were sent out and 23 were responded to (19%). The **Deputy Director of Nursing** recognised in oral evidence that the response rate for feedback was low and said there is a move towards calling complainants by telephone for feedback which produces richer information.³¹⁵

243. The **Deputy Director of Nursing** said, in response to a question about complainants not feeling confident that SHFT would learn from their complaint, “where we have had people who have said they’re not happy, we have invited them to join our quality improvement programme to help tell us what it is we can be doing to move forward... I haven’t got the answer, but I feel we do have strong mechanisms to support people to give us that feedback” and she said that more work is planned for this year (2021) to ensure there are more routes for feedback.³¹⁶

244. One of the key feedback mechanisms in SHFT, introduced in 2019, is the Service User-Led Standards Audit Report, which is conducted quarterly and was expanded in September 2020, so that it now covers all mental health inpatient services and all community mental health services. There was also a pilot of physical health community services. This is routinely provided to the SHFT Board.

³¹³ Evidence of Director of Nursing & AHPs at SHFT, 9 March 2021

³¹⁴ SHFT Annual Complaints Report 2019/2020

³¹⁵ Evidence of Deputy Director of Nursing at SHFT, 4 March 2021

³¹⁶ Ibid

245. In the 2019 to 2020 (Q3) Survey, 104 service users completed it (only four were mental health in-patient services) and in response to the question, '*are you aware of how you can make a complaint?*', 20 said 'no' and 64 said 'yes'. In response to the question, '*do you feel safe to make a complaint?*', 29 said 'no' and 58 said 'yes'.
246. For the April - September 2020 Survey, it is asserted by SHFT that 12,578 registered service users across SHFT were contacted for feedback and 9,581 responded. Further, 1,834 registered carers on RiO were contacted and 701 responded. This is discussed here and again in the 'Communication and Liaison' section.
247. A **Service User Involvement Facilitator** said that in every audit there is an Action Plan and that everything the Facilitators do is fed back to the services and sometimes to the individual and if there are concerns about an individual then it is raised directly with the Head of Nursing in that area. Further, "... the positives and negatives are both shared quickly, as both are as important as each other... it's about working together to create an active plan to ensure everybody sees a benefit from it".³¹⁷
248. A **Clinical Ward Manager** explained that in their ward a patient representative captures the service user experience through feedback questionnaires which are passed to her. Other methods used include weekly community meetings where patients can ask what it's like on the ward, say what it feels like and what they need more or less of; family and friends testing and texting survey links. She said she works with the information/feedback, but it doesn't always end up where it needs to (i.e. the Board).³¹⁸
249. The **Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement** said that as part of their QI and safety culture approach, senior clinical leaders regularly go back to the floor to understand how people are feeling about the service with 'back to the floor days'. She said the visits start on a Monday with a briefing and senior clinical leaders spend the week going out to each other's services, then on the Friday, any feedback will be formally fed back and written up for the Senior Professionals Committee or the relevant specialist forum/committee.³¹⁹

³¹⁷ Evidence of Service User Involvement Facilitator at SHFT, 18 March 2021

³¹⁸ Evidence of Clinical Ward Manager, 12 April 2021

³¹⁹ Evidence of Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement at SHFT, 29 March 2021

250. The **Director of Nursing & AHP** acknowledged that it was a challenge to complain about the complaints department and did not set out a method for doing so, but said they might need to think of an independent way to do it.³²⁰

251. The NHS Annual Staff Survey results also provided some informative responses to the questions regarding the organisation's approach to 'patient/service user experience feedback'. This was not asked about in the 2020 NHS Annual Staff Survey. In 2019, 94% of staff said that patient/service user experience feedback was collected within their directorate/department. In 2019, *64% said they receive regular updates on patient/service user experience feedback (up 1% from 2018)* and *63% said that feedback from patients/service users is used to make informed decisions within my directorate/department (up from 56% in 2018)*.

Panel's Views on where SHFT are now: feedback from complainants

- SHFT responded to the lack of responses to the feedback surveys on paper by moving to obtaining feedback by telephone. SHFT should continue with this approach and consider using new technologies to develop and diversify its methods of collecting feedback.
- The Panel is concerned by the admission by SHFT and the apparent lack of prior consideration that had been given to the ways in which a complainant could complain about the Patients Experience Team or the Investigation Officer. This should be considered and implemented immediately with mechanisms for extracting learning and improving the way complaints are dealt with.
- The evidence shows complainants lack confidence that their complaint will result in change. SHFT says that those individuals would be invited to get involved in their QI programme. However, SHFT should not assume that all complainants have the time, capacity, or inclination to do so. The Panel's view is that SHFT should be 'getting it right first time' to avoid the complaint in the first place and to deal with it properly if it does arise.

Number of complaints

252. SHFT were keen to inform the Panel that there had been a reduction in complaints by approximately half from 2015/16 to 2019/20 and, in the same period, the overall ratio

³²⁰ Evidence of Director of Nursing & AHPs at SHFT, 9 March 2021

of complaints to concerns decreased, which they attribute to SHFT's commitment to local resolution of issues at an early stage.³²¹

253. In 2018 to 2019 there were 329 complaints, 1038 concerns and 5839 compliments received.³²²

254. In 2019 to 2020 there were 232 complaints, 1113 concerns and 4647 compliments received - 29% reduction in complaints between 2018/19 and 2019/20.³²³

255. The **Quality & Safety Committee Chair** said, "it is difficult to benchmark complaints and does too many complaints mean we are making it too easy?".³²⁴

Panel's Views on where SHFT are now: the number of complaints

- The evidence of the number of complaints going down should not be relied upon alone as a metric for measuring the success or effectiveness of SHFT's complaints handling system, when it may indicate a lack of trust in SHFT's processes or lack of accessibility.

³²¹ Statement of Deputy Director of Nursing at SHFT, 2 February 2021

³²² SHFT Annual Complaints Report 2018/19

³²³ SHFT Annual Complaints Report 2019/20

³²⁴ Evidence of Quality & Safety Committee Chair, SHFT, 9 March 2021

Communications and Liaison and 'Care for the Carer'

B. Where are SHFT now?

Introduction

256. The Panel received a great deal of evidence regarding the initiatives that SHFT have put in place to encourage and improve communications, both internally and externally. Therefore, they were very keen to hear from all of the participants as to how successful and effective these have been, particularly in light of developments in technology and any constructive impact that COVID-19 may have had on utilising this.

257. The Panel also received evidence regarding the communication, support and initiatives in place for carers. In this Review, the Panel have considered 'carers' widely, to include healthcare professionals, volunteers and partners, family and friends who may carry out this role. This is an important topic; it goes beyond just communicating and liaising with carers and it is one that the Panel have deemed sufficiently important to warrant separate consideration as an additional theme. However, it is inextricably linked with the topic of communication and liaison and given the overlap in the evidence on both topics they will be addressed and considered together.

258. SHFT have appointed two Service User Involvement Facilitators to encourage more engagement and to offer support.

259. A **Service User Involvement Facilitator** said that where there is evidence of really good practice and that staff need to be aware of the good and bad for staff to grow and that, in terms of learning, the organisation has "grabbed that bull by the horn and run with it".³²⁵ The **Chair** echoed this message and said, "I think now is a good time for us to start to think about how we can communicate some of the good news more widely. I think it is now time for staff to be able to talk about some of the good work they do".³²⁶

260. The **Chief Executive** described to the Panel the challenges he sees with communication and liaison in SHFT: "it is about complexities in relationships between staff, families and service users, within teams and the organisation... at the heart of it

³²⁵ Evidence of Service User Involvement Facilitator at SHFT, 18 March 2021

³²⁶ Evidence of Chair at SHFT, 16 April 2021

has to be the fundamental belief that the carers and service users have enormous knowledge of what it is they're engaging with the organisation for and experience of managing their conditions, that has to be the foundation of the partnership with service users and carers".³²⁷

261. As to how that plays out in SHFT, the **Chief Executive** said, "in most examples, we see very good practice around that, there are occasions when it's not as good as it should, but that is not surprising, as even the best practitioners who are exemplary in how they engage and it can be for nobody's fault that in particular circumstances, the relationship doesn't work and its important then about how we respond to that".³²⁸

262. In regards to his own approach to communications, he said, "I will talk to anybody at any time... and anyone can come to see me and they do; on the other side, some staff will feel inhibited by status or perceptions of it". He said, "I know Non-Executive Directors and the Chair go out and talk with people directly... on their own and staff talk to them directly and when they come back, they share that with us; that is what underpins the culture in SHFT".³²⁹

263. He was asked how he will enable and ensure that families and carers receive advice, support, information and mutual respect, every-time and he said, "That is the challenge for this and every organisation, those characteristics are fundamental to how we should be engaging and how we make it universal every time is the challenge... How we manage those difficult situations, is fundamental to the principles of care and it is difficult and at times, highly emotional, but it is really important that that is where we invest, in developing the skills and empathy of the people we have providing a service...".³³⁰

264. He said, "SHFT has responded to the wishes of carers and service users, we haven't been prescriptive, there is no perfect structure to engage with carers; we have evolved from the willingness and enthusiasm of individual carers and we shape what we're doing with them and we are co-producing with them... I think that is the right way to do it, rather than there being a perfect structure beautifully leading into a Board sub-committee".³³¹

³²⁷ Evidence of Chief Executive at SHFT, 16 April 2021

³²⁸ Ibid

³²⁹ Ibid

³³⁰ Ibid

³³¹ Ibid

265. The Panel heard from the **Chair of Hampshire Healthwatch, Ann Smith**, who came into post in 2019. Hampshire Healthwatch's role is to *'understand the needs, experiences and concerns of people who use health and social care services and to speak out on their behalf'*.³³² She said that the new incumbent Chief Executive (of SHFT) was keen to speak with them individually when he first came into post, which she took as a positive sign, as it does not always happen. She said they had an open and frank discussion and met with the Chair, Chief Executive, Chief Operating Officer and other Healthwatch groups, which was productive.³³³
266. The **Chief Medical Officer** said, "people raise issues with me clinically and I can deal with it there. I've had people contact me through the Chief Executive and I have engaged with them for more than a year to support them and help them in finding a solution..."³³⁴
267. The **Head of Patient and Public Engagement and Experience** said that "sometimes, engagement is seen as an add-on, whereas the leadership (in SHFT) have given staff the permission to take time to listen to families... we do make the time to do that. It's of such value. We encourage staff to make sure this is a priority"³³⁵
268. The Panel heard from a **Clinical Ward Manager** she has been in this post for two years and worked for SHFT for ten years. In regards to any changes that she has seen in communication and liaison with families she said, "I have seen a massive development with carers and families, a real shift in the last two years and there is still room for improvement and work to be done, as we should always strive for better, but we have made really good growth already"³³⁶
269. A **Clinical Ward Manager** said in their wards, due to COVID-19, they have been using more technology to involve carers and families in patients' care, including them in ward rounds and meeting with the doctor and informing them and making sure they can speak to relatives once on the ward. Further, she said their staff nurses on the ward are allocated a patient and they speak on the phone to families and carers to make sure they are kept up-to-date.³³⁷

³³² <https://www.healthwatchhampshire.co.uk/what-we-do>

³³³ Evidence of Chair of Hampshire Healthwatch, Ann Smith, 6 April 2021

³³⁴ Evidence of Chief Medical Officer of SHFT, 12 April 2021

³³⁵ Evidence of Head of Patient and Public Engagement and Experience at SHFT, 10 March 2021

³³⁶ Evidence of Clinical Ward Manager, SHFT, 12 April 2021

³³⁷ Ibid

270. A **Consultant Psychiatrist** in SHFT said in her written statement the reasons why, from her experience in clinical practice, involving carers and families in every step of the patient's care pathway is so important. The statement ends by saying "I do believe, however, that further improvement is still needed. Communication could still be more proactive, in my view. Even where specific communication needs have not been identified, good practice would mean that we seek out carer views and aim for the involvement of families and carers for all our patients, as well as proactively trying to identify which carer and family members might need support themselves".³³⁸

271. In oral evidence, she developed this further and said, "I think we could still do things better, I think we get prompts to make this contact ... for example, if a family member calls and asks to speak to me, I will get back to them, but unless I had a reason to, I might not have rung them in the first place... we might ring families for important information or if we have been asked to call, but not where we have not had the prompt, I'm not sure we would always think to call". She thinks this will change with prompts from the Carer Leads, FLO and Care Workers and said, "I think we have come a long way... I think it's pleasing to see a genuine appetite at the top of SHFT to get this right... there are lots of plans to continue to improve on this journey, which I really welcome".³³⁹

272. The Panel heard from the **Director of Workforce, Organisational Development and Communications at SHFT**, who has been in post for three years and has responsibility for the People Strategy, Organisational Development Strategy across the organisation and communications, both internal and external. He said described his primary role as being around culture. In two years, he said, SHFT has "come forward and made really good strides... we still have loads of room for improvement". He gave examples of improvement: "our vacancy rate two years ago was 10%, now it is 3.4%... from a turnover perspective, we have reduced by 25%". He referred to a culture insight tool (or barometer), as a way to understand how engaged people are and to understand where SHFT staff are and how they feel working for SHFT.³⁴⁰

273. In regards to written communications that SHFT produces, the Panel heard from the **Deputy Chair of the Working in Partnership Committee** who said, "two to three years

³³⁸ Statement of a Consultant Psychiatrist at SHFT, 2 February 2021

³³⁹ Evidence of a Consultant Psychiatrist at SHFT, 10 March 2021

³⁴⁰ Evidence of Director of Workforce, Organisational Development and Communications at SHFT, 19 April 2021

ago, it was difficult, I tried to see things from a lay person's perspective and to understand the jargon. Now this has all been addressed and information is more lay person friendly. It's noticeable that SHFT staff and managers when talking to us are able to adapt the information they have to give to us".³⁴¹ However, the **Chair of the Working in Partnership Committee and a carer** said he would like to see an improvement in the documents going out to people so that the communication is at a level people understand.³⁴²

274. The **Deputy Chair of the Working in Partnership Committee** spoke about where he believes SHFT are now and said, "my experience now is of much greater openness... we don't have the old consultant in his white coat waving people away and saying 'don't ask any questions'".³⁴³

275. He acknowledged how they won't reach complete satisfaction with some families, because the answers and actions they seek are not always deliverable. He said it's a matter of trying to change their perception of the organisation and they must not be ignored, but the priority must be working on the perception that when people come to SHFT's front door, by whatever means, they will get an answer. He said, "the key point is how we are able to reach out to people... it's a question of how we encourage people who have been hurt to explore new ways of doing things". He believes some of this change is happening with the change in procedure on complaints and the work of the FLO.³⁴⁴

276. The Panel heard from a **Non-Executive Director and Chairman of the Audit, Risk and Assurance Committee** and he described how one of the most important roles to him personally in SHFT is as a Mental Health Act Review Manager (MHARM). He said, "I sit on panels and it's been tremendously helpful and important to me... it keeps you close to what is actually going on and for getting insight into the way patients are treated... it's been a tremendous source of assurance for me as to what is happening in our services... I have served on 39 panels in the last 12 months". He described how the panels are enhanced if members of the family or carers attend. He said there are three

³⁴¹ Evidence of Deputy Chair of the Working in Partnership Committee at SHFT, 17 March 2021

³⁴² Evidence of Chair of the Working in Partnership Committee at SHFT, 11 March 2021

³⁴³ Evidence of Deputy Chair of the Working in Partnership Committee at SHFT, 17 March 2021

³⁴⁴ Ibid

Non-Executive Directors in SHFT who are MHARMs and the Chair of SHFT also chairs the MHARM Forum.³⁴⁵

277. The Panel heard from the **Lead Governor and Chair of Carers Together**, who is a MHARM too. He spoke about SHFT's improvement in communicating with the Council of Governors and said their communications team went through a quality improvement process, which he attended and now there is a professional communications team. He said, "I never see anything in the papers or TV that I've not been told about before. There is a good sense of the good and bad news coming to us nicely and in a timely and professional manner".³⁴⁶

278. He said that he meets the Chair and Deputy Chair of SHFT every fortnight; the Independent Senior Director of SHFT every month; and if he needs to, he can contact the Non-Executives and Executives at SHFT. He said the conversations are directed by what they want to talk about, not SHFT and they have our own agenda. He said, "we needed to get the culture in the organisation right, so I have done loads of visits to individual hospitals... and we do the Star Award...". In terms of keeping up-to-date, he said they received a daily update from the communications team during the COVID-19 pandemic and a media update weekly.³⁴⁷

279. He believes that there have been challenging conversations between himself and the SHFT Board.

280. As the **Lead Governor** he spoke about the Council of Governors plans for communicating with the general public, and specifically, carers. He said they have a detailed action plan on this topic with the SHFT Board's support and that they are encouraging the public Governors to do that and to report back. He said, "I am not saying we have it right yet, we are slightly disappointed with the progress, but a lot of that is down to circumstance, not a lack of will".³⁴⁸

281. The **Director of Quality and Board Nurse for West Hampshire CCG**, who has been in post since 2017 said "... whilst I'm in awe of the improvement there has been in SHFT, there is absolutely more work to be done. From my experience in my roles,

³⁴⁵ Evidence of Non-Executive Director and Chairman of the Audit, Risk and Assurance Committee, SHFT, 13 April 2021

³⁴⁶ Evidence of Lead Governor, 30 March 2021

³⁴⁷ Ibid

³⁴⁸ Ibid

including this one with SHFT, the one area it always pays to improve significantly is communication”.³⁴⁹

282. The Panel received evidence from a **carer**, who said that for people who do not have the confidence or resilience to communicate with SHFT as he has, “it is absolutely horrendous for them. We have sat in the waiting room in the past and the way some people are spoken to is not acceptable... I’ve never heard anyone say anything good about the service as a whole... but I have hope and optimism that some people will want to help... it is very frustrating, difficult and not easy”.³⁵⁰

283. A **family member** said that she was inspired with confidence having listened to the evidence given by SHFT during this Review. She said, “I have been really impressed by the people higher-up, who really seem to know the structure and what has been done and what needs still to be done; but the cynic in me thinks ‘what if that person leaves?’ and ‘how can this be sustained?’”.³⁵¹

Initiatives and mechanisms for communication and liaison with service users and family members

284. The **Head of Patient and Public Engagement and Experience**, who is the strategic lead in co-ordinating SHFT’s approach to community engagement and partnership working, provided evidence about the processes and mechanisms SHFT have put in place to improve communication and liaison with families and service users.

285. She said that over the last two years they have put structures in place to enable involvement and to support staff, including, a nominated ‘Patient Champion’ or ‘Patient Lead’ in all services, a ‘Patient Lead Network’, which meets every three months and gets staff together to talk about challenges, barriers and to share good practice and identify training needs, a suite of tools to help staff to engage and listen to patient’s stories and invite other organisations in to speak to staff. She gave an example of a co-production workshop with patient and public involvement leads, delivered by Hampshire Carers

³⁴⁹ Evidence of Director of Quality and Board Nurse for West Hampshire CCG, 15 April 2021

³⁵⁰ Evidence of a carer, 6 April 2021

³⁵¹ Evidence of a family member, 6 April 2021

Together. Finally, she said they use the expertise in the community to enable the staff to get involved.³⁵²

286. The **Head of Patient and Public Engagement and Experience** also referred to the Trust-wide structures, including the Working in Partnership Committee which meets every month and has representation from carers, service users; Governors, voluntary organisations, partner organisations and Healthwatch. She said, staff are encouraged to attend committee meetings to discuss projects, seek advice and act as a critical friend.³⁵³

287. She said there is, “not one way of doing engagement, we have introduced lots of ways to connect: surveys, focus groups, events, working with external organisations, peer reviews, patient stories and local organisations also share their skills to ... support them. We are embedding a menu of ways to engage with divisions, who are taking responsibility for it themselves”.³⁵⁴

288. The divisions are overseen by the Directors of Divisions who meet regularly with the Director of Nursing, and they all meet regularly with the Heads of Nursing and anything arising from that can be escalated to the Board. The Head of Patient and Public Engagement and Experience also provides a report to the Director of Nursing, which is delivered to the Board.

289. A **Service User Involvement Facilitator** referred to there being issues around communication during COVID-19, so they provided iPads to in-patient units, which meant they could speak to their family, friends and carers.³⁵⁵

290. The **Clinical Director for Mental Health and Learning Disability for West Hampshire CCG** said, “it’s always possible to speak to someone in terms of if we had acute concerns in the community mental health team or crisis team; and after 5pm, it goes to the crisis team”.³⁵⁶

291. A **family member** said, “... the family should be involved all the time in supporting their loved one and should be given the service we need to do that. That has been done

³⁵² Evidence of Head of Patient and Public Engagement and Experience at SHFT, 10 March 2021

³⁵³ Ibid

³⁵⁴ Ibid

³⁵⁵ Evidence of Service User Involvement Facilitator at SHFT, 18 March 2021

³⁵⁶ Evidence of Clinical Director for Mental Health and Learning Disability for West Hampshire CCG, 17 March 2021

previously by a unit in SHFT. What I'm receiving now is the opposite of world class performance... the first-class response was 11 to 14 years ago... (they) supported, educated and were available to answer the family's questions whenever they wanted it... the family were part of their team... they were guided on the wellbeing of the individual by the family... if you needed help, they were there... the family gained confidence". He said that he does not believe that this high-level of service could be provided today due to the structure of the wider NHS.³⁵⁷

Initiatives and mechanisms for communication and liaison with carers

292. This is an overview only of SHFT's approach to, and implementation of, the initiatives and mechanisms for communication and liaison with carers. Following this there is a more in-depth discussion about where SHFT are now in relation to some of those initiatives.

293. The **Chief Executive** said, "I'm not sure we can ever do enough to support and recognise our carers and as a society we don't do that enough. But we are investing resources and we put carers at the heart of what we do and understand from them what can be done to help and support them... we have to tailor it and personalise it where we can and on the other side, see how we can encourage self-support".³⁵⁸

294. He said 'experts by experience' had been considered in setting-up and running Carers' Groups and that there are Non-Executive Directors with lived experience, who challenge the Executives and act as an advocate for other carers.³⁵⁹

295. SHFT's evidence is that in 2020 they: appointed a Carer Strategy Officer and Triangle of Care Project Lead; the CQC inspection recognised improvements in carer communication and staff understanding and application of the Duty of Candour; and they refreshed the Carers Action Plan, with its delivery identified as a key priority in SHFT's Organisational Strategy 2020/21-2023/24.³⁶⁰

³⁵⁷ Evidence of a family member, 14 April 2021

³⁵⁸ Evidence of Chief Executive of SHFT, 16 April 2021

³⁵⁹ Ibid

³⁶⁰ Statement of The Head of Patient and Public Engagement and Experience at SHFT, 2 February 2021

296. In its Carer Strategy SHFT has set out to achieve the following ‘four standards’ across all services: 1) Carers Leads; 2) Triangle of Care Training; 3) Carers Booklets and 4) Carers Communication Plans.³⁶¹

297. The **Carer Strategy Project Officer and Triangle of Care Project Lead** has been in this position since June 2020. Her role is to support any work SHFT does with carers – anyone providing care or support to service users, family members or friends – to engage with services, support them and ensure they feel involved with SHFT and give them a voice and to support staff, to equip them to work with carers, family and friends effectively.³⁶²

Carer Groups

298. The **Carer Strategy Project Officer** set out some of her specific work and that of SHFT more widely, in line with the Carer Strategy. She said that she hosts monthly events for Carer Leads in SHFT and asks carers to join. In October 2020, they delivered a session on Carer Peer Support Worker roles and received a number of interested parties who wanted to develop their own carer-type roles in their services. In response, she said they recently hired four Carer Liaison Workers within four wards in Basingstoke, therefore, at the time of giving evidence there were 9 Carer Support Worker roles.³⁶³

299. She said that she facilitates a Peer Support Carers’ Group every Friday for carers, with education, guest speakers and they invite Divisional Directors and members of the Board to listen to what carers are saying and there are a number of those Groups across SHFT which do similar. She gave an example in North-Mid Hants of a Carers’ Group which takes place monthly for Adult Mental Health Services and is led by a Carer Lead in SHFT. She said that Group has grown in numbers and has an education section. She said, “lots of the carers’ feedback has been about the challenges they face with communication and education, to understand the condition of their loved one so they can do the right thing”.³⁶⁴

³⁶¹ Ibid; Evidence of Carer Strategy Project Officer and Triangle of Care Project Lead at SHFT, 18 March 2021

³⁶² Evidence of Carer Strategy Project Officer and Triangle of Care Project Lead at SHFT, 18 March 2021

³⁶³ Evidence of Carer Strategy Project Officer and Triangle of Care Project Lead at SHFT, 18 March 2021

³⁶⁴ Ibid

300. The **Carer Strategy Project Officer** said they have recently developed a toolkit for staff to set-up their own Carer Group. She said they recommend researching what is already in the local area, to communicate with third sector organisations who are providing support, which may allow for SHFT staff to attend other external groups and hold education slots or quarterly sessions.³⁶⁵
301. The **Carer Strategy Project Officer** said that they are recognising that staff can be carers themselves and are doing some work around it.³⁶⁶
302. The **Head of Patient and Public Engagement and Experience** also developed this topic in her written statement. She said, "... the carers have access to our Recovery College... and we offer a 'fast-track service to help carers access our 'italk' psychological therapies service". SHFT also signposts to, and contracts or works with other organisations. For example, Hampshire Carers' Together, Princess Royal Trust for Carers', Age Concern, Unloc Learning, Andover MIND and Carers' in Southampton.³⁶⁷
303. During COVID-19, the Patient Experience Team carried out weekly carers' support sessions via Zoom. Feedback from one was: "it's been my lifeline – I was out here on my own, fighting on my own" and they have produced a 'signpost to services' document.³⁶⁸
304. The **Community Mental Health Team Manager**, who has been in post since 2013, described how there have been a lot of changes in regard to carers. She is in the process of recruiting a dedicated Carers' Worker, who was starting in two weeks (at the time of giving evidence). However, she acknowledged that support for carers is limited at the moment in her team and said it needs to be improved. She said they do not have a Carers' Group in their team which is led by them, but they do have access to the Princess Royal Trust and are looking to set up their own groups.³⁶⁹
305. Furthermore, she said that, "if a patient wants a carer involved (in the discharge process), they will attend meetings, form part of the care plan and discussions around

³⁶⁵ Ibid

³⁶⁶ Ibid

³⁶⁷ Evidence of the Head of Patient and Public Engagement and Experience at SHFT, 10 March 2021

³⁶⁸ Ibid

³⁶⁹ Evidence of Community Mental Health Team Manager at SHFT, 31 March 2021

discharge”, but admitted, they had not identified all of the carers and that it is something they are looking at improving.³⁷⁰

306. The **Carer Strategy Project Officer**, recognised that they need to do more to promote the Family, Carers’ and Friends Group and get more representation: it is 60% staff and 40% carers.³⁷¹

307. The Panel heard from the **Lead Governor, Chair and appointed Governor for Carers Together**. He is not employed by SHFT. He said he speaks to carers a lot, independently, and with SHFT and regularly attends Carers’ Groups. He said SHFT wants to go further in the support it provides carers and they recognise that some things have not gone as well as they should have done. He said there is a detailed plan in place, following a presentation to the Board last summer, where carers explained their experience.³⁷²

Carers’ Booklets

308. The **Head of Patient and Public Engagement and Experience** said, “we currently have, or are working on, co-producing 19 Carers’ Booklets, and aim to have 83 Carers’ Booklets, covering all our services, in place by July 2022. We are adopting a staggered approach to co-producing the Carers’ Booklets, based on priority areas in line with the Triangle of Care accreditation process”.³⁷³

Carer Leads

309. The Panel received evidence about the appointment and role of Carer Leads in SHFT, who act as champions and advocates for carer support and are responsible for the delivery of key elements of the Carers’ Action Plan, the development of Carers’ Booklets, Carers’ Communications Plans and training in the teams. Their role will differ between teams, so some Carer Leads may exclusively focus on supporting carers or be the main contact for carers or support the team to communicate with carers.³⁷⁴

³⁷⁰ Ibid

³⁷¹ Evidence of Carer Strategy Project Officer and Triangle of Care Project Lead at SHFT, 18 March 2021

³⁷² Evidence of Lead Governor, Chair and appointed Governor for Carers Together at SHFT, 30 March 2021

³⁷³ Statement of Head of Patient and Public Engagement and Experience at SHFT, 2 February 2021

³⁷⁴ Ibid

310. The Divisional Directors of Nursing and AHP have committed to being a Carer Lead for their division to role model the importance of carer involvement. There are a number of additional Carer Leads who will support the Triangle of Care.³⁷⁵
311. There are 156 Carer Leads across SHFT, approximately one for every 40 members of staff. The Carer Leads attend monthly Carers' and Carer Leads Network meetings. The **Head of Patient and Public Engagement and Experience** said, "most Carer Leads are on our frontline services: 19 are in specialist services covering 20 teams, 34 are in the South-West Division. We have 42 additional Carer Leads who are Executive staff, Non-Executives, Divisional Directors and Heads of Nursing... (and) a great number of our staff are carers, but don't always share it".³⁷⁶
312. The **Head of Patient and Public Engagement and Experience** said the Carer Leads are there to "go the extra mile to work with carers". She said there are also Carer Support Workers, which were recently appointed as permanent paid posts, they have experience of caring and they bring first-hand knowledge and experience.³⁷⁷

Measuring the impact of the improvement work for carers

313. The **Head of Patient and Public Engagement and Experience** said that SHFT's engagement with carers is measured and monitored based on feedback from carers and families; the increase in staff signing-up to the Triangle of Care training, which she attributes to the leaders in the divisions saying it's important and Carer Awareness sessions, which are voluntary and delivered by carers.³⁷⁸
314. The **Carer Strategy Project Officer** said that some Carer Groups have a feedback mechanism to the Public Engagement Network and she feeds comments directly into the Carer Action Plan. She said that she has been developing a log and contacting Carer Leads to ask for regular feedback to put into the Action Plan. She said that currently only three Carer Leads report regularly.³⁷⁹

³⁷⁵ Ibid

³⁷⁶ Evidence of Head of Patient and Public Engagement and Experience at SHFT, 10 March 2021

³⁷⁷ Ibid

³⁷⁸ Ibid

³⁷⁹ Evidence of Carer Strategy Project Officer and Triangle of Care Project Lead at SHFT, 18 March 2021

315. Further, she said they are developing a Quality Dashboard for patient experience and carer data to make the data more accessible. This data will include, use of the Carer Communication Plan, staff that have completed the Triangle of Care training and a snapshot of the data regarding the Carer Survey. She said it is still under development. She confirmed the data is readily available elsewhere, apart from the Carer Survey.³⁸⁰ The **Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement**, also spoke about the development of the Quality Dashboard and said it will bring the Head of Safety, Head of Improvement, Head of Patient and Public Engagement and Head of Safeguarding together, to triangulate the information in one place, rather than in separate reports. She acknowledged that their ability to triangulate information has not been as strong as it needs to be.³⁸¹

316. A **Consultant Psychiatrist** said in her written statement: "... specific audits of carer feedback at a local service level would help us know how successful this cultural change has been from the carers' experience of our services".³⁸²

External views on SHFT's work with carers

317. The **Chair of Hampshire Healthwatch, Ann Smith**, spoke generally and said, "I won't say (the voice of carers is captured) sufficiently. This stems back to GPs, if they don't know who the carers are then we are waiting for them to come forward and say they are carers. We have undertaken a survey of carers... which was well-received, and we fed it back to the local authority and NHS and a lot of carers said they felt they were abandoned and left to get on with it. It was a small survey but we hold them in high regard in terms of needing their voice to be heard".³⁸³

Evidence of carer's experience

318. The Panel received a written statement and heard from a **carer** who has cared for his son for more than ten years. His experience with SHFT has been extensive and therefore it is set out in some detail here.

³⁸⁰ Ibid

³⁸¹ Evidence of Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement, SHFT, 29 March 2021

³⁸² Evidence of a Consultant Psychiatrist at SHFT, 10 March 2021

³⁸³ Evidence of Chair of Hampshire Healthwatch, Ann Smith, 6 April 2021

319. The **carer** said that his experience of SHFT is to focus only on treating mental health crisis and that no communication occurs with families before a crisis occurs, to prevent a re-occurrence, thus resulting in a higher than necessary hospital admission and readmission.³⁸⁴

320. He gave his personal experience and said, “as a family we needed help to prevent a crisis, but when communicating with SHFT for help, they said his records had been referred to the GP and we have to go through the GP. Due to our son’s illness, he had no insight of being ill and refused to go to the GP. So, we had to wait for a crisis to have him committed (under the MHA). Communication with the family is then good while he is in hospital and after in the community for twelve weeks or so, after which he is discharged again to the GP. This is repeated once a year for three years, with three periods in hospital”. He said that as a result of current SHFT policy which means they are only involved with a crisis and sectioning to hospital, “the patients become terrified of the NHS and in no way wish to seek NHS help”. He attributes this to “silo working” and said that he does not observe that SHFT policies have moved sufficiently in the direction of joined-up working along the whole system pathway to benefit patient health.³⁸⁵

321. The **carer** said, “we... contacted Mind asking for details of any Carer Groups where we could talk with similar families, but such a group no longer existed in this area and only leaflets were available”.³⁸⁶ He said he did attend a Carers’ Group in the past, but there was nobody in the group having the same experience and there isn’t a specific group, despite his son’s condition affecting 1 in every 100.³⁸⁷

322. He said, “consultants ask families how things are going with the patient in order to provide the consultant with extra information on how best to treat the patient. However, our experience is that there is no help to the family on how they are coping”. He said, “(the) Community Mental Health team focus on the patient not the family. Advice to family has been limited to trying to keep calm and create a low stress environment... the patient is discharged to the care of the family, with no prior training for them nor subsequent support help line”.³⁸⁸

³⁸⁴ Evidence of a carer, 6 April 2021

³⁸⁵ Ibid

³⁸⁶ Ibid

³⁸⁷ Ibid

³⁸⁸ Ibid

323. The **carer** described it as being, “a bit of a lonely journey when looking after someone... it’s just not possible to find anybody to answer your questions”.³⁸⁹

324. When asked by the Panel how he felt SHFT had interacted with him as a carer he said, “I got the feeling we were part of the problem... maybe we were, but we would want advice on how to do it better... you have 24/7 daily contact and you’re in the firing line, you’re the supporter and you don’t know how to do it for the best. I feel a service and sympathy should be provided...”. He said he did not have any evidence either way that there was more support for carers.³⁹⁰

325. He said he was not aware of any groups or forums in SHFT that he could attend to have his views represented to the Board. He said he receives no information as a carer from the Community Mental Health Team and said, “you would have to find it yourself... the division do not reply and are extremely poor... it has been quite tortuous dealing with the team. When we contacted the Medical Director, he referred us to a lead in psychiatry who responded fast, but the team tend to ignore you, which is down to the management in SHFT”.³⁹¹

326. The Panel received samples of the End-User Feedback Survey responses for the period of 2019 to 2021 and some of the comments were:

‘She said she is not listened to and feels that a document in which carers can list triggers and list the nice things that help in a trigger situation would be helpful for all, when a loved one is admitted. (brilliant idea, although should this be discussed with them when they are assessed) – Mum said they never ask her anything’ (January 2021)

‘Lack of responsiveness from the service. it is a ‘devil to get anything in reply’. Very difficult to get through to people and get staff to talk to the parents. Can’t get to speak to a psychiatrist. Difficult to navigate the consent/confidentiality’ (January 2021)

³⁸⁹ Ibid

³⁹⁰ Ibid

³⁹¹ Ibid

Panel's Views on where SHFT are now: developing initiatives and mechanisms for communication and liaison with carers

- SHFT acknowledged that improvement work was required to increase the involvement and engagement with carers and that they are on this continuous improvement journey.
- In response to this acknowledgment, SHFT developed different processes for communication, which are all positive and encouraging steps in ensuring that a 'care for the carer' approach is embedded within SHFT on a daily basis and communication in general is improved. For example, the role of the Carers' Strategy Project Officer and Triangle of Care Lead and the Carer Leads. The Panel's view is that currently the processes are not necessarily all aligned with each other and that should be rectified without delay.
- The Panel's view is that the Carer Leads should be experts by experience and their role widely publicised.
- The Panel highlights the good work that has been carried out by SHFT during the COVID-19 pandemic. For example, the Patient Experience Team carried out weekly carer support sessions via Zoom. However, the Panel is not satisfied that SHFT has paid sufficient attention to 'digital exclusion', or the fact that the use of technology could alienate some groups of carers. This must not be forgotten.
- In the Panel's view, SHFT has not yet gone far enough in responding to the individual needs of carers. The Panel is not satisfied that the sufficient support is in place for carers who ask for advice. This gap needs addressing and Carer Support Workers may be able to help to resolve this.
- SHFT should also continue its work around establishing more, and a range of, Carers' Group. They must be publicised widely and in an accessible way.
- The Panel is reassured to hear that a Carer Booklet is being co-produced and this should continue at pace. There should be consideration given to its contents and dissemination. For example, it should include signposting to local Carers' Groups and should be available in digital and paper formats.

Triangle of Care

327. The Panel heard from the **Triangle of Care Project Lead** who said that the accreditation process for the Triangle of Care takes three years and that SHFT started the process in mid-to-late 2019. They had one year to complete the self-assessment documents. She confirmed they submitted the self-assessment on 29 January 2021 for all in-patient wards in adult mental health, OPMH, Forensics and CAMHS in-patient

wards. However, the Carers' Trust asked them to re-submit the self-assessments, which she said would be done by the end of March 2021. SHFT hopes to have its 'Third Star' by 2023.³⁹²

328. The **Triangle of Care Project Lead** set out the three levels of accreditation:

- 1) Inpatient wards within the mental health and learning disability services, OPMH, Forensics and CAMHS in-patient wards (not physical services, or children and family services).
- 2) Community teams for all mental health and learning disability services.
- 3) Physical health and other services not previously listed.³⁹³

329. The evidence showed that the Board raised concern regarding SHFT's lack of progress on training for the Triangle of Care, which the Chief Executive acknowledged too. The **Head of Patient and Public Engagement and Experience** was asked about this and said, "when it was first introduced it was sitting in a different directorate and it was part of someone's role and progress was quite slow... now we see this is a role of itself and now the Triangle of Care comes firmly under the Involvement and Engagement agenda and we have used additional resources to get it moving".³⁹⁴

330. The **Triangle of Care Project Lead** said, "we now have a succinct model from which we are embedding the Triangle of Care... it is also a model through which we hope to embed a culture which is effectively collaborative with carers, families and friends".³⁹⁵

331. She said that the Triangle of Care Carer Awareness Training started in late 2018 or early 2019 and they became involved in the Carers' Trust, a network for best practice and learning. The Triangle of Care is specifically for adult mental health services. The **Triangle of Care Project Lead** said other NHS and Foundation Trusts she had spoken to about the Triangle of Care in physical health services had said that it is not entirely appropriate, but that SHFT would meet with their physical health services to explore options in future and draw on experiences of other NHS and Foundation Trusts.³⁹⁶

³⁹² Evidence of Carer Strategy Project Officer and Triangle of Care Project Lead at SHFT, 18 March 2021

³⁹³ Ibid

³⁹⁴ Evidence of Head of Patient and Public Engagement and Experience at SHFT, 10 March 2021

³⁹⁵ Evidence of Carer Strategy Project Officer and Triangle of Care Project Lead at SHFT, 18 March 2021

³⁹⁶ Ibid

332. Two **carers** who gave evidence said they had never heard of the Triangle of Care.³⁹⁷ One of the carers said the term 'liaison officer' did not mean anything to him and he had not come across any QI projects that he could get involved in as a carer.³⁹⁸
333. The **Chief Executive** said "there is significant focus around the Triangle of Care. It's an overreaching principle and approach to trying to reflect the six principles in all we do, to build up an approach to working with families and carers and putting them at the centre of what we're doing".³⁹⁹
334. He proceeded to say, "... what we need to be clear about is, what parts of the Triangle of Care we're going to continue with. The Triangle of Care is just one approach to the philosophy of engaging carers... there is an overarching carers action plan, developed with our Local Authority and the principles are broadly the same, but not exactly the same. I think we have put too much emphasis on the specifics of the Triangle of Care and sometimes people have interpreted it as something you just do; but it's not something you just do, or something that happens, or something that you just train on... this is about winning hearts and mind, culture and that staff... it should naturally involve families and respect what they have to say and bring them into partnership. It's not about a straight training programme and the answer isn't doing it quickly".⁴⁰⁰
335. The **Chief Executive** said, "I think we can show that families are being engaged in different ways. Most of the time it works very well, but there are lots of times it won't work well and that's where the learning is and where we will evolve to becoming better, never perfect, but always better in terms of our engagement with families".⁴⁰¹

Training on the Triangle of Care

336. The Triangle of Care training is for frontline staff but SHFT hope that all staff will be trained in it.⁴⁰² The evidence indicates that it has been undertaken by the Lead Governor, Board of Trustees, Non-Executive Directors, Executive Directors, Divisional Directors,

³⁹⁷ Evidence of a carer, 31 March 2021

³⁹⁸ Evidence of a carer, 6 April 2021

³⁹⁹ Evidence of Chief Executive of SHFT, 16 April 2021

⁴⁰⁰ Ibid

⁴⁰¹ Ibid

⁴⁰² Evidence of Head of Patient and Public Engagement and Experience at SHFT, 10 March 2021

Heads of Nursing and Matrons.⁴⁰³ Further, that in February 2021, SHFT had planned a Board Seminar where additional Board members would receive the training. The **Triangle of Care Project Lead** said that the attendance of higher management has really sparked an increase in the number of frontline staff attending.⁴⁰⁴

337. The **Triangle of Care Project Lead** said that since February 2019, 725 staff have been trained, but acknowledged that there will have been turnover of staff during that period. She said the training has been updated so a number of staff will be completing refresher training. She commented that staff attendance varies and that they typically see a lot of nurses, AHPs, support workers and administrative teams and occasionally consultants. She said they are looking to get more consultants and doctors actively involved and that doctors in training will have access to it too. The training is not mandatory.⁴⁰⁵

338. The training is delivered online through Zoom and it is available through the SHFT online learning portal. It is co-delivered by the Triangle of Care Project Lead and a colleague, with carers. It was redesigned in 2020 to be applicable across all services and more accessible. The plan, moving forward, is for Carer Leads in their teams, to train new staff and SHFT are looking at online bitesize training sessions, which are not facilitated, but are available for reminders.⁴⁰⁶

339. The Triangle of Care training covers challenges and barriers staff might experience working with carers, family and friends. The Triangle of Care Project Lead's role is to take the feedback on board and work with the teams and services to solve problems and work with them to make improvements. The **Triangle of Care Project Lead** said another part of the training is about getting staff to think about talking to services users to appoint who their carer might be, who supports them most and who they want actively involved, as it might be someone different to who they expect.⁴⁰⁷

340. The Panel were interested to know how SHFT measures and evaluates the impact of the Triangle of Care training and the **Triangle of Care Project Lead** said there is no real number-based evidence. She gave an example of them acting upon feedback: "we

⁴⁰³ Statement of Head of Patient and Public Engagement and Experience at SHFT, 2 February 2021;
Statement of Head of Patient and Public Engagement and Experience at SHFT, 2 February 2021

⁴⁰⁴ Evidence of Carer Strategy Project Officer and Triangle of Care Project Lead at SHFT, 18 March 2021

⁴⁰⁵ Ibid

⁴⁰⁶ Ibid

⁴⁰⁷ Ibid

recently started to co-facilitate it with carers attending and sharing their stories at the full session... we felt it important to get feedback from staff... to see whether we should amend it to make it more user-friendly for them... some staff said it was invaluable to have a carer present... and it improved engagement and reflective practice, but some said they were not comfortable talking as openly about challenges with carers present. In response, we are looking to have half the session co-facilitated with carers and the other half as an open space for staff to feel confident sharing their own challenges”.⁴⁰⁸

341. She said she had received feedback from a member of staff who said that after the training she had more understanding of where the carer was coming from and what the situation was and what they needed support with. She said that the “long-term evidence base will come from more feedback from staff, carers, complaints, concerns and themes and what we hear during Carer Groups... (it will be) another six months from now, before we can really see a massive impact”. Her hope is that in one year they will see really strong working relationships across all three parts of the Triangle of Care.⁴⁰⁹

342. The **Lead Governor** said he undertook the Triangle of Care training and commented that, “the reality was that the training didn’t deliver what was required for frontline staff to put something meaningful in place that worked. Since then, the training has been revamped and I’m redoing it”. However, he said that he is able to see the training being put into practice during his work as a Mental Health Act Review Manager in SHFT.⁴¹⁰

343. A **Matron** said, “there is a lot more engagement... we have all done the Triangle of Care training, there is more frontline involvement in terms of understanding processes and why we need to work collaboratively with families and carers, for example, and the expectation is there, to engage and have contact with (carers)”.⁴¹¹

344. A **Clinical Ward Manager** said, “we had the Triangle of Care training initiative and we did most of the training before COVID-19, so there was a big push to get staff through it and it made a big difference. I have seen more understanding or appreciation in managing delicacies around consent to share”.⁴¹²

⁴⁰⁸ Ibid

⁴⁰⁹ Ibid

⁴¹⁰ Evidence of Lead Governor at SHFT, 30 March 2021

⁴¹¹ Evidence of Matron, SHFT, 29 March 2021

⁴¹² Evidence of Clinical Ward Manager, 12 April 2021

345. In a **family member's** opinion, the Triangle of Care training should be three days; it should be implemented with great haste (within months); the standard of training needs to be dramatically improved; there should be targets; and it should be mandatory.⁴¹³

Alternatives to the Triangle of Care

346. The **Head of Patient and Public Engagement and Experience** said, “the Triangle of Care is one way, but lots of services are doing other work. For example, the Learning Disability group have not done the Triangle of Care training, but have done a lot of work, and the training is being adapted for them now”.⁴¹⁴ Examples of the other work that is being done are provided in her written statement: “there are dedicated Carer Involvement Leads, alongside Champions within individual teams... some teams hold Carer Groups, others produce a Carers' Newsletter. Teams proactively seek feedback from carers to ask how they have done, using a common feedback form for consistency... and carer communication and involvement activity is reported upon in team governance meetings”.⁴¹⁵

347. She said, “as an organisation an important next step is to clarify and prioritise the specific Triangle of Care actions, and to describe how they form part of a more comprehensive and multi-layered approach to improving carer communication and support”.⁴¹⁶

Panel's views on where SHFT are now: implementing the Triangle of Care

- Overall, the Panel's view is that SHFT have taken some really positive steps towards implementing the Triangle of Care and the associated training. This momentum should continue and grow, so that all members of staff undergo the initial training and receive refresher training too. There is a risk that this momentum will be lost as a result of a shift to locally based training delivered by Carer Leads so future planning needs to account for this.
- The Panel is not satisfied that the evidence points to there being sufficient training and awareness amongst the staff at SHFT, at all levels, as to who can be a 'carer'. It is vital that this is covered in the Triangle of Care training and that the training is undertaken by all members of staff; SHFT may consider making the training mandatory.

⁴¹³ Evidence of a family member, 14 April 2021

⁴¹⁴ Evidence of Head of Patient and Public Engagement and Experience at SHFT, 10 March 2021

⁴¹⁵ Statement of Head of Patient and Public Engagement and Experience at SHFT, 2 February 2021

⁴¹⁶ Evidence of Head of Patient and Public Engagement and Experience at SHFT, 10 March 2021

Panel's views on where SHFT are now: implementing the Triangle of Care continued...

- The co-production work in the Triangle of Care is progressive and should continue.
- SHFT should give consideration to the ways in which it can more systematically obtain feedback on the implementation and success of the Triangle of Care and the training, in order to inform its future strategy.
- In regard to the future, the Panel notes the Chief Executive's view is that this is only one way to approach engagement. Other participants acknowledged the risk that it could be seen as a panacea for improvement, which, in the Panel's view, it shouldn't be, but it should instead complement other methods of engagement and improvement. It may not work for all.
- The small sample of carers, service users and family members the Panel heard from were not aware of the Triangle of Care and the Panel did not see any publicity information about it that SHFT have produced. SHFT should consider ways in which it can increase its publicity of the model and of its practical application and engagement opportunities.

Carer Communication Plans

348. The Panel received evidence regarding the introduction and use of Carer Communication Plans. There were also references to Carers' Assessments, and at times the two terms were used interchangeably. This section will focus on the former, but the Panel is clear that both should be taking place as a matter of course.

Purpose of the Carer Communication Plan

349. The Panel were told that the Carer Communication Plan ("the Plan") has been developed based on feedback from carers. The **Head of Patient and Public Engagement and Experience** said that the Plan helps to enable a structured conversation with carers, families and friends at the first point of contact with a service user, it is a proactive method for developing a relationship with the carer and can be used to agree with them how they want to be communicated with and to obtain:

- Important information from the carer about the service user to aid assessments, care planning and discharge;

- Insights into the carer and their needs, to be able to provide information, advice and signposting to support them and to reduce the risk of the carer becoming the service user of tomorrow.⁴¹⁷

350. The **Carer Strategy Project Officer** added that another purpose of the Plan is to stop the carer having to repeat their situation and background information, as it would already be there. The Plan is two pages of A4 and it can be modified at any time.⁴¹⁸

351. A **Matron** said, “Carer Communication Plans do help, as they can identify suitable times for contacting families and a system for contacting families, which helps to individualise the communications”.⁴¹⁹

352. A **Clinical Ward Manager** said that carers complained that they did not know what was going on. Therefore, they have been trying to use the Carer Communication Plan more frequently, especially now that they are embedded on their records system, as they were previously only available if a formal carer was assigned.⁴²⁰

353. She said, “in the Triangle of Care training, we learnt that a carer could be anyone and our team has got better, so that when someone is admitted we try and recognise who the carer might be and we put them on the records system as an ‘informal carer’, so it links with the Carer Communication Plan... and triggers a conversation with the carer about the service user”.⁴²¹

Implementation of the Carer Communication Plan

354. As to where SHFT are in implementing the Carer Communication Plans, the **Head of Patient and Public Engagement and Experience** said: “SHFT are still embedding the Carer Communication Plan as a central document for communication between carers and staff. We are aiming for 90% compliance for the completion of Carer Communication Plans for every team and ward in every service by July 2021”.⁴²²

⁴¹⁷ Statement of The Head of Patient and Public Engagement and Experience at SHFT, 2 February 2021; Evidence of Head of Patient and Public Engagement and Experience at SHFT, 10 March 2021

⁴¹⁸ Evidence of Carer Strategy Project Officer at SHFT, 18 March 2021

⁴¹⁹ Evidence of Matron, SHFT, 29 March 2021

⁴²⁰ Evidence of Clinical Ward Manager, SHFT, 12 April 2021

⁴²¹ Ibid

⁴²² Evidence of Head of Patient and Public Engagement and Experience at SHFT, 10 March 2021

355. The **Deputy Director of Nursing** said that 1204 carers have a Plan in place.⁴²³ The **Head of Patient and Public Engagement and Experience** accepted that the rate for completing the Plan had increased from 29% to 41% and agreed that progress has been slow. She said, “we have made significant progress recently, now we have sorted some things with RiO... we have aspirations to get that higher”.⁴²⁴
356. However, she said it is clear that some services are doing regular liaison and communication with carers and families despite not having an official Carer Communication Plan.⁴²⁵
357. The **Carer Strategy Project Officer** said the focus should be on the quality of the use of the Plan, not the numbers and that the Plan would be one step in the right direction to having free, open and communicative relationships with carers, family and friends. Therefore, getting staff to use it is a high priority and the next step is to get them to use it effectively.⁴²⁶
358. As to how they will get staff to use the Carer Communication Plan effectively, she said, “it comes down to me having the time and space to work with individual teams to negotiate... the reason that the Plan should be the way to move forward is because it’s a separate form from all the information that we have about the service user... it is a one-stop-shop and as a service user moves, all staff would know where to look for the information from the carer and separate it from the usual assessment and notes”.⁴²⁷
359. The **Community Mental Health Team Manager** said they have recently started working on implementing the Carer Communication Plan. She said that they had recognised that they had not identified all of the carers, so in April 2021, she tasked staff with looking at the demographics to check people have understood who a carer is. She also said that it will be one of the main roles of the Carer Worker they have employed. She said their aim is to try to identify carers at the initial assessment, then to review it if they are taken on in the service and the allocated staff will contact the carer within three appointments with the service user, to go through the Carer Communication Plan with them and identify a good time to call. She said that carers can ask for a copy of it.⁴²⁸

⁴²³ Evidence of Deputy Director of Nursing at SHFT, 4 March 2021

⁴²⁴ Evidence of Head of Patient and Public Engagement and Experience at SHFT, 10 March 2021

⁴²⁵ Ibid

⁴²⁶ Evidence of Carer Strategy Project Officer at SHFT, 18 March 2021

⁴²⁷ Ibid

⁴²⁸ Evidence of Community Mental Health Team Manager at SHFT, 31 March 2021

360. The **Community Mental Health Team Manager** said that they had had two new members of staff who had been in the team for three weeks and thought that the Carer Communication Plan was for ‘paid-for’ carers only. She said that this has been addressed and is now covered in the induction, but is something they need to improve on. She said the new Carer Worker would also form part of the induction.⁴²⁹

361. She said that carers and family members can contact the team directly, but that it is probably not as widely acknowledged as it could be.⁴³⁰

Changes to the Carer Communication Plan

362. The **Carer Strategy Project Officer** gave evidence as to the amendments to the Carer Communication Plan that SHFT were intending to make in the next month (at the time of giving evidence), which she said would make it more applicable to all services and easier to find.⁴³¹

363. She said, “we have come to an agreement through the Task and Finish Group, that the new amendments will lead to a more generic form, but we will work with individual teams and services with the questions they will ask within that form. The form is a tool to record conversations and it is up to the teams, with my support, to decide on what they cover within it”. She said it will have generic boxes: what do we need to know about the service user? What do we need to know about the carer? Is there anything we can offer? There will also be a free-text box, where staff can provide regular updates, with dates.⁴³²

Evidence from carers

364. In the Service User-Led Standards Audit Report, April-September 2020, 701 carers responded. The results, in summary, showed the following:

- Over 80% of the carers spoken to did not know what a Carers’ Assessment was and those that did voiced that they were 50-50 as to *‘whether they were worth the paper they were written on’*.

⁴²⁹ Ibid

⁴³⁰ Ibid

⁴³¹ Evidence of Carer Strategy Project Officer at SHFT, 18 March 2021

⁴³² Ibid

- Over 80% stated that they don't have a Carer Communication Plan. The Report narrative states, '*In the Carers' Feedback Report to the last Board, a deep dive (was) done, using 80 carers details, and it appears they do (have) a plan recorded. However, these are not recorded in the correct form... which means that it hasn't been explained as a communication plan and on some they have been recorded in the progress notes instead*'.
- Feedback from carers suggests, '*Community teams listen and take the carer seriously, however our inpatient services have had less favourable feedback. Often carers say they feel shut out and, in some instances, have been treated like they are a part of the problem*'.

365. A **Service User Involvement Facilitator** was questioned by the Panel on these results and said, "I did a deep-dive to find the cause... I discovered a lot of our carers had Plans, but it hadn't been described as that... the moment this came-up, we did work around telling people what a Carer Communication Plan looks like".⁴³³

366. A **carer** told the Panel, "I think it's important for senior people in the teams to communicate with families and carers, but they don't seem to engage". He said he was not aware of ever having a Carers' Assessment but had heard the term. He said he has to keep repeating his story to new Care Coordinators and said, that they might have a completely different approach as they might not know what happened before.⁴³⁴

367. A **carer** whose son has a psychiatric condition thought it would help with continuity to have service standards for care coordinators. He said, "when our Care Coordinator left, she said she was surprised there would be no handover and she left within one-to-two weeks and she said she'd have liked a handover but there wasn't one. We have had at least ten Care Coordinators, about one a year, and at least ten psychiatrists, but no forward progression".⁴³⁵

368. A **family member** said "there is huge expertise in carers, they have a huge amount of knowledge you can draw-upon to make your expertise more effective".⁴³⁶

⁴³³ Evidence of Service User Involvement Facilitator at SHFT, 18 March 2021

⁴³⁴ Evidence of a carer, 6 April 2021

⁴³⁵ Evidence of a carer, 6 April 2021

⁴³⁶ Evidence of a family member, 14 April 2021

Panel's Views on where SHFT are now: implementing the Carer Communication Plan

- The Panel welcome the development of the Carer Communication Plan and can see that they have potential to help both the carer, the service user and SHFT staff, to all work more cohesively together, which SHFT should be aiming for.
- The Panel acknowledges that the Carer Communication Plan is just one of the mechanisms that is at the centre of SHFT's strategy to improve its engagement with carers.
- However, the Panel heard how its roll-out has been slow, inconsistent and the improvements required to its template have also been delayed. The updates to the template on RiO, training and an awareness campaign should be done as a matter of priority across the whole of SHFT, including with carers, to ensure that its potential benefits are shared and promoted. This is currently a missed opportunity to improve the experience for carers.
- The Panel also considers that the Carer Communication Plan as presented, and the amendments SHFT proposes to make, could go further. For example, it does not specifically ask carers what their preferred method of contact is and presumes telephone calls are best. However, there could be wider use of technology, such as text messages or emails for contact. Any preferences should be recorded in the Carer Communication Plan.
- Furthermore, the Carer Communication Plan does not acknowledge that communication is a two-way process, as it does not provide an option for how carers can contact SHFT, its focus is solely on how SHFT will contact them. This should be rectified in the revised Plan before it is rolled-out.
- As a matter of course, the carers that are identified through the Carer Communication Plan should be given the opportunity to become more involved in SHFT, for example, they should be sent the Carers' Booklet, information about the Carers' Groups available, SHFT's QI programme and the Triangle of Care.

Carers' Action Plan

369. The Panel reviewed and scrutinised the Carers' Action Plan by questioning the Carer Strategy Project Officer and Head of Patient and Public Engagement and Experience. The **Carer Strategy Project Officer** was questioned about whether the Carers' Action Plan is SHFT's strategy for its work with carers and accepted that it was.⁴³⁷

⁴³⁷ Evidence of Carer Strategy Project Officer at SHFT, 18 March 2021

370. She said they want the Carers' Action Plan to be a living document, responding to feedback from carers, family and friends. She said that the Carers' Action Plan is co-produced with carers and updated when new information comes in, but that the majority of the updating takes place when she is preparing reports for the Board or Family, Carers and Friends Group.⁴³⁸

371. She recognised that often the Carers' Action Plan is not seen as the 'Trust's overarching plan'. She said they are aiming for a cultural shift where they give ownership to Divisional Directors and managers at service-level and back to the service, so they enact things moving forward, so it's not just down to their small team.⁴³⁹

372. The **Carer Strategy Project Officer** reports to the Patient Experience Engagement Group, the Working in Partnership Group and the Family, Carers' and Friends Group, but not all to the same level and depth. She said that the plan moving forward is to have more time to discuss the Carers' Action Plan and for it to be a rolling agenda item in the Family, Carers' and Friends Group meeting.⁴⁴⁰

373. She said "if I meet a carer I've not met before, I draw out of the Carers' Action Plan and explain all of the things we have going on which might be of interest to them specifically and tell them about the three groups: Working in Partnership Group; Family, Carers' and Friends Group and the Patient Experience and Engagement Caring Group, which they are welcome to join to learn more about our progress".⁴⁴¹

374. The **Carer Strategy Project Officer** said that she produces, "quarterly reports on SHFT's progress against the Triangle of Care and Carers' Action Plan... in the past they have focussed heavily on numbers... moving forward, we have a Carers' Lead Insight Report and we'll get more qualitative data... it can tell us where to make changes and what isn't working in practice".⁴⁴²

⁴³⁸ Ibid

⁴³⁹ Ibid

⁴⁴⁰ Ibid

⁴⁴¹ Ibid

⁴⁴² Ibid

375. The statement of the **Head of Patient and Public Engagement and Experience**, set out some of the actions for the coming year (2021-2022), which includes:

- Roll out of carers' advice and information drop-ins provided by Hampshire Carers' Together;
- Identify community settings to host carers' drop-ins;
- Second campaign to ensure clarity around consent to share;
- Achieve second stage of accreditation in Triangle of Care;
- Targeted work with carers and families from BAME communities following on from two workshops completed in February 2020;
- Co-design of Patient and Carer support model; and
- Promote the 'Connect to Support' app.⁴⁴³

376. The **Carer Strategy Project Officer** said, "the plan moving forward in April (2021), is to develop a Carer Planning Strategy Monitoring Group, where some Carer Leads and representatives from services in SHFT can see the progress made against actions and to provide feedback". She intends to set up monthly sessions with a focus on the Carers' Action Plan and on a quarterly basis, to invite the Board members and Divisional Directors to attend for a full overview update.⁴⁴⁴

377. The Panel critiqued parts of the Carers' Action Plan and the **Head of Patient and Public Engagement** accepted, for example, that the action, '*Carers' Communication Plans to be completed for all carers*', is not very informative for the reader and that it should be more specific.⁴⁴⁵

378. Furthermore, SHFT were keen to point out that the Carers' Action Plan is co-produced and co-owned with carers, however, the Panel identified that the carers are not named in the Plan and the **Head of Patient and Public Engagement and Experience** said, "it is absolutely co-produced... there was no Carers' Action Plan when I arrived and we set up focus groups to develop it and the Lead Governor had a role...

⁴⁴³ Statement of Head of Patient and Public Engagement and Experience at SHFT, 2 February 2021

⁴⁴⁴ Evidence of Carer Strategy Project Officer at SHFT, 18 March 2021

⁴⁴⁵ Evidence of Head of Patient and Public Engagement and Experience at SHFT, 10 March 2021

we will make the change straight away”.⁴⁴⁶ The Chief Executive at SHFT, when questioned about this, said he is confident that it has been co-produced.⁴⁴⁷

379. The **Chair of the Working in Partnership Committee** said they have had regular presentations on the Carers’ Action Plan and said, “we feel we have made a good contribution, had our say and are listened to, but... its actual ownership in terms of responsibility for implementation is back to SHFT... we have gone through the work with them, so believe they are trying to do the right thing”.⁴⁴⁸

380. The **Carer Strategy Project Officer** was asked how the public are kept informed about the Carers’ Action Plan and access information about it. She said it is not on their website due to resource issues in keeping it updated and she felt that there are “other more important priorities”. However, she accepted it should be on the website and said they have a user-friendly version.⁴⁴⁹

Panel’s Views on where SHFT are: Carers’ Action Plan

- The Panel sees the Carers’ Action Plan as positive, but it is not satisfied, on the evidence, that it is in fact co-owned and co-produced with carers and it should be. For example, the name of carers who have co-produced the plan should be included (where they consent).
- They are also not satisfied that the actions are sufficiently precise or SMART (Specific, Measurable, Achievable, Relevant, Time-bound).
- There was some vagueness around whether the Carers’ Action Plan is also SHFT’s Strategy for its work around carers. This needs to be clarified, but in any event, there should be an overarching strategic plan in place for this work.
- If the Action Plan is SHFT’s Carers’ Strategy (i.e. an external document, not just internal), it should be more widely publicised, shared and accessible for carers, service users and family members, not just staff or those that attend a specific group or committee. Openness and transparency are key here.
- In Part 5C and the Recommendations, the Panel proposes an alternative or addition to the Carers’ Action Plan which, in its view, would be more effective in achieving SHFT’s aims.

⁴⁴⁶ Ibid

⁴⁴⁷ Evidence of Chief Executive at SHFT, 16 April 2021

⁴⁴⁸ Evidence of Chair of the Working in Partnership Committee, 11 March 2021

⁴⁴⁹ Evidence of Carer Strategy Project Officer at SHFT, 18 March 2021

Information sharing and consent to share

381. The consent to share is enshrined in the UK Caldicott Guardian Council Principles: *'the duty to share information for individual care is as important as the duty to protect patient confidentiality'* (Principle 7) and *'patients and service users should be informed about how their confidential information is used'* (Principle 8, added in 2020). The issues and challenges surrounding this are particularly acute in mental health settings and learning disability services, of which SHFT has many.

382. SHFT acknowledges that any engagement with an individual about information sharing should be respectful of the individual's wishes, but should not be used as an artificial boundary or obstruction (to information sharing). Further, that in some cases, there may be important safeguarding or legal reasons, which clinicians must take into account when making decisions about information sharing. These factors mean that they cannot guarantee that they will be able to satisfy all parties in all cases. They said that they recognise that it is crucial that they are guided by sound principles, and support clinicians to make the right decisions, always prioritising the safety of their patients above all other considerations.⁴⁵⁰

383. This was reiterated by a **Consultant Psychiatrist in SHFT** who said, "sometimes we know the patient or their relationships well, sometimes they're new, so we have to learn and some may or may not have capacity... it is a complex situation and not as simple as looking at the form".⁴⁵¹ However, she said in her written statement, "staff awareness and confidence in this area has noticeably improved. In complex situations, sometimes ward staff refer the family member to the ward manager, the nurse in-charge, or the consultant, but it is very rare to hear lack of consent to share as a reason simply not to talk to relatives".⁴⁵²

384. Furthermore, SHFT have an Information Sharing Policy and associated Staff Guidance, including a statement that was developed by the Department of Health in 2014, which SHFT has adopted: *'Even where a person wishes particular information not to be shared, this does not prevent practitioners from listening to the views of family*

⁴⁵⁰ Statement of The Head of Patient and Public Engagement and Experience, at SHFT, 2 February 2021

⁴⁵¹ Evidence of Consultant Psychiatrist at SHFT, 10 March 2021

⁴⁵² Statement of Consultant Psychiatrist at SHFT, 2 February 2021

members, or prevent them from providing general information, such as how to access services in a crisis’.

385. It is also averred that there is a co-produced leaflet for patients, carers and families, which describes the principles around information sharing. The Panel did not have sight of it.⁴⁵³

386. The **Chair of the Working in Partnership Committee** said, “... one to two years ago, the Family, Carers’ and Friends Involvement Group adopted the term ‘common sense confidentiality’, which is used by Cumbria, Northumberland Tyne and Wear NHS Foundation Trust”. In his opinion, in the past, the training on information sharing, was focussed on the legal position and what not to do, so that SHFT would not get in trouble, rather than looking at what can be said to carers even if they don’t have permission to share.⁴⁵⁴

Access to records

387. The **Head of Patient and Public Engagement and Experience** acknowledged that patients are not always aware of SHFT’s policies on how to access their records. She said their Child and Family Services have secured a digital portal and if that works well, they hope to create a patient portal to access records.⁴⁵⁵

388. The procedure in SHFT now if a service user, carer or family member wants to access records is to make an official request to SHFT’s ‘Records, information and governance department’. She said, “I would like to think conversations are had with the patient about it, so it’s not so daunting”. She said, “they know this is a patient’s right and I like to think they would help the patient to do this. The fact we want to procure a portal shows our commitment to patients being able to access their records more easily”. She accepted that she had not personally had conversations with clinical teams about releasing records.⁴⁵⁶

389. In oral evidence, a **Consultant Psychiatrist in SHFT** said, “(service users) are entitled to request access (to their records) and frequently they do; it is a difficult bureaucratic process ... and clinicians get involved, as we receive an email from the

⁴⁵³ Statement of The Head of Patient and Public Engagement and Experience, at SHFT, 2 February 2021

⁴⁵⁴ Evidence of Chair of the Working in Partnership Committee at SHFT, 11 March 2021

⁴⁵⁵ Evidence of Head of Patient and Public Engagement and Experience at SHFT, 10 March 2021

⁴⁵⁶ Ibid

records department asking if there is anything ... clinically detrimental to the patient and then have to go through thousands of pages of care records to redact any third party information... it is a difficult and lengthy process that clinicians feel worried about”.⁴⁵⁷

Training

390. The **Head of Patient and Public Engagement and Experience** said, “we have recommended confidentiality and sharing of information (training) on top of the mandatory information sharing training and we are developing more training for carers and recommending that becomes mandatory too”.⁴⁵⁸

391. She said she was not surprised that people wanted more clarity on consent to share as it had been “a theme for a long time”. She said they organised a communications campaign around it and from that, realised that they have to keep reiterating it and going over it. She agreed that it had been an issue on her radar for decades.⁴⁵⁹

392. A **Consultant Psychiatrist in SHFT** said the Triangle of Care training includes information on consent to share and that there are reflection sessions available to all (but it is not mandatory).⁴⁶⁰

393. The **Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement** said, “... we did a QI project in a team on this issue and we found there were a lot of pre-conceived ideas about whether families would want information or not... we asked (staff) to talk to people to find out what they would actually want and some of those pre-conceived ideas were quashed... it goes back to the question of... ‘how do we get our teams to be autonomous, inclusive practitioners that feel safe to ask about inclusion and not fearful of information sharing?’ and that’s a culture change”.⁴⁶¹

⁴⁵⁷ Evidence of Consultant Psychiatrist at SHFT, 10 March 2021

⁴⁵⁸ Evidence of Head of Patient and Public Engagement and Experience at SHFT, 10 March 2021

⁴⁵⁹ Ibid

⁴⁶⁰ Evidence of Consultant Psychiatrist at SHFT, 10 March 2021

⁴⁶¹ Evidence of Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement at SHFT, 29 March 2021

Communicating about consent to share

394. When asked about communicating with carers or family members about a patient or service user's consent to share, a **Consultant Psychiatrist in SHFT** said, "... often I find it's important to pick up the phone and talk to them, you don't have to give details of the patient, but you can understand where the carer or family member is coming from and what is important to them. When that is all understood, I rarely find that there is a true conflict and people tend to understand when you explain consent to share".⁴⁶²

395. A **Consultant Psychiatrist** said, "I think it's about very sensitive communication which is why some members of staff, particularly if they are junior, have found this very difficult as they don't want to do the wrong thing or get into trouble; it is easier to say they don't have consent then to unpick the complexity of the situation... it is perfectly reasonable to say, 'I can't speak without permission but you can speak to a consultant etc.' and that's what we are seeing now".⁴⁶³

396. A complaint in the SHFT Annual Complaints Report 2019/20 was that there was '*Poor communication regarding a loved one's discharge*' and the improvements and learning from this was that '*Processes regarding updating consent to share information had not been followed on this occasion and as a result, the relative had discovered that the service user had been discharged from hospital following a further Emergency Department admission. The process of consent to share and its review and recording to be reflected/raised in the local Quality and Safety Meeting*'.

Panel's Views on where SHFT are now: information sharing and consent to share

- The Panel acknowledges, as SHFT does in similar terms, that mental illness can affect people's willingness to talk openly and share details of their treatment or illness. The Panel adds, from experience, that the decision can be fluid and changeable. Thus, it does not seek to diminish the enormous challenges that this topic brings with it. However, that should not stop SHFT improving in this area.
- The Panel is pleased that there have been, on SHFT's evidence, improvements in this area already and that training has been implemented. There should now be a focus on the junior doctors that are joining SHFT to receive this training to try to combat some of the issues that were highlighted in the evidence.

⁴⁶² Evidence of Consultant Psychiatrist at SHFT, 10 March 2021

⁴⁶³ Ibid

Panel's Views on where SHFT are now: information sharing and consent to share continued...

- Furthermore, SHFT could be more proactive in engaging with carers and family members about this topic and ensure that any literature provided to them, or policies that they are directed to, are displayed in an accessible format, with language that recognises that this can often be a complex area and one where there are heightened emotions and tensions.
- SHFT are encouraged to give consideration to improving their access to records process, to ensure that it is no longer a “difficult bureaucratic process” for clinicians and service users alike. SHFT’s policies should be publicised and accessible to all.

Communication and liaison between primary and secondary care

397. The evidence given by a **Consultant Psychiatrist in SHFT** summarised the importance and issues surrounding the communication and liaison between primary and secondary care very well when she said, “we are in a position where we have different teams looking after patients in units and in the community; there is a debate playing out nationally as to whether it would be good for teams to do both, where you would get more continuity of care, but not the specialisms. We are working at the moment (in) different teams, so... communications between those teams and the GP are essential, because we need everybody to be in the loop, particularly where the patient changes between teams and throughout that journey”.⁴⁶⁴

398. The **Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement** acknowledged that there is a risk at the point of handover associated with the transfer between services, even if it is internal, so how they communicate between teams is also always a point of risk.⁴⁶⁵

⁴⁶⁴ Evidence of Consultant Psychiatrist in SHFT, 10 March 2021

⁴⁶⁵ Evidence of Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement at SHFT, 29 March 2021

What are SHFT doing to improve communication and liaison between primary and secondary care?

399. A **Consultant Psychiatrist** described, in brief, how SHFT are improving the communication and liaison between primary and secondary care: discharge planning meetings, meetings with the community team and electronic patient records.⁴⁶⁶

400. The **Chief Medical Officer** stated that the communication with GPs was not as responsive as it needed to be, and had been identified in medication management incidents. Therefore, he said that in 2020, SHFT's Clinical Effectiveness Group developed a standardised discharge form, to strengthen the information flow, which is completed on the day of discharge to include care planning, as well as medication information and the patient receives a copy before they leave the ward. This is sent to the GP on the same day. He confirmed that the form has been introduced at three of the four acute mental health inpatient hospitals, with the plan for a Trust-wide roll out to all wards for adults and older people in 2021.⁴⁶⁷

401. The **Lead Governor at SHFT** who was involved in a five day QI workshop on 'Improving the Discharge Process', described a turning point after a question from a service user or carer spoke about a patient being held for a long time and the meeting for that patient was called a 'Stranded patient meeting'. He said that the service user said she wasn't a 'stranded patient'. Following this workshop, he set out what was achieved, which included reducing the steps for discharge from 72 to four and out-of-area placements to almost zero. He described these as examples of getting it right first time. He also spoke of the positive relationship building between the County Council, CCG, SHFT and patients.⁴⁶⁸

402. The **Chief Medical Officer** said in his statement that SHFT has strengthened the way in which it collaborates with external partners in supporting patients who frequently present to multiple services, to deliver the right care at the right time and place. He said, monthly meetings are held in each of the divisions to look at how best to support and manage the risk of these high intensity users. He said this has reduced the number of

⁴⁶⁶ Evidence of Consultant Psychiatrist in SHFT, 10 March 2021

⁴⁶⁷ Statement of Chief Medical Officer at SHFT, 2 February 2021

⁴⁶⁸ Evidence of Lead Governor at SHFT, 30 March 2021

detentions under Section 136 of the Mental Health Act, and unnecessary admission, which was acknowledged by the CQC in their January 2020 report.⁴⁶⁹

403. The **Community Mental Health Team Manager** said that when patients are discharged back to their GP, they always offer advice to the patient and look at voluntary agencies they might link them to. She described how they have a 'fast track back', which is not used for all, but if they need their services within six months or so, they can be on the track and contact them directly, rather than any other referral route, and they will pick them back up.⁴⁷⁰

404. The **Community Mental Health Team Manager** said they have monthly meetings with physical health colleagues, to see if they have patients in common but it is predominately about the physical health element. She gave an example from three months prior, where one of their patients needed physical adaptations to her property and said she was able to get them quite quickly because all of the relevant people were there in the room.⁴⁷¹

405. She also spoke about how they are linking in with the primary care network to provide a collaborative approach to their services in general. She said, "we are looking at creating new roles that are 50/50 funding between us and the primary care network. We are looking at mental health practice and expanding that and working together more... we have regular weekly meetings with the primary care networks, to look at how we can work together to help bridge the gap between us".⁴⁷²

406. However, the Learning from Deaths: Mortality Data and Learning for Quarter One (Q1) 2020 stated, '*Discharge communication has featured as a theme with poor quality discharge planning and lack of take-home medication*'.

Evidence of the CCG

407. The Panel received evidence from West Hampshire CCG on this topic as the commissioners for the primary and secondary care services concerned and heard from a local GP in Hampshire who has regular contact with the services SHFT. The **Clinical**

⁴⁶⁹ Statement of Chief Medical Officer at SHFT, 2 February 2021

⁴⁷⁰ Evidence of Community Mental Health Team Manager, 31 March 2021

⁴⁷¹ Ibid

⁴⁷² Ibid

Director for Mental Health and Learning Disability for West Hampshire CCG said, "... in terms of GPs referring into secondary care and the levels of communications coming back to them, I would expect that if someone is referred to secondary care, that there is some notification of the level of urgency of the referral; I'd expect a quick response to the GP if it is urgent, and if it's a routine referral I would expect a letter back signposting or information that the patient has been invited to book an appointment, then to hear the outcome later on. That would be the information expected for community mental health services".⁴⁷³

408. The **Clinical Director for Mental Health and Learning Disability for West Hampshire CCG** also spoke of the discharge process back to GPs and summarised what she would expect to happen, but acknowledged that she can't say it is happening everywhere yet and that the processes have improved, but it's often down to individual teams communicating with primary care and vice versa. She hopes that as they continue to build those relationships, it will become normal business and easy for both sides to identify who they need to speak to about it. She said the planning is really important so people don't suddenly feel that they have been 'discharged off a cliff edge', which she said is a term sometimes used, and it is one of the expectations and aspirations of community mental health development - to end the feeling 'cliff edge discharge'.⁴⁷⁴

409. She gave evidence about the changes that have taken place in regards to when an in-patient is discharged and said, "... the process a few years ago was for a short discharge letter to be sent to the GP, with brief details and medication, with a longer detailed letter coming later... (now), I would expect to understand straightaway who was going to continue to support from mental health (services) and the input that is needed from the GP".⁴⁷⁵

410. She said that when there is discharge back to primary care from the Community Mental Health Team, in particular if it is locally within her CMHT, she will ask them to notify them before the discharge if they expect they will have a difficult transition, so that they can support the transition. She provided an example of a Multi-Disciplinary Team meeting where she said they, "spoke about four people being discharged from secondary

⁴⁷³ Evidence of Clinical Director for Mental Health and Learning Disability for West Hampshire CCG, 17 March 2021

⁴⁷⁴ Ibid

⁴⁷⁵ Ibid

care or due to be discharged and because we had social prescriber and wellbeing services there, we could plan the support needed... for their onward recovery”.⁴⁷⁶

411. In terms of the effects of COVID-19 on communications, the **Clinical Director for Mental Health and Learning Disability for West Hampshire CCG** said, “one thing COVID-19 has allowed, is greater use of technology, which has made things easier to do in some ways. For example, a Multi-Disciplinary Team meeting I hold, prior to the pandemic only included GPs from my practice, psychiatrists and the CMHT manager. I re-started it in May/June 2020 and now have representatives from talking therapies, third sector, social prescribers, mental health social workers, psychiatric nurses, our psychiatrist, the CMHT manager and myself”.⁴⁷⁷

Evidence from carers

412. A **carer** spoke about how his son had been discharged from secondary care back (home) and to his GP, and said he was, “thrown under the bus and received no subsequent help...”. However, he said, now, “... because of relentless pursuit, the Director of Nursing in the South-West Division said he will look at how his quality of life can be improved”. He described this being a struggle and said, “we had to fight for it; there must be families who don’t have the ability to put this into words and challenge and fight... there needs to be an easier process to access people with power in SHFT, it’s very difficult to do that”.⁴⁷⁸

413. He added, “professional engagement has been very poor. Psychological services are extremely poor and (my son) needed this; they’re thin on the ground and a lot of the work tends to be down to support workers and care coordinators...”.⁴⁷⁹

Panel’s Views on where SHFT are now: communication and liaison between primary and secondary care

- The Panel is pleased that the use of technology has improved in this area and it encourages this to continue with the sharing of patient notes and records, for example. The Carer Communication Plans must form part of this process.

⁴⁷⁶ Ibid

⁴⁷⁷ Ibid

⁴⁷⁸ Evidence of a carer, 6 April 2021

⁴⁷⁹ Ibid

Panel's Views on where SHFT are now: communication and liaison between primary and secondary care continued...

- The evidence points to some continuing issues with the recording of information for the purpose of communication and proper discharge planning by SHFT's services and wards. SHFT appears to recognise that this remains an area for improvement and it should remain under review.
- There are lessons that must be learnt in this area as the issues have persisted for far too long, given that they arose during the Stage 1 Review too and the consequences could be catastrophic. They should be addressed as a priority. The Panel hopes that the move towards an ICS approach will also lead to improvement in this area.

Recording of information

414. The Panel identified the 'recording of information' as a recurrent topic in the documentary evidence it was presented with at Stage 2. Therefore, an analysis and discussion of that evidence is required.

415. The Panel reviewed the sample of the 48-hour Review Panel Minutes and identified a number of concerns.

416. In an Incident Detail Report in March 2021, the findings showed: *'Unclear discharge planning led to a lack of communication and understanding of medications required in the community... discharge letter is not on the EPR... depot given is not recorded on the EPR... there is no community plan in place'*.

The conclusions were: *'There appears to have been confusion in discharge planning which can be assumed as a result of usual discharge processes not being followed at the time; there is no real evidence of the discharge being planned or a clear view on who was responsible for the care moving forward'*.⁴⁸⁰

417. In an Incident Detail Report in January 2021, the event happened because the clinician did *'Not document clinical assessments or outcomes for 7 assessments in November. 3 of which were urgent referrals... There is no documentation to record if the assessments took place or patients were contacted'*.⁴⁸¹

⁴⁸⁰ 48-hour Review Panel Minutes, page 547

⁴⁸¹ Ibid, page 656

418. The Panel also reviewed a sample of SI Reports. Following an incident in January 2020 where the cause of death was suicide, the Report set out the ‘Care and Service Delivery Problems’, which included two incidents of a lack of recording and one incident of a lack of information sharing. In the ‘Contributory Factors’ section of the Report, the ‘Communication Factors’ were identified as: *‘Communication strategy and policy not defined/documents – there is no guidance on whether patients should be probed about withdrawing their consent to share or whether it should be shared with clinicians and/or family’*.⁴⁸²

419. In a further Report relating to an incident in April 2020, it was recorded as a *‘Probable suicide in the community/outpatient’*. In the ‘Contributory Factors’ part of the Report, the ‘Communication Factors’ were identified as: *‘Ineffective communication to staff up, down and across – there was no escalation to the Medical Director regarding the cancellation of an appointment for a high-risk patient and the lack of alternative arrangements’*.⁴⁸³

420. A **service user** said she had a care coordinator in 2019, who she described as lovely, but she left. Her experience is that problems arise because the care coordinators change so frequently and have not been good at writing all of the relevant notes for the next one to pick up. She said this means she has to repeat herself constantly. She believes this could be improved. She provided an example from September when she said she had asked to move teams and the new team had not been notified that she could not drive to them for face-to-face appointments, despite having had several discussions with the previous team about this. She does not think this was communicated to the new team.⁴⁸⁴

Panel’s Views on where SHFT are now: the recording of information

- The evidence suggests there are continuing serious issues with the recording of information for the purpose of communication and proper discharge planning. In one case reviewed by the Panel it could have led to a patient safety incident.
- SHFT should continue to improve to ensure that information is updated, recorded accurately and shared in a timely and appropriate manner to ensure patient safety, consistency in care and to reduce the need for service users, carers and families to have to keep repeating their stories. Training should be provided on this specific issue.

⁴⁸² Serious Incident Reports, pages 180 – 181

⁴⁸³ Ibid, page 284

⁴⁸⁴ Evidence of a service user, 15 April 2021

Training in communication and liaison

421. The Panel wanted to know what training had been implemented by SHFT for communication and liaison with service users, carers and family members, in addition to the Triangle of Care training.

422. The Panel were interested by a complaint in the SHFT Annual Complaints Report 2019/20, which concerned the complainant's '*late husband's end of life care and treatment*' and the improvement and/or learning for SHFT was recorded as:

'A lack of effective communication to patients/relatives/carers of risks: To attend communication course in palliative care and Inappropriate experience or lack of quality experience: To shadow experienced colleagues to improve triaging and communication skills with end-of-life patients'.

423. Furthermore, a **Consultant Psychiatrist in SHFT** said, "we have some very junior members of staff and often they are in the ward and having to take a phone call and perhaps have not been through training. Training could be helpful".⁴⁸⁵

424. The **Chief Executive** said, "SHFT has lots of training, I can't tell you all of it, but I know we're providing training programmes... but there are lots of people who go on them and don't necessarily practice in the way expected and the training is not sufficient".⁴⁸⁶

425. He said he places weight on the coaching beyond the training. Thus, the importance of first-class quality mentoring, role models who know what is happening and are coaching in terms of learning, not chastising or blaming; reflective practice and a safe space to do it. He said, they want people to say they find something difficult and to have, and access, in confidence, the support they need.⁴⁸⁷

426. He described how "... with the best will in the world, there are some people who you cannot train in customer service and I am probably one of them, you wouldn't put me on the front desk of a hospital to greet people coming in; so whatever training and principles

⁴⁸⁵ Evidence of a Consultant Psychiatrist in SHFT, 10 March 2021

⁴⁸⁶ Evidence of Chief Executive at SHFT, 16 April 2021

⁴⁸⁷ Ibid

would go with it, I wouldn't be the person to do it. On the other side, we have people who do it naturally and are superb...".⁴⁸⁸

427. The **Director of Workforce, Organisational Development and Communications** said he does not think SHFT have specific communication skills training for staff and said that it is embedded in other areas of training. If there was a communication problem he said, "... it's as much about helping and coaching those people, as it is about the skills bit... it's about understanding where they are, so, development plans to support them are really important".⁴⁸⁹

428. He also spoke about the training for agency nurses and said that if they are going to be with SHFT for a while then they are given an organisational induction, which is local. He would expect the team to go through the culture and organisation with them.⁴⁹⁰

429. The **Carer Strategy Project Officer** said they are looking at having separate training on negotiating conversations between service users and carers, and recognising both may have valid points and good intentions.⁴⁹¹

Panel's Views on where SHFT are now: training in communication and liaison

- The Panel is pleased that the QI training and Triangle of Care training has been rolled out across the organisation and has been attended by Governors, staff, service users and carers. There is an evidenced strategy in place to continue with it.
- However, the Panel is disappointed that separate, specific training for communication and liaison is not mandatory in SHFT and given some of the past and present issues identified and discussed on this topic, the Panel encourages SHFT to review this position. There is a perceived need for improvement in the competency and confidence of permanent and temporary staff when interacting with service users, carers and family members.

⁴⁸⁸ Ibid

⁴⁸⁹ Evidence of Director of Workforce, Organisational Development and Communications at SHFT, 19 April 2021

⁴⁹⁰ Ibid

⁴⁹¹ Evidence of Carer Strategy Project Officer at SHFT, 18 March 2021

Staff meetings and internal communications

430. The Panel asked questions of the participants from SHFT about the state of internal communications and attendance at staff meetings.

431. Although the Panel has been cautious in attaching too much weight to the NHS Annual Staff Survey, given the low-response rate, it has been relied upon by SHFT to show improvements in other areas and this is an area where SHFT have not scored-well over the last two years.

When asked whether there is effective communication between senior management and staff:

- 40% (989 out of 2493 responses) agreed or strongly agreed in 2018;
- 44% (1091 out of 2520 responses) agreed or strongly agreed in 2019; and
- 46% (this was not expressed in terms of numbers in the National Staff Survey Full Report) agreed or strongly agreed in 2020. Overall, in real terms, this reflects a 3.03% reduction on the previous year and does not reach the sector average which is 49%.

When asked, whether senior managers try to involve staff in important decisions:

- 35% (863 out of 2493 responses) agreed or strongly agreed in 2018;
- 37% (916 out of 2520 responses) agreed or strongly agreed in 2019; and
- 38% (this was not expressed in terms of numbers in the National Staff Survey Full Report) agreed or strongly agreed in 2020. Overall, in real terms, this reflects a 2.67% reduction on the previous year and does not reach the sector average which is 41%.

432. The **Community Mental Health Team Manager** said there have been changes in the way information is communicated, which has improved across the whole Trust, such as, regular bulletins. However, she said they do not meet across the divisions and that it is an area needing further work: how they can learn from each other.⁴⁹²

⁴⁹² Evidence of Community Mental Health Team Manager at SHFT, 31 March 2021

433. In terms of meetings on the ground, the **Community Mental Health Team Manager** said that the consultants in her team are managed by the Medical Director for the division but form part of the leadership monthly meetings and she has regular communications with them, even if she does not have line managership for them.⁴⁹³

434. A **Matron** said that they rotate the staff attending the staff meetings. They have 'morning safety huddles' to share risks, where all members of the multi-disciplinary team attend and their own local meetings too. She said there is a staff meeting which is for nursing staff; group supervisions, which are open to all staff; reflective practices, which staff attend when they are available; and a monthly whole-unit reflective practice, which is hosted externally.⁴⁹⁴

435. A **Clinical Ward Manager** said that over the last 18 months they have done a lot of work on 'safety huddles', which are ward huddles that take place every morning and feed into a unit huddle. They are chaired by the Matron or Head of Nursing and it is a daily platform where she can take any ward problems, talk about what she is going to do, raise any incidents, or ask for advice and they are minuted. She said the Director of Nursing will dial-in to the huddle a couple of times a week and the psychology doctor is always in attendance; the consultants attend the daily ward huddle; and the Director of Nursing visits every now and again. However, attendance of junior medic staff at the daily unit huddle is about once a week and their attendance has dropped off.⁴⁹⁵

436. In the Learning from Deaths: Mortality Data and Learning (Q1) 2020, it states,

'Handovers and communication between teams has remained a theme in Q1... Adult Mental Health (AMH) have implemented a shift co-ordination system with protected time for handovers to review shift leadership, task management and to clarify responsibilities. This has resulted in improved communication internally and maximises clinical capacity to meet the increasing demand on services'.

⁴⁹³ Ibid

⁴⁹⁴ Evidence of Matron, SHFT, 29 March 2021

⁴⁹⁵ Evidence of Clinical Ward Manager, SHFT, 12 April 2021

Panel's views on where SHFT are now on staff meetings and internal communications

- The Panel is encouraged by the fact that 'safety huddles' have been introduced and urges them to continue. However, the Panel is concerned that not all of the relevant staff and clinicians, for example, consultants, are attending meetings and 'safety huddles'. As a result, the Panel is not assured that satisfactory internal communication systems are consistently in place to ensure that those that were absent would be aware of what was discussed during that meeting. SHFT should maximise the opportunities for all appropriate staff members, at all levels, including clinicians and junior doctors, to attend them.
- There is some evidence and suggestion of the divisions and teams working in silos. This should not be happening if SHFT wants to be an organisation that aims for QI and learning and joined-up working and communication between the divisions is strongly encouraged.
- The results of the recent NHS Annual Staff Survey indicate that communication between staff and senior management is an area that requires significant improvement in SHFT.

Culture and attitudes towards communication and liaison

437. The top themes to come out of the Service User-Led Standards Audit Report, April - September 2020, to which 701 carers responded were: *'respect, trust, listening, important, understanding and care'*.

438. The **Director of Nursing & AHP** gave evidence about what SHFT are doing to ensure these values are upheld and said, "... we have invested heavily in the 'Elevate' leadership programme, so there is leadership support in place and role modelling (which) supports us to develop the sorts of communications we want to have with patients". She said, "even when it is challenging and emotional, we stick to our values of respect and dignity: they are 100% our values".⁴⁹⁶

439. The **Chief Executive** said, "there is no simple measure for culture... the way we do things are informed by the values we hold dear... grounded in respect for each other... (but) where it doesn't work, is where those values and cultures are not being lived as we would want them to be and it isn't picked up by reports or formalities... but it is picked up by seeing complaints were badly handled or something has happened because we haven't engaged or been respectful of someone's views".⁴⁹⁷

⁴⁹⁶ Evidence of Director of Nursing & AHPs at SHFT, 9 March 2021

⁴⁹⁷ Evidence of Chief Executive of SHFT, 16 April 2021

440. The **Chief Executive** was asked what mechanisms he uses to assure himself that there is a culture which is more proactive, than reactive and he said, “when I look at an SI, I’m watching how we respond to them, that is contemporary and current and sometimes asking questions”.⁴⁹⁸
441. The **Head of Patient and Public Engagement and Experience** spoke about the benefit of divisions in terms of engagement and said, “... we have provided community profiles to understand working in partnership in the community and (they are) enabling and giving staff the skills and confidence... I want to see it embedded totally across SHFT”.⁴⁹⁹
442. The **Triangle of Care Project Lead** said the culture of working with service users and carers varies from team-to-team, some services do this work day-in-day-out and some services they are working more closely with to remind them that it is important.⁵⁰⁰
443. In response to a question about how compassion can be developed with people in practice, the **Head of Patient and Public Engagement and Experience** said, “I think it is difficult because we know the pressure our staff are under. The most powerful thing we can do is that when people are hearing from patients and carers, they really try to understand it, which lends itself to people being more compassionate. We have examples where people are compassionate and caring. It’s about allowing the staff space and time to work with their patients and carers... in the change of leadership, we are able to demonstrate that now”.⁵⁰¹
444. A **Consultant Psychiatrist in SHFT**, who was the Clinical Services Director in SHFT between 2013-2016 and the Divisional Medical Director between 2019-2020, spoke about staff some years ago, being afraid of doing the wrong thing and so ended up not communicating. She said, “I think now people have more confidence and understanding and there is a genuine culture shift from the top of the organisation that has filtered down; I think there is more confidence, will and understanding about why it’s so important”.⁵⁰²
445. The Panel asked a **Service User Involvement Facilitator** about the Patient Experience, Engagement and Caring Group meeting on 22 September 2020, where the

⁴⁹⁸ Ibid

⁴⁹⁹ Evidence of Head of Patient and Public Engagement and Experience at SHFT, 10 March 2021

⁵⁰⁰ Evidence of Triangle of Care Project Lead at SHFT, 18 March 2021

⁵⁰¹ Evidence of Head of Patient and Public Engagement and Experience at SHFT, 10 March 2021

⁵⁰² Evidence of Consultant Psychiatrist in SHFT, 10 March 2021

minutes shows that the date was exceeded on the 'Risk Register, in regard to an identified risk. The minutes state, *'There is a risk patients will not receive a positive experience due to a failure to capture, understand and develop a culture which supports a positive patient experience'*.⁵⁰³ The response was that in January 2019, patients were not necessarily at the heart of everything that happened in the organisation, but now we're in a better place with this around the culture of supporting our service users and patients; it is around looking at the whole approach to the service user. It could be their housing and there is someone to help with this now and there are activity coordinators on the wards. However, the Facilitator could not say if the risk is still there.⁵⁰⁴

Panel's Views on where SHFT are now: culture and attitudes towards communication and liaison

- On balance there is some evidence of a cultural shift and a determination to continue this in SHFT, where improvement is required. However, SHFT has some way to go to achieve an overall organisational culture shift which it requires.

Duty of candour

446. The 'Duty of Candour' is defined in Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. It requires all health and social care organisations registered with the CQC in England, to act in an *'open and transparent way with relevant persons in relation to care and treatment provided to service users...'* when something goes wrong that has caused, or there is reason to believe it has caused, or could lead to, significant harm and the reporting of safety incidents, including, a mandated apology.⁵⁰⁵

447. A **service user** who complained between 2017 to 2019 said, "we require openness and honesty. If it's deemed something has gone wrong, be open and honest about it and ask, what could we do to help put this right?".⁵⁰⁶

⁵⁰³ The risk is owned by the Director of Nursing & Allied Health Professionals and the Management Lead is the Head of Patient and Public Involvement and Patient Experience.

⁵⁰⁴ Evidence of Service User Involvement Facilitator at SHFT, 18 March 2021

⁵⁰⁵ Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Schedule 1 (as amended)

⁵⁰⁶ Evidence of a service user, 4 March 2021

448. A **carer** gave evidence that SHFT had not shared information with her and it had been given out without her knowledge and she declared that the person who had made the error knew it was wrong, so should own up and say, “we have done wrong, sorry”. She said people just want honesty from who they’re talking to, why they said what they did and what happened.⁵⁰⁷
449. The **Chief Executive** said, “... we have a service delivered by people, for people, who are motivated by the right motivations and join the profession for the right reasons, yet we need a Duty of Candour... I recognise why we need it and I think it should be there, but I think it’s too restrictive and it should apply to everything we do. We need openness and transparency; it should be part of the way of working and expectation”.⁵⁰⁸
450. The **Deputy Medical Director** said, “over and above the legal duty, the key thing for me, as a doctor, is as soon as something has gone wrong, the ability to pick-up the phone up and say ‘sorry’ and ‘this is what I know, I’ll find out more’; to set out the process that will follow, and in the meantime ‘this is what we will do immediately to make sure people are safe’”. She said, “I think, on the whole, there has been a massive shift in the organisation, even in the last five years and even before that, it’s now very much accepted to be the norm... the key value is that any of us could be on the other side of the table at any given point and that is what we would want”.⁵⁰⁹
451. The **Interim Director of Nursing and Quality for North Hampshire, South-East Hampshire, Fareham, Gosport and Isle of Wight CCG** stated, “I am legally responsible to my chief executive officer, but I am morally responsible, within my NMC Code, to my patients”.⁵¹⁰
452. The **Deputy Medical Director** said that training on the duty of candour is mandatory for all staff at SHFT.⁵¹¹
453. The **Family Liaison Officer** was asked about the difference between SHFT’s ‘Being Open Policy’ and ‘Duty of Candour Policy’ as her name appears as the author on the

⁵⁰⁷ Evidence of a carer, 9 March 2021

⁵⁰⁸ Evidence of Chief Executive of SHFT, 16 April 2021

⁵⁰⁹ Evidence of Deputy Medical Director at SHFT, 1 April 2021

⁵¹⁰ Evidence of Interim Director of Nursing and Quality for North Hampshire, South-East Hampshire, Fareham, Gosport and Isle of Wight, 14 April 2021

⁵¹¹ Evidence of Deputy Medical Director at SHFT, 1 April 2021

'Being Open Policy and Procedure' and she said that she was not too sure, but accepted that she had been asked to, and did pull them together, which is why her name appears on it.⁵¹²

454. The sample 48-hour Review Panel Minutes and Notes reviewed by the Panel included an Incident Detail Report for an incident in December 2020. It was graded as 'moderate harm' and the 48-hour Review Panel decided no further investigation was required. The patient had a personality disorder and mild learning disability. The 48-Review Panel minutes note: *'As per duty of candour P1 furnished with a letter'*, that letter starts with *"I am writing to say that we are sorry you suffered an accident..."*, then it says there was a delay in identifying the injury and *"Actions to reduce swelling may have helped"*. It says, *"We owe you a duty of 'Candour' this means we should tell you if we think we did something wrong or could have done better"*.

Panel's Views on where SHFT are now: Duty of Candour

- The Panel is satisfied that it heard from staff within SHFT who were all aware of the Duty of Candour and its importance. This professional obligation is absolute.
- SHFT could improve the way it informs service users, carers and family members about the Duty of Candour – what it means, how it applies in a specific context and what SHFT are doing to comply with its duty. Information provided about it should use clear, non-technical language and should not assume that readers will understand what it means.
- The letter the Panel reviewed, that was received by the patient in December 2020 and reviewed at a 48-hour Panel, does not demonstrate compliance with the Duty of Candour. The letter was not candid about a mistake made by staff, nor was it clear what could have been done better. There was no apology for the delay in identifying the patient's injury and the 'learning' recorded in the Minutes/Notes did not acknowledge the delay in diagnosis, but instead focussed on the circumstances of how the injury was suffered.
- The 'Being Open' Policy and Procedure was referred to less frequently by participants. The Policy includes a mechanism for patients and service users who *'may not accept the information provided, or wish to participate in the Duty of Candour Process'* (4.16), to try and find a resolution. The purpose and use of the Policy in SHFT were not clear from the evidence. SHFT should ensure that the Policy is fit for purpose and ensure that it is actively promoted to ensure service users are aware of their rights and staff uphold them.

⁵¹² Evidence of Family Liaison Officer at SHFT, 30 March 2021

Openness and transparency in note-taking by clinicians

455. This topic arises from the evidence the Panel received from service users. One **service user** said, “I know there is no basis for a lot of things that are said in notes, no contact with the person, but it seems to come out of gossip or nastiness”.⁵¹³

456. A further **service user** told the Panel, “I had another Care Coordinator who admitted that he wasn’t familiar with my notes, he hadn’t had time to look at them and there were limited notes, and he spoke to another staff member... they had a ‘corridor chat’ and decided that I didn’t need (the therapy) ... this was inconsistent with what I had been told so I was asking when I’d start the therapy and they said ‘there was a chat about me not having it’. I contacted the Care Coordinator and asked why and why it hadn’t been included in my notes; he was nice, but he didn’t phone me back, so I kept phoning him asking for an explanation, which took 2-3 weeks”.⁵¹⁴

457. Furthermore, a complaint in the SHFT Annual Complaints Report 2019/20 was: *‘I have a list of points regarding the last few years and the lack of support I have received, plus the details of lies that have been said/possible notes being altered retrospectively’.*

The ‘Improvements/learning’ for SHFT recorded is:

‘It was recommended that if the service user disputes the content of letters, or her version of events differ from what she believes is recorded that she put this in writing as per policy SH IG 07 and CMHT to review their message taking procedure to ensure a more robust and auditable trail’.

Panel’s Views on where SHFT are now: openness and transparency in note taking by clinicians

- The recording of information in order for there to be an effective handover, particularly in the case of care coordinators, needs to be addressed by SHFT. Training and guidance on this issue may be required. Additionally, wider use of the Carer Communication Plan throughout the organisation should assist with improving upon this current problem.

⁵¹³ Evidence of a service user, 9 March 2021

⁵¹⁴ Evidence of a service user, 15 April 2021

Communication support for service users, carers and family members and ensuring their voice is heard

458. The **Chair** said, “I want to say a huge thank you to our carers and service users for their involvement in this organisation and for playing a huge part in shaping our future; by coming to our Board and telling us what they like and don’t like about the things we’re doing, sharing their experiences with us openly and honestly... when I first came here the thing that struck me about the distress of this organisation, was that we had to have open and honest debate and shine some light in on the good things happening and what wasn’t going well, so people could learn and move forward”.⁵¹⁵

459. The **Chief Executive’s view** is that the service user support, infrastructure and independence in Hampshire is not well enough developed. He said there is a Recovery College, but it’s limited in what it does and they do not have the support and infrastructure for service users to enable them to engage.⁵¹⁶

460. In response to the question as to whether SHFT engages proactively with patients and families, who can be ‘experts by experience’, a **Consultant Psychiatrist in SHFT** said, “we know it’s there, but sometimes, we don’t know what we don’t know and sometimes the Community Team will ask us if we have spoken to a specific person, but if the patient is very unwell they might not have volunteered that information to me unless I’ve specifically asked, so perhaps it is not always done as a matter of routine... we learn so much from the family... one example was literally a penny-drop moment, when I picked up the phone, spoke to the relative, and found out about a prescription”.⁵¹⁷

461. A **Consultant Psychiatrist in SHFT** identified that there have been issues with staff engaging with carers, families and service users at night, when there are more agency staff.⁵¹⁸

462. The FLO was referred to by various participants in regards to communications with service users, family members or carers who are involved in a SI investigation and her role is explored further in that section of this Report.

⁵¹⁵ Evidence of Chair of SHFT, 16 April 2021

⁵¹⁶ Evidence of Chief Executive of SHFT, 16 April 2021

⁵¹⁷ Evidence of Consultant Psychiatrist in SHFT, 10 March 2021

⁵¹⁸ Ibid

Role of Service User Involvement Facilitators

463. SHFT have introduced and appointed two Service User Involvement Facilitators. The role of the Service User Involvement Facilitator in SI investigations will be set out in that section of the Report.

464. The **Head of Patient and Public Engagement and Experience** said “the Service User Facilitators have lived experience and are assigned to the Quality Improvement Team; their role is to be the voice in our ear, questioning and making sure service user’s voices are heard in everything we do. They are an asset to SHFT...”.⁵¹⁹

465. A **Service User Involvement Facilitator** spoke of the communication methods they used during COVID-19 and said, “one area where we discovered we slipped... was the Older People’s Mental Health services so, we got had magnets and leaflets printed to say how to look after your mental health and sent them out by post to all of those registered for physical and mental health”. The resources required to do this kind of activity are available.⁵²⁰

466. A **Service User Involvement Facilitator** said that “all mental health services and the vast majority of physical health services have Carer Booklets and anything that is drawn-up for a service user, has to go through three-stages before being published: it is seen by ten service users who approve it; it goes to the Working in Partnership or Family & Friends Group for sign-off; and it comes to me for final sign-off”.⁵²¹

467. In comparing the position now to 2019, in regard to service user engagement and involvement, it was said that “With community meetings, in 2019, I was lucky if I got staff engaged, let alone service users, but now, they are at community meetings, because things do change from them... it also enables all senior staff to attend”. That is where the Facilitators’ weekly workload comes from and they can get a quick understanding whether patients feel safe or not, so if the same thing is said over two consecutive weeks, they can speak to the Matron of the unit. The information will also be shared with the practice safety people as part of the Patient Safety Strategy.⁵²²

⁵¹⁹ Evidence of Head of Patient and Public Engagement and Experience, 10 March 2021

⁵²⁰ Evidence of Service User Involvement Facilitator at SHFT, 18 March 2021

⁵²¹ Ibid

⁵²² Ibid

468. In addition, the Facilitators have access to all senior leadership in all directorates; they can attend their monthly meetings and they have a 20-minute slot on their agendas to discuss any service user or carer issues that have come up from the audit or from feedback.⁵²³
469. The Facilitators are approached for service users and carers to sit on interview panels; thus, nobody will be employed in Forensics, CAMHS, doctors, senior executives, Band 7 or senior managers and above, without a service user on the Panel.⁵²⁴
470. A **Lead Governor** said, "... when we did an appraisal for the Chair, we decided to ask service users and carers for their views of the Chair, so I went to (the Service User Involvement Facilitator) and told her what I wanted to ask and she came up with ways to get feedback; that was really useful...".⁵²⁵
471. In regards to providing a service user with advocacy support, a **Service User Involvement Facilitator** said, "if a service user is right and has not been heard and has put their case forward and feels they've not been heard, I will sit with them... to go through what the issue may be. We have to remember in mental health, a presentation of a service user, or someone who is unwell, can change from one day to the next and how they respond to what they need can change". "We need to find that balance as an NHS, not just SHFT, between what is needed, correct and right; versus, what sometimes people believe is right and should be provided".⁵²⁶

Harder-to-reach groups

472. The **Chair of the Working in Partnership Committee** said that his committee have not yet discussed how to penetrate groups that really need their help across the locations, as their location visiting agenda is driven by senior management's focus. He said this means that their local engagement agenda is driven by senior management's priorities and they are not necessarily going to put 'harder-to-reach groups' at the top of the agenda.⁵²⁷

⁵²³ Ibid

⁵²⁴ Ibid

⁵²⁵ Evidence of Lead Governor at SHFT, 30 March 2021

⁵²⁶ Evidence of Service User Involvement Facilitator at SHFT, 18 March 2021

⁵²⁷ Evidence of Chair of the Working in Partnership Committee at SHFT, 11 March 2021

473. The **Deputy Chair of the Working in Partnership Committee** said, “one big asset in our Committee is representation from the Carers’ Group and Healthwatch, who have a wider reach and we have a much wider reach into the population... we use those assets to reach out, because we don’t have the means or technology or money to reach out to people and can’t use newspapers... we have user representatives on our committee.... and it’s important our representation isn’t all like me, but wider, and can be reached through organisations that come to our committee”.⁵²⁸

Communication with the Board, Executives and Non-Executives

474. A **Lead Governor** said he had spoken to some people who are in a really bad place with SHFT he tried to talk and listen to them. He said “I absolutely believe the Board and SHFT would talk to people and I think they have for a long time; that approach is in the DNA in some people in SHFT”.⁵²⁹

475. The **Chair** spoke about the service users and families that come to the Board to present and said, this is usually at the invitation of the team or from the Board directly and the FLO will have worked with them. She said they usually see people at the end of a process and have the team there, or a representative from the service, to talk in an open and honest way about what happened. She described how they are coming to tell their story and that is what the Board want to hear: what happened, how have they been treated and supported? Have they been given the right information? Is there anything they can do to help them move forward?⁵³⁰

476. A **Non-Executive Director and Chairman of the Audit, Risk and Assurance Committee** said that at almost every Board session, there is a presentation or visit by service user, family member, or carer, so at 90% of the meetings they are talking about patients or services or carers. He said, “three years ago, we were seeing more reactive management and at the Board we want proactive leadership. Today, we have moved a long way in that and a lot is informed by the specific experiences of patients, carers, families and individual teams, who come to the Board”.⁵³¹

⁵²⁸ Evidence of Deputy Chair of the Working in Partnership Committee, SHFT, 17 March 2021

⁵²⁹ Evidence of Lead Governor, SHFT 30 March 2021

⁵³⁰ Evidence of Chair of SHFT, 16 April 2021

⁵³¹ Evidence of Non-Executive Director and Chairman of the Audit, Risk and Assurance Committee, SHFT, 13 April 2021

Involvement and engagement in Quality Improvement

477. The **Chair** said that service users, carers and families have a role and are involved in QI and that one of the six top QI trainers in the organisation is a service user and has a full-time senior job. She said that in all of the Rapid Improvement Workshops that are run as part of their QI programme, there is significant representation from service users and carers. She stated, “in my world, you don’t do anything without the involvement of carers and service users, not just in QI, but in how we get our strategies signed-off, agreed and co-produced... this has been a social movement across the organisation, that is how I see it and how it is in my heart”.⁵³²

478. This was reiterated by the **Head of Patient and Public Engagement and Experience** who said service users and/or carers have been involved in all but one of over one hundred QI projects that have taken place in SHFT so far.⁵³³

Experts by experience

479. The **Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement**, has visited Sweden to learn from their QI programme and said SHFT had recently agreed the development of an ‘Esther Coach’ and funding with Sweden to set up SHFT’s first ‘Esther’ network and SHFT have their first cohort from Sweden who will work with them in May 2021.⁵³⁴

480. The **Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement** said this is a developed approach in Sweden that is so embedded, that instead of using the word ‘patient’ they use the word ‘Esther’. It is a patient with a story and used for training in solution-focussed coaching. They have set up ‘Esther cafes’ for stories to be told, learnt and improved.⁵³⁵

481. She said that it is underpinned by ‘what matters to Esther?’, so a care plan would be based on what is best for that individual and what is most important for them. For example, a community team with three patients and a coach, who could be a family

⁵³² Evidence of Chair of SHFT, 16 April 2021

⁵³³ Statement of Head of Patient and Public Engagement and Experience at SHFT, 2 February 2021

⁵³⁴ Evidence of Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement at SHFT, 29 March 2021

⁵³⁵ Ibid

member, would run a two-hour café, where service users would tell their story and the coach would help people hear the message and together, they would co-produce the solution for improvement. It is measured by feedback from the user's experience" There is also an International Network that they intend to work with to look for best practice examples.⁵³⁶

Materials for engagement and communication with service users, carers and family members

482. A **Matron** said they have displayed on the SHFT website a virtual tour for families to see the unit; they have Carer Leads, one whom is a social worker and one whom is a family therapist and their role is to link with the family to speak about the unit. She said, SHFT have provided them with iPads and they have looked at introducing mobile phones for young people on the unit. There are have virtual attendance at meetings for families and they have introduced the sharing of multi-disciplinary team weekly reports with families. Additionally, families can attend CPA meetings.⁵³⁷

Evidence from service users, carers and family members

483. A **carer** said, "communications with families could improve. Some individuals do great communications and in a recent complaint to Southampton City, the Head of Nursing/Area Manager was extremely helpful and was good. But because the personnel change so much... it's a revolving door of staff, which makes it very difficult as you don't have consistency... some individuals have been outstanding in their communications and some just don't want to know".⁵³⁸

484. A distressed **service user** told the Panel, "I was frustrated because (the services) never listen to me... I think (their communication) is poor on all levels. I don't think they communicate well with service users or with families... emails are often ignored... I think they speak a lot behind the scenes and that isn't discussed with the family or service

⁵³⁶ Ibid

⁵³⁷ Evidence of Matron, SHFT, 29 March 2021. Care Programme Approach ("CPA") is a package of care for people with mental health problems.

⁵³⁸ Evidence of a carer, 6 April 2021

user”. She said, “respect works both ways and the people I deal with in SHFT make me feel like I am disbelieved or just fobbed-off”.⁵³⁹

485. The **service user** said, “I appreciate I am a complex case and that’s hard work for them and I won’t sit there with my mouth shut if something is wrong, which is difficult for them too... but this has made me so tired. I have a physical condition and all of this is making me worse and it’s just so unfair. They said they make mistakes as they’re human, which I understand happens sometimes, but not all of the time. I don’t get treated like a human, I get treated like I am worth nothing, that is a really hard pill to swallow”.⁵⁴⁰

486. Finally, she said, “I’ve been waiting in limbo land and... they have achieved nothing. If I had a broken leg, I wouldn’t be turned away from hospital and told to keep walking on it and damaging it more...”.⁵⁴¹

487. In the Patient Insight, Involvement and Partnership Report, April-September 2020, which included the Service User-Led Standards Audit Report, the key themes for ‘Carers’ were:

- *Some of our divisions are better at communicating with our carers than others*
- *Our services don’t record carer information in the right place on RiO*
- *Carers want us to trust them like we ask them to trust us.*

Representation and ‘a voice’ for service users, carers and family members

488. The Panel heard from the **Chair of Healthwatch Hampshire, Ann Smith**, she was appointed in April 2020 and has been involved in Healthwatch since 2019. Healthwatch is an independent organisation and it is there primarily to ensure the patient’s voice is heard. Healthwatch Hampshire are limited by funding and resources - they have a budget of £250,000 for 2.5million people, so the vast majority of work is undertaken by volunteers.⁵⁴²

⁵³⁹ Evidence of a service user, 15 April 2021

⁵⁴⁰ Ibid

⁵⁴¹ Ibid

⁵⁴² Evidence of Chair of Healthwatch Hampshire, Ann Smith, 6 April 2021

489. **Ms Smith** said that when she became Chair, she was asked by the Chair of SHFT to attend quarterly meetings, where the four Healthwatch Chairs and managers in Hampshire met with the Chair of SHFT, the Chief Executive and Chief Operating Officer. She describes these as informal meetings and said they have continued throughout the pandemic and they are able to bring any issues and SHFT can let them know of any developments that they are implementing.⁵⁴³
490. She said SHFT will request their help if there is a project they want help on. For example, on a recent hospital development in North Hampshire, they were approached early on to ensure the least-heard groups in the community have a voice and they worked with them on a one-off pilot.⁵⁴⁴
491. Hampshire Healthwatch have conducted an audit of SHFT's in-patient areas and produced a report. **Ms Smith**, said, "we quite often don't hear anything back from the organisation, but we have heard that they have taken on board the recommendations from the audits and told us how they will implement them".⁵⁴⁵
492. Healthwatch cannot hold SHFT to account for implementing, **Ms Smith** said, "we can ask them how it's going... and we hear it from patients on the grapevine... the action plan is there and if we get intelligence from our networks that it's not happening, then we would let those who commission the organisation's services know". She said, "if we keep hearing the same issues being raised by many other patients, we would be concerned and we're not averse to going back after an audit to ask what has been done about 'X,Y and Z'".⁵⁴⁶
493. **Ms Smith** said, "I have been in the NHS over 50 years and learnt more listening to patients than I do from any other interactions... If we were made aware that nobody is listening, we find a route in and make sure their concern is articulated". She said that she cherishes her independence.⁵⁴⁷
494. For the future of their relationship with SHFT, she hopes, SHFT continue to liaise with them; that the new management team listen to patients and are really interested in

⁵⁴³ Ibid

⁵⁴⁴ Ibid

⁵⁴⁵ Ibid

⁵⁴⁶ Ibid

⁵⁴⁷ Ibid

patient's voices. She said, "I hope SHFT has listened, learned and is on a new path now".⁵⁴⁸

495. Healthwatch is only able to respond to information received through their monitoring system, they are not involved in complaints, but **Ms Smith** said they have made recent contact with Voice Ability Hampshire, who provide local advocacy services and the managers of both organisations meet every four to six weeks to pick up any confidential noises in the system. She said, "we have had individuals make contact with us, with their dissatisfaction with a service in SHFT, but nothing in masses of numbers that are out of kilter with anything else we see from any other Trusts. So, there is nothing there to suggest things are not in a good place at the moment (at SHFT)".⁵⁴⁹

Panel's Views on where SHFT are now: providing communication support for service users, carers and family members and ensuring their voice is heard

- The Panel is confident that SHFT have made some improvements in supporting service users, carers and family members to ensure their voice is heard. Some examples of their progress include the appointment of a FLO and Service User Facilitators; the work undertaken to include service users, carers and family members in their QI programme; and employing experts by experience in various roles across the organisation. This work and the individuals conducting the work on the ground should all be commended.
- The Panel acknowledges the FLO has limited capacity to provide support to everyone that requires it. Therefore, the Panel endorses the suggestion of a Patient and Carer Support Service to fulfil a similar role to that of the FLO when required.
- The Service User-Led Standards Audit Report clearly provides rich and current data that SHFT must pay close attention to and act upon promptly when required.
- However, the Panel's view is that more work needs to be done by SHFT to reach those in harder-to-reach groups. A strategy to improve this must be implemented as a priority.
- The Panel welcomes the positive relationship that SHFT is building with Hampshire Healthwatch and believes their engagement will help to ensure that more voices are heard, particularly those who are less engaged or harder to reach.
- The Panel is not satisfied that SHFT have gone far enough to ensure that its committees, senior leadership team and staff body are representative of the population it represents. It must ensure there are strategies in place for improving this as a priority.

⁵⁴⁸ Ibid

⁵⁴⁹ Ibid

Panel's views on where SHFT are now: providing communication support for service users, carers and family members and ensuring their voice is heard continued...

- The Panel is clear that SHFT must be able to respond appropriately when a service user, carer or family member needs advice or support. They are not satisfied that SHFT has this in place yet in a consistent and formalised way which adequately responds to their needs. The Panel hopes that by strengthening further the relationship that SHFT is building with Hampshire Healthwatch and connecting with local advocacy services, they will be in a better position to ensure that support is available when required.
- The Panel did not see evidence of sufficient proactive engagement with service users and family members in SHFT as a matter of course, which there should be in order to re-build trust and confidence with the population it serves. This is particularly important given the evidence of past, and some current, defensive and unsatisfactory responses that SHFT have produced.

Feedback from services users, carers and family members

496. The evidence from SHFT is that it obtains feedback in a number of ways, some of these are: Service User Led Standards Audits, Friends and Family Test, Carers Survey, Peer Reviews, Patient Led Assessments of the Care Environment (PLACE) Audits, Patient Stories, Engagement Forums and Local Insight.⁵⁵⁰

497. The themes arising from the feedback received are: communication, clarity on consent to share, crisis and emergency planning, respite and taking a break, physical, mental and emotional wellbeing.⁵⁵¹

498. The **Head of Patient and Public Engagement and Experience** provided two examples in her statement from 2017 as to how SHFT has responded to the feedback it received. One example was the co-creation of a Carers' Confidentiality Booklet, that provided a 'common sense' approach to confidentiality for carers in response to the feedback that the full document was not easy to read.⁵⁵²

⁵⁵⁰ Statement of The Head of Patient and Public Engagement and Experience at SHFT, 2 February 2021

⁵⁵¹ Ibid

⁵⁵² Ibid

499. The Panel heard that in 2020 a **Service User Involvement Facilitator** in SHFT contacted 12,000 service users and 1800 carers. It was explained that the Service User-Led Standards Audit Report contained ‘user-led standards’ which had been co-produced with service users across all mental health and learning disability and specialist services. The ‘user-led standards’ are based on how those groups want to be treated and what is important to them; from each standard there is a theme. From this, it is possible to see if the themes rise, drop or stay the same and then interpret from that what needs to be improved.⁵⁵³

500. The Facilitator gave examples from the Patient Insight, Involvement and Partnership Report, April-September 2020, which included the Service User-Led Standards Audit Report, for the same period. There was an example of patients having ‘*one-to-ones with their named nurse each day*’, in responding to the survey, the majority of service users had said that they had not had one, but their notes suggested that they had. Therefore, the Facilitator worked with the in-patient teams and ward managers to ensure that staff described it in the right way, so that service users understood it. Once this training had been completed, the standard climbed dramatically.⁵⁵⁴

501. The ‘Overall themes’ in SHFT for ‘Mental Health Service Users’, of which 10,621 responded to the survey were:

- *In some areas we failed to inform our users of what was happening during COVID-19.*
- *A vast majority users are not sure about the crisis services that are available to them in their community.*
- *The lack of communication within teams managing the 136 Suite.*
- *Lack of communication around discharging.*⁵⁵⁵

502. The **Head of Patient and Public Engagement and Experience** said that she works with staff to ‘close the loop’ – find out what has been done about the feedback and what the outcomes are. She said the services have lots of different ways of doing it and they try to report outcomes in the quarterly Patient Insight Reports.⁵⁵⁶

⁵⁵³ Evidence of Service User Involvement Facilitator at SHFT, 18 March 2021

⁵⁵⁴ Ibid

⁵⁵⁵ Patient Insight, Involvement and Partnership Report, April – September 2020

⁵⁵⁶ Evidence of Head of Patient and Public Engagement and Experience at SHFT, 10 March 2021

503. The **Director of Workforce, Organisational Development and Communications** said SHFT has lots of ways they try to engage and collect feedback from families and carers, who may also be staff, and they listen to them through the staff carers network of thirty-odd people. He said, “I think there is always room for improvement and learning from wider organisations who do it well”.⁵⁵⁷

504. A **Matron** said they introduced ward round feedback so young people are supported by nurses to write requests with someone they’re comfortable with and then they are presented at ward rounds. She said they also devised mutually agreed expectations between staff and patients, including what they thought would be good language to use amongst themselves and they use them to hold staff to account. These posters are displayed around the ward. They also hold weekly patient meetings which they invite patients and staff to attend, with a view to addressing issues and to empower young people to bring up issues openly. She said the feedback from the young people did improve in the short term, but because they are constantly recruiting, they need to always be on top of the appropriate use of language and constantly remind people of it and not become complacent.⁵⁵⁸

505. A **Matron** also said that the Ward Managers have group supervisions to discuss issues and can escalate them if required.⁵⁵⁹

506. The Panel reviewed the End-User Feedback Survey samples and the notes from one telephone call stood out:

‘...I asked if a carer’s comms plan had been completed – she said, not that she knows of... she said that she is not listened to and feels that a document in which carers can list triggers and list the nice things that help in a trigger situation would be helpful for all...’.

The author of this feedback call has stated that the (Carers’ Strategy Project Officer and Triangle of Care Project Lead) was informed so that, *‘Mum could be invited to her group*

⁵⁵⁷ Evidence of Director of Workforce, Organisational Development and Communications at SHFT, 19 April 2021

⁵⁵⁸ Evidence of Matron, SHFT, 29 March 2021

⁵⁵⁹ Ibid

and she was signposted to Carers and Princess Royal Trust for carers support’.

507. A **family member** described their experience: “nobody asked the family for any feedback on the quality of services given... customer feedback should be put in every unit... and there needs to be outcome performance measurements: feedback on how (the family) feel they have been treated and is their family member getting well...”.⁵⁶⁰ In a written statement the family member said, “the alienation of family, friends and carers, makes no sense because their knowledge as to the service user’s character and past history is vital in assessing care needs... and their continued support is vital to the patient’s recovery and maintenance of longer-term optimum good health...”.⁵⁶¹

Assurance and Governance

Board, Executives, Non-Executives and Governors

508. The evidence received from the **Head of Patient and Public Engagement and Experience**, on behalf of SHFT, provides an overview of the monitoring and scrutiny processes in place in the area of communication and liaison:

- The Board Quality and Safety Committee monitors the delivery of the People and Partnership Commitment Strategy (via the Patient Experience and Caring Committee), of which the Carers’ Action Plan is part.
- The Complaints and Patient Experience Team produces a quarterly Patient Insight, Involvement and Partnership report on progress and key outcomes, which are shared with the Quality and Safety Committee. These reports are also published on the SHFT website.
- During the SHFT Board meetings in 2020/21, carer stories, feedback, or progress reports have formed part of the main agenda on several occasions.
- The Lead Governor from SHFT is an appointed governor from Carers’ Together, a local carers’ charity.⁵⁶²
- The Working in Partnership Committee produce a quarterly report, which goes to the Patient Experience and Caring Committee.⁵⁶³

⁵⁶⁰ Evidence of a family member, 14 April 2021

⁵⁶¹ Statement of a family member, ‘Communication and Liaison with Families’, 27 February 2021

⁵⁶² Statement of The Head of Patient and Public Engagement and Experience at SHFT, 2 February 2021

⁵⁶³ Evidence of Head of Patient and Public Engagement and Experience at SHFT, 10 March 2021

- The Chair of the Working in Partnership Committee also sits on the Patient Experience and Caring Committee. Therefore, concerns can be escalated to that Committee which go to the Board and policies are reviewed by that Committee.⁵⁶⁴
- The Working in Partnership Committee “Review literature and information going out to patients to make sure they’re user-friendly and people on the committee from learning disability services have supported staff in producing easy-reads”.⁵⁶⁵

509. A **Service User Involvement Facilitator** said they feed the minutes from the meetings in the community and in-patient services to the Patient Experience and Engagement Group and that a lot of service users and carers do attend that Group, but perhaps not as many as should do.⁵⁶⁶

510. It was commented that at a lot of meetings, services users are comfortably coming and knowing that when they share their story, or what they want or think, it is taken into account (and) service users are also members of the group. Further, in the majority of minutes and terms of references, there are service user and carer representatives: the Patient Quality and Safety Committees, all have service user leads within them.⁵⁶⁷

511. The **Chair of the Working in Partnership Committee**, who is a volunteer and also sits on the Family, Carers’ and Friends Group, said he does feel listened to by the Board and his Committee were invited to give a presentation at the Board focus meeting last year (2020) and Board Executives, Non-Executive Directors and a couple of Governors have been along to the occasional meeting. He said they can go directly to the Board if necessary and have a connection with the Director of Nursing & AHP. He said he has attended the Patient Experience, Engagement and Carer Group meetings too.⁵⁶⁸

512. He said that more than half of the members of the Family, Friends and Carers’ Group, are also in the Working in Partnership Committee. He said there is a concept that the Working in Partnership Group can act as a ‘hub’ for any other group and the idea that you need co-production at all levels of an organisation, but he was not sure how well-developed that is in practice and said it is more informal.⁵⁶⁹

⁵⁶⁴ Ibid

⁵⁶⁵ Ibid

⁵⁶⁶ Evidence of Service User Involvement Facilitator, at SHFT, 18 March 2021

⁵⁶⁷ Ibid

⁵⁶⁸ Evidence of Chair of the Working in Partnership Committee at SHFT, 11 March 2021

⁵⁶⁹ Ibid

513. He said there is representation of external organisations at the Working in Partnership Committee Group and carers and internal people at the Family, Friends and Carers' Group meetings. He said the FLO regularly attends both meetings.⁵⁷⁰

514. The **Chair of the Working in Partnership Committee** said that the involvement of one of their members in the QI Project on the Carers' Action Plan and Carer Communication Plan made an impact. He said they are waiting to see how the Carer Communication Plan works and may still say something needs adjusting. He said that there have been changes in policy documents because of feedback they have given. When challenged by the Panel on the omission of this information in the Committee minutes, he said that some of this is done by email, beyond meetings. He said they were asked for their thoughts about uniforms but that he was not sure where that had got to and he did not know the results".⁵⁷¹

515. He said a fair bit of the Committee's work involves 'project leaders' or 'project admin' coming to them to get feedback on a project. He gave an example of a leaflet project, where he believes they made quite a bit of difference as they said it was aimed at clinicians, not ordinary people. As a result, SHFT developed a more user-friendly leaflet and it came back to them for review. His view is that if he is struggling to understand the information provided when he went to university, then it is not at the required level, as SHFT should be in a position where it is able to communicate with people that have not been to university.⁵⁷²

516. He said that the Working in Partnership Committee do not have a process of annual self-assessment, but they report their activities and intentions for the future to the Patient Experience Involvement Group. They also receive feedback from the Head of Patient and Public Involvement and Patient Experience and from those who ask for the Committee's input on a project, through their administrative support. He acknowledged that it would probably be a good idea for to think about introducing a process of annual self-assessment.⁵⁷³

⁵⁷⁰ Ibid

⁵⁷¹ Ibid

⁵⁷² Ibid

⁵⁷³ Ibid

517. Furthermore, he said that the representation of the local community on the Committee is not as broad as they would like it to be. This is an action they would like to improve; however, it was in 2019 too and it was put on hold as the meetings in 2020 were cancelled due to other Trust priorities responding to the COVID-19 pandemic.⁵⁷⁴
518. The **Chair of the Working in Partnership Committee** said there is some justice in the observation that the Committee does not often get service users as regular participants, but said that some of that need is partly met by having Service User Facilitators who are also staff and they have reporting lines to the Head of Patient and Public Involvement and Patient Experience outside of the meeting.⁵⁷⁵
519. The **Deputy Chair of the Working in Partnership Committee** said he feels listened to by the SHFT's senior leadership team and said they are not seen as outsiders or interlopers; but are heard and listened to. He stated, "we are not seen as delegates because we can give the voice of the populous... I would have no difficulty contacting people and taking to them frankly".⁵⁷⁶
520. The **Lead Governor** said that not all Trusts allow for Governors to be MHARMs. He emphasised that his work is all voluntary and independent. He also sits on the Patients, Carers' and Family group and said SHFT comes to the Group for views on things they're looking to implement or change to ask them to review them. He said he attends local carer groups and feeds that information into SHFT. He described how the Non-Executive Directors at Board meetings show real empathy with service users.⁵⁷⁷
521. The **Director of Workforce, Organisational Development and Communications** said the Board are kept aware of what is happening on the frontline through the Workforce Organisation Development Committee. The Committee was developed two and a half to three years ago and they have a workforce information/data pack that goes into the Workforce Committee as part of the Integrated Performance Report. He believes it's important the Board understands that it's more than just communications, but culture too.⁵⁷⁸

⁵⁷⁴ Ibid

⁵⁷⁵ Ibid

⁵⁷⁶ Evidence of Deputy Chair of the Working in Partnership Committee at SHFT, 17 March 2021

⁵⁷⁷ Ibid

⁵⁷⁸ Evidence of Director of Workforce, Organisational Development and Communications at SHFT, 19 April 2021

Internal audit

522. SHFT undertook an internal audit in July 2020 of their patient experience approach. The auditors commented positively on the '*significant levels of service user engagement*'.⁵⁷⁹

523. The internal audit concluded:

'...processes relating to patient engagement and experience are well embedded with particularly strong controls in place regarding service user engagement. The inclusion of Service User Facilitators and Experts by Experience has increased the levels of involvement with service users and carers and enabled valuable insight... However, some areas of improvement were identified such as in the process of analysis and triangulation of patient feedback where it was felt there were still difficulties in collating information into a central point.'

SHFT aver to have responded by saying that the recommendations have been incorporated into their plans.⁵⁸⁰ The Panel did not receive any direct evidence of this.

External assurance

524. The **Clinical Director for Mental Health and Learning Disability for West Hampshire CCG** said she has seen SHFT take steps in improving communications with the introduction of the Triangle of Care and she has heard, at CQRM Meetings, that they are involving carers. She said, "I don't think it is completely solved in terms of carers always being involved, but I realise it's difficult if consent is not given".⁵⁸¹

525. She explained how there are a lot of people who work in SHFT and one complexity is knowing who to go to, but said that when you do find the right person, they communicate effectively, the conversation is good and you can get the help you need.⁵⁸²

⁵⁷⁹ Carried out by BDO LLP

⁵⁸⁰ Statement of The Head of Patient and Public Engagement and Experience at SHFT, 2 February 2021

⁵⁸¹ Evidence of Clinical Director for Mental Health and Learning Disability for West Hampshire CCG, 1 April 2021

⁵⁸² Ibid

526. She was asked about the Service User-Led Audit Report and she said she believed it would have come to the CQRM, so she would have seen it, but that she would not have seen the most recent ones as the CQRM has not taken place since February 2020. She said, “I did value CQRM and I do miss it, I could see a lot of benefits, but there have been other things in place and I continue to be involved in different ways”.⁵⁸³

Assurance within the services and wards

527. A **Matron** responded to a virtual CQC inspection, which identified that the low secure unit had a gap in communication. In response they worked as a team to find gaps in their systems and looked at the feedback to see what could be improved. One result was that they bought in electronic devices to support young people to have face-to-face contact with their families, who could not visit. They also appointed Carer Leads to support with championing communication with the families and to link-up with SHFT to find out what was happening elsewhere. The CQC carried out a follow-up visit which found they had made significant progress, with no further concerns.⁵⁸⁴

528. In terms of ensuring SHFT’s standards of communication and behaviour by agency staff are met, a **Matron** said they use the ‘buddy system’ and get feedback from the agency about how they found the services. They also have regular meetings with the young people where they can feed back on the service, including if they are concerned about any agency staff.⁵⁸⁵

529. If there is poor communication with a patient, then there is supported reflective discussion and they can support conversations to open up avenues to understand what is causing it and address whether it is the system that might be causing it.⁵⁸⁶

530. A **Community Mental Health Team Manager** who has been in post since 2013 said there is a lot more emphasis on Key Performance Indicators, looking at referral rates, speed, care plans, crisis plans, and although it is about quantity, rather than quality, to ensure you have got those in place is part of the quality. The managers look at the quality

⁵⁸³ Ibid

⁵⁸⁴ Evidence of Matron, SHFT, 29 March 2021

⁵⁸⁵ Ibid

⁵⁸⁶ Ibid

beneath it. This is much higher on SHFT's agenda. There is monthly reporting, where they have to explain if targets are not met and what is being done about it.⁵⁸⁷

531. When asked by the Panel if they review patient notes, the **Community Mental Health Team Manager** said they do every now and again and will randomly choose a patient and look to see if there are any issues, or if any patient calls in with a concern, they will look at the file in its entirety. The Team has a member of staff who has responsibility for interpreting the data as part of their role and the headline figures are provided to the Manager.⁵⁸⁸

532. Further, service users' complete questionnaires and they are looking at adapting and improving them, so they can hand them out as part of the discharge planning process. Additionally, there is a weekly report to care coordinators and in the weekly business meetings they review a list of people who do not have a risk assessment or care plan and those that are coming up in the next two months for renewal.⁵⁸⁹

533. However, the Panel heard from a **service user**, of the Community Mental Health Team who said, "my care plan expired and I had to keep going on at them to update it, I should not have to do that as they are meant to do it yearly".⁵⁹⁰

534. A **Clinical Ward Manager** said that there is the ability to "step things up" in the following ways: monthly one-to-one with a line manager; collective ward manager group meetings once a month, where, as peers, they can go through any quality and assurance or issues and this fits into a larger network of more senior nurses who meet monthly at the Performance and Quality meeting.⁵⁹¹

⁵⁸⁷ Evidence of Community Mental Health Team Manager at SHFT, 31 March 2021

⁵⁸⁸ Ibid

⁵⁸⁹ Ibid

⁵⁹⁰ Evidence of a service user, 15 April 2021

⁵⁹¹ Evidence of Clinical Ward Manager, SHFT, 12 April 2021

Panel's Views on where SHFT are now: governance and assurance of communications and liaison in the organisation

- The Panel is satisfied that SHFT have developed an acceptable process of integrated governance reporting to provide quality improvement and quality assurance information through the committees and the organisation (i.e. Board-to-Ward and Ward-to-Board). The spread of involvement in the QI programme to improve communications and engagement across the organisation is also commendable and should continue.
- The experience that being a MHARM provides to individuals is positive and should be encouraged where appropriate.
- The Panel is pleased that the Board have received regular presentations from service users, carers and family members. It endorses this practice and encourages it to be more widespread across the committees.
- The committees should work harder to increase the voice, representation and involvement of service users, carers and family members in their membership. This is currently not at the levels it should be given the diversity of the population that SHFT serves.
- The Panel is satisfied that there are processes in place to ensure that the Board, Executives and Non-Executives are observing what happens on the ground. If this was reduced in light of the COVID-19 pandemic, it should be revived as soon as it is safe to do so.
- SHFT are reminded that the culture of open and transparent communication, which they strive for, and the values they seek to engender needs to be driven from the top: leaders must lead by example.
- The effectiveness of the Working in Partnership Committee would be improved through an annual cycle of self-assessment and action planning, which should be implemented.
- However, there are an excessive number of meetings held within SHFT. The governance systems could, and should be, streamlined. Utilising the QI methodology, SHFT could examine their current practices to see where their resources can be used most effectively and productively to help to secure improvement. The Panel emphasises that the real work has to be done after the meetings - in the implementation and change work - they are not yet satisfied that this is happening consistently.

Investigations

B. Where are SHFT now?

Introduction

535. The topic of independent investigations is one that featured heavily in Stage 1 and was of considerable importance to the Chair and Panel to consider further at Stage 2. The Panel welcomed a body of evidence on this topic from SHFT and the CCG. The Panel also received samples of Serious Incident (“SI”) Investigation Reports and 48-hour Panel Reviews. However, they acknowledge that they only heard direct evidence from one individual who had been through the SI Investigation process at SHFT, which was quite historic, and no other direct evidence was received from individuals or families who had been through the process recently. This has been borne in mind when the Panel were reaching their views on this topic, and wider conclusions.

536. By way of context, in 2019/20 there were 28,173 incidents reported within SHFT and of those, 96 (0.34%) were assessed as ‘Serious Incidents’; during the same period in 2016/17, there were 22,211 incidents reported, with 219 (0.99%) meeting the criteria of ‘Serious Incident’.⁵⁹²

537. However, the **Deputy Director of Nursing** said that if you just look at the number of incidents purely as a number, it is not in the context of the level of activity or complexity of the activity, so it may lead to improvement efforts being focused in the wrong place. SHFT see 5200 people every day, so, she said, if you look at their data over five years, there is a significant reduction in SIs, but that doesn’t take into account when new and old services transfer, so you can draw incorrect conclusions from the data. The new Quality Dashboard, will convert incidents and data points into rates of harm, so SHFT can prioritise their safety commitments and have the right focus for their improvement projects.⁵⁹³

⁵⁹² Statement of Deputy Medical Director at SHFT, 2 February 2021

⁵⁹³ Evidence of Deputy Director of Nursing at SHFT, 4 March 2021

538. The Panel acknowledges the findings in the CQC Report, January 2020: *'SIs were thoroughly investigated at a senior level and lessons were learned and shared across teams'*.⁵⁹⁴
539. The majority of participants were asked to compare where SHFT are today with two years ago on the subject of independent investigations and a selection of those answers are included below.
540. The **Deputy Medical Director**, who has been a Consultant in SHFT since 2007 and employed in leadership roles since 2009 said, "my unqualified and unhesitant answer is, yes, there has been significant improvement in nearly all areas in dealing with the SI process".⁵⁹⁵
541. In her statement, she stated: "SHFT has taken significant action to improve the rigour of the incident investigation process and the way we support and engage with those most impacted by such events. We have strengthened and reinforced our internal oversight arrangements. Our focus has been on improving quality, developing a safety culture, ensuring learning from incidents are identified, and changes implemented. These changes have been enabled through a conscious shift in the organisational culture".⁵⁹⁶
542. However, she also said that they are not complacent and recognise that there are areas for further and ongoing development.⁵⁹⁷
543. The introduction of the new national, NHS-wide, Patient Safety Incident Response Framework and Patient Safety Incident Management System will be considered further in Part 5C of this Report, but its introduction has been delayed until Spring 2022. Therefore, the Serious Incident Framework 2015 ("the 2015 SI Framework") is still applicable to any Serious Incident that occurs within SHFT, which is defined in the Framework as: *'Events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.'*⁵⁹⁸

⁵⁹⁴ Southern Health NHS Foundation Trust, Inspection Report, CQC, 23 January 2020:

<https://api.cqc.org.uk/public/v1/reports/3bfd1da5-1a89-47cf-8011-1c6ab96495eb?20210114105252>

⁵⁹⁵ Evidence of Deputy Medical Director at SHFT, 1 April 2021

⁵⁹⁶ Statement of Deputy Medical Director at SHFT, 2 February 2021

⁵⁹⁷ Ibid

⁵⁹⁸ <https://www.england.nhs.uk/wp-content/uploads/2020/08/serious-incident-framework.pdf>

544. The **Deputy Medical Director's** written statement sets out, succinctly, the context of investigations into SIs, the applicable 2015 SI Framework and National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care, March 2017 ("The Guidance"),⁵⁹⁹ therefore, it is quoted below in some detail.

545. The 2015 SI Framework sets out a three-tiered approach to determining the appropriate level of investigation required for a serious incident based on the complexity and, or severity of the incident. It recognises that within the NHS, most serious incidents are investigated internally using a comprehensive investigative approach (Level 2), where the investigation is owned by the provider organisation in which the incident occurred, as long as principles for objectivity are upheld. The 2015 SI Framework also recognises that providers may wish to commission an independent investigation or involve independent members as part of the investigation team to add a level of external scrutiny or objectivity.⁶⁰⁰

546. The 2015 SI Framework defines the parameters for Level 3 investigations as being: *'Required where the integrity of the investigation is likely to be challenged or where it will be difficult for an organisation to conduct an objective investigation internally due to the size of organisation or the capacity or capability of the available individuals and, or number of organisations involved'*. A key feature of these is the need for the investigation to be both commissioned and undertaken entirely independently of the organisation whose actions and processes are being investigated.⁶⁰¹

547. The Guidance aligned the approach to identifying, reporting, investigating and learning from deaths and set standards for every organisation. It reinforced a number of key messages within the 2015 SI Framework, including the intention to prevent recurrence through review and investigation of deaths, for which problems in care may have been a contributory factor, alongside the importance of sharing and acting on findings to support learning.⁶⁰²

548. The Guidance recognised and defined three levels of scrutiny that may be applied to the care provided to someone who subsequently dies; (1) death certification; (2) case

⁵⁹⁹ <https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf>

⁶⁰⁰ Statement of Deputy Medical Director at SHFT, 2 February 2021

⁶⁰¹ Ibid

⁶⁰² Ibid

record review; and (3) investigation. The Guidance prescribes those deaths that should be subject to case record review, acknowledging that this would be a wider definition than deaths that constitute serious incidents.⁶⁰³

549. The **Deputy Medical Director** suggested that SHFT has put in place an incident management system which has several elements:

- A central investigation team which is independent of the clinical divisions;
- A detailed process for the management and oversight of every single incident, with a number of compliance metrics at each stage; and
- A Trust-wide 'Learning from Events Forum', which scrutinises all aspects of the incident system, commissions thematic reviews and is responsible for incremental improvement to the incident management process itself.⁶⁰⁴

550. The Panel were informed that SHFT had intended to review and amend their policies and processes for investigating SIs when the Patient Safety Incident Response Framework was rolled out. However, the **Deputy Medical Director** said the new SI Framework is coming out next year, but they would not wait for that and would start their review and update their policies later.⁶⁰⁵

551. The Panel received evidence from the **Incident Investigation Manager** in SHFT's Central Investigations Team, who has been in post since December 2015. She said, "we are today unrecognisable from where we were five to six years ago. We always involve families in our investigation now; some do not want to be involved and we respect that decision, but we always approach them at the conclusion of the investigation to see if they would like a copy of the final report... and now, we contact GPs to be involved in the investigation as a matter of course..."⁶⁰⁶

552. She described how there is a "very different feel about investigations now amongst the staff group: less defensiveness and a culture of wanting to learn from incidents... people are open to the idea of an investigation, to look at how we can learn and do things differently. Gone are the days of hearing staff say 'we always do things like this'... in the reports from five to six years ago, the evidence to support our conclusions wasn't there,

⁶⁰³ Ibid

⁶⁰⁴ Ibid

⁶⁰⁵ Evidence of Deputy Medical Director at SHFT, 1 April 2021

⁶⁰⁶ Evidence of Incident Investigation Manager, SHFT Central Investigations Team, 19 April 2021

they weren't tools we used as part of the investigation process, it wasn't done in a systematic way; now that looks very different".⁶⁰⁷

553. From a commissioner perspective, the **Acting Director of Quality & Nursing in the CCG** was asked how SHFT compares to other organisations in this area and he referred to SHFT's dedicated pool of Investigation Officers, which he said, not all providers have that. He said SHFT are compliant with timescales and the quality of what they produce is very good and superior to some other SI reports he sees in the system. He commented, "we have seen a step change in the quality of what we are getting through from them".⁶⁰⁸

Processes in place for an SI Investigation

554. The Incident Investigation Manager has oversight of all of the SIs, including the SIs that meet the 2015 SI Framework definition and the 'Red RCAs'. The same methodology is followed for both investigations.

555. A 'Red RCA' is subject to an internal investigation on the basis that SHFT has determined it important enough to pull-out learning from, but does not necessarily meet the 2015 SI Framework criteria. An example of a 'Red RCA' is if there has been a number of self-harm incidents with the same patient, SHFT might want to look more closely at it to see if they can learn anything from a patient that is repeatedly self-harming and it is not being managed as well as it could be. The **Incident Investigation Manager** was questioned on this further and said, "if there is a ward where there are some concerns because 20 out of 24 of the patients are self-harming on a daily basis, we might want to do an SI investigation to see what other factors might be at play... a self-harm incident of itself, would not necessarily trigger an SI investigation".⁶⁰⁹

556. SHFT's 48-hour Review Panel determines the grading of the incident and level of investigation required and will determine if it is a 'Red RCA' (the Investigation Team can also declare a 'Red RCA' or that one should be an SI if they think it should be at a later date). At the Review Panel, the scope of the terms of reference will be agreed and the

⁶⁰⁷ Ibid

⁶⁰⁸ Evidence of Acting Director of Quality & Nursing in the CCG, 5 March 2021

⁶⁰⁹ Evidence of Incident Investigation Manager, SHFT Central Investigations Team, 19 April 2021

Initial Management Assessment (“IMA”), prepared by the service or team, will be reviewed.⁶¹⁰

557. In 2019/2020, there were 96 SI Investigations, in addition to the internal ‘Red RCA’ investigations. Thus, SHFT’s Central Investigations Team are conducting an average of 40 to 50 investigations at any one time.⁶¹¹

558. The **Incident Investigation Manager** set out the process following an incident in SHFT:

- 1) The local team or service would produce the IMA which is discussed at the 48-hour Review Panel⁶¹² and a decision is made on how to move forward and a questionnaire is also completed;
- 2) The Incident Investigation Manager would be notified of a SI investigation being requested as a consequence of a 48-hour Review Panel and would look for the most appropriate Investigation Officer to allocate it to;
- 3) The Investigation Officer would write to the family, including the terms of reference for the investigation and ask them if they’d like to participate or contribute to the terms of reference and direct them to two or three organisations that support bereaved families, including, Victim Support;
- 4) The Investigation Officer would then telephone the family and negotiate how often they’d like to be kept informed and updated. SHFT states it is led by the families and always offers them the opportunity to see the draft report;
- 5) The Investigation Officer would do a review of the clinical records to identify: who to interview, the evidence to gather and documents to review... then, they interview the families before interviewing staff or anyone else involved. The **Incident Investigation Manager** said they do it this way round, because it’s helpful to get an understanding of their concerns and what they want addressed. Sometimes they meet the family with the FLO and sometimes without, and will look at the terms of reference and translate their concerns into the terms of reference;
- 6) A roundtable discussion takes place;

⁶¹⁰ Ibid

⁶¹¹ Ibid

⁶¹² 48-hour panels are usually chaired by a senior clinician and have a representative from the clinicians involved in the care and a safeguarding lead

- 7) Once there is a draft investigation report, it is shared in full with the team where the SI occurred and staff concerned, that is their opportunity to challenge anything in the report;
- 8) Once it is received back from the team, they share the draft report in full with the family and they can provide comments on the report;
- 9) Once the division has signed-off the report and completed the action plan, it goes through the Corporate Panel, where the Head of Patient Safety and one of the Executive members of SHFT will scrutinise the report;
- 10) Once signed off by the Corporate Panel, it will go to the Commissioner Panel for final sign-off.⁶¹³

559. The **Incident Investigation Manager** said, “from my perspective, it’s a smooth-running process, but I am not involved in the detail at every step”.⁶¹⁴

560. The deadline to complete the investigation is 60 days and she said they do their best to meet it and in 99.9% of cases they do meet it and they try to have an investigation complete at 45 days. She was challenged on the fact that the sample reports showed that the 60 day deadline was continuously missed. She said, “we have identified an issue in the system where the target date was set at 45 days, not 60 days, so the sample reports would show as a breach, but they are within the 60 days, possibly”.⁶¹⁵

561. She said their Investigation Officers work extremely hard as they know there is a family at the end waiting for answers. On many occasions, she said, they go above and beyond to make sure they complete a report within those timescales.⁶¹⁶

562. The **Patient Safety and Quality Facilitator for the Southampton Division** said, “you could always improve on timescales. Some Investigating Officers might be doing two to three investigations at once, so time might be tight for them, I think they do it quite well”.⁶¹⁷

563. A **Matron** said, “there is pressure on the investigating team to process the investigation and report on time, it is why SHFT have recruited a team to do the

⁶¹³ Ibid

⁶¹⁴ Ibid

⁶¹⁵ Ibid

⁶¹⁶ Ibid

⁶¹⁷ Evidence of Patient Safety and Quality Facilitator for the Southampton Division at SHFT, 13 April 2021

investigations; it used to be us (i.e. management), and it was difficult to find the time to do it, but they have separated the teams that do investigations on time”.⁶¹⁸

564. In fact, of the ten sample SI Investigation Reports that the Panel were provided with, five had missed the target for completion and all of those were missed by six weeks or more and the longest delay was four months. The remaining five did not have a completion date entered on the Report.

565. The Panel were told that families do not see the IMA report and the IMA report is not the full picture or whole story, but if an incident does not go for fuller investigation, the IMA report may include an action plan and should demonstrate what was done next.⁶¹⁹

566. The **Clinical Director of the South-West Division** spoke about how it operates in her division and said that they have a single 48-hour Review Panel process that is local and internal to Lymington Hospital, which is an acute medical hospital where there are a high number of deaths. Their local Panel is available daily and consultants in the hospital meet daily to discuss the deaths. However, she said that, “... if there is a problematic event in the hospital and it’s not standard, or there are complex issues with care prior to hospitalisation, I will discuss it with the central clinical governance team... and they see all of my incidents as my IMA feeds into the Corporate Panel and the Executive Director of Nursing”.⁶²⁰

567. A **Matron** spoke about the process that follows a SI on her ward and gave a practical explanation of what would happen. She said that she would email senior management to say it was going to a 48-hour Review Panel and they would ask what I had done so far. The Panel would review it and see whether or not any immediate learning has taken place, identify any gaps and any immediate actions that are needed and escalate it to a potential SIRI (serious incident requiring investigation). If they did, it would be allocated to a commissioner who has terms of reference; then it would go to an external investigator with the terms of reference, they sit in the central investigations team, not the clinical team, and will make contact with the Matron to get details.⁶²¹

⁶¹⁸ Evidence of Matron, SHFT, 29 March 2021

⁶¹⁹ Evidence of Incident Investigation Manager, SHFT Central Investigations Team, 19 April 2021

⁶²⁰ Evidence of Clinical Director of the South-West Division, SHFT, 1 April 2021

⁶²¹ Evidence of Matron, SHFT, 29 March 2021

568. A **Matron** said she would normally let the family and young person know that it was going through the external investigation process. Within the SI investigation process, the Investigation Officer will make contact with the family and young person with the terms of reference and ask them if there is anything that needs to be looked at in more detail or whether anything has been missed.⁶²²

569. She said the Investigation Officers work with them to find the staff involved and will do group or individual interviews to find out what took place, speak to the family to see if there are any issues about the unit and speak to the young person. Then they compile a report of their findings, which goes to the relevant division to see if the report has addressed all of the issues and it goes to a more senior team for sign-off and the family have to see the report at each stage too.⁶²³

570. The **Community Mental Health Team Manager** said that there have been two SIs that went to full investigation after a 48-hour Review Panel in her team in the last two years. She explained the process as quite smooth and said that her staff felt supported and they offer support to the team if there are incidents and she shared the report with the team during their weekly multi-disciplinary team meeting.⁶²⁴

571. In terms of wider sharing with other mental health team managers she said she would do this if there was anything appropriate and they meet monthly in the division, but there is no opportunity to meet other divisions.⁶²⁵

Panel's Views on where SHFT are now: the SI Investigation process

- The Panel is satisfied there is a systemic governance process in place to deal with SIs that occur within SHFT, which is led by a centralised team and is separate from the divisions.
- The Panel welcome SHFT's addition of a 'Red RCA' undergoing full investigation, but suggests that this process is more widely shared and publicised in its SI Policy and Procedure documents, all of which should be accessible to the general public (not just online) and in a format and language that is straightforward to follow and understand.

⁶²² Ibid

⁶²³ Ibid

⁶²⁴ Evidence of Community Mental Health Team Manager at SHFT, 31 March 2021

⁶²⁵ Ibid

Panel's Views on where SHFT are now: SI Investigation process continued...

- Although the Panel welcomes SHFT's ambitious target created by having 48-hour Review Panels it acknowledges that a number of other Trusts have 72-hour Review Panels. This latter option allows for greater opportunity to produce high quality accurate reports that properly collate the relevant evidence and offer a greater opportunity for learning, particularly if the incident does not undergo a full SI investigation. A 72-hour Review Panel would also reduce the documented delays caused by the requests for more information by the 48-hour Review Panel. The evidence indicates that the existing process may not be as effective as it should be and an over focus on meeting deadlines to produce a report within 48-hours, may compromise the quality of the reports and potentially the safety of patients.
- The Panel is not satisfied that SHFT have demonstrated that they recognise the difference in the National Guidelines that investigations into physical health, mental health, or learning disability incidents can be different and require different approaches. These should be consulted and included in the Investigation Officer's training.
- Although SHFT sought to provide an explanation as to why the sample SI Investigation Reports showed the deadline had been missed, upon deeper examination, the Panel is not satisfied that SHFT is meeting the deadline set for SI Investigations to be completed. In some examples, there was significant delay. There were multiple and contrasting reasons given for this by SHFT in evidence (i.e. Board Reports and QSC meeting minutes and oral evidence). Therefore, SHFT must investigate the true cause as a priority and rectify it.

Independence in the SI Investigations

572. The Panel received evidence of the key safeguards that SHFT states it has put in place to ensure independence in the investigation of SIs that occur within the organisation and these are summarised in the **Deputy Medical Director's** statement as follows:

- The central investigation team is not part of any of the clinical divisions but part of SHFT's Quality Governance function;
- Investigation Officers are required to declare any conflict of interest before undertaking an investigation and where any conflicts are identified, a different Investigation Officer is assigned;
- Patients and families are invited to contribute to the terms of reference of the investigation;

- The draft investigation report is shared with patients and families and all feedback and any further queries are addressed before the report is finalised; and
- The report is subject to scrutiny by a SHFT Corporate SI Panel to which commissioner representatives are invited.⁶²⁶

573. Furthermore, the **Deputy Medical Director** said that since 2016/17 there have been five incidents which have been, or are expected to be, subject to an independent (Level 3) investigation (i.e. commissioned by a party external to SHFT). She stated that there are occasions when SHFT will commission an external body to undertake the Level 2, comprehensive investigation, in particular for incidents such as inpatient suicides. Between 2016/17 and 2019/20 there were four cases where SHFT commissioned an investigation from an external party, and one investigation has been commissioned to date in 2020/21.⁶²⁷

574. The Panel challenged SHFT participants during the hearings on what they consider ‘independence’ to be and the effectiveness and rigour of the safeguards set out above.

575. The **Chief Executive** said, “‘independence’, as we have it, is an internal independent unit, it’s not independent of SHFT, but independent of the individual services. For most investigations, I believe that is appropriate: they are skilled and focused on how to conduct investigations... but there is grading and judgment throughout the process...”.⁶²⁸

576. He said in terms of independence, “where it’s appropriate and there should be no hesitation about it, we will and have gone, completely independent, to have investigations done by people outside. For example, in one event, we commissioned a consultant psychiatrist and former director of nursing to come in and do a review for us independently and I know we have used neighbouring Trusts to review”.⁶²⁹

577. The **Chief Executive** referred to there being a spectrum of independence and as to when there will be an external independent investigation, he said there is no hard criteria, it is flexible, it is not prescribed and it’s a discussion about the context. He said they would consider the nature of the event; seriousness in terms of impact and knowledge of other possible related events; whether it’s part of a sequence or pattern of events; or

⁶²⁶ Statement of Deputy Medical Director of SHFT, 2 February 2021

⁶²⁷ Ibid

⁶²⁸ Evidence of Chief Executive of SHFT, 16 April 2021

⁶²⁹ Ibid

whether it's important to have independence, as there might be concerns about the inability of an in-house team to hold to account and investigate. They would also consider if there have been a number of events in a service or geographical patch, or the same event has happened a number of times, which would suggest SHFT were not learning quick enough from it, or there was further learning to be had and bringing in someone independent to do it brings a real benefit.⁶³⁰

578. When asked what 'independence' means to the **Deputy Medical Director**, she said, "... in the last few years, there is more recognition in the organisation, and outside, that SHFT's central investigations team is separate from the clinical divisions and the Investigation Officers are not working as clinicians, as they are employed as Investigation Officers... some of the evidence of their independence, notwithstanding that they are employed by the organisation, comes from their practice; we have all seen they are perfectly prepared and comfortable to challenge us in delivering services".⁶³¹

579. She gave an example from her own clinical practice some years ago when there was a SI Investigation in a service she worked in and the Investigation Officer who was initially identified had worked in that service in the not-too-distant past. So, they have first-hand clinical understanding, but they decided it would be better to have an Investigation Officer that had never worked in the service, because it might be seen as a conflict of interest at a later date. She said it's about perceived conflicts too. She described how they have that conversation in every investigation when appointing the Investigation Officer and ask them to make a declaration on the SI Report at the start.⁶³²

580. The **Deputy Medical Director** said that a decision as to whether an investigation is undertaken externally to SHFT is made in conjunction with the commissioners of the service. She said some are always external and would be commissioned by NHSE/I and carried out by an external body and they would receive the report, such as in any mental health homicides.⁶³³

581. In the cases that are investigated externally, either under the 2015 SI Framework or because a family requested it, SHFT would go to the commissioners and if it is a family's request, SHFT would represent that to their commissioners and advocate on behalf of

⁶³⁰ Ibid

⁶³¹ Evidence of Deputy Medical Director at SHFT, 1 April 2021

⁶³² Ibid

⁶³³ Ibid

the family. The **Deputy Medical Director** said that, “for the most part, the commissioner would find investigators, they might ask us if we know of ones with a specialism, but in terms of managing perceived conflicts of interest, we would expect it to be commissioned externally, identified externally and investigated externally”.⁶³⁴

582. The externally commissioned investigations would be carried out by firms who are in the business of providing that service, but the people who do them have had clinical backgrounds. Where investigations are carried out externally and commissioned by SHFT, they have been clinicians from other organisations. The **Deputy Medical Director** said she had been contacted to help with investigations by other Trusts and in both, she was the external person and Chair and they both had a Non-Executive Director, who had a lay background, as part of the panel. Further, she commented on how the presence of a lay member from a non-health background was enormously helpful in both cases and that the Non-Executive Director had been clear that they would have needed a significant amount of clinical input to understand the nature of the adverse event and draw conclusions from it. Thus, her experience is that both are needed.⁶³⁵

583. The **Chief Medical Officer** was asked if the Central Investigations Team conducting SI investigations in SHFT are ‘independent’ and he said it has a degree of independence, it is not within the team itself. He said it means that they are one step removed, so there is objectivity and that objectivity should be challenged by the team, which is what check and challenges are and that involves a discussion around the incident”.⁶³⁶

584. The **Incident Investigation Manager** said that to recognise conflicts of interest it requires self-awareness and consciousness, but she was not aware of any formal criteria to check for conflicts of interest. She stated that she sees herself as ‘independent’ in the organisation.⁶³⁷

585. She was asked how she would identify at the start of an investigation whether it needed to be independently reviewed and said there is no set criteria as to when it should be conducted by an external organisation and each investigation is taken on its own merit.⁶³⁸

⁶³⁴ Ibid

⁶³⁵ Ibid

⁶³⁶ Evidence of Chief Medical Officer at SHFT, 12 April 2021

⁶³⁷ Evidence of Incident Investigation Manager, SHFT Central Investigations Team, 19 April 2021

⁶³⁸ Ibid

586. The **Incident Investigation Manager** said, “for the majority of investigations, I think we are best placed to do it, we’re separate from all the divisions and teams, and almost in a ‘little bubble’. If we were attached, they would become part of it and the objectivity could be compromised”.
587. She said they are not independent from SHFT as they are employed by them. This is, she stated, explained to families when they meet with them and if a family are not happy with their level of independence, she said she would take it to her manager who would escalate it to see if should be done externally.⁶³⁹
588. The **Incident Investigation Manager** said she would describe someone as ‘independent’ if they do not know the staff or patients in a part of SHFT or on a ward and have never worked in the team, so they have no pre-conceived ideas of the individuals or what they normally do.⁶⁴⁰
589. The **Regional Medical Director for NHSE/I for the South East Region, Dr Lewis**, said that he has not commissioned an external independent investigation for SHFT and if there was one, he would expect to be aware of it. The decision, he said, would be made by the multi-disciplinary team or a group of individuals. In his view, an external independent investigation would need to take place where there was a suggestion of systemic failure of care, whatever the perceived root cause.⁶⁴¹
590. A **family member and ex-Governor at SHFT** spoke in general terms and said, “with the existing organisation paradigm, in the way the NHS is managed, you will never get people to carry out independent investigations... it is so unsuited to honest investigations, you have to rely on independent investigators for the big reviews...”⁶⁴²

⁶³⁹ Ibid

⁶⁴⁰ Ibid

⁶⁴¹ Evidence of Regional Medical Director for NHSE/I for the South East Region, Dr Lewis, 6 April 2021

⁶⁴² Evidence of a family member and ex-Governor at SHFT, 14 April 2021

Panel's Views on where SHFT are now: independence in SI Investigations

- The Panel accepts SHFT have developed a Centralised Investigation Team, which they state to be independent to the teams, services and divisions at SHFT.
- Perceived independence is very important in this context and the Panel is not reassured that SHFT recognises the critical need for the perception of independence to be present in every investigation conducted. The Panel is not satisfied by the lack of formalised mechanisms and processes currently in place for recognising where there is, or might be, a perceived lack of independence or conflict of interest.
- The Panel is concerned by the lack of transparent, objective and clear criteria that SHFT has in place to determine the degree of independence required in an investigation, who would commission such an external investigation and SHFT's involvement in that decision.
- The Panel's view is that currently SHFT is 'independent in secret' because it has not seen SHFT provide a clear and transparent definition of 'independent' that is available to service users, carers, family members and the staff of SHFT. The Panel is not able to endorse what 'independent' means in SHFT without a clear definition and a transparent and open explanation about its processes for ensuring its investigations are in fact, 'independent'.

Investigation officers

591. The Panel were informed that in the Central Investigations Team there are 6.8 whole-time equivalent Investigation Officers and one full-time manager who has oversight of them and investigates too. There is a separate Complaints & Patient Experience Team, but the Central Investigation Officers do sometimes investigate complex complaints.⁶⁴³ Those who investigate complaints locally in the divisions are also called 'Investigation Officers'. They receive the same training, but do not carry out SI Investigations, unless the demand in the Central Investigations Team outweighs capacity, then they may offer to help.⁶⁴⁴

592. The **Incident Investigation Manager** said that having the central team is the envy of many other organisations. She said the Investigation Officers are very busy, highly skilled, in high demand and that many come from clinical backgrounds.⁶⁴⁵

⁶⁴³ Evidence of Incident Investigation Manager, SHFT Central Investigations Team, 19 April 2021

⁶⁴⁴ Ibid

⁶⁴⁵ Ibid

Experience and skills of Investigation Officers

593. In regard to the experience and skills of an Investigation Officer, the **Incident Investigation Manager** said, "... what is more important are the skills, rather than how many years' experience someone has. I would be looking at the skill sets for: communication, interviewing skills, honest, ethical, empathetic, basic research skills, technology skills, critical skills and ability to analyse data/information".⁶⁴⁶

Training of Investigation Officers

594. The Investigation Officers receive two days training.

595. The **Incident Investigation Manager** was asked about their training and said that nobody will do an investigation unless they have done the two day training, where they look at Root Cause Analysis and tools to support investigations. For example, the contributory factor framework and double column analysis.⁶⁴⁷

596. As to whether two days was sufficient training, she said the skills required to be an Investigation Officer come from doing them every day and their skills progress and they build on them with every one they do. She said that when they start, she works with them closely, on an individual basis and they are allocated an investigation after a couple of weeks and shadow a more experienced Investigation Officer. She also meets with them regularly.⁶⁴⁸

597. She does not have a particular training needs programme for them, but as part of their appraisals, she will look at any training updates they might need and if training comes up, then a couple of staff attend and then share it with the rest of the team.⁶⁴⁹

598. The **Chief Medical Officer** said, "I take some heart in HSIB hopefully giving more consistent and reliable training and expectations in investigations".⁶⁵⁰ However, the **Incident Investigation Manager** said she does not have regular contact with the HSIB,

⁶⁴⁶ Ibid

⁶⁴⁷ Ibid

⁶⁴⁸ Ibid

⁶⁴⁹ Ibid

⁶⁵⁰ Evidence of Chief Medical Officer at SHFT, 12 April 2021

but confirmed that they would take up the opportunity of exchange programmes with them.⁶⁵¹

Support for Investigating Officers

599. In terms of support for the Investigation Officers, the **Incident Investigation Manager** said she provides six weekly one-to-one supervisions with the team; they have peer group supervision once a month; and they are in the process of getting enhanced supervision for the team. They also have access to iTalk.⁶⁵²

600. When asked about the potential for 'rotation', she acknowledged that it is easy to get burn-out in the role, so there is a place for rotation, but it has to be coupled with training someone up to work to the standards of the team, which can take a few months.⁶⁵³

Quality assurance

601. The **Incident Investigation Manager** stated that she looks at how the Investigation Officers have conducted every investigation: what they have reviewed, how they have conducted the fact-finding, the data collected and how they analysed the evidence.⁶⁵⁴

602. She said they assure the quality of investigations through a number of different mechanisms and listed them in detail. They are summarised below:

- The most complex SIs may be investigated by two Investigation Officers, or one buddied with a senior clinician from a different division, but with the same speciality.
- At each stage of the investigation process, the manager of the Central Investigation Officer Team will check-in with them regularly.
- At various stages of the investigation, the Investigation Officer maintains contact with the patient or family, so any concerns are flagged early.
- The first draft report is shared with the patient, family and the responsible division and sometimes the patient or family have additional questions and we look at them and may incorporate them.

⁶⁵¹ Evidence of Incident Investigation Manager, SHFT Central Investigations Team, 19 April 2021

⁶⁵² Ibid. 'iTalk' is the 'Improving Access to Psychological Therapies' service for most of Hampshire.

⁶⁵³ Ibid

⁶⁵⁴ Ibid

- The final report goes to a Corporate SI Panel, which sits weekly and where necessary twice a week. That is the final check and challenge – “there are robust discussions and every part of the report is scrutinised”.⁶⁵⁵

603. The **Incident Investigation Manager** said they are getting much better at getting to root causes. She stated that she also relies on feedback from the patients and families. When she started in 2015/16, she said it was not uncommon for patients and families to be dissatisfied with the report, but it happens a lot less now. She acknowledged that they are not perfect and said there are many areas of improvement, but, overall the theme is that they are better at answering the exam question: why did it happen and what is going to be done to stop it happening again?⁶⁵⁶

Panel’s Views on where SHFT are now: SI Investigation Officers

- The Panel is pleased that SHFT has a centralised, trained team of Investigation Officers and has gone some way in professionalising this role.
- The Panel views the Job Description for the Investigation Officers and noted that it omits the personal qualities that are expected of them (e.g. integrity, objectivity and honesty). Although the Panel is reassured by the evidence of some of the processes in place for values based recruitment, the qualities should be set out in the Job Description.
- The Panel is not satisfied that the two day Investigation Officer training is sufficient and is concerned that it is the same amount of training given to Investigation Officers who are investigating complaints in the divisions.
- It was not confirmed whether the Investigation Officer training includes the qualities and values required of them, so if it does not then this should be rectified.
- The Panel is surprised that the training and reporting is still focused on the Root Cause Analysis tool, when other organisations and the national movement has been towards Human Factor training. The importance of this approach was acknowledged by a few of the SHFT participants. It should be included in the Investigation Officer training and implemented in their investigations and reports.

⁶⁵⁵ Ibid

⁶⁵⁶ Ibid

Investigation Reports

604. The Panel reviewed a sample of the SI Investigation Reports and noted that a template is used. Therefore, the Panel were keen to hear from participants as to how the reports are prepared, scrutinised and quality assured.

Contents of the Investigations and Reports

605. The **Incident Investigation Manager** said, “I think the quality is very good, detailed and robust, and many families have given feedback on how detailed and robust they have been, some have said they expected ‘a cover-up or whitewash’ and were surprised it wasn’t that and it was an open and honest reflection of what occurred”.⁶⁵⁷

606. The **Clinical Director for Mental Health and Learning Disability for West Hampshire CCG** said that when there is an incident with a patient whilst under SHFT’s care and an investigation, “we ensure GPs are asked for information regarding the care of the patient... and they are included in the output too and given the opportunity to attend Evidence of Improvement Panels. I would hope there would be the opportunity for shared learning for the future too”.⁶⁵⁸

607. The Panel commented on the length of the reports and asked the **Deputy Medical Director** about this. She said some families have come back and said a 40 page report is too much and then they would produce an easy-read summary of findings for them. More commonly they ask for time and want SHFT to go back to them so they can ask questions and they will do that. If it appears they need additional support, SHFT provide it, “in any way they want them too”.⁶⁵⁹

608. The **Deputy Medical Director** said that in January 2020, SHFT had been the subject of a voluntary review by the Royal College of Psychiatrists as part of their accreditation process. The feedback from reviewees and the College was on the length of report and templates.⁶⁶⁰

⁶⁵⁷ Evidence of Incident Investigation Manager, SHFT Central Investigations Team, 19 April 2021

⁶⁵⁸ Evidence of Clinical Director for Mental Health and Learning Disability for West Hampshire CCG, 17 March 2021

⁶⁵⁹ Evidence of Deputy Medical Director at SHFT, 1 April 2021

⁶⁶⁰ Ibid

609. When it was suggested to the **Incident Investigation Manager** that a lot of the content can be challenging to understand, she said they are going to review the template and were going to do it last year, but it was pushed back by COVID-19. She said she foresaw them being in a position to use it now, but it's on their priority list.⁶⁶¹
610. She said the (Ulysses) system pulls data from other parts of the system - the chronology, care and service delivery problems and contributory factors - so the system needs to be changed to change the template. She explained that some of the information is pulled from the IMA form and they overwrite it in the RCA template.⁶⁶²
611. The **Deputy Medical Director** said they recognised that the software in Ulysses is not adequate for mental health; it has an in-built list of contributory factors, but it doesn't capture the complexities of adverse events in mental health. They discovered last year that they are able to replace it with a more sophisticated list of contributory factors. She said that the reformed template should have the involvement of families, available at the start of the report, not towards the end.⁶⁶³
612. The **Incident Investigation Manager** said the reports in the acute Trusts are not very personal and are very clinical and mechanical, but the investigations and reports in mental health and learning disabilities are very personal. She said, "when we came together as a central team, I was clear that all investigations across the board had to meet those standards and all investigators now work to those standards".⁶⁶⁴
613. In the FLO Quarterly Report, 31 December 2020, the feedback from a family member was: "*The final report is cumbersome as a document to consume*".

Quality Assurance

614. The **Incident Investigation Manager** said, "I personally review and scrutinise every investigation that is conducted by my team and I always read every report and I put myself in the position of 'what care would I want if it were a member of my family?' so, I always try to personalise it to a degree... I look to see what evidence has been provided

⁶⁶¹ Evidence of Incident Investigation Manager, SHFT Central Investigations Team, 19 April 2021

⁶⁶² Ibid

⁶⁶³ Evidence of Deputy Medical Director at SHFT, 1 April 2021

⁶⁶⁴ Evidence of Incident Investigation Manager, SHFT Central Investigations Team, 19 April 2021

to support their conclusions. If there are any gaps, I sit down with the Investigation Officer and explore ways to close the gap. But it's not just me reviewing them, it goes through a Divisional, Corporate and Commissioner Panel process".⁶⁶⁵

615. **The Deputy Medical Director** said, "we have an informal test when we get a report... we ask ourselves whether one of our family members would understand it. If the answer is no, we would look at it again. I think our reports are too long and complex and some of that is the function of the template and the new one will help enormously".⁶⁶⁶

616. **The Service User Involvement Facilitator** said that they get to see SI Investigation Reports to ensure they have a service user voice attached to them.⁶⁶⁷

617. **The Patient Safety and Quality Facilitator for the Southampton Division** said that after the Investigation Officers have held interviews, there is a 'Round the Table Talk', which she attends. They go through the report and look at what happened, how it happened, identify good practice and where SHFT can learn.⁶⁶⁸

618. In regard to the 'SI Checklist' introduced by the CCG and used by SHFT, the **Incident Investigation Manager** said the odd thing can slip if you are doing it daily so it is important to make sure they are covering the basics.⁶⁶⁹

619. The Panel were informed that SHFT shares the SI Investigation Reports with their commissioners and the **Acting Director of Quality & Nursing in the CCG** said, "we have seen the quality of the narrative in the Report is more detailed and deeper, it does dig-in to the root causes".⁶⁷⁰

620. The Panel received evidence from multiple participants that in 2019/20, 74% of SI Investigation Reports were approved by the CCG at first presentation (i.e. 25% were sent back for further work by SHFT). In 2017/18, 71% were sent back and this is a significant improvement from the levels reported prior to 2016.⁶⁷¹

⁶⁶⁵ Ibid

⁶⁶⁶ Evidence of Deputy Medical Director, SHFT, 1 April 2021

⁶⁶⁷ Evidence of Service User Involvement Facilitator at SHFT, 18 March 2021

⁶⁶⁸ Evidence of Patient Safety and Quality Facilitator for the Southampton Division, SHFT, 13 April 2021

⁶⁶⁹ Evidence of Incident Investigation Manager, SHFT Central Investigations Team, 19 April 2021

⁶⁷⁰ Evidence of Acting Director of Quality & Nursing in the CCG, 5 March 2021

⁶⁷¹ Statement of Deputy Medical Director of SHFT, 2 February 2021 and evidence of Acting Director of Quality & Nursing, West Hampshire CCG, 5 March 2021

621. The **Acting Director of Quality & Nursing** explained that the SI will go back to SHFT, with clear feedback and comments on why they would not sign it off and what needs to be done; they would set a deadline and if it was still not satisfactory, it would go back to SHFT and would not be closed. He said that if it had to be returned a third time, which had not happened, he or the Director would speak to SHFT directly about it and could move into contractual processes around remedial action plans and penalties.⁶⁷²

Recommendations

622. The **Incident Investigation Manager** said they set the recommendations, but the teams make the action plans (with a timeline). The recommendations will be drawn from any caring service delivery problems identified and they recommend changes.⁶⁷³

Panel's Views on where SHFT are now: SI Investigation Reports

- The Panel heard a significant amount of evidence about the current process of review that the template SHFT use to prepare the SI Report is undergoing. The amendments should take place promptly and the discussions that need(ed) to be had with software providers to make the urgently required changes, should not prohibit this now or in future.
- The Panel's view is that the current SI Report template is used more for convenience, as it allows for information to be pulled from other systems and does not focus on quality. As a result, it is repetitive and technical language is frequently used, which makes the final report difficult to navigate, particularly for a lay person. Further, because of the layout and the fact that it is not personalised, the individual is not at the heart of the report.
- It is understood that the full report is shared with the service user, family or carer and the CCG. However, the Panel's analysis is that the reports are written for internal teams and their "cumbersome" length and contents are inappropriate for a service user, family or carer to receive.
- With the omission of a Human Factors approach in the reports, the quality does not meet the standard of analysis the Panel would expect.

⁶⁷² Ibid

⁶⁷³ Evidence of Incident Investigation Manager, SHFT Central Investigations Team, 19 April 2021

Panel's Views on where SHFT are now: SI Investigation Reports continued...

- The use of terms such as “must” and “should” in the recommendations, in the context of following SHFT policies and procedures, are not appropriate for ‘SMART’ recommendations. First, the policies should always be followed, without the need for a recommendation. Second, the language used should be clear and straightforward.
- The action plans in the Reports, which it is acknowledged are completed by the service or team involved in the investigation, do not have deadlines, nor do they list the individual(s) or role of the person who is responsible for implementing the actions. Therefore, accountability is lacking, and their value in ensuring change and learning, is diminished.
- The Panel is concerned about the delay at the sign-off stage caused by the CCG having to return approximately 26% of reports. Although this is primarily due to action plans, the evidence indicates that it can also be due to the quality of the reports or a failure to meet the terms of reference. SHFT should continue to work towards improving the quality of the reports to reduce the number that have to be returned.

The involvement of service users, carers and family members in the SI Investigation

623. The Panel heard evidence from SHFT about how they involve and support the service user, carer or family member during the SI Investigation process.

624. The **Chief Executive** said that if there has been a death, “... we need to approach the families, identify who to talk to, ask how they wish us to progress, what they want us to look at and the families should be engaged at all stages... we won’t always get that right, nevertheless, that has to be what we’re focussed on... we have to try and engage on their terms as far as they want to and be transparent about what is happening”.⁶⁷⁴

625. He said, “I have personally sat with families where there are untoward events or complaints, I see it as my responsibility to do that and I should not be kept separate or immune from it... (in one case) it had gone through the whole process, I didn’t think we had addressed the issues raised by the family and I became directly involved, as I felt it necessary for me, as Chief Executive, to come in to provide the information to the families and apologise...”⁶⁷⁵

⁶⁷⁴ Evidence of Chief Executive of SHFT, 16 April 2021

⁶⁷⁵ Ibid

Process for engaging with service users, carers or family members

626. The **Deputy Medical Director** gave an overview of the process, from her point of view, as a senior leader in the organisation and also a clinician. She said that if a service user or family member experienced harm, the team, service or multi-disciplinary team, in contact with the patient, would have an important role to play in explaining what was likely to happen; they would say ‘sorry that it’s happened, but a number of things will now happen’ and depending on the nature and severity, they would talk through the reporting of the incident and the 48-hour Review Panel. She said, if it is clear it’s going to be a SI, the clinical team would tell them early on. They might be contacted by the division’s senior management team, depending on the severity.⁶⁷⁶

627. The **Deputy Medical Director** said the Investigation Officer’s role is also to keep the family informed regularly of the process of the investigation through telephone, email and, prior to the pandemic, face-to-face.⁶⁷⁷

628. She said if families do not want to be involved at an early stage, they proceed with the investigation, but they can get involved at any time and even if they don’t, they will make contact with them when the final report is ready to see if they want it and if they want to be involved. Occasionally a family feels ready many months later to come back and re-engage, then they will reopen the case. She stated that they accept and it is not uncommon for a family to be involved and then decide to withdraw as it is not the right time. She said, “100% of the time, when we know about a family member, service user or loved one, we ask them to be involved in the investigation”. The key indicator that she uses is, ‘have they felt that they have been engaged adequately?’⁶⁷⁸

629. The **Incident Investigation Manager** was challenged by the Panel on the fact that there was no evidence that the terms of reference set out in the sample SI Investigation Reports included the family’s concerns. She confirmed they do contact the families about the terms of reference, but said the majority, have nothing to add, however, if they do, they add them to the terms of reference in that section of the report. She said she had done it on numerous occasions and the team do too.⁶⁷⁹

⁶⁷⁶ Evidence of Deputy Medical Director at SHFT, 1 April 2021

⁶⁷⁷ Ibid

⁶⁷⁸ Ibid

⁶⁷⁹ Evidence of Incident Investigation Manager, SHFT Central Investigations Team, 19 April 2021

630. The **Patient Safety and Quality Facilitator for the Southampton Division** said that the family and patients have an opportunity to meet with the local team during a SI investigation if they want too.⁶⁸⁰

Cultural shift

631. A **Service User Involvement Facilitator** said, “SHFT are now flexible and open to having service users as part of those discussions, for example, there was an incident two weeks ago involving a service user and one year ago they wouldn’t have been involved as part of the discussion, but I was asked to support them so they could have a proper discussion with the service user and look at what the service user would have done differently in that situation”.⁶⁸¹

632. The Facilitator said if there is an incident or issue, they will, more often than not, receive an email asking if the service user is well enough to be a part of it or can they have the discussion and get the information from them so they don’t feel so overwhelmed. An example was provided of a medication error a month ago and the Facilitator was asked by the person investigating: ‘we need to understand how the user felt about it and what could have been done differently for that user’.⁶⁸²

633. A shift in the way medical teams and doctors work with service users was described. It was acknowledged that SHFT still has a way to go, but that they have robust senior leadership in place, so the Facilitators can go directly to a doctor or to a senior person and raise any issues.⁶⁸³

Reflecting the service user’s, carers’ or family member’s views in the SI Investigation Report

634. The **Incident Investigation Manager** said that if the family have a very different viewpoint or opinion to the draft investigation, they would look at the points raised and discuss them in detail. They would look if they had got it wrong or misunderstood things. She said they would always take their views on board and if they can’t reach a

⁶⁸⁰ Evidence of Patient Safety and Quality Facilitator for the Southampton Division, SHFT, 13 April 2021

⁶⁸¹ Evidence of Service User Involvement Facilitator at SHFT, 18 March 2021

⁶⁸² Ibid

⁶⁸³ Ibid

conclusion, because there is a difference of opinion or expectations, they will always reflect that in the report and what those views are.⁶⁸⁴

635. She said they have families who do not accept their findings, but because of the relationship they have built with them during the investigation, they might not agree with the outcome but might accept it. She said there is a distinct difference and in the five and a half years she has been with SHFT, she had not come across a family that had not accepted that difference of opinion. They do signpost families to a senior member in the division – a consultant or Director of Nursing – once the investigation is complete and if anything comes out of those discussions, they will come back to look at again, but she had not known that to happen and attributed this to the dialogue they have with families at the early stages of the investigation process.⁶⁸⁵

Information about SHFT's procedures and policy

636. The **Deputy Medical Director** said the Central Investigating Team and their manager are developing a leaflet information resource and the communications will be in a format the family want, so they will email, or phone, or do both, if they wish. She said that no family should be expected to read the policy and the leaflet will set out the expectations, which are currently provided in individual communications with the families during first contact.⁶⁸⁶

Support for the service users, carers or family members in the SI investigation process

637. The **Incident Investigation Manager** set out the options for support for service users, family members or carers, from the perspective of the Central Investigations Team. She said they will contact the family and tell them they have a draft available and ask them how they want it to be shared and will say that it can make distressing reading and offer to be there and talk through it with them. If they decline, she said, they strongly recommend they have someone close or a family member with them. They will also ask if they want it by paper, or email, or both and sometimes they want a copy then to meet later.⁶⁸⁷

⁶⁸⁴ Evidence of Incident Investigation Manager, SHFT Central Investigations Team, 19 April 2021

⁶⁸⁵ Ibid

⁶⁸⁶ Evidence of Deputy Medical Director at SHFT, 1 April 2021

⁶⁸⁷ Evidence of Incident Investigation Manager, SHFT Central Investigations Team, 19 April 2021

638. In regards to more vulnerable individuals, if there is someone with a learning disability, she said their colleagues in the learning disability service will assist them in wording a report or letter, that may help them understand it and they can work with their care coordinator to gain an understanding of their literacy needs. They also use interpreters when required.⁶⁸⁸

639. A **Matron** said that if an Investigation Officer needs to communicate with a young person, they make sure they have someone else they feel comfortable around with them and ensure they are understanding what the Investigation Officer is saying. If someone external is coming in, they make sure an appropriate adult they are comfortable around is provided. Further, if a letter is sent out following an investigation, the young person will be sent the same version as their family (the report is not adapted for them), but it is not sent straight to them, so they will sit with the young person and share with them what the investigation is saying and ensure they understand it.⁶⁸⁹

640. The Panel received extensive evidence about and from the FLO. The **Chief Executive** said, “the FLO does a fabulous job... it’s obvious the demand for the service is one we need to put more resource into... the FLO had requested additional support and I think SHFT was a bit slow in responding to that, but it has responded and additional support is being provided to her now”. He acknowledged, “the very direct support the FLO gives to families at bereavement is not as extensive as it might be... we would like to provide support at all inquests”.⁶⁹⁰

641. The current FLO has been in post since July 2019. She confirmed that she did not receive specific training from SHFT for this role, or the Police, where she worked previously. The **FLO** said her first port of call was the other FLOs in the NHS, who she meets with regularly. There are only about twenty FLOs across the country.⁶⁹¹

642. She confirmed that she receives fewer referrals than her predecessor (and when she joined), which she states is because her job role is more specific and defined. Her role, as she describes it, is to, “assist families where there is a SI that SHFT are investigating

⁶⁸⁸ Ibid

⁶⁸⁹ Evidence of Matron, SHFT, 29 March 2021

⁶⁹⁰ Evidence of Chief Executive of SHFT, 16 April 2021

⁶⁹¹ Evidence of Family Liaison Officer, 30 March 2021

internally". Her job description is linked to SIs, root cause analysis and complex complaints, so she does not work with all families. She added, "we still need a clear description of when and how the FLO can support. It's not a case of contacting the FLO where there has been an enquiry or a breakdown in communications, we still have to have parameters for referrals. It's not a team of people... we need local responsibility".⁶⁹²

643. On independence, the **FLO** said, "my support is offered to every family where they're investigating, so I am the link and often the family will not like the fact I'm part of SHFT, but I'm trying to be as impartial as I can be to 'bridge the gap', so the communication is there. I will never be independent".⁶⁹³

644. She recognised that the service she provides might not be suitable for some people and in those circumstances, she will signpost people to other charities and support groups, but said that they need support as early as possible.⁶⁹⁴

645. She explained that she would normally receive the referral after the 48-hour Review Panel and before an Investigation Officer is appointed. If there is an in-patient death within the hospital setting, she would be involved before the 48-hour Review Panel, as the team manager would contact her directly to support the family. She also receives referrals after an Investigation Officer is appointed. She said that she has asked for Investigation Officers to send the referral regardless of whether the family wants her help, for recording purposes.⁶⁹⁵

646. In regards to the initial contact, the **FLO** said she sends an email, which has been usual practice during the COVID-19 pandemic, but prior to that, she would usually have called to introduce herself, pass on condolences, talk about her role and how she can support them. Before the COVID-19 pandemic she would usually have offered a meeting and during that, find out how she can support the family.⁶⁹⁶

647. As to ongoing contact, she said the preferred option is usually face-to-face meetings. She explained that she becomes the single point of contact for the family and is led by

⁶⁹² Ibid

⁶⁹³ Ibid

⁶⁹⁴ Ibid

⁶⁹⁵ Ibid

⁶⁹⁶ Ibid

the family's need and the support is tailored to them. She said she agrees the method of communication with the family.⁶⁹⁷

648. The FLO provides support to a family during the coronial process where they do not usually have representation. The **FLO** said she will be their moral support and make sure they understand the process and ask for documents in advance.⁶⁹⁸

649. The **FLO** said that she believes that her role in helping families at inquests is "absolutely crucial" to ensure they understand the process and she can answer their questions afterwards. She explained that, before COVID-19, she would arrange an informal visit with the coroner's officer in advance; then on the day, she would meet the family before-hand and sit with them in the court.⁶⁹⁹

650. She said she will also sit with the family afterwards and signpost if needs be. If the family are represented, she will remain in the background, but is still the single point of contact, she still goes to the inquest and sits with the family and gives post-inquest support if requested.⁷⁰⁰

651. The FLO reports on a quarterly basis to the Family, Carers' and Engagement Group, she goes to the Patient Experience Group and the internal Suicide Prevention Group meetings. She does not report annually, but said it would be useful for development.⁷⁰¹

652. The **Clinical Director for the South-West Hampshire Division** said the FLO has been "invaluable and really amazing". She gave an example of her work with a patient and his next of kin who was a lady with learning disabilities and the FLO was really helpful in getting the easy read literature on what death was and helping her to explain what had happened.⁷⁰²

653. She said there is also the chaplaincy service alongside that who are linked in the communities. The Chaplain also will signpost bereaved people to local bereavement and social support services, do follow-up calls and pass on any questions; and the Chaplain is trained in bereavement counselling.⁷⁰³

⁶⁹⁷ Ibid

⁶⁹⁸ Ibid

⁶⁹⁹ Ibid

⁷⁰⁰ Ibid

⁷⁰¹ Ibid

⁷⁰² Evidence of Clinical Director for the South-West Hampshire Division, SHFT, 1 April 2021

⁷⁰³ Ibid

654. The **Deputy Medical Director** said, “a (key benefit) for me is that, if an individual comes to harm or an adverse event occurred, families may feel betrayed and disappointed and unable to speak with the clinical team, and in those cases, having a person seen as separate from the division, but not doing the investigating and having them to talk to, from the feedback, families have found that useful”.⁷⁰⁴

655. As to the future of the role of the FLO, she said that they have taken steps to employ another FLO to help with the workload and to provide a service to all families, not just when an investigation is in the background, because there is no other support the family would get” This will be a Family Liaison Support Officer to support families going to inquest and possibly post-inquest too.⁷⁰⁵

656. The **Head of Patient and Public Engagement and Experience** spoke highly of the role of the FLO and said, “our aspirations are that when a family has worked with the FLO and are moving to a different phase, we can offer support through our Patient and Carer Support Service”.⁷⁰⁶

Panel’s Views on where SHFT are now: involving the service user, carer or family member in the SI Investigation process

- The Panel acknowledges SHFT’s position is that family members, carers or service users are actively included in the investigation process and are supported by the FLO.
- However, the Panel is not satisfied that the family’s involvement is properly captured and reflected in the SI Investigation Reports. For example, the sample reports do not show their involvement in agreeing the terms of reference, or their level of involvement in the investigation itself. So, without the documentary evidence or testimony from family members in support of SHFT’s contention that this does happen, the Panel cannot be sure.
- SHFT suggested that they would re-open an investigation, if requested to do so. This is positive on the one hand, in that they are responding to the wishes of the family, but on the other hand, if they are getting it right first time, this should not be happening at all.
- The Panel suggests that the SI Investigation Reports, going forward, set out separately and clearly the views of service user’s, carers and family members on the terms of reference (or that they do not have any if that is the case) and the communications that are had with them, including when they took place and a summary of what was discussed.

⁷⁰⁴ Evidence of Deputy Medical Director, 1 April 2021

⁷⁰⁵ Ibid

⁷⁰⁶ Evidence of Head of Patient and Public Engagement and Experience at SHFT, 10 March 2021

Panel's Views on where SHFT are now: involving the service user, carer or family member in the SI Investigation process continued...

- The Panel heard that SHFT will continue to make contact with families throughout the investigation process and to continually check if they have changed their mind if they initially indicated that they did not want to be involved. This is a positive step forward. The Panel hopes this practice is a regular practice of all Investigation Officers.
- It is clear to the Panel that the FLO has an important role and, in principle, it is a very good idea, which is reinforced by the fact that she is at capacity. However, this also means that there is a gap for support to be provided. The Panel is pleased that SHFT have agreed to additional support for the current FLO, but are disappointed that this was initially met with some resistance by the Executive Team. They are not persuaded that there is joined-up, strategic system-wide thinking in place for the role of FLO and its development.
- Throughout the evidence received by the Panel, there was some confusion and contrasting evidence about the remit and role of the FLO. This should be resolved promptly by the remit of the role being made clear to staff, service users and family members.
- The Panel heard that SHFT were planning to implement a Patient and Carer Support Service to support the FLO but only one participant mentioned this and no timeframe for its implementation was provided.
- The Panel is reassured that, through the FLO, Chaplaincy service and signposting to third-sector organisations, there is support for families to read the Investigation Reports. This is important as the contents of the reports can be extremely distressing, particularly as some of the information for the reports is pulled directly from Ulysses and the IMA form, so is unfiltered.
- The Panel's view is that there is a lack of access to legal advice, advocacy and support for families, service users and carers during the process of an SI investigation. The absence can create a divide between them and SHFT. It is a fundamental injustice if families, service users and carers are not able to have a voice because they cannot afford or access representation.

Categorisation of harm

657. The categorisation and evaluation of risk where there is a SI is a formal process set out in the 2015 SI Framework, but it is not a measure of the actual harm. The Panel were keen to hear evidence from SHFT as to how they approach and carry out the categorisation of harm for SIs.

658. The **Deputy Medical Director** said in her statement that the percentage of SIs scoring at 'Moderate Harm' or above against the overall total remains consistent.⁷⁰⁷

659. She said SHFT's definition of a 'Serious Incident' is based on the 2015 National SI Framework definition, but that it is a guide and not rigid. The examples of events that are automatically an SI are: the death of a patient detained under the Mental Health Act; any in-patient death; any community death, if there is cause to believe it might be a suspicious suicide; any incident where the potential for learning is so great that it would benefit from a detailed overview; or the harm suffered to the patient or family, is so great that it warrants a SI Investigation.⁷⁰⁸

660. The **Deputy Medical Director** said there are several stages when deciding on the level of harm and there is challenge in every direction. These stages are:

- 1) Initial Incident Report form – this asks for an indication of the initial severity and tends to be a higher level than the final level given.
- 2) 48-hour Review Panel – it is graded again and, again, it tends to be higher than the final level given.
- 3) Corporate Panel – a final grade is applied.
- 4) Commissioner Closure Panel – again, a final grade is applied.⁷⁰⁹

661. The **Chief Executive** said, "all deaths are examined and a risk and evaluation tool is used to decide which of the most serious SIs are graded at levels four or five and go to a fuller investigation. In some circumstances, it will be a full independent investigation".⁷¹⁰

662. The **Patient Safety and Quality Facilitator for the Southampton Division** said that the incidents that are graded 'moderate' (level three) or above go to a 48-hour Review Panel and the rest are reviewed by Team Managers and closed at that level with the outcome put on Ulysses. Therefore, she confirmed it will be determined locally whether an incident is considered by a 48-hour Review Panel. Once it has been graded, the team or service, have until the 48-hour Review Panel date to write their IMA and then it is

⁷⁰⁷ Statement of Deputy Medical Director at SHFT, 2 February 2021

⁷⁰⁸ Evidence of Deputy Medical Director at SHFT, 1 April 2021

⁷⁰⁹ Ibid

⁷¹⁰ Evidence of Chief Executive of SHFT, 16 April 2021

decided at the Panel whether or not it goes for further investigation, or is closed, with local learning. She acknowledged that the IMAs could be improved and said they have set up a working group to improve the process of writing them before they get to the Panel.⁷¹¹

663. Furthermore, the **Incident Investigation Manager** agreed that there has historically been a lot of back and forth with the reports going to the 48-hour Review Panel, but said that it should reduce with the introduction of Patient Safety Practitioners who will be supporting staff to write the reports.⁷¹²

664. As to whether families or patients should be involved in grading, the **Deputy Medical Director** believed that they had done a piece of work on it internally. She said SHFT are not yet at the stage of asking families or the person harmed to determine the level of harm but hoped they would get to that point.⁷¹³

665. SHFT's analysis of their own reporting has been delayed due to the COVID-19 pandemic, but they hope to carry out an analysis in the next few months.⁷¹⁴

666. The SHFT NHS Annual Staff Survey results support the assertion that there is a high level of awareness of how to report unsafe clinical practice in SHFT. In response to the question: '*If you were concerned about unsafe clinical practice, would you know how to report it?*', 96% said yes in 2020 (in 2018 and 2019 it was 97%).

Panel's Views on where SHFT are now: categorisation of harm

- The Panel did not hear any evidence as to the training provided to clinicians, on the categorisation of harm and reporting, at all levels, but particularly ward managers and matrons. However, the Panel does acknowledge the positive results in the NHS Annual Staff Survey in response to this question.
- The Panel welcomes the multiple layers of scrutiny and assurance that are in place at SHFT in regard to categorising harm.

⁷¹¹ Evidence of Patient Safety and Quality Facilitator for the Southampton Division at SHFT, 13 April 2021

⁷¹² Evidence of Incident Investigation Manager, SHFT Central Investigations Team, 19 April 2021

⁷¹³ Evidence of Deputy Medical Director at SHFT, 1 April 2021

⁷¹⁴ Ibid

National and Internal Reporting

667. The 2017 Guidance on Learning from Deaths imposes an expectation on provider organisations to have a comprehensive system in place for reporting, recording, investigating and learning from all SIs, including deaths.⁷¹⁵

668. The **Deputy Medical Director** provided evidence on the benchmarking and reporting that SHFT do. They are set out in summary below:

- SHFT inputs incidents into the National Reporting and Learning System (“NRLS”). The central governance team receive a report in arrears every six months, which shows the benchmarking information, so SHFT can see their own incident reporting against a comparable organisation. That also allows for comparison of the levels of harm. She said, “we have seen each year for a number of years, that our incident reporting and level of harm, mirrors that of other comparable organisations (big mental health providers). For example, 98% of our incidents tend to be in the ‘low’ and ‘no-harm’ category and 2% in the ‘moderate’, ‘major’ or ‘catastrophic or severe’ categories”.⁷¹⁶
- Annually, SHFT uses the annual National Confidential Inquiry into Suicides and Homicide Report (“NCIS”) to carry out a comparison. She said they carried out their own comparisons using the last NCIS report published in 2019, for 2017/18 and found they were not outliers and the profile of those using SHFT’s services mirrors the national profile.⁷¹⁷
- For mental health homicides SHFT uses the NHSE/I Independent Report on Mental Health Services and Homicides.
- Any deaths of people with a learning disability are referred to the Learning Disability Mortality Review Programme (“LeDeR”) at the University of Bristol. She said SHFT cannot directly benchmark on deaths specifically in the organisation, but can only look back over the previous year to do benchmarking, until there is a national data set available.⁷¹⁸

⁷¹⁵ A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care (March 2017)

⁷¹⁶ Evidence of Deputy Medical Director at SHFT, 1 April 2021

⁷¹⁷ Ibid

⁷¹⁸ Ibid

669. The **Deputy Medical Director's** view is that SHFT's reporting across the whole organisation is very good overall and much better than five to ten years ago.⁷¹⁹

670. The **Incident Investigation Manager** said the SIs are reported onto the Strategic Executive Information System ("StEIS") externally (but the internal 'Red RCAs' are not). She had not heard of the National Standards for Patient Safety Incident Reporting, set by NHSE and thought the Patient Safety Investigation Reporting Framework sounded familiar.⁷²⁰

671. The **Chief Medical Officer** said, "I believe SHFT has very good reporting systems where data is collected".⁷²¹

672. The Panel reviewed SHFT's recent NRLS reporting history using the publicly available Organisation Patient Safety Incident Reports ("OPSIR").⁷²² The purpose of NRLS reporting is for SHFT to contribute to the national process of safety reporting, to use the feedback provided to reflect where it is in terms of other systems of similar size and caseloads, and to identify changes in terms of reporting style, culture and content. The local risk management system is used to access the NRLS and report on the degree of harm, the category of event, and the care setting.

673. The OPSIR provides collated information for Trusts to better understand the incidents reported in the context of their relevant peer group and care setting. It identifies and prompts organisations to reflect on their reporting culture and patterns, the timeliness and accuracy of reporting the degree of harm. It uses the comparative data to bring to the attention of a Trust actions that are considered important to put in place to improve the culture of reporting and improve the quality and safety of care.

674. The Panel observed that:

- There was no evidence of potential under reporting from SHFT, although there was a significant change in the number of incidents reported per 1,000 bed days (75.28 (2018/2019) to 60.37 (2019/2020)).

⁷¹⁹ Ibid

⁷²⁰ Evidence of Incident Investigation Manager for Southern Health, 19 April 2021

⁷²¹ Evidence of Chief Medical Officer at SHFT, 12 April 2021

⁷²² <https://www.england.nhs.uk/patient-safety/organisation-patient-safety-incident-reports/>

- SHFT were slower in the timeliness of reporting during 2019/20 than 2018/2019. 5% of incidents were reported at 104 days in 2019/2020; this was 63 days in 2018/2019. The Trust is seen as within the benchmark of other organisations within this care setting.
- In the periods 2018/2019 and 2019/2020, SHFT assessed 39.2% of incidents as 'low harm', this is compared to the overall return from mental health trusts nationally during this period of 32.9%.
- SHFT reported less deaths than the benchmark: SHFT reported no deaths in 2019/2020, however, in 2019/2020 there were 1213 deaths (0.6%) reported on the NRLS for mental health trusts nationally.
- SHFT are also reporting low numbers of 'moderate' incidents, they reported 13 (0.3%) and 'severe' harm incidents, 4 (less than 0.1%). Those reported nationally in mental health settings are 5.6% for 'moderate' and 4% (770 incidents) for severe harm.

Reporting culture

675. The SHFT NHS Annual Staff Survey results do support the assertion that there is a positive reporting culture in SHFT.

676. In response to the question: *'The last time you saw an error, near miss or incident that could have hurt staff or patients or services users, did you or a colleague report it', 96% said 'yes' in 2019 (in 2018 it was 98%).*

677. In response to the question: *'My organisation encourages us to report errors, near misses or incidents', 93% said 'yes' in 2020.*

678. In response to the question: *'My organisation treats staff who are involved in an error, near miss or incident fairly', 63% said 'yes' in 2020 (in 2018 it was 54% and in 2019 it was 60%).*

679. The **Chief Executive** said he is assured of a positive reporting culture through the data coming through, talking to people on a regular basis and listening to people and how they feel. He said, "I would expect to see lots (of reporting) coming through, they may not be the most serious, but they were serious enough for someone to feel they

wanted to report it and we should never disregard that... generally speaking, a high level of reporting is a good thing".⁷²³

Panel's Views on where SHFT are now: national and internal reporting

- The Panel acknowledges that SHFT's evidence is that they have developed a culture where incidents are now being reported and the fear of future blame has reduced.
- SHFT must ensure that it is following the 2015 SI Framework in relation to the circumstances in which it is appropriate to report 'near-misses', such as self-harm incidents.
- The Panel is not satisfied that all of the appropriate members of SHFT staff demonstrated the level of awareness and knowledge of the NRLS that they would expect. Some were unaware of the link between local reporting, learning and wider national systems.
- The Panel is concerned that SHFT are not contributing in a consistent manner to the NRLS through the use of its local risk management system.
- The Panel have reviewed the high level NRLS data for SHFT. The Panel acknowledges that the reasons for this were not expressly explored with SHFT. However, the numbers call into question whether SHFT's reporting is capturing all relevant SIs and Learning from Deaths reviews.
- The reporting by SHFT, when compared with the national picture for mental health trusts, for the years 2018/2019 and 2019/2020 suggests that SHFT may have under assessed the degree of low and moderate harm incidents and the reporting of deaths.
- The Panel did not see appropriate processes and mechanisms in place to share information that is uploaded to the SI reporting system, the STEIS, the Learning from Events programme and the incidents reported to the NRLS. This should be joined-up to ensure continuous sharing, learning and improvement is taking place across the organisation and externally too.

Role of the Medical Examiner

680. The National Medical Examiner System is being rolled out across England and Wales, with the aim of providing greater scrutiny of deaths and offering a point of contact for bereaved families to raise concerns about the care provided to a loved one before their death. The role will be filled by senior medical doctors who undertake these duties in a number of sessions a week, alongside their usual clinical duties. NHSE/I

⁷²³ Evidence of Chief Executive of SHFT, 16 April 2021

have produced 'Good Practice Guidelines'.⁷²⁴ They have currently only been rolled out in acute settings and since 8 June 2021, it has been decided that the roll out will be extended to non-acute settings, '*as early as possible in 2021/22, so that all deaths are scrutinised by the end of March 2022*'.⁷²⁵

681. The **Regional Medical Director for NHSE/I for the South East Region, Dr Lewis**, outlined the Medical Examiner role, which will be to provide scrutiny of all deaths that are not referred to a coroner. He said they will have a very important role in scrutinising deaths and looking for patterns that may raise concern; they will also link in with the bereaved families and offer an opportunity for them to raise concerns, independent of the team providing care and the intention is to improve the quality of death certification and mortality data, for improved learning from it.⁷²⁶

682. The **Chief Medical Officer** who has now left SHFT said his replacement is a Medical Examiner.⁷²⁷

Panel's Views on where SHFT are now: Medical Examiner process

- The Panel wholeheartedly endorses and supports the introduction of this role and encourages SHFT to embrace it. However, the evidence received about the new Chief Medical Officer appointed at SHFT being a Medical Examiner should not be seen as SHFT satisfying this requirement, as they would not be sufficiently independent enough, or be perceived to be such, to fulfil this role.

Learning from deaths and events

683. By way of an introduction, the Learning from Deaths process is through a structured review and all Trusts should follow it to look at the deaths occurring in their systems. Following that review, they should identify if there are any contributions to harm causing deaths that are greater than one would normally expect. Secondly, they should decide if

⁷²⁴ Implementing the medical examiner system: National Medical Examiner's good practice guidelines, NHS England and NHS Improvement, January 2020

⁷²⁵ Letter from NHSE to health care settings and CCGs nationally: 'System letter: extending medical examiner scrutiny to non-acute settings', 8 June 2021: <https://www.england.nhs.uk/wp-content/uploads/2021/06/B0477-extending-medical-examiner-scrutiny-to-non-acute-settings.pdf>

⁷²⁶ Evidence of Regional Medical Director for NHSE/I for the South East Region, Dr Lewis, 6 April 2021

⁷²⁷ Evidence of Chief Medical Officer at SHFT 12 April 2021

the death needs to be reported to the Learning from Deaths in Learning Disability services (“LeDeR”).

684. The Panel received evidence that SHFT have implemented a Learning from Events process, which is analogous to the Learning from Deaths process, and that it is done internally in SHFT’s mental health settings.

685. The **Director for Experience, Participation and Equalities at NHSE/I, Dr Churchill** described his involvement in the national Learning from Deaths’ initiative. He said he worked with families who had lost loved ones in NHS care to look at how they should be treated going forward, including recommendations on the introduction of the Medical Examiner. They also looked at the importance of meeting families, listening to them and genuinely understanding what they wanted to know, their outstanding questions, and involving them in investigations where there was a concern that something had gone wrong. He said, “you can look at individual Trusts who do appear to have improved against those benchmarks and others that haven’t. It is about cultural change, so it does take time.”⁷²⁸

SHFT’s Learning from Events Forum

686. The **Deputy Medical Director** has chaired the Learning from Events Forum since 2016. She spoke about the changes in this committee over the years and said there is still a bit of work to do. From her perspective, no matter what it is – event, complaint, or workforce investigation or claim – they are all events and SHFT need to find a way to extract learning from them.⁷²⁹

687. In her statement she described how SHFT has a Learning from Events Forum which has representation from all clinical divisions and specialities, where all aspects of the incident investigation process are scrutinised, including compliance with key metrics in the previous month. This forum also receives the output of a monthly audit of the 48-hour Review Panels, commissions thematic reviews when themes emerge from SI investigations and shares learning across clinical services. This Forum, now, also scrutinises learning from external organisations nationally, which investigate adverse

⁷²⁸ Evidence of Director for Experience, Participation and Equalities at NHSE/I, Dr Churchill, 20 April 2021

⁷²⁹ Statement of Deputy Medical Director at SHFT, 2 February 2021

patient safety events, such as MAPPA (Multi-Agency Public Protection Arrangements), Serious Case Reviews and Prevention of Future Deaths Orders by coroners.⁷³⁰

688. The **Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement** said the Learning from Events Forum started in 2015-16 as specifically for SIs, but as they began work on the safety culture, it was important to learn from all incidents thematically, so now it is for all incidents and themes and feeds across all the specialities and each division has a forum.⁷³¹

689. The **Director of Nursing & AHP** explained that SHFT's Learning from Events Forum considers safeguarding, SIs and complaints. She said the message you get back is very powerful on the priority areas, when you consider them all together.⁷³²

690. The **Incident Investigation Manager** said she attends the Learning from Events Forum and shares the learning with the wider Central Investigation Team. She described it as a useful addition and said they sometimes present an investigation for discussion if there is wider learning and that it is a good place to look at themes and trends, so it is absolutely invaluable.⁷³³

691. The **Clinical Director for the South-West Hampshire Division** said that the Learning from Events meeting is her, "... favourite Trust-wide meeting, because it's about what matters; it's attended by people who bring stuff to the table and we go out with what we are going to do and move forward and (the Deputy Medical Director) has a way of driving things forward and getting us to do it". She confirmed the meeting has continued throughout the pandemic.⁷³⁴

692. The **Clinical Director for the South-West Hampshire Division** clarified that the minutes of the Learnings from Events meetings locally are sent to the SHFT-wide Learning from Events Forum and discussed there. If an event or issue needed to be escalated from there, it would go to the Quality and Safety Committee. There are also

⁷³⁰ Ibid

⁷³¹ Evidence of Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement at SHFT, 29 March 2021

⁷³² Evidence of Director of Nursing & AHPs at SHFT, 9 March 2021

⁷³³ Evidence of Incident Investigation Manager at SHFT, 19 April 2021

⁷³⁴ Evidence of Clinical Director for the South-West Hampshire Division, SHFT, 1 April 2021

divisional Board meetings, which touch-upon complaints and SIs and the minutes are shared internally on 'share point' and in the Executive Performance Group Report.⁷³⁵

693. The **Acting Director of Quality & Nursing in the CCG** said, "we have seen SHFT start with a mortality group, which has become a Learning from Events group, which takes into account SIs in a holistic way. We're invited to that group and do attend. We are satisfied, as a CCG, that SHFT has robust processes in place to scrutinise and learn from deaths".⁷³⁶

Sharing data and learning

694. The **Deputy Medical Director at SHFT** said that in regard to the process for analysing and measuring if there has been change, since 2018/19, they do it in a more systematic manner, but acknowledged that they have further work to do in ensuring staff members, who have participated in the investigation, get feedback.⁷³⁷

695. She said they improved the feedback for trainees, so that their supervisor and deanery are informed and see the report. She explained that when she undertook the audit for 2020 the gaps were related to the feedback loop. She said, "I set myself a high target of 'not met' unless it was 100%. I couldn't find evidence in some cases that the feedback had been completed, so if I couldn't find the evidence, then I said it didn't meet the standard".⁷³⁸

696. The **Deputy Medical Director at SHFT** proceeded to say, "... we spend so much time and energy carrying out high-quality investigations... once it's done, there is a tendency to see it as just done; but in some ways, that is when the real, important work starts, because the diagnostic piece has been done, but the changes require the engagement of staff". In her view, this works best with a workshop-style approach.⁷³⁹

⁷³⁵ Evidence of Clinical Director for the South-West Hampshire Division, SHFT, as part of fact-checking exercise

⁷³⁶ Evidence of Acting Director of Quality & Nursing West Hampshire CCG, 5 March 2021

⁷³⁷ Evidence of Deputy Medical Director at SHFT, 1 April 2021

⁷³⁸ Ibid

⁷³⁹ Ibid

697. The **Director of Nursing & AHP** said that the learning from deaths data is shared on the National Quality Dashboard, at the SHFT Quality & Safety Meeting on a quarterly basis and it was on the public board on SHFT's website.⁷⁴⁰

698. The **Patient Safety and Quality Facilitator for the Southampton Division** said that in her role she has overview of all of the incidents reported through Ulysses and Southampton Division and the complaints and concerns coming through the Complaints & Patient Experience department. She said she reads nearly all of the incidents coming in daily, but focusses on how they're closed and the learning. She then shares this locally with her team for them to then to share across their divisions.⁷⁴¹

699. She explained that she uses Tableau (the Trust's electronic data warehouse), fortnightly, to see where they are with the learning from the SI investigations. She was not sure if the rest of her team do it, but said that if there is an action with an imminent date and a name next to it, she will contact the person and offer to help and see if there is any learning she can share from it, or if anything could be done differently.⁷⁴²

700. In regard to how this information is shared, she said that for any incident that goes to the 48-hour Review Panel, each Monday, she produces a small report for the division on Southampton learnings, which she shares with the Southampton divisional Heads of Nursing, the Director of Nursing, all Ward Managers and Team Managers and they share it with their teams. She said there is a larger weekly report with an update on all of the learning from the Panels too. She also writes a monthly report in which she will extract data from Tableau and look deeper on Ulysses to draw out anything obvious or interesting.⁷⁴³

701. The **Patient Safety and Quality Facilitator for the Southampton Division** admitted, "I don't know the full extent of how learning (from the 48-hour Review Panels that do not go for further investigation) is shared. Before I came into post (in June 2020) ... I heard staff say 'we never know what happens once it's gone off to Panel'... once I had heard it a few times, I decided that I would share it and I send it to a substantial amount of people every Monday. It's not just with the team who put in the report, but I share the learning from the teams across the whole division to the whole division. It's not

⁷⁴⁰ Evidence of Director of Nursing & AHPs at SHFT, 9 March 2021

⁷⁴¹ Evidence of Patient Safety and Quality Facilitator for the Southampton division, SHFT, 13 April 2021

⁷⁴² Ibid

⁷⁴³ Ibid

just something going wrong, but might be amazing work identified and we like to share that too.”⁷⁴⁴

702. She does not know for certain if the Patient Safety and Quality Facilitators in the other divisions share the learning in the same way she does, but said they do discuss her reports and feedback from other divisions, when they meet weekly.⁷⁴⁵

703. The **Deputy Medical Director** said that whether or not learning is to be shared widely across SHFT is considered in the action planning stage. If there are specific thematic themes, they are shared through the completion of the action plan, Learning from Events Forum and in the governance snapshots.⁷⁴⁶

704. A **Matron** said lots of reports are shared and SHFT communications are sent out and if there is learning specific to them, they receive it from the Head of Nursing. She said that she meets with the Head of Nursing regularly and attends a Matron Group, with the Heads of Nursing and can talk about incidents in other relevant forums. She said that the decision as to what is applicable to her unit mostly comes from the divisional level.⁷⁴⁷

705. The **Clinical Director for the Hampshire South-West Division** said they will learn about recommendations from an incident in another division, “if it is very serious and specific, then it would be sent as a safety alert immediately and must be done immediately. If it is more generalised... we record it in Ulysses. And now the Patient Safety Practitioner comes to the division’s Board meetings, presents at local governance meetings and produces a regular newsletter, which goes out to the teams”.⁷⁴⁸

706. The **Deputy Director of Nursing** said that in her experience, incidents that might have national relevance would be escalated to the CCG and shared into NHSE/I, such as an alert.⁷⁴⁹

707. The **Clinical Director for Mental Health and Learning Disability for West Hampshire CCG** said, “if someone raises a concern within their practice, then we can bring it to a Significant Event meeting depending on the level of concern... we would take

⁷⁴⁴ Ibid

⁷⁴⁵ Ibid

⁷⁴⁶ Evidence of Deputy Medical Director at SHFT, 1 April 2021

⁷⁴⁷ Evidence of Matron, SHFT, 29 March 2021

⁷⁴⁸ Evidence of Clinical Director for the Hampshire South-West Division, SHFT, 1 March 2021

⁷⁴⁹ Evidence of Deputy Director of Nursing at SHFT, 4 March 2021

clinical incidents higher and would want to share it for learning. It is possible to share that with other practices through wider IT systems... there is also the GP feedback tool in West Hampshire, so, it is easy for people to upload information there about concerns and that is helpful for spotting trends”.⁷⁵⁰

708. In the NHS Annual Staff Survey, in response to the question: ‘*We are given feedback about changes made in response to reported errors, near misses and incidents*’, 67% said yes in 2020.

Evidence of Improvement Panels

709. Evidence of Improvement Panels are discussed further below under ‘action plans’. However, the statement provided by the **Deputy Medical Director** provides SHFT’s intentions with setting them up:

“Evidence of Improvement Panels routinely consider what learning has been embedded and what practice has changed as a result of any SI. The panels examine whether there have been any similar incidents. This process aims to ensure that we avoid similar incidents occurring and demonstrates an improvement in the safety culture within the organisation. SIs graded with a final impact score of 4 (‘Major’) or 5 (‘Catastrophic’) are reviewed through Evidence of Improvement Panels, to provide assurance that the action plan has been completed and the changes made are in practice. Since June 2016, the Trust has held 59 such panels.”⁷⁵¹

Culture of learning

710. The **Deputy Medical Director** said that she no longer hears clinicians say that investigations are not part of their day job and that there is a framework in place. She explained that they will be doing more, but that they have, in her view, moved along in the way they now see investigations as a vital part of patient’s care. She recognised that if they do not learn when things go wrong then they do not know if they are doing a good job. She believes that is now accepted and embedded in SHFT.⁷⁵²

⁷⁵⁰ Evidence of Clinical Director for Mental Health and Learning Disability for West Hampshire CCG, 17 March 2021

⁷⁵¹ Statement of Deputy Medical Director at SHFT, 2 February 2021

⁷⁵² Evidence of Deputy Medical Director at SHFT, 1 April 2021

Sharing learning on the ground

711. A **Matron** explained how they monitor how many incidents each staff member is involved in, to analyse if it's a training need, or something in their personal life, which means they may need to be withdrawn from administering medications. She described how they have learning from incident meetings that are local and feed into the CAMHS governance and local governance and the Quality and Safety meeting. She said they also have the CAMHS Matron Forum and a Matrons Forum as a specialist service, where issues in the units and the management of incidents are discussed. She also said they have a SHFT Matron Forum and that she has joined the National Matron Forum. There is also a wider specific network for her unit, which she is a part of and common issues arising can be discussed there.⁷⁵³

712. She said that from the previous learning from incidents meeting they had five errors which they monitor for severity and ensure that processes are followed for the young people to be safe. She said they encourage any reporting so that people are not hiding any error.⁷⁵⁴

Key themes

713. The **Deputy Medical Director** set out how themes arising from SIs are monitored within SHFT. She said this is done monthly and reported to the Quality & Safety Committee and where themes or trends are identified, actions are taken to address them. She said this may include specific changes, such as amendments to documentation or instigating bespoke training for staff, or broader QI initiatives, such as work to improve discharge planning for service users.⁷⁵⁵

714. A **Consultant Psychiatrist in SHFT** described how key themes are extracted from the SI investigations and are then shared at local level, which tends to happen at the end of the investigation, if they are very specific and they are fed back in business meetings to more senior members of SHFT. For broader learning themes they are communicated

⁷⁵³ Evidence of Matron, SHFT, 29 March 2021

⁷⁵⁴ Ibid

⁷⁵⁵ Statement of Deputy Medical Director at SHFT, 2 February 2021

through the Learning from Events meetings, or by targeting people, or at Quality and Safety meetings at Divisional or Service level.⁷⁵⁶

715. She said it is shared with the Board if it is very serious or represents part of an emerging common picture of a theme.⁷⁵⁷

Thematic Review

716. The **Patient Safety and Quality Facilitator for the Southampton Division** said that the incident reports, which do not go to the 48-hour Review Panel, are closed at local level and thematically reviewed. She said she recently conducted an ad-hoc deep-dive into one theme which led to a bigger QI project. She said the Matron and Head of Nursing look at quite a few of them too and if there are any issues, it will be bought back and they into them further.⁷⁵⁸

717. As to whether that system is rigorous and systematic enough, the **Patient Safety and Quality Facilitator for the Southampton Division** said, “there is always room for improvement... I am not fully embedded in my role, there are lots of ideas and plans for the future... the system at the moment does seem to be working, we do talk a lot about learning and we hold a daily ‘safety huddle’ in the in-patient wards and talk about incidents and what can be learnt from incidents we think need to be discussed but not all of the incidents in the last 24-hours”. She said there are learning events held too.⁷⁵⁹

Evaluation of the impact of learning

718. The **Patient Safety and Quality Facilitator for the Southampton Division** said they do not evaluate the impact of their learning and admitted that she does not know how things have improved since 2015 and if there is a mechanism in place, she is not aware of it.⁷⁶⁰

⁷⁵⁶ Evidence of a Consultant Psychiatrist in SHFT, 10 March 2021

⁷⁵⁷ Ibid

⁷⁵⁸ Evidence of Patient Safety and Quality Facilitator for the Southampton division, SHFT, 13 April 2021

⁷⁵⁹ Ibid

⁷⁶⁰ Ibid

719. In response to the NHS Annual Staff Survey question: *'I am confident my organisation would address my concern'*, 63% said 'yes' in 2020, which was the same in 2019.

Panel's Views on where SHFT are now: learning from deaths and events

- SHFT have adopted a Learning from Events Forum, an internal meeting, with attendance by the CCG. The Panel is satisfied that it is an effective and positive system for learning in the organisation. The Panel is concerned that not enough staff are attending from across the organisation and this should be encouraged and promoted moving forward. The Panel's view is that the Forum could be improved with more external views represented - SHFT is invited to consider welcoming the NHSE/I Regional Team as participants.
- The Panel is pleased that SHFT staff place a lot of value on the Learning from Events process and that it has continued during the COVID-19 pandemic – this demonstrates the importance SHFT attaches to it.
- The Panel is pleased to see other formal systems in place for learning, including the Evidence of Improvement Panels and the Quality & Safety Committee.
- The Panel sees scope for wider learning and sharing of learning across the organisation, for example, through the use of technology. The Panel does not consider that learning should only be shared if it is deemed "relevant" as it may result in opportunities to learn and improve being missed. All learning should be shared and the professionals should be trusted to judge whether it is relevant to their team, ward, service or division.
- The Panel is not satisfied, on the evidence received, that there is a systematic process for sharing learning from the SI investigations to staff across the organisation. It is acknowledged by SHFT, that the 'feedback loop' needs to be improved. This was repeated by multiple participants, so it should be considered a priority for improvement.
- The evidence suggests that Tableau, SHFT's data management and storage system, is in its infancy. There was no evidence as to the investment SHFT is putting in to train its managers on extracting and using the data to share for learning and QI more widely.
- The Panel is not satisfied, on the evidence, that SHFT is able to identify the key themes arising from their SI investigations and to demonstrate that actions have been taken in response to identified issues.
- The Panel acknowledges the learning that comes from the sharing of stories of harm and success at the Board meetings and this should be encouraged further. However, the evidence was lacking as to how issues arising from them are actively followed up on to ensure the learning and improvement follows through.

Patient Safety

720. The topic of patient safety is pervasive throughout all of the areas being considered during this Review and it is a large area to consider, such that it could form its own additional theme, or even its own Review. Therefore, in this Report the Panel have opted to provide summaries only as to where SHFT are now in terms of patient safety and then in the next section, where they should be. However, that does not detract from the significance and importance that this Panel attaches to this topic.

721. The Panel acknowledges that the January 2020 CQC report rated SHFT as 'Good' for patient safety.

722. As to whether there is a safe system at SHFT, the **Regional Medical Director for NHSE/I for the South East Region, Dr Lewis** said, "... it is not an organisation currently flagging on my radar at the current time. I am aware of the history, but also encouraged by a number of the conversations I have had and indicators I have seen more recently... I was in SHFT two weeks ago interviewing for a new Chief Medical Officer and I was impressed by one of the strongest fields I have seen for some time. It speaks volumes, that people are seeking employment in SHFT at the moment".⁷⁶¹

Patient Safety Culture

723. The Panel received evidence about their being an emerging 'patient safety culture' within SHFT and the **Chief Executive** emphasised this. He pointed to the NHS Annual Staff Survey and said, "one of the most positive aspects of our 'people story' is a positive safety culture... there are two markers that matter: 'would you recommend our services as a place for patients?', this is at 74%, a couple above the national average, but that is not good enough; and 'would you recommend it as a place to work?'. The fact that one-third still feel they would not recommend it is a national challenge".⁷⁶²

724. He said people have to be prepared to report or speak up and referred to past scandals he said had happened because internally people were not prepared to do so.⁷⁶³

⁷⁶¹ Evidence of Regional Medical Director for NHSE/I for the South East Region, Dr Lewis, 6 April 2021

⁷⁶² Evidence of Chief Executive of SHFT, 16 April 2021

⁷⁶³ Ibid

725. The **Clinical Director for the Hampshire South-West Division** also said that one of the metrics she uses to judge whether they have a patient safety culture is the response to the NHS Annual Staff Survey question, '*does SHFT treat fairly people who report incidents?*'.⁷⁶⁴ In response to this question, 63% said 'yes' in 2020 (in 2018 it was 54% and in 2019 it was 60%).
726. The **Director of Nursing & AHP** said that to improve the safety culture in SHFT they have to work with people to improve and embrace what can be learnt from the issues. She said they have developed an appreciative inquiry model to learn what works well, engage people in it and replicate it.⁷⁶⁵
727. The Panel heard from a local Hampshire resident who is also the **Deputy Chair of the Working in Partnership Committee**. He said, "if something caused me or a member of my family to become a patient or service user of SHFT, I would not have any doubts at all that they are going to get the best possible service that SHFT's clinicians and staff are able to offer". He said the word 'safe' is not always interpreted the same way.⁷⁶⁶
728. The **Director of Workforce, Organisational Development and Communications** described where SHFT were and where they are now on patient safety: "we have come from a place of a lack of confidence in the organisation, people were not trusting it or what was going on around them, we are seeing that increase now, trust takes time; but it's important we get to a place of trust if we are going to engender a culture of safety".⁷⁶⁷
729. A **Matron** said that there are quite a lot of metrics they use to identify if their environment is safe and a part of that is to look at incidents. She said, "we want an open and transparent culture with a team who report incidents, so we have a flavour of the risk on the ward... we look at trends and... benchmark ourselves with similar services to see if we have a high level of incidents and if so, why?... in most cases there is an explanation and you want that insight".⁷⁶⁸

⁷⁶⁴ Evidence of Clinical Director for the Hampshire South-West Division, SHFT, 1 April 2021

⁷⁶⁵ Evidence of Director of Nursing & AHPs at SHFT, 9 March 2021

⁷⁶⁶ Evidence of Deputy Chair of the Working in Partnership Committee, 17 March 2021

⁷⁶⁷ Evidence of Director of Workforce, Organisational Development and Communications at SHFT, 19 April 2021

⁷⁶⁸ Evidence of Matron, SHFT, 29 March 2021

730. She also said that feedback is important as a benchmark to use to judge the impact of the service.⁷⁶⁹

Patient Safety Specialists

731. The Panel heard from the **Patient Safety and Quality Facilitator for the Southampton Division**, who has been in post since June 2020. She said there are five colleagues in each division doing similar roles who are employed by SHFT and managed by the Patient Safety Specialist, who leads the team and reports to the Head of Patient Safety. She is employed by the Southampton Division, so is also managed by the Divisional Director of Nursing for Southampton and sits in the central governance team. She described her role as being to share learning across SHFT and her division and to make sure the patient is at the centre of what they do.⁷⁷⁰

732. The **Deputy Medical Officer** spoke about the new Patient Safety Specialists in each division and said, “the benefits are immense, as they are working with staff on the ground, so they can influence practice, do clinical record reviews, small thematic reviews and share learning straight away... and attend Learning from Events meetings... they add real value on the shop floor”. Their impact is measured through a tool on Ulysses.⁷⁷¹

733. A **Clinical Ward Manager** said, “we have a Patient Safety Lead now in place and she is writing reports on the wards and delivers her summary and reports, which is very useful, as I can see trends that I might not have seen otherwise”. It was explained that Key Performance Indicators are written on the supervision template and if there is an area of concern, the Manager will make sure it is recorded with details on how they plan on improving it. They then cascade through the team and the Manager will put it on the staff meeting agenda too.⁷⁷²

⁷⁶⁹ Ibid

⁷⁷⁰ Evidence of Patient Safety and Quality Facilitator for the Southampton Division, SHFT, 13 April 2021

⁷⁷¹ Evidence of Deputy Medical Director at SHFT, 1 April 2021

⁷⁷² Evidence of Clinical Ward Manager, SHFT, 12 April 2021

Crisis services

734. The **Community Mental Health Team Manager** said her responsibilities include, ensuring the safety of staff and patients within CMHT and the operational management.⁷⁷³
735. She said that since March 2020 (the start of lockdown due to COVID-19), her team have not provided weekend visits and they link with crisis colleagues who provide the support if it is needed at the weekend. She said they have regular discussions with the crisis team and review their patients on Thursday and Friday to see if they will need crisis support over the weekend. She said this approach has allowed them to have more cover in the day, so the patients will see the team they know more frequently.⁷⁷⁴
736. If a family member needed to contact the team at the weekend, she said they could contact the crisis team and if it was linked to a crisis, they would pick it up; but if it is more routine, they would ask them to contact the community team on a weekday.⁷⁷⁵
737. However, a **service user** told the Panel that she was told recently, “to phone Samaritans and that (the SHFT crisis service) only deals with people in crisis”.⁷⁷⁶

Access to treatment

738. A **carer** for his son with a psychiatric condition said, from their experience, “it is not a safe system, because, if the way we experienced it is the way people who have a life threatening psychiatric condition do, then it would not be safe...”.⁷⁷⁷
739. He went on to say that his son keeps above water because of his strong family support but that he needs a support worker to go out and get social exposure, at the moment that is all down to the family. He said he does not know what would happen if they were not there, which is a great concern, as he believes his son’s depression would then get worse. He said, “SHFT have not been helpful, they have said they will be now,

⁷⁷³ Evidence of Community Mental Health Team Manager for Havant, Waterlooville and South East Division, SHFT, 31 March 2021

⁷⁷⁴ Ibid

⁷⁷⁵ Ibid

⁷⁷⁶ Evidence of a service user, 15 April 2021

⁷⁷⁷ Evidence of a carer, 6 April 2021

but it's been a long fight". He described how their care coordinator left and the people who carried on, they found, did not provide continuity of care. He said that they have not experienced good management.⁷⁷⁸

740. Further to this evidence, the **Director of Workforce, Organisational Development and Communications** was asked if he believes there are enough psychologists in SHFT. He said, "I think some of our services probably haven't got enough access to psychologists and psychology... but... we need a psychologically informed workforce, that can give brief psychological interventions as well as the expertise of psychologists; so that we have a tiered approach, where our inpatient and community staff start interventions, then they move into more specialist treatment, as required, so we don't have to necessarily wait for a psychologist to provide low level Cognitive Behavioural Therapy (CBT)".⁷⁷⁹

Safeguarding

741. The **Deputy Medical Director** said that safeguarding is looked at during the 48-hour Review Panel process and if it is evidently an issue before that, members of the safeguarding team attend the Panel. It must also be specifically considered at each stage of the SI Investigation process and the safeguarding team are present at the final Corporate SI Panel, where appropriate, and work with the team during the action planning.⁷⁸⁰

Role of the Responsible Officer

742. The **Regional Medical Director for NHSE/I for the South East Region, Dr Lewis** gave evidence about the role of the Responsible Officer, he said they have a role to ensure the professional standards are maintained by medical staff across the region. He said if there were any concerns about professional standards in SHFT, the Responsible Officer would refer them directly to the GMC and the GMC would only contact him if there

⁷⁷⁸ Ibid

⁷⁷⁹ Evidence of Director of Workforce, Organisational Development and Communications at SHFT, 19 April 2021

⁷⁸⁰ Evidence of Deputy Medical Director at SHFT, 1 April 2021

had been more referrals than expected. He said this hasn't happened in the two years he has been in the role.⁷⁸¹

743. The **Director of Workforce, Organisational Development and Communications** said that if a senior medical staff's performance was a cause for concern, they have a Responsible Officer Advisory Group that meets monthly to discuss any issues, which he and another member of his team, attend regularly.⁷⁸²

Disciplinary action

744. The **Chief Medical Officer** confirmed SHFT has disciplinary processes and said that locum doctors have left due to safety concerns and some doctors in the organisation are being supported in changing their practice. He said four doctors have been referred to the GMC Fitness to Practice in the last three years and he has discussed numerous others. The SHFT Chief Medical Officer has clinical responsibility, but is not the Responsible Officer for locums.⁷⁸³

745. The **Deputy Medical Director** said a relatively small number of SIs involve some disciplinary procedure.⁷⁸⁴

Monitoring performance

746. The **Chief Medical Officer** said that if a service or unit requires intensive support it will lead to monthly reporting in Executive Performance Meetings, where the improvements and risks will be discussed and they would go to the Quality and Safety Committee. Further, if required, they would go into a Board report, however, he said it would mainly be flagged on the Integrated Performance Report, which includes numbers and a narrative. Any discussions at Board-level would be through the Chief Operating Officers structure, which the Clinical Directors in the divisions report to.⁷⁸⁵

⁷⁸¹ Evidence of Regional Medical Director for NHSE/I for the South East Region, Dr Lewis, 6 April 2021

⁷⁸² Evidence of Director of Workforce, Organisational Development and Communications at SHFT, 19 April 2021

⁷⁸³ Evidence of Chief Medical Officer at SHFT, 12 April 2021

⁷⁸⁴ Evidence of Deputy Medical Officer at SHFT, 1 April 2021

⁷⁸⁵ Evidence of Chief Medical Officer at SHFT, 12 April 2021

Use of Agency Staff and Locums

747. A **Matron** said their service has four long term agency staff, which was planned for. She explained how they have a local induction process for their staff and a shorter version for agency staff before they can come on to the ward. She said that for agency staff they have devised a buddy system; they have a brief on the young person; and are very supported with observations and day-to-day duties. However, if there is a complex young person, they normally use regular staff until the agency staff have enough experience in the unit to feel competent and confident to do such duties.⁷⁸⁶

748. The **Director of Workforce, Organisational Development and Communications** said they mostly use long term locums and will obtain references; they try to interview them and use agencies that have the quality standard framework. He said they can give notice of termination if necessary.⁷⁸⁷

Vacancy rates

749. The **Director of Workforce, Organisational Development and Communications** confirmed the current vacancy rates in the organisation for mental health nurses is 12% and higher in a couple of units where it is over 20%, which he said, is not unusual across the NHS, but is concerning. He said this issue is discussed at the Quality and Safety Committee, at Board, at Executive team level periodically and that the Operations Division have a focus on it too.⁷⁸⁸

Quality Improvement

750. The **Chief Medical Officer**, who supports the divisions on patient safety quality, said his recommendation is that safety is continuously improving and one should never say it is 'good' as, care isn't as safe as it could be unless, the learnings from Berwick, HSIB and other individuals, such as Dr Kirkup, are embraced.⁷⁸⁹

⁷⁸⁶ Evidence of Matron, SHFT, 29 March 2021

⁷⁸⁷ Evidence of Director of Workforce, Organisational Development and Communications at SHFT, 19 April 2021

⁷⁸⁸ Ibid

⁷⁸⁹ Evidence of Chief Medical Officer at SHFT, 12 April 2021

751. A **family member** said, “total quality requires as little hierarchy as possible, everyone speaking up to point out a danger, even if junior”.⁷⁹⁰

Panel’s Views on where SHFT are now: patient safety

- The appointment of Patient Safety Specialists and their roles in the divisions are a positive step in the right direction. The Specialists should be fully embedded and encouraged to work with all staff, management, the Board, service users, family members and carers. There must be the funding and resources available for this role to develop and grow. SHFT are behind on implementing this, so must now pursue it fervently.
- SHFT participants spoke of investigations and complaints being seen in the context of patient safety, which is welcomed and encouraged by the Panel.
- The Panel acknowledges the CQC’s findings during its inspection of SHFT in January 2020 in the area of patient safety.
- The Panel saw a lack of evidence demonstrating that SHFT are actively collecting data on patient safety, or triangulating the information that is available. Therefore, although the oral evidence was that SHFT offers a safe environment, the Panel did not receive convincing documented evidence to support this assertion.
- Further, the Panel is unable to find any analysis by SHFT in the integrated performance data, included in the Board report, of the key themes and issues arising around patient safety and what is being done about them. This should be included in the reports to the Board in future
- The Panel did not see any evidence of a Patient Safety Plan in place in SHFT and this should be considered, co-produced and implemented.
- The Panel share the concerns of some participants and acknowledged by some at SHFT, that there are issues regarding the number of agency staff being used in the organisation, particularly at night, and the vacancy rates in mental health settings. It is acknowledged that SHFT has targets to reduce these numbers, but they are not being met, and whilst some progress has been made, more work should be done to resolve and improve on that position.
- The Panel’s overall view is that SHFT are early on in their journey of ensuring patient safety and have a long way to go, so the hard work must continue at pace.

⁷⁹⁰ Evidence of a family member, 14 April 2021

Assurance and Governance

752. This topic is addressed here and again later in this section of the Report under ‘supervisory structures’, with specific reference to the assurance and oversight functions of the CCG.

753. The **Regional Medical Director for NHSE/I for the South East Region, Dr Lewis** said they have a wide email distribution of SIs requiring investigation, which is summarised in an email and ordered by provider and received on a daily basis. He said SHFT has not stood out to him over the last two years.⁷⁹¹

754. The **Chief Executive** said the governance arrangements are pretty good but they are never perfect. He said one also has to rely on the observations and experience of the Chief Nurse, Medical Director and Operations Director and others, to complement the governance arrangements.⁷⁹²

755. He stated that some processes are being tightened up, for example, complaints and investigations and that he has been involved in that. He said, “I have met with the (investigations) team and the processes are going to evolve: there are discussions about the 48-hour Review Panel reports, around the fact that they’re focused on the operational management of the untoward events, rather than the learning...”.⁷⁹³

756. The **Incident Investigation Manager** said that every week the Patient Safety Manager and a member of the Governance team, speak to the Director of Nursing and discuss 48-hour Review Panels, SIs or Red RCAs and escalate any issues. She said that when she receives an SI notification by email, she reviews the incident and she has gone reverted to say that she thinks that it should be an SI so that it will then go through the process of review again.⁷⁹⁴

757. The **Deputy Medical Director** said that the central governance team measures the trends from the SIs and Mortality Reports on a weekly basis and alerts the clinical service team of any spike, in conjunction, a deep dive would be conducted, an immediate safety

⁷⁹¹ Evidence of Regional Medical Director for NHSE/I for the South East Region, Dr Lewis, 6 April 2021

⁷⁹² Evidence of Chief Executive of SHFT, 16 April 2021

⁷⁹³ Ibid

⁷⁹⁴ Evidence of Incident Investigation Manager at SHFT, 19 April 2021

check would be done and depending on what is found, they will look to put in any additional input that is needed.⁷⁹⁵

Monitoring compliance

758. The **Deputy Medical Director's** statement sets out the ways in which SHFT states that they are monitoring compliance. The key process indicators which are monitored are:

- The percentage of SIs reported onto STEIS within 48 hours of being identified as an SI;
- The percentage of SIs where a 72-hour report has been sent to commissioners within 72 hours of an incident being recorded as an SI on STEIS;
- The percentage of all SI investigation reports uploaded to STEIS within 60 days of being reported.⁷⁹⁶

759. The **Deputy Medical Director** said the data is shared at a summary level with the Quality and Safety Committee on a quarterly basis, and monthly at the Learning from Events Forum and Patient Safety Group Meeting.⁷⁹⁷

760. The data is available to local teams through Tableau (the Trust's electronic data warehouse) and the compliance target for each of the above indicators is 100%. Where compliance has deviated from 100%, it is stated that, the reasons have been documented in the monthly monitoring reports and in the quarterly report to the Quality and Safety Committee.⁷⁹⁸

761. The **Quality and Safety Committee Chair** said the Quality and Safety Committee only discuss a death if it is graded five during the SI process and homicides from patients in their care.⁷⁹⁹

⁷⁹⁵ Evidence of Deputy Medical Director at SHFT, 1 April 2021

⁷⁹⁶ Statement of Deputy Medical Director at SHFT, 2 February 2021

⁷⁹⁷ Ibid

⁷⁹⁸ Ibid

⁷⁹⁹ Evidence of Quality & Safety Committee Chair, SHFT, 9 March 2021

762. The **Lead Governor** said the Integrated Performance Reports have, “moved from something that did not tell me anything to becoming stronger... we use the performance information to make decisions about the business, what we are going to do and change and where the pressure is. I see that more now than ever, there is still further to go, we are not at the end of the journey, we could become slicker”.⁸⁰⁰

763. However, the **Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement**, accepted that the Executive Summary in the Integrated Performance Report is high level and does not provide the full breakdown of the incidents.⁸⁰¹

764. In the Quality and Safety Committee meeting on 28 January 2020,⁸⁰² the Quality & Safety Committee Chair commented on the ‘*Decreasing compliance of deaths being reviewed at a panel within 48 hours of being reported on Ulysses... and asked that the trend be monitored*’. In evidence, the **Quality and Safety Committee Chair** was asked about this and explained that this concern arose from the Learning from Deaths report. He said he expected to be informed and if it is not in the next set of minutes, he would have hoped it was a temporary event. He accepted it was not listed as a specific action and he did not know if it was in an action plan.⁸⁰³

Executives and Non-Executives

765. The Panel were told that the Board has designated Executive and Non-Executive Director leads for mortality and SIs.⁸⁰⁴

766. SHFT’s evidence was that Non-Executive Directors regularly meet separately from the Executives and meet the Chair and the Chief Executive of SHFT. The **Quality and Safety Committee Chair** said, “I know our role is around challenging our Executive colleagues constructively, but I think it can be done in a positive, supportive way. I think it’s a good unitary Board and I do not feel any restriction on what I can say and ask”.⁸⁰⁵

⁸⁰⁰ Evidence of Lead Governor, SHFT, 30 March 2021

⁸⁰¹ Evidence of Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement at SHFT, 29 March 2021

⁸⁰² QSC meeting, 28 January 2020, page 106, at 9.2

⁸⁰³ Evidence of Quality & Safety Committee Chair, SHFT, 9 March 2021

⁸⁰⁴ Statement of Deputy Medical Director at SHFT, 2 February 2021

⁸⁰⁵ Evidence of Quality & Safety Committee Chair, SHFT, 9 March 2021

767. The **Deputy Medical Director** said that the Non-Executive and Executive Directors do not attend the Learning from Events Meetings, but they do attend the Corporate SI Panels for a particularly serious incident and in the last 18 months, a few have opted to follow SI Investigations through.⁸⁰⁶ The **Incident Investigation Manager** referred to this experience too and commented, “I found (it) absolutely great, because it demonstrated to me that the Board are interested, I didn’t think they weren’t, but it showed activeness in what was happening”.⁸⁰⁷

768. The Panel heard from a **Non-Executive Director and Chairman of the Audit, Risk and Assurance Committee** who said they have had a number of detailed Board seminars which are specific sessions on issues, such as SI investigations. He gave an example of such a session where there had been a SI over a weekend and there was an error on the weekend cover roster. He said, “I found the rosters were kept on an excel spreadsheet and an error had been made... I asked how many teams were using excel, rather than the functionality in the system... we followed it over a few Risk and Assurance meetings, and finally took assurance that it was not ‘teams’ that were not following them, but individuals, or where the service was 9-5pm”. He described it as a pretty robust affair for those on the receiving end.⁸⁰⁸

769. The Board receive a quarterly Learning from Deaths report produced by the Medical Director and it’s reviewed by the Learning from Events Forum. The **Quality and Safety Committee Chair** said that the reports should be in the public domain.⁸⁰⁹ The **Chief Executive** said individual SIs are not received at Board, but catastrophic events are. There are currently five cases waiting to go to the Board that are not complete and a schedule goes to the Board sub-committee, where themes are looked at in more detail.⁸¹⁰

770. He said the Board are also alerted to SIs through the Chair and Non-Executive Directors, who meet regularly. He explained how there may be a forewarning before an investigating starts and guidance sought from Non-Executive Directors in some

⁸⁰⁶ Evidence of Deputy Medical Director at SHFT, 1 April 2021

⁸⁰⁷ Evidence of Incident Investigation Manager at SHFT, 19 April 2021

⁸⁰⁸ Evidence of Non-Executive Director and Chairman of the Audit, Risk and Assurance Committee, SHFT, 13 April 2021

⁸⁰⁹ Evidence of Quality & Safety Committee Chair, SHFT, 9 March 2021

⁸¹⁰ Evidence of Chief Executive of SHFT, 16 April 2021

circumstances.⁸¹¹ The **Chair** emphasised this too and said the aim is to ensure the Board and Governors do not find out about it from the press.⁸¹²

771. The **Incident Investigation Manager** said, “the Board receive a report on all our SI investigations and any that are ‘catastrophic’ are presented at the Board and we always invite the family to participate in that, as there is nothing more powerful than the family members sitting in front of the Board and telling them of their experience. I have supported a family in such a meeting and the Board have been very receptive”.⁸¹³

772. The **Chief Executive** said, “all (SI Reports) come across my screen, I cannot possibly read them all, but I do, on a daily basis, scroll through and look through the top-lines and certain themes will draw my attention and for those, I look at them in detail and ask for further information. On a weekly basis, I ask to see a number of 48-hour Reports and on occasion I have asked for the full details of an event. I have a running notebook of cases that I track - there are five to six I am tracking currently”.⁸¹⁴

773. He said the expectation is that information about SIs is shared with Commissioners. He described a close relationship of regular dialogue to make sure the CCG is informed as events occur. He said that the arrangements under the Integrated Care System are still to be worked through. He described his experience of reporting to NHSE/I and CCG colleagues is that they are expecting him, and he sees it as his responsibility, as Chief Executive, to appear before them and account for what has happened, where SHFT are and what it has done.⁸¹⁵ This is explored further below under ‘supervisory structures’.

774. The **Incident Investigation Manager** said that there is not an Annual Serious Incident Report to the Board but said it would be a useful exercise that she could do alongside her manager, the Associate Director of Patient Safety.⁸¹⁶

Monitoring feedback from families

775. Whilst SHFT monitors the engagement of families in the investigation process, the metric does not currently record views as to the quality of the experience of their

⁸¹¹ Ibid

⁸¹² Evidence of Chair of SHFT, 16 April 2021

⁸¹³ Evidence of Incident Investigation Manager at SHFT, 19 April 2021

⁸¹⁴ Evidence of Chief Executive of SHFT, 16 April 2021

⁸¹⁵ Evidence of Chief Executive of SHFT, 16 April 2021

⁸¹⁶ Evidence of Incident Investigation Manager at SHFT, 19 April 2021

involvement in that process in a structured way. The Panel were told that in early 2021, SHFT will implement a structured process to seek feedback from families regarding their experience of being involved in a SI investigation and the support they are offered by the investigator and the FLO.⁸¹⁷ The Panel did not receive any evidence of this.

Panel's Views on where SHFT are now: assurance and governance of SI investigation process

- The Panel received comprehensive evidence about the internal audit system for quality assurance that SHFT have put in place for SIs. However, the Panel is not satisfied that this is rigorous and robust enough and have already suggested improvements.
- The Panel heard how some SIs are reported to the SHFT Board and Non-Executives, both before the investigation takes place in some circumstances and afterwards too. This should, where appropriate, continue and grow.
- It is positive that some Non-Executive Directors opted to follow a SI investigation through. Their involvement should be actively encouraged and supported in the future.
- However, in the Panel's view, the omission of an annual report to the Board to provide them with the assurance, summary, or analysis of the last twelve months' activity for SIs should be rectified in the next cycle of reporting.
- The Panel will develop its views further below regarding the assurance processes in place with the CCG and SIs, but, in summary, the Panel considers these specific processes are satisfactory.
- The Panel is not as assured as to the processes in place between SHFT and the NHSE/I Regional Office for quality assurance in relation to SI investigations. Processes should be clarified and improved by both organisations, which are explored further below.
- Furthermore, the Panel notes and indeed SHFT accepts that as part of the assurance process there is currently no mechanism in place for capturing the families' views and feedback about the investigation process. This should be rectified promptly.

⁸¹⁷ Statement of Deputy Medical Officer at SHFT, 2 February 2021

Supervisory Structures

B. Where are SHFT now?

History

776. CCGs are clinically led statutory NHS bodies, who have responsibility for planning and commissioning health services for their local area. They were created under the Health and Social Care Act 2012.

777. The local CCG relevant for the purposes of this Review is West Hampshire CCG.

778. The Panel received evidence about the national changes that are being undertaken, under the direction of NHSE/I, by CCGs and providers with the introduction of Integrated Care Systems (“the ICSs”).

779. The CCGs are held to account and regulated by NHSE/I.

CCGs Merger

780. CCGs were authorised and have been in place since 2013, in Hampshire and the Isle of Wight, the CCGs were Fareham and Gosport, Isle of Wight, North Hampshire, Southampton City CCG, South Eastern Hampshire, Portsmouth CCG and West Hampshire CCG. On 1 April 2021, six CCGs merged together to form one CCG: NHS Hampshire, Southampton and Isle of Wight CCG. Portsmouth CCG remains as a statutory organisation.

781. The **Clinical Director for Mental Health and Learning Disability for West Hampshire CCG** described the local changes from 1 April 2021: “I think there will be a move towards an Integrated Care Partnerships (“ICPs”) place-based system... there is a commitment to strong clinical leadership in the system, not just GPs, but it will include clinicians from across the system, which will be a valuable addition, and potentially we have not previously had enough of it”.⁸¹⁸

⁸¹⁸ Evidence of Clinical Director for Mental Health and Learning Disability for West Hampshire CCG, 17 March 2021

782. The **Clinical Director for Mental Health and Learning Disability for West Hampshire CCG** explained the ICPs as being related to where you are registered at a GP surgery, but that ICPs have a different geographical footprint to CCGs. She said it will bring together all of the people in charge of care of the population in that area: primary care, secondary care, mental health services, community health services and acute trusts, alongside local authorities. She said she hopes that it will be a much more collaborative grouping.⁸¹⁹

783. She explained that the purpose of the Primary Care Mental Health and Community Care Mental Health Transformation Programme is to bring together community mental health teams and primary care networks. She acknowledged that there have been big gaps between those two systems, that people have fallen between, which the transformation programme is trying to fill with the appropriate support around people to allow them to move from primary care, through secondary care and up and down that continuum. She said this is in recognition that this is what happens for the vast majority of service users, they are not just under one or the other, but always somewhere along that spectrum.⁸²⁰

784. She said that the divisional changes SHFT had made fitted with the ICP shapes, but there are a lot of smaller changes that are needed on the ground.⁸²¹

785. The **Acting Director of Quality & Nursing** stated the merger of the CCGs on 1 April 2021 provides an opportunity to reduce complexity and the associated risks of multiple commissioning structures. He discussed the complaints specifically and said the merger will lead to a review of the internal CCG complaints process and that work is proceeding to merge the complaints teams, with the aim of reducing fragmentation and to support the collation of themes relating to complaints.⁸²²

786. The **Interim Director of Nursing and Quality for North Hampshire, South-East Hampshire, Fareham, Gosport and Isle of Wight CCG**'s view is that the new system will be better for service users and carers who want to complain, as there will be one

⁸¹⁹ Ibid

⁸²⁰ Ibid

⁸²¹ Ibid

⁸²² Statement of Acting Director of Quality & Nursing, West Hampshire CCG, 16 February 2021

place for them to go into. She said they are working to align their policy and local complaints team in each area and it will be reviewed every six months.⁸²³

Panel's Views on where SHFT and the CCG are now: CCG merger

- The Panel hopes that the new and improved, larger CCG, will assist the shared specialist Mental Health and Learning Disability Team to secure an increase in the scale of expertise in commissioning these types of specialist services, which are particularly pertinent to SHFT.

Move to Integrated Care Systems

787. The Panel received evidence from the CCG participants and SHFT about the move to ICSs that is currently in process in Hampshire. This included the positives, negatives and challenges that they will face. The evidence addressing the future of ICSs is set out in Part 5C of this Report.

788. ICSs are: *'Partnerships that bring together providers and commissioners of NHS services across a geographical area, with local authorities and other local partners, to collectively plan health and care services to meet the needs of their population. The central aim of the ICSs is to integrate care across different organisations and settings, joining up hospital and community-based services, physical and mental health, and health and social care. All parts of England are now covered by one of 42 ICSs'*⁸²⁴

789. ICSs form part of the Health and Care Bill 2021 which is currently progressing through Parliament. If the Bill is passed in its current form, the CCGs will be replaced by ICSs. This is expected to pass in April 2022 at the time of writing. Further, the move to an ICS approach was set out in the NHS Long Term Plan.⁸²⁵

790. The **Interim Director of Nursing and Quality for North Hampshire, South-East Hampshire, Fareham, Gosport and Isle of Wight CCG**, who has the portfolio for

⁸²³ Evidence of Interim Director of Nursing and Quality for North Hampshire, South-East Hampshire, Fareham, Gosport and Isle of Wight CCG, 14 April 2021

⁸²⁴ https://www.King'sfund.org.uk/publications/integrated-care-systems-explained?gclid=Cj0KCQjwwLKFBhDPArisAPzPi-IPnRCffbvWYQD1tg3RxIRnRf46AmS-M-0bHBSkNQ1NI6s31J4mYwwaAvSJEALw_wcB

⁸²⁵ NHS Long Term Plan, January 2019: <https://www.longtermplan.nhs.uk/>

developing the local ICS, said there is one director of mental health services across the CCGs and ICSs and a team working under her, which will enable them to do one thing at scale for people that may need something systematic or big picture and there are localised teams too.⁸²⁶

791. The **Acting Director of Quality & Nursing** said ICSs will make it, “easier for us to have place-based discussions with all people in the room through Quality and Safety Committees... which will be our way of holistically overseeing the system”. He described this as a move away from, “holding individual providers to account, to recognising our patients go on pathways and use more than one service. We need to look at the longitudinal process our patients go through, rather than the horizontal process and that Committee is a way of doing that”.⁸²⁷

792. The new approach should, he believes, ensure that patients can go through the entire system with no awareness of boundaries and ultimately improve the quality of care to a patient. He said it will result in the joining up of services.⁸²⁸

793. The **Senior Quality Manager of West Hampshire CCG** said, “as a health system, I think (ICSs) will benefit everybody... but I cannot see that there will be a huge change in how we manage the provider”.⁸²⁹

794. The **Clinical Director for the Hampshire South-West Division** expressed her view as to whether the move to ICSs would benefit patients: “there is good and bad: we have to work together as we serve the same population. I believe families and patients will benefit, but it’s difficult, as you feel a tribal loyalty and some places are served better than others and if you’re going to be equitable, regionally, you either have to increase the level of care, or take it away from somewhere, and nobody will want to reduce their own provision... so we have to do it right, it will be difficult, but it has to be done”.⁸³⁰

795. The **Chair of Hampshire Healthwatch, Ann Smith**, said the organisation is working on organisational changes with local ICSs and working closely with the communication

⁸²⁶ Evidence of Interim Director of Nursing and Quality for North Hampshire, South-East Hampshire, Fareham, Gosport and Isle of Wight CCG, 14 April 2021

⁸²⁷ Evidence of Acting Director of Quality & Nursing, West Hampshire CCG, 5 March 2021

⁸²⁸ Ibid

⁸²⁹ Evidence of Senior Quality Manager, West Hampshire CCG, 5 March 2021

⁸³⁰ Evidence of Clinical Director for the Hampshire South-West Division, SHFT, 1 April 2021

teams to ensure that they are part of the strategic development so that patients' voices are heard at the strategic level.⁸³¹

796. **Ms Smith** said they are waiting for final clarity as to where Healthwatch will sit in the ICS. She said they believe they should have a statutory seat as currently it is only by voluntary invitation. She commented that the establishment of primary care networks and devolvement of funding to them in 2022 is going to impact on the services that patients receive and if they are not able to provide the patients' voice, especially of those least represented in society, things will happen that they will have no opportunity to comment on.⁸³²

797. The **Chief Medical Officer at SHFT** gave evidence about the potential for ICSs in regards to the investigation of SIs and said it will allow for resources to be utilised across a wider population. For example, he said, a number of SHFT's SIs related to substance misuse co-morbidity and if the ICS conducts an investigation of the incidents looking at how the services are delivered in a larger population, there will be more weight behind it to change the national or regional position.⁸³³

798. He said that SHFT has taken on the ICSs QI hub role, so they can make changes at local level and host QI. He described that as a massive place for SHFT to be at.⁸³⁴

799. The **Chair** at SHFT said, "with an ICSs approach, we will be engaging with communities in a much more practical way and thinking about how we can build healthy communities together, we have a lot to do with our local communities, so they know who we are, what we stand for and how we can help them to develop into the healthy communities they want to be and see for the future".⁸³⁵

800. A **family member** commented, "I think there are opportunities for people to come together (with a move to an ICS approach)".⁸³⁶

⁸³¹ Evidence of Chair of Hampshire Healthwatch, Ann Smith, 6 April 2021

⁸³² Ibid

⁸³³ Evidence of Chief Medical Officer, SHFT, 12 April 2021

⁸³⁴ Ibid

⁸³⁵ Evidence of Chair of SHFT, 16 April 2021

⁸³⁶ Evidence of a family member, 14 April 2021

Panel's Views on where SHFT and the CCG are now in the move to ICSs

- The Panel acknowledges that the specific future arrangements for ICSs remain uncertain as it is not yet on a statutory footing. Therefore, the Panel have formed a view based on the current position, as opposed to what might happen.
- The Panel is reassured by some of the evidence showing the improvements that would follow from a move to ICSs. However, it also suggests that the focus on this future work, may have distracted the CCG's attention from SHFT on current issues. They must ensure that if this has happened, it is acknowledged, and rectified.
- The Panel acknowledges that it received evidence of express reservations and concerns about the new approach and the risk associated with it, which should not be overlooked. It is clear that the design and development of ICSs must, where legislation allows, be co-produced with local populations and subject to consistent and regular review, to ensure that the appropriate assurances are in place.

Role in commissioning

801. The Panel were keen to hear from the CCG about their role in commissioning services. The **Director of Quality for West Hampshire CCG** was asked how they reconcile the disparity in commissioning services for mental health and learning disability services, compared with physical health services. She said, "the CCG, in recognising it's a challenge, has taken the step of appointing a single Director, who sits across all of Hampshire and Isle of Wight CCGs and has that responsibility. She is a very stout advocate of the whole parity of esteem agenda and I have sat in a number of meetings where we have debated long and hard the mental health investment spend and ensuring that the right amount of income is going where it should to SHFT".⁸³⁷

Panel's Views on where the CCG are now: commissioning role

- The Panel is pleased that the disparities in mental health and learning disabilities and acute care and physical health have been acknowledged by the CCG in its commissioning role. It is encouraged to pursue this improvement work through ICSs and beyond. Dr Cleary and Professor Kendall recognised in evidence that such disparities have been an ongoing problem for a number of years and any increase in funding in such areas, to address the imbalance, would be welcomed and indeed should be encouraged.

⁸³⁷ Evidence of Senior Quality Manager, West Hampshire CCG, 5 March 2021

Relationship between SHFT and the CCG

802. The Panel received a significant body of evidence regarding the relationship between the commissioners and SHFT and where that is today in comparison to two years ago.

803. The **Acting Director of Quality & Nursing** stated: “the relationship between SHFT and the CCG has improved significantly since 2016 with a much more transparent, supportive and collaborative approach, which is designed to ensure that any challenges are raised early and managed in a constructive manner”.⁸³⁸

804. In oral evidence, he defined the CCG’s role as a critical friend to SHFT. He said, “I am really confident that if there is an issue at SHFT, there is very good communication, so we can both lift the phone to see what we need to do to collectively to own that problem”. He acknowledged, upon questioning, the potential conflict around perceived independence.⁸³⁹

805. He explained how the CCG were involved in SHFT’s QI Rapid Process Improvement Workshop training and that they have put four of their own quality managers through the training and the CCG are invited to the workshops. He said they are as fully integrated into that process as they choose to be.⁸⁴⁰

806. On the topic of the standard NHS contracts the CCG have in place with SHFT he described how it has in the past led to an adversarial and transactional approach between the two. He recognised that, although there was value in what they were doing, their focus is now on QI and supporting SHFT with its own internal quality assurance, so, doing it once, getting it right first time and adding extra capacity and value to that.⁸⁴¹

807. He said, “we need to be much more interested in what is the reality on the shop floor and how we can change outcomes that really benefit patients”. He believes this has led to more open and transparent relationships where they are able to challenge SHFT more openly.⁸⁴²

⁸³⁸ Statement of Acting Director of Quality & Nursing, West Hampshire CCG, 16 February 2021

⁸³⁹ Evidence of Acting Director of Quality & Nursing, West Hampshire CCG, 5 March 2021

⁸⁴⁰ Ibid

⁸⁴¹ Ibid

⁸⁴² Ibid

808. The **Acting Director of Quality & Nursing** also explained that they now have open access to multiple internal committees and all of SHFT’s internal reporting, which he said, means they are much closer to the detail and can challenge in real time.⁸⁴³
809. The **Director of Quality and Board Nurse for West Hampshire CCG**, who has been in the CCG since August 2017, said, “when I joined the CCG, the way we and SHFT interacted and engaged with one another was very different to how it is now. I genuinely feel there has been a continuous level of good improvement since I joined. Some of the ways it has demonstrated itself for me, is by SHFT’s complete transformation around the openness and willingness to engage”.⁸⁴⁴
810. She said that in 2017 there were occasions where they would hear about incidents, complaints and investigations later than they would have liked to, and occasionally, they had to probe for details and the responses that they had requested. However, she described how over the last couple of years, working alongside the Director of Nursing, Director of Workforce, Organisational Development and Communications and with input from the Medical Director and engagement with the previous Chief Executive, SHFT have turned it around. So, it is, she said, fairly regular practice for her to be contacted within an hour of an event happening to discuss how jointly to approach managing it.⁸⁴⁵
811. She attributes this change in their relationship to the fact that SHFT opened itself up with its work on QI, and the way they have trained staff on it has been excellent. She forms this opinion by comparing SHFT with her experience of QI in other organisations she has worked in.⁸⁴⁶
812. When asked how the CCG simultaneously balances the need to challenge SHFT with a positive relationship with them, the **Director of Quality and Board Nurse for West Hampshire CCG** commented, “I think there is a level of trust and understanding there... we know we can have the discussions, but equally, if I need to hold the organisation to account, they would expect me to do it. If needs be, we would follow the contractual routes around getting responses. But, the benefit of the good working relationship is that it enables us to do some of those things without having to go down the formal contractual route”. She believes that she can maintain her objectivity.⁸⁴⁷

⁸⁴³ Ibid

⁸⁴⁴ Evidence of Director of Quality and Board Nurse, West Hampshire CCG, 15 April 2021

⁸⁴⁵ Ibid

⁸⁴⁶ Ibid

⁸⁴⁷ Ibid

813. The **Director of Quality and Board Nurse for West Hampshire CCG** was challenged by the Panel on the idea, or perception, that the CCG and SHFT have a relationship that is ‘too cosy’ and ‘lacks independence’. In response, she said, “...I am quite sure that if you asked any senior team member from SHFT, including Executives, about their experiences of presenting to one of our Boards or committees to account for why we’re concerned about an issue and what they’re doing to address it they would concur that, on those occasions, the relationship was absolutely not cosy and we sought to get to the bottom of the issue and that the actions required to address it, took place”.⁸⁴⁸

814. She said the Medical Director of SHFT was challenged in this way by GP members of the CCG Quality Board. She said “... a major constituent part of our Governance Boards and sub committees have lay members and GP representation and they would not have the same direct relationships with colleagues in SHFT that I would have. They are tough characters and are there to represent their patient population and will not be satisfied until they have the answers and evidence they want, particularly given their clinical background, they always want evidence.”⁸⁴⁹

815. She concluded that, “... I now have, what I would class as, a very good relationship with individuals (in SHFT) ... who enable frank, honest and early conversations to happen. That is the biggest difference...”. She said, “in a nutshell, I believe SHFT are in a very different and much better position than it was previously”.⁸⁵⁰

816. The **Clinical Director for the Hampshire South-West Division** said, “we are really close with the commissioners, we have met twice a week since COVID-19 (March 2020) ... and we have contract review meetings. We all have our views on where we should go, but if we only worked in a challenging environment nothing would get done and if we worked only in a cosy environment then patient safety might suffer, so there is a balance”.⁸⁵¹ The bi-weekly quality assurance calls between SHFT and the CCG throughout the COVID-19 pandemic were confirmed by the Acting Director of Quality & Nursing at West Hampshire CCG.⁸⁵²

⁸⁴⁸ Ibid

⁸⁴⁹ Ibid

⁸⁵⁰ Ibid

⁸⁵¹ Evidence of Clinical Director for the Hampshire South-West Division, SHFT, 1April 2021

⁸⁵² Evidence of Acting Director of Quality & Nursing, West Hampshire CCG as part of the fact-checking exercise

817. The **Chief Medical Officer** described SHFT's relationship with the CCG in contracting for mental health services: "we are working more closely with them... the change with the ICSs and CCGs merging and some of the relationships might be disentangled... (but), I have chaired Evidence of Improvement Panels when a SI Investigation comes back with at least two CCG quality managers, I promise it's not a cosy, but challenging conversation".⁸⁵³

Panel's Views on the current relationship between SHFT and the CCG

- The Panel's view is that the general move towards a relationship of co-production and partnership between SHFT and the CCG is positive and the evidence demonstrates a strengthening of their relationship.
- However, the Panel is concerned about the extent to which the CCG is able to demonstrate its independence from SHFT, and the perception of independence, should it be required to do so. It is vital that the relationship is not too close such that the CCG's ability to challenge SHFT and hold them to account is compromised.
- The Panel's view is that they are lacking persuasive evidence that the CCG could identify an issue in SHFT and what would be done about it. For example, some of the participants who gave evidence had been present in SHFT and the CCG during the period of SHFT's significant problems and the 'requires improvement' rating from the CQC. However, it appears that the problems were not identified by the CCG, or if they were, they were not responded to and dealt with effectively.
- Therefore, overall, the Panel is not satisfied, on the evidence, that the relationship has moved to one of scrutiny, objectivity and rigour, which is what they would expect to see and consider is needed in this partnership if they are to re-build the trust and confidence in the population they serve.

Assurance and oversight function of the CCG

818. In light of the previous concerns that were raised at Stage 1 regarding the assurance, oversight functions and mechanisms put in place by the CCG and at a time of change in the CCGs, with the merger and move to an ICS, the Panel were keen to hear from participants how this is working today and to consider where the CCG and SHFT are

⁸⁵³ Evidence of Chief Medical Officer, SHFT, 12 April 2021

now. The Panel does acknowledge and has taken into account the fact that this is a time of flux given the presence of the COVID-19 pandemic and changes mentioned above.

819. The **Acting Director of Quality & Nursing of West Hampshire CCG** recognised that the merger of the CCGs on 1 April 2021 and after that, has been a high risk time. He said, with specific reference to SHFT that their oversight structure is well-established. He described how the CCGs' have Quality Managers inputting into the local divisional structure and there are Senior Quality Managers, who have strategic oversight.⁸⁵⁴

820. He described it as a struggle to manage large disseminated organisations whilst having reference to 'place' and said, "we need to join the dots to ensure we are not missing themes across SHFT, the oversight structure will provide that and it won't change when this CCG ceases and forms a new one".⁸⁵⁵

Clinical Quality Review Meetings

821. The Panel received evidence about the purpose, attendance and extent to which the Clinical Quality Review Meetings ("CQRM") are operating today. There is some overlap between the evidence set out here and earlier in the Report and it should be considered together.

822. The **Senior Quality Manager** stated that up until February 2020 there were monthly CQRMs which were attended by the CCG to go over the quality aspects of its contract with SHFT and the CCG would receive and review documents and reports from SHFT in advance of the meeting.⁸⁵⁶

823. She explained that the meetings had become too busy, so, in December 2018, it was decided that the corporate reports from SHFT, including complaints and safeguarding incident reports, would be reviewed outside of the CQRM in a pre-meeting. A template was completed by each CCG Quality Manager with comments to send to SHFT for their response, in time for the CQRM. If further discussion and questioning of SHFT was required it could take place at the substantial meeting.⁸⁵⁷

⁸⁵⁴ Evidence of Acting Director of Quality & Nursing, West Hampshire CCG, 5 March 2021

⁸⁵⁵ Ibid

⁸⁵⁶ Evidence of Senior Quality Manager, West Hampshire CCG, 5 March 2021

⁸⁵⁷ Ibid

824. Due to COVID-19, the last substantial CQRM was held in February 2020. Weekly virtual meetings were set up almost immediately, with the Head of Quality Assurance and Head of Patient Safety and exceptional reporting has continued. From October 2020, presentations from SHFT staff on specific issues were received by the CCG on request. For example, the progress on complaints, as the CCG had previously had concerns that SHFT were not providing a response within ten working days. As a result of this presentation, the CCG state that they are watching with interest.⁸⁵⁸

825. The Panel were told of continuing discussions about the re-starting and structuring of the CQRM in the future.⁸⁵⁹ There are no patient representatives at the CQRM, but there are presentations on issues in the contract from service users, carers and staff.

826. The **Senior Quality Manager** said that SHFT provide a quarterly report to the CQRM to update them on their progress against the quality priorities. This includes a summary of complaints, themes and actions taken.⁸⁶⁰

827. The Panel reviewed CQRM minutes for the period of 2019 to 2020. On 26 February 2020, the minutes included an update from SHFT on the Quality Dashboard and on Mental Health Act Breaches in a SHFT facility. They request further assurance on:

'Previous SI actions/processes put in place, what went wrong, details of how many patients were affected by this recent incident, how this differs to the previous SI and why it was not reported as an SI, with information to be provided as soon as possible and in advance of the next meeting'.

This action was allocated to a named individual but without a date to complete it by or details about how the action would be carried-out. Further, it is recorded that:

'It was also noted that this raises questions around the wider assurance process around SIs, for example if a gap is identified to make sure that it is not replicated in other areas'.

However, no action or date is put to this statement.

⁸⁵⁸ Ibid

⁸⁵⁹ Ibid

⁸⁶⁰ Ibid

SHFT's internal governance processes

828. The **Senior Quality Manager at West Hampshire CCG** explained how since SHFT moved to the five divisions 18 months ago, the CCG have moved to using SHFT's internal governance processes to carry out a lot of their assurance work. She said they have been invited to SHFT's meetings and they regularly attend them; they are getting appropriate assurance and she is aware of exceptional reporting.⁸⁶¹
829. The **Acting Director of Quality & Nursing** said the CCG attends SHFT's peer reviews and speaks to people on the wards and said they are not tick-box exercises.⁸⁶² The **Senior Quality Manager** said she used to write a crib sheet for anyone going out on a peer review to remind them of anything that had cropped up in that ward or team and broader Trust-wide issues to check if there was embedded learning on those visits.⁸⁶³ She acknowledged that the visits were regular before COVID-19 (March 2020).
830. The **Director of Quality and Board Nurse** said that she has participated in SHFT's one-week QI training. In regards to the QI strategy in SHFT, she said it improves the service for the people that they are planning on buying services on behalf of and it reduces the duplication of oversight, because they have some senior Quality Managers from the CCG working alongside SHFT in initiating the improvement, so they can see it first hand. She said it leads them to being in a place where they can feel better assured, rather than reassured.⁸⁶⁴

Contract compliance

831. The **Senior Quality Manager** said the CCG see a draft of SHFT's annual report and provide a response to its priorities. The CCG also develop quality priorities for SHFT, which are in a schedule attached to their contract for the following year. She said that the quality indicators are very detailed, there can be no possibility of poor interpretation of what is required and they are very specific.⁸⁶⁵

⁸⁶¹ Ibid

⁸⁶² Evidence of Acting Director of Quality & Nursing, West Hampshire CCG, 5 March 2021

⁸⁶³ Evidence of Senior Quality Manager, West Hampshire CCG, 5 March 2021

⁸⁶⁴ Evidence of Director of Quality, West Hampshire CCG, 15 April 2021

⁸⁶⁵ Evidence of Senior Quality Manager, West Hampshire CCG, 5 March 2021

832. In regards to escalating contractual matters or concerns with SHFT, the **Director of Quality and Board Nurse** said, “there have been a number of occasions where we’ve escalated items to the contract group, but only one or two I can recollect where we have gone down the formal route (with SHFT)”. She attributes this to their better relationship and said it leads to more sustainable improvement to work this way.⁸⁶⁶

833. The Panel received the West Hampshire CCG Patient Experience & Complaints Annual Report 2019/20, which suggested that the CCG are using a GP Feedback Tool for GPs to notify them of concerns about potential breaches of contract – if a notification was received about SHFT, the Senior Quality Manager would notify the appropriate person in SHFT for a response and then provide that to the GP.

Quality Surveillance Oversight Group

834. The **Acting Director of Quality & Nursing** said that they have instituted a Quality Surveillance Oversight Group as part of the new Hampshire and Isle of Wight ICSs, which has a current membership of CCGs, but the intention is to invite providers in future, to review information from all the providers, with the idea of having, providers around the table for holistic discussion for quality improvement.⁸⁶⁷

835. The **Director of Quality** confirmed that the information on the quality measures employed by them to measure the performance of SHFT are shared with the other CCGs that they are taking a lead on behalf of.⁸⁶⁸

Panel’s Views on where the CCG are now: assurance and oversight functions of SHFT

- The Panel is satisfied that the CCG have been actively involved in SHFT’s QI programme and encourages this to continue and develop further. The Panel would argue that the CCGs’ involvement in QI should be in addition to their usual assurance functions. Over reliance on the QI programme by the CCG is discouraged.

⁸⁶⁶ Evidence of Director of Quality, West Hampshire CCG, 15 April 2021

⁸⁶⁷ Evidence of Acting Director of Quality & Nursing, West Hampshire CCG, 5 March 2021

⁸⁶⁸ Evidence of Director of Quality, West Hampshire CCG, 15 April 2021

Panel's Views on where the CCG are now: assurance and oversight functions of SHFT continued...

- It is positive that the CCG have been involved in SHFT's peer reviews, although it is acknowledged that these have not been able to proceed as normal due to COVID-19 restrictions, so staff are encouraged to resume these once permitted. However, the reviews should not be relied on by the CCG for assurance purposes. This is because the Panel considers that they are simply not widespread enough across such a large Trust and there is no scientific underpinning to their assurance and scrutiny during such sessions.
- The Panel is concerned that the CQRM has been running on 'exceptional reporting' only since February 2020, due to the COVID-19 pandemic. The Panel was not provided with evidence that demonstrated a clear strategy for the future of this assurance function and more than one participant acknowledged their value.
- The Panel was not provided with any written report or minutes of the exceptional reporting meetings. Therefore, they do not know if these meetings are being formally recorded or not, and if not, then they should be for auditing and assurance purposes.
- The Panel's view is that following the CQRM, if the actions are not assigned to an individual(s), role, or with a date to complete the action by, it is not possible to know who has responsibility for the action, to ensure accountability and to measure the outcome. This omission and lack of rigour suggests weaknesses in the CCGs' assurance process.
- A part of the CCGs' role is to manage the SHFT contracts and monitor its performance in the delivery of care. However, the Panel is not satisfied, on the evidence, that the CCG fulfils this function with rigour and diligence.
- Overall, the Panel is not satisfied, on the evidence provided, that the CCG is doing enough to drive SHFT forward in its aspirations to improve, by properly carrying out the function of challenging and monitoring.

Oversight and contractual management of the complaints handling process in SHFT

836. There exists a contractual requirement on SHFT to provide the CCG with an '*annual complaints monitoring report, setting out the number of complaints received and analysis of key themes*' on a quarterly basis. This is presented for the CQRM. Therefore, the CCG has a responsibility for oversight of it. It is important to consider how this is done in practice and how effective it is today.

837. Firstly, if a complaint is made about SHFT and the complainant notifies the CCG first, the CCG would coordinate the complaint response with the provider, but they will not investigate the complaint if it is being, or has been, investigated by the provider.⁸⁶⁹

838. The **Acting Director of Quality and Nursing** said that if the complainant came to the CCG with a multi agency complaint, they would work with SHFT and if a complainant was not satisfied after the SHFT investigation was complete, although they cannot completely reinvestigate it, they would work with them and SHFT to get local resolution and answer any remaining questions that may not have been answered properly.⁸⁷⁰

839. He said that the top three themes in the complaints that go directly to SHFT are: attitude of staff, care and delivery of care and communication (the same as they were seeing in 2014/15). He explained that the role of the CCG is to scrutinise the account and to gain assurance and to support them where they can; to review the themes quarterly and work with SHFT to understand exactly where the themes are and encourage them to undertake activity required to rectify them. He said they are difficult themes to resolve, but they want to see a movement on the number of complaints that have those recurrent type of themes in them.⁸⁷¹

840. The Acting Director of Quality and Nursing and the **Senior Quality Manager** work alongside SHFT in their Peer Reviews to ensure the learning is apparent on the ground and to talk to patients to make sure they know how to, and feel safe to, raise a complaint or concern and they are positively supported.⁸⁷²

841. The **Acting Director of Quality and Nursing** said there has been no specific work done by the CCG into specific issues in SHFT outside of the QI work that has been undertaken by SHFT and supported by the CCG. He said that if there is a significant variance in data, they do ask whether it's because there is less cause for complaint or because people are not being encouraged to access the service.⁸⁷³

842. The last peer review in SHFT on complaints was in 2017.

⁸⁶⁹ Evidence of Interim Director of Nursing and Quality for North Hampshire, South-East Hampshire, Fareham, Gosport and Isle of Wight CCG, 14 April 2021

⁸⁷⁰ Evidence of Acting Director of Quality & Nursing, West Hampshire CCG, 5 March 2021

⁸⁷¹ Ibid

⁸⁷² Evidence of Senior Quality Manager, West Hampshire CCG, 5 March 2021

⁸⁷³ Evidence of Acting Director of Quality & Nursing, West Hampshire CCG, 5 March 2021

843. The **Acting Director of Quality & Nursing** stated, “the CCG acknowledges that, despite the monitoring of response times and high-level complaint themes, this has not always ensured the necessary open, transparent and effective response to individual complainants that has been needed”.⁸⁷⁴
844. The CCG does not see SHFT’s responses to complaints, as the complaint is directed to SHFT and the patient’s consent to share with external parties is not routinely obtained to allow for this. However, the **Acting Director of Quality & Nursing** said that he thought that it would be helpful to see some responses, but that he would expect Non-Executive Directors at SHFT to look at the narrative and to be dip-sampling complaints. He said that he would need to check if this is happening.⁸⁷⁵
845. However, the **Quality and Safety Committee (“QSC”) Chair** said that they receive 10 to 15 complaints and responses per month, but that he doesn’t read them personally. He said that he can open them if he thinks they might need more explanation or analysis at the QSC.⁸⁷⁶
846. The **Acting Director of Quality & Nursing** explained that the CCG are moving away from pure reliance on narrative reporting, which he said does not allow them to identify individual cases where the complaint system has not been satisfactory and they are now triangulating the reports with Peer Reviews and more service user involvement at the CQRM.⁸⁷⁷
847. For example, the Panel had sight of SHFT’s report to the CQRM on ‘Complaints, Concerns and Compliments Quarter 3, 2019’, dated 17 February 2020. One of the stated purposes of the report is *‘to evidence adherence to the Trusts Complaints, Concerns and Compliments Policy and Procedure’*. However, the Report only provides high level quantitative data on complaints handling at SHFT for the relevant period and points out the *‘main reasons for complaints not being responded to within the agreed time frames’* and a brief description of why.

⁸⁷⁴ Statement of Acting Director of Quality & Nursing, West Hampshire CCG, 21 February 2021

⁸⁷⁵ Evidence of Acting Director of Quality & Nursing, West Hampshire CCG, 5 March 2021

⁸⁷⁶ Evidence of Quality & Safety Committee Chair, SHFT, 9 March 2021

⁸⁷⁷ Evidence of Acting Director of Quality & Nursing, West Hampshire CCG, 5 March 2021

848. Furthermore, the **Clinical Director for Mental Health and Learning Disability for West Hampshire CCG** did not believe she had seen that Report (above), as the CQRM has not been taking place since February 2020.⁸⁷⁸
849. The CCG's evidence is that their focus is to scrutinise culture and leadership of organisations they commission services from. They said that they do this by: triangulating information on patient experience, through the results of the Friends and Family Test, NHS Choices reviews and feedback from Patient and Public Participation Groups.⁸⁷⁹
850. The **Interim Director of Nursing and Quality for North Hampshire, South-East Hampshire, Fareham, Gosport and Isle of Wight CCG** said that it is about having the relationship with the provider to allow them to have a conversation and know whether they have a good complaints process or not; whether they are engaging with their populations and families. She said she also looks at the preventative work, which she described as, "listening, engaging and triangulating information and really truly having those conversations with our providers".⁸⁸⁰
851. In March 2019, the CCG attended SHFT's Rapid Process Improvement Workshop into the complaints process and the CCG monitors this through the Learning from Events Forum, which they attend. The CCG also attend SHFT's Quality and Safety Committee meetings, where the policy on complaints should be discussed.
852. The Panel reviewed the Commissioner Virtual Review meeting papers for February to March 2020 where SHFT were challenged by the CCG to respond to their comment on SHFT's failure to meet response times for complaints and were questioned on the themes and trends for concerns and the triangulation of those with complaints. SHFT's responses were:

'Unfortunately we have no funding to for 3 band 5 investigating officer posts and this is impacting on our timescales. Every Friday (...) sends a breach report to the divisions, and she now includes a list off all the trained investigating officers, to ensure the divisions have a full list of people to approach. We believe with COVID-19, this

⁸⁷⁸ Evidence of Clinical Director for Mental Health and Learning Disability for West Hampshire CCG, 17 March 2021

⁸⁷⁹ Statement of Acting Director of Quality & Nursing, West Hampshire CCG, 21 February 2021

⁸⁸⁰ Evidence of Interim Director of Nursing and Quality for North Hampshire, South-East Hampshire, Fareham, Gosport and Isle of Wight, 14 April 2021

will now reduce the number of IO's free, as they will be required to carry our clinical work.'

'We see the same themes month on month including – attitude of staff, communication & clinical care – i.e unhappy with their treatment, expectations haven't been met. We have also seen an increase in concerns for out of area beds.'

Panel's Views on where the CCG are now: oversight and contractual management of the complaints handling process in SHFT

- The Panel is assured by the evidence in the Commissioner Virtual Review meeting papers that SHFT are robustly challenged by the CCG. The Panel understands that this form of review is continuing and considers it sufficient.
- The SHFT report to the CQRM on 'Complaints, Concerns and Compliments Quarter 3-2019' does not comment on the quality of investigations and responses, despite one of the purposes of the report being: *'to evidence adherence to the Trusts Complaints, Concerns and Compliments Policy and Procedure'*. Instead, the focus is on the timeframe for reporting and a brief description of why SHFT are not meeting the deadline in the Policy. The Report does not include quantitative data.
- Furthermore, SHFT's response does not demonstrate whether they have taken any action in response to the CCGs' concerns that there are, for example, recurring themes in complaints, or whether they are taking measures to fund more Investigation Officers to complete the complaint investigations in a timely manner.
- Therefore, taken as a whole, the Panel is not satisfied that the evidence provided by SHFT to the CCG on this topic would be sufficient to fulfil the CCGs' assurance function and these documents do not provide any evidence of CCG carrying out a challenging and monitoring role upon receipt of SHFT's response.
- It is understood that the CCG attends SHFT's QSC meetings, where the Policy on complaints should be discussed. However, it is not clear from the evidence what the CCG does to monitor the standard of complaints handling within SHFT. This should be made clearer.

Oversight and contractual management of the SI investigations process in SHFT

853. Although SHFT have responsibility for investigations, the CCG have contractual responsibilities in overseeing investigations in SHFT. These are:

- To ensure SHFT detects incidents.
- To ensure they are robustly investigated.
- To sign off and review the investigations, findings and action plans.
- To ensure they are reported on Strategic Executive Information System (“StEIS”) by SHFT.⁸⁸¹

854. The **Acting Director of Quality & Nursing** said that the Quality Managers in the CCG scrutinising the SI Reports from SHFT are trained, including in Root Cause Analysis, and when asked about refresher training, he said they do not have a huge turnover of people in those roles.⁸⁸²

SI Checklist

855. The **Acting Director of Quality & Nursing** described how they have worked with SHFT to develop a sign-off checklist for SIs and action planning to make sure they get to the nub of the problem and can demonstrate measurement and expected outcomes. He said they want to know how the staff have reached the root cause, so that the actions result in change.⁸⁸³

856. The **Director of Quality for West Hampshire CCG** said the SI Checklist is used to, measure performance against specific elements in the Checklist. She described an improvement in the number of reviews being signed off for closure at first presentation and said that those that do have to go back for further checking are often in response to items in the Checklist. She described it as giving them the belts and braces on quality assurance.⁸⁸⁴

⁸⁸¹ Statement of Acting Director of Quality & Nursing, West Hampshire CCG, 21 February 2021

⁸⁸² Evidence of Acting Director of Quality & Nursing, West Hampshire CCG, 5 March 2021

⁸⁸³ Ibid

⁸⁸⁴ Evidence of Director of Quality for West Hampshire CCG, 5 March 2021

Investigation Reports

857. The **Acting Director of Quality & Nursing** said that since 2015 there has been training of Investigation Officers at SHFT and they have seen the quality of narrative reporting is more detailed and gets to the root causes. She said, “I would confidently say, the quality of reports and insights generated by SHFT are significantly better... they are very thorough, show they have engaged with the family, have good terms of reference and a full narrative”. She said they are superior to some other SI reports she sees in the system.⁸⁸⁵

858. The **Interim Director of Nursing and Quality for North Hampshire, South-East Hampshire, Fareham, Gosport and Isle of Wight CCG** said, “the SI and complaint reports are considerably improved, we monitor it through metrics, so percentages, numbers and narrative and we triangulate it to get a picture. We also have patients’ stories at the Hampshire & Isle of Wight Quality Board now... it sobers us all and makes us ground ourselves”.⁸⁸⁶

859. In the Commissioner SI Panel Minutes 2019/2020, the CCG provided feedback to SHFT on the quality of one of their investigation reports and stated,

‘Subjective statement not based on any factual evidence should be removed’, “half way down starts; ‘On the morning of (...)’ the response does not address the concern by the family that (...) was not eating or drinking and was thirsty” and “Report is very long. Analysis is very clear and root cause sound. Introductory paragraph is too long and tends to repeat the chronology’.

48-hour Review Panels and Commissioner Panels

860. The CCG produce a report on the percentage of SIs closed by Commissioner Panels at the first presentation which provides an indication as to the quality of reports and associated action plans.

⁸⁸⁵ Evidence of Acting Director of Quality & Nursing, West Hampshire CCG, 5 March 2021

⁸⁸⁶ Evidence of Interim Director of Nursing and Quality for North Hampshire, South-East Hampshire, Fareham, Gosport and Isle of Wight, 14 April 2021

861. The **Acting Director of Quality & Nursing** said the SI Reports are predominantly sent back because action plans are not actionable to ensure there is real change.⁸⁸⁷ For example, the CCG provided feedback to SHFT in a Commissioner SI Panel:

*‘Four of the actions appear “reactive” rather than written as SMART objectives... not specific or measurable” and they ask “Is this local protocol or organisational wide? In order to change staff culture there needs to be senior member of the team not the (... Manager) to lead on change within the team and encourage ownership’ and ‘Action plan is poor and cannot see that the actions will prevent this recurring’.*⁸⁸⁸

862. Through the SI Commissioner Closure Checklists, North Hampshire CCG have been monitoring the quality of SI Investigations and Reports produced by SHFT. These are a couple of examples:

‘A good well written report. There are three recommendations but only one action – need additional actions or clarify if they are all covered by the one action – which will need amending. The one action could do with being slightly reworded to indicate how it will be reviewed – is it within a team meeting or something separate’ (February 2020)

‘...could I recommend that a summary only of the report is shared with the family as part of the Duty of Candour. I have concerns that if the detail of the report was to be shared with the youngest daughter, it may have an absolutely devastating impact...’ (November 2019)

Independent investigations

863. The **Acting Director of Quality & Nursing** was asked for his views on independence in the SI investigation process within SHFT and said that he thought it would be very positive to have an independent view in the investigation process, but believed that there was enough clinical expertise in the CCG to support SHFT and external scrutiny to provide independence.⁸⁸⁹

⁸⁸⁷ Evidence of Acting Director of Quality & Nursing, West Hampshire CCG, 5 March 2021

⁸⁸⁸ Commissioner SI Panel minutes 2019/2020

⁸⁸⁹ Evidence of Acting Director of Quality & Nursing, West Hampshire CCG, 5 March 2021

864. He referred to the Medical Examiner role and said they have a CCG LeDeR Programme for investigations of deaths involving those with a learning disability.⁸⁹⁰

SHFT's communication with the service user, patient, carer or family member during a SI investigation

865. In the Commissioner SI Panel minutes 2019/2020, the CCG provided feedback to SHFT on the involvement of the family in the investigation:

'Report has been shared with the family but the trust may not have had any feedback from them prior to this meeting. To agree any amendments required following input from the family to be captured in an addendum to the report' and the CCG have asked SHFT: "How do we ensure that the views of family members (where appropriate and where consent has been given) are considered as part of the discharge process?" and suggested "a joint team debrief/reflective discussion could be helpful" and in another the CCG records that "the family have been given time to read through the report and make any comments to the Investigating Officer...'

Learning from deaths and events in SHFT

866. The **Acting Director of Quality & Nursing** said they are satisfied that SHFT has "robust processes in place to scrutinise and learn from deaths" and the CCG (including clinical staff) attend their Learning from Events Group meetings.⁸⁹¹

867. In the Commissioner Serious Incident Panel minutes 2019/2020, the CCG provided feedback to SHFT about the sharing of learning from an SI investigation:

'This seems like a great opportunity for internal (and external) system-wide learning... Has this been considered?' and "On reading the full report, a key learning opportunity appears to be around the need for collaborative discharge planning based on robust and timely risk assessment? This should include contingency planning. Make the action clearer about a multi-agency discharge CPA.'

⁸⁹⁰ Ibid

⁸⁹¹ Ibid

Panel's Views on where the CCG are now: oversight and contractual management of the SI investigations in SHFT

- The Panel is satisfied that the evidence shows the CCG are holding SHFT to account for the quality of SI investigations and reports. It is satisfied that the CCG can identify missed opportunities for family involvement, challenges SHFT to improve and highlights opportunities for learning.

Complaints direct to the CCG about SHFT

868. The Panel acknowledges the application of the NHS Complaints Regulations 2009, which means that if the complainant has already complained to SHFT, they cannot then complain to the CCG about the same issue. But, the CCG may, at the complainant's request, offer to help broker a resolution where it appears more could be done by the provider. If there is no resolution, the next step is to approach the Parliamentary and Health Service Ombudsman ("PHSO").

869. However, a person may complain to the CCG directly about their services. The CCG receives significantly fewer complaints than SHFT does. The types of complaints the CCG receives directly are focussed on the commissioning of services. The top themes are: access to services, commissioned pathways and negotiating between different providers.⁸⁹² The **Acting Director of Quality & Nursing** said their ambition is to exhaust all local resolution options before getting to the PHSO stage, as once that stage is reached it is a lost opportunity to improve local systems.⁸⁹³

870. He said that in order to seek to address the balance and improve the themes arising in their complaints, they have recommissioned pathways and put additional investment into pathways that haven't been working, which he said has been successful.⁸⁹⁴

⁸⁹² Evidence of Acting Director of Quality & Nursing, West Hampshire CCG, 5 March 2021

⁸⁹³ Ibid

⁸⁹⁴ Ibid

871. If the CCG receive a complaint directly about their services it will be dealt with by a single internal complaints team at a local level now that the CCGs have merged, with the aim of resolving them quickly. The process will be as follows:

- 1) Contact with the complainant within 72 hours or three working days by a member of the Patient Experience Complaints Team, or a Commissioning Manager, or someone from the continuing healthcare team.
 - If the terms of reference are complex, they will be agreed with the complainant, with touch points to update them.
- 2) The investigation is conducted by an appropriate person (who may be part of the service or a commissioning manager), typically, within 30 working days.
- 3) The investigation is written-up in a cover letter by the Head of Department or Deputy Director, with a summary of the findings, actions and an apology, if appropriate.
- 4) The investigation will go to the Managing Director or Director of Nursing for scrutiny and is signed off by the Accountable Officer.
- 5) Finally, they send out a feedback questionnaire to the complainant.⁸⁹⁵

872. The **Acting Director of Quality & Nursing** said words like ‘upheld’ are not used in their investigation reports as they are not helpful. He said people want to know someone is listening to them and that they have some tangible actions. He said that they do not seek to agree with the complainant what is upheld or not before the letter is sent out, but that they can come back for answers to questions if they are not satisfied. However, he said their feedback is generally positive in terms of people feeling they understood their complaint, they were listened to and could access the process.⁸⁹⁶

873. If the CCG receives a complaint about SHFT, or any other provider, and considers it appropriate to handle or co-ordinate the complaint itself, it is passed to the Senior Quality Manager, who will ask the Patient Experience Team (in SHFT) to write their response and final letter, with the actions they are going to take. It is then returned to the Senior Quality Manager, who follows-up on those actions. They are also monitored through the CQRM and sent to the Heads of Assurance/Complaints.

⁸⁹⁵ Ibid

⁸⁹⁶ Ibid

Service user's, carers' and family member's voice in the commissioning of services

874. The Panel were told by multiple participants that the service users' voice informs commissioning through: QI work in new services; presentations at the CQRM by service users; input from Wessex Voices and Patient and Public Involvement Groups. There is also funding for a Citizens Panel of 6000 people across Hampshire and the Isle of Wight.

875. The CCG has its own Patient and Public Participation Groups, it works with Healthwatch and other agencies, but accepts it needs to do more to gain people's views and concerns on the services its commissioning. The **Acting Director of Quality & Nursing** thought that within the NHS Long Term plan and ICSs, there is much greater use of the patient voice and the Patient and Public Involvement Groups would be looking to do more on this.⁸⁹⁷

876. The CCG have Engagement Officers who go into the community to seek out and engage with harder to reach groups. They acknowledge this needs to be improved and said that they plan on strengthening the roles to ensure they are reaching carers.

877. The **Chair of Hampshire Healthwatch, Ann Smith** said, "I think people see the NHS as operating as a delivery unit. What goes on behind closed doors and how they're monitored and who decides on money, I don't think it even enters the public psyche..."⁸⁹⁸

878. The **Interim Director of Nursing and Quality for North Hampshire, South-East Hampshire, Fareham, Gosport and Isle of Wight CCG** said that they have Non-Executive Directors running the Quality Improvement, Finance and Audit Committee and Clinical Delivery Group and they have local governance committees, but there are no Non-Executive Directors or lay members. She acknowledged that this is needed and said they get an independent scrutineer for the Quality Committee.⁸⁹⁹

879. She said her contact with families is usually by telephone, face-to-face meetings or online consultations, but acknowledged that they are not suitable or accessible for

⁸⁹⁷ Ibid

⁸⁹⁸ Evidence of Chair of Hampshire Healthwatch, Ann Smith, 6 April 2021

⁸⁹⁹ Evidence of Interim Director of Nursing and Quality for North Hampshire, South-East Hampshire, Fareham, Gosport and Isle of Wight, 14 April 2021

everyone and said they must ensure they do not disadvantage those people who cannot access the digital world.⁹⁰⁰

Panel's Views on the where the CCG are now: promoting the voice of the service user, carer and family member in the commissioning of services

- The Panel is not satisfied, on the evidence presented, as to the extent to which the CCG is obtaining the views and input of service users, carers and families, when they are commissioning services for the population they serve. There is no evidence as to how the CCG assures itself that it is doing so, and if so, how well it is doing it.
- The Panel hopes the merger of the CCGs will bring improvement in the commissioning of services and they will seek to work closer with their population in this process.
- It is hoped that the move to ICSs will improve this activity in the very near future and it should be a priority for them.

NHSE/I - Regional level

880. The purpose of inviting evidence from NHSE/I was to examine the supervisory functions and structures that they have in place with SHFT and the CCG, then to analyse the effectiveness and appropriateness of them.

881. 'NHS England and NHS Improvement South East' are the Regional team that cover the geographical area under which SHFT falls. Their work involves:

*'supporting the six Integrated Care Systems, 32 NHS Trusts and 11 Clinical Commissioning Groups in the South East regions, to ensure that together, they provide excellent services that meet the needs of the patient'. They state that this is done by, 'providing professional leadership to the local NHS on commissioning, digital transformation, assurance and delivery, finance, nursing, medical and clinical leadership'. They 'offer the support these providers need to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable. By holding providers to account and, where necessary, intervening...'*⁹⁰¹

⁹⁰⁰ Ibid

⁹⁰¹ <https://www.england.nhs.uk/south-east/about-us/>

They also have some commissioning functions, including health services for children, young people and adults in secure and detained services.

882. The Panel received evidence from the **Regional Medical Director for NHSE/I for the South East Region, Dr Lewis**. He described working very closely with the Medical Directors of all provider organisations and as being the first amongst equals. However, he does not have any direct line management for any provider's Medical Directors. He reports directly to the Regional Director for the South East and has a dotted reporting line to the National Medical Director and described having a close working relationship with him.⁹⁰²

883. He said, "I have a key responsibility in securing the improvement of clinical outcomes and through that, the experience of care that the population has in their existing health services. I have a key role in disseminating information to Medical Directors in all provider sectors, but more important than that, is establishing a relationship, so that if at any time a Medical Director feels uneasy about something, they can approach me to discuss it, without prejudice, and... I am in a good position to link them up with sources of support..."⁹⁰³

884. In regard to his role in overseeing SHFT's engagement with patients and carers, **Dr Lewis** said that he does not have a direct or specific overview on a day-to-day basis, but more by association, rather than by design.⁹⁰⁴

885. If there were a failure in the quality of service in SHFT, he said that he would rely on those one or two steps closer to the organisation to flag it to him and on the systems in place to escalate concerns. He confirmed that SHFT had not been drawn to his attention over the past 24 months. If there were an ongoing risk to patient safety, he said he would work with colleagues who are one step closer to quality surveillance and the providers and the Director of Nursing.⁹⁰⁵

886. In regard to its quality and improvement assurance role, **Dr Lewis** said that the NHSE/I Regional team assesses SHFT's capability by obtaining information from multiple sources on an ongoing basis and they have a close working relationship with

⁹⁰² Evidence of Regional Medical Director for NHSE/I for the South East Region, Dr Lewis, 6 April 2021

⁹⁰³ Ibid

⁹⁰⁴ Ibid

⁹⁰⁵ Ibid

the CQC, GMC, NMC, and Health Education England (the experience of trainees and ability to attract them to work there, is often a good indicator of how an organisation are perceived). He said they have active quality surveillance mechanisms in place. They cover a population of nine million, with between 20 to 30 organisations, so, he said he has to rely on the structures and processes in place to obtain intelligence, which is mostly through working with partner organisations and Medical Directors.⁹⁰⁶

887. He said that the Quality Surveillance Group (“QSG”) meet monthly as a Regional team, but that it is increasingly attended by system leads who are at an executive level or the tier below with responsibility for safety and quality, than individual Trust representatives, but by. He said there tends to be a thematic approach taken. In regards to how an issue in SHFT would emerge at the QSG, he said it could come through the quality leads in the CCGs and now ICSs, or directly through the Director of Nursing with their own Director of Nursing.⁹⁰⁷

888. When **Dr Lewis** was asked by the Panel what would happen to a concern about a division that they noted was minuted in the Hampshire and Isle of Wight QSG minutes on 18 March 2020, he said he did not know where it would go and could not recall if it was escalated to the QSG.⁹⁰⁸

889. In relation to a reoccurring theme in a Trust or division within it and whether that triggers a particular action, he said, it should, but that it is possible that sometimes it doesn't. He said, “I don't know what I don't know. If it's escalated to our own QSG then, provided I have been in attendance, I will see it; but unless it is specifically escalated to me as a concern, I wouldn't necessarily see it and I'd rely on the systems in place to pick that up and escalate it to me should it be deemed necessary”.⁹⁰⁹

890. **Dr Lewis** gave evidence about Healthwatch's involvement and role in promoting the voice of service users in NHSE/I. He explained that Healthwatch are represented on the QSG and there is one Healthwatch member representing all the South-East Healthwatch organisations. Further, he acknowledged that more recently, as Regional Medical Director, his direct involvement with service users is mostly through Healthwatch, but

⁹⁰⁶ Ibid

⁹⁰⁷ Ibid

⁹⁰⁸ Ibid. The Hampshire and Isle of Wight QSG was suspended due to COVID-19 after March 2020.

⁹⁰⁹ Ibid

said that this is perhaps a reminder that they could often do better at involving patients at all levels of the NHS.⁹¹⁰

891. He spoke about his own job description describing himself as a patient's champion and stated how he has fulfilled this in the past: "one thing I have done from an early stage is that in any meeting considering safety and quality, I encourage the use of patient stories... to reinforce that healthcare is about people, processes are important, but it's about people and it's the population we're providing care for and ensuring services are there for them. It's very much part of my professional DNA... I have, in commissioning roles, involved patient representatives in committees..."⁹¹¹

892. In regards to NHSE/I working with the CCG in their commissioning roles, **Dr Lewis** said his involvement with the CCG on quality surveillance and the CCG itself has been very limited but anticipated that through ICSs they would be better sighted in future.⁹¹²

893. The **Chief Medical Officer at SHFT** said NHSE/I are less involved in the day-to-day management, but things do get escalated to their Regional office, and he described the relationship as good, but it could be improved.⁹¹³

894. **Dr Lewis** said that if there were evidence of poor complaints handling by SHFT, it would not come to him first and he would rely on SHFT to decide if it reached the threshold for escalating it to him and that he would like to think that were that to happen then he would be involved. He believes that the threshold has changed due to the previous concerns with SHFT, but said that there is no codified threshold for raising concerns about an organisation, so it is quite subjective whether issues identified are escalated.⁹¹⁴

895. The **National Clinical Director for Mental Health in NHSE, Professor Kendall**, said a Trust in difficulty would telephone them, so they would know. He said the Regional team is much more involved now and they have an important role in ensuring the

⁹¹⁰ Ibid

⁹¹¹ Ibid

⁹¹² Ibid

⁹¹³ Evidence of Chief Medical Officer at SHFT, 12 April 2021

⁹¹⁴ Evidence of Regional Medical Director for NHSE/I for the South East Region, Dr Lewis, 6 April 2021

systems are working properly and that they are addressing the healthcare in local populations.⁹¹⁵

Panel's Views on where NHSE/I (Regional level) are now: support/supervisory role of SHFT

- The Panel is pleased that there are Quality Committees, Quality Boards and Quality Surveillance Groups in place at NHSE/I. However, it is unclear as to the outcomes of these meetings or the process for follow up of actions or issues arising from them, which reduces their assurance and monitoring functionality. This should be improved and shared widely.
- The Panel is concerned that there are limited formal links, or joined-up thinking, between the CCG and NHSE/I, particularly given the assertions by participants that the regional links between NHSE/I and SHFT are relied upon heavily for assurance purposes.
- The Panel is not satisfied that there was consistent evidence that the Regional team have the necessary assurance, accountability and connections in place with SHFT and the CCG to carry out their 'supervisory' role effectively.
- The primary role of NHSE/I, in its supporting capacity, is to support the CCG and SHFT by '*providing professional leadership... on commissioning, digital transformation, assurance and delivery, finance, nursing, medical and clinical leadership*'. The Panel considered whether this is taking place in the South-East Region effectively. The Panel is not satisfied on the evidence provided as to who in the Regional team is supporting SHFT in the matters described and how that information is shared to ensure wider learning takes place.

Care Quality Commission

896. The Panel invited evidence from the **Deputy Chief Inspector of Hospitals, Dr Cleary** who covers Mental Health and Non-Mental Health services at the CQC. The Panel were keen to establish, in public, the ways in which the CQC assesses and inspects a Trust in order to give it a rating. The evidence received was more generalised than specific to SHFT and the Panel have taken this into account.

⁹¹⁵ Evidence of National Clinical Director for Mental Health for NHSE, Professor Kendall, 29 April 2021

897. **Dr Cleary** explained how they have regional teams involved in the oversight and regulation of local health care providers; the teams are involved in inspections and as part of that inspection process, they talk to patients, carers and families.⁹¹⁶

898. The CQC are not doing announced visits at the moment, but just go out unannounced. He said, "I absolutely think it's more effective... but we make sure people get the opportunity to tell us what is going on and people can talk to us outside these visits to tell us what they're experiencing and we follow it up in an appropriate way..."⁹¹⁷

899. Additionally, he explained that, "each Trust has a relationship manager, who is one of the inspecting team and they have regular contact with the organisation and speak with them about any issues in the last month, any incidents, concerns or what is going well. There is regular contact outside the inspection activity".⁹¹⁸

900. **Dr Cleary** said, "... I think it's part of the CQC function, to make sure the quality assurance processes in an organisation are working and the Board and senior leadership has the right oversight of it".⁹¹⁹

901. He described it as a, "rigorous (process to rate an organisation); a lot of information is pulled together, there are lots of on-sight inspections and quality assurances in the organisation... the report is produced and it goes to the Quality Assurance Group, where there is significant challenge and testing of the ratings before a decision is made. It is then sent to the organisation for factual accuracy checking. When it's returned, it's gone through line by line and the rating is either upheld or changed. If its rated 'inadequate' or 'outstanding', it has to come to me to ensure we're making the right judgment".⁹²⁰

902. He explained that after the report is published if the CQC says that someone must do something, they require evidence within a few months that they've taken the action. If they do not do it, they can issue a warning notice (one short of prosecution) and if they still do not do it, they can put a limit on their registration. He said this does not happen often in NHS organisations. The final step would be prosecuting an organisation.⁹²¹

⁹¹⁶ Evidence of the Deputy Chief Inspector of Hospitals, Dr Cleary, CQC, 19 April 2021

⁹¹⁷ Ibid

⁹¹⁸ Ibid

⁹¹⁹ Ibid

⁹²⁰ Ibid

⁹²¹ Ibid

903. Furthermore, **Dr Cleary** said that families and carers can and do contact the CQC. They have a contact centre that takes information from patients around the care provided. That information is used to inform future regulatory activity.⁹²²

904. He said that even if the organisation is rated 'good', "it shouldn't feel comfortable and should want to continue to improve. We would look for evidence that the organisation is getting better and what it was struggling with a couple of years ago, has improved...".⁹²³

905. **Dr Cleary** explained how they have regular contact with NHSE/I and local commissioners and will often pass on concerns about care provided if it is NHS commissioned, but the CQC does not regulate the commissioners.⁹²⁴

⁹²² Ibid

⁹²³ Ibid

⁹²⁴ Ibid

Action Plans

B. Where are SHFT now?

Introduction

906. The Stage 2 terms of reference required the Panel to consider the extent to which recommendations from previous investigations referred to in the Stage 1 Report have been developed, implemented and monitored by SHFT, including action plans and whether areas for further improvement have been identified and actioned.

907. In light of the families involved in Stage 1 withdrawing from Stage 2, to fulfil this part of the terms of reference, the Panel invited evidence of experiences beyond that of the five families. They were also able to question the participants representing SHFT and the CCG, to inform their views on where SHFT are today in terms of developing, implementing and monitoring recommendations and action plans that flow from investigations undertaken in the organisation.

Human Factors Approach

908. A Human Factors approach is widely thought of as valuable in the NHS. The principles and practices of Human Factors is a focus on optimising human performance through better understanding the behaviour of individuals, their interactions with each other and their environment.⁹²⁵ The system-wide adoption of these concepts offers a unique opportunity to support cultural change and empower the NHS to put patient safety and clinical excellence at its heart.⁹²⁶

909. Human Factors principles can be applied in the identification, assessment and management of patient safety risks, and in the analysis of incidents to identify learning and corrective actions. More broadly, Human Factors understanding and techniques can be used to inform quality improvement.⁹²⁷

⁹²⁵ Human Factors in Healthcare, A Concordat from the National Quality Board, 2013

⁹²⁶ Ibid

⁹²⁷ Ibid.

910. The **Chief Medical Officer** submitted a statement providing an overview of where SHFT state that they are today. Parts of that statement will be set out here.
911. He said that few adverse events in mental health services are the result of simple failures of process or equipment and are much more often the result of complex interactions and dynamics, multi-systemic in origin. Notwithstanding this fact, action plans or improvement plans are expected, by internal governance structures and external regulators, to be SMART (Specific, Measurable, Attainable, Relevant, and Time-Bound), which results in actions that reduce the above complexity to measurable parts and which do not necessarily capture the complexity of the original situation”.⁹²⁸
912. He goes on to say that the literature on this topic has found that most action plans propose, as solutions, additional or repeated training for staff, a process change, or reinforcement of policy. These actions do not typically capture the complex reasons why adverse events occur in mental health, therefore, have low potential to effect lasting change. They also create an expectation of a ‘perfect clinician’ rather than attempting to make change at a systemic level for the ‘average’ clinician with a failsafe solution. He believes that this is why certain themes recur in mental health SI investigations: communication between professionals and agencies, liaison and communication with families and carers, risk assessment, care planning and access to services.⁹²⁹
913. The **Chief Medical Officer** recognised the need for adopting a Human Factors approach in incident investigation methodology with a move away from a purely Root Cause Analysis approach. He said SHFT has moved to a Human Factors approach in its investigation of SIs and work is currently underway to revise the templates used for SI reports to make this explicit. He states that this shift in mindset has led to a significant improvement in the quality of action plans arising from SIs over the past five years.⁹³⁰
914. The **Deputy Medical Director** said, “if you look at the literature around adverse events in mental health community services... the traditional action plans probably only go so far and no further in changing culture and behaviour. A key problem with action plans is that they are constructed as Root Cause Analysis, so they assume a linear

⁹²⁸ Statement of Chief Medical Officer at SHFT, 2 February 2021

⁹²⁹ Ibid

⁹³⁰ Ibid

causation of events with a cause and effect and that's often not an adequate conceptual framework when you are trying to understand adverse events in mental health care".⁹³¹

915. She also acknowledged the need for a Human Factors approach. However, she was less confident that SHFT had adopted such an approach and said there is a tremendous amount to do to embrace a Human Factors approach into their thinking. She set out several things they are hoping to do:

- Move away slightly from only using a Root Cause Analysis Framework and incorporate a more Human Factors approach into our thinking.
- Apply a Human Factors approach to diagnostic investigative processes, so that when an adverse event occurs and SHFT look back they can try and understand why it occurred and what factors we need to change to prevent reoccurrence.
- Apply a Human Factors approach to be solution focussed, which is not to be found in traditional action planning.⁹³²

916. The **Chief Medical Officer** said SHFT are trying to move the organisation towards measurable improvement, culture, behaviour and mindset, not specifically to tick a box, so that it becomes sustainable. As to where they are now on that journey, he said, "we are trying to use emotional thinking, human practice and engaging people on the journey of improvement... we are trying to move beyond process, to actual change". He believes SHFT are in a good position now to accelerate co-production and change, but acknowledged that they have a long way to go to sustain and embed these improvements and change.⁹³³

917. The **Chief Executive** was asked for his views on the use of action plans and where SHFT are today on this topic. He said, "something I have seen in all of the organisations I have worked in is action plans created with lots of repetitive actions... but what is important is to understand the themes from the events and then in constructive and engaging ways, to try and address those issues". He said the learning and wish to learn and self-improve, from whatever source they identify something, is not as it should be.⁹³⁴

⁹³¹ Evidence of Deputy Medical Director at SHFT, 1 April 2021

⁹³² Ibid

⁹³³ Evidence of Chief Medical Officer at SHFT, 12 April 2021

⁹³⁴ Evidence of Chief Executive of SHFT, 16 April 2021

918. The **Chief Executive** discussed the actions arising from the CQC report in January 2020. He said, “there was an Action Plan following (the CQC Report) and I have been through every line of it and many things had been done well, but... many things described were processes rather than changing the services and what needed to be done and we have dealt with all of those”.⁹³⁵

Panel’s Views on where SHFT are now: action plans

- The topic of action plans permeates all of the areas that the Panel have been considering and the overarching view that they have formed is that SHFT have begun to recognise that traditional action plans, with a focus on Root Cause Analysis and tick-box exercises, only go so far. SHFT should use the QI methodology and Human Factors approach more habitually in action planning.
- However, in the Panel’s view, SHFT is still fairly early on in this journey and the improvements must be more widespread and implemented across the organisation to ensure action plans are carried out and result in learning, change and improvement.

Quality Improvement

919. The use of the QI methodology in the implementation of action plans was discussed with participants and its suitability and effectiveness was challenged by the Panel.

920. The **Deputy Director of Nursing and Head of Quality Improvement Strategy** said, “...when we think about what needs to improve, if we are trying to change behaviour, it is about understanding the human factors that led to the problem and human engagement is key to sustainability. If we want a fundamental change in behaviour, often a QI approach, where you bring people with you and own why you’re doing something difficult, is more sustainable”. However, she said, it is not always appropriate to use it, for example, operational changes can be implemented without QI.⁹³⁶

921. The **Chief Medical Officer** stated that SHFT are using more of the QI methodology to achieve improvement, than the quality assurance processes and that it sees action plans as providing a potential for continuous improvement. He believes that a person’s

⁹³⁵ Ibid

⁹³⁶ Evidence of Deputy Director of Nursing and Head of Quality Improvement Strategy at SHFT, 29 March 2021

mindset changes when they are engaged in finding solutions to problems and not just ticking a box. His view is that SHFT need to have assurance processes running alongside QI to ensure that things are improving.⁹³⁷

922. The **Deputy Medical Director** said, “in all of our investigations and thematic reviews we create action plans and we’re better now at completing them. However, I think particularly for mental health and community organisations, like ours, it’s very important to look beyond them and embrace the promise of quality improvement”.⁹³⁸

Implementation

923. The **Deputy Director of Nursing and Head of Quality Improvement Strategy** said the COVID-19 pandemic has had an impact on SHFT’s ability to complete the actions set out in the Quality Improvement Strategy for 2019/2020. For example, she said that following SHFT’s structural redesign in 2018 quality is now a priority and prior to that they had a gap between physical and mental health and as a community provider they acknowledge that they should be skilled at providing both services. She said, “I think we need to do more to strengthen the existing links between physical and mental health teams and expertise, which is part of the national patient safety refresh published at the end of February (2021)”.⁹³⁹

924. The Panel have reviewed the January 2020 CQC Report and note that in July 2018 the CQC carried out an unannounced focussed inspection at a child and adolescent mental health ward facility to check if SHFT had undertaken the actions identified in its action plan. It found then that SHFT had undertaken such actions. Specifically, it has:

‘Increased staffing levels... no shifts were left uncovered and as such there were always sufficient, suitably qualified and competent staff on duty at all times... observations were conducted appropriately... staff and young people told us that they now felt safe’.

Therefore, they lifted the warning notice but it was rated as ‘requires improvement’ and further improvements were specified. Following the unannounced inspection in

⁹³⁷ Evidence of Chief Medical Officer at SHFT, 12 April 2021

⁹³⁸ Evidence of Deputy Medical Director at SHFT, 1 April 2021

⁹³⁹ Evidence of Deputy Director of Nursing and Head of Quality Improvement Strategy at SHFT, 29 March 2021

October 2019, the CQC found that SHFT had made all the required improvements identified and as a result it was rated 'good'.⁹⁴⁰

925. Furthermore, the CQC inspections in October 2019 found that:

'Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. We reviewed 26 care records and found that most care records included a detailed care plan. Staff completed care plans with patients following their admission. Staff worked to develop care plans to help staff and patients focus on recovery. A new recovery focussed care plan was being used and developed, staff focussed on collaboration with the patients and to help them identify own risks and develop and action plan based on these'.⁹⁴¹

926. However, the Panel note that during an inspection of a community health in-patient service in May to July 2018, although it was rated as 'good', the CQC reported, *'There were gaps in the collection of data and action plans in some areas were not completed'.⁹⁴²*

927. The Panel received evidence from a small sample of service users, carers and family members on this topic. A **service user** said, "I had input into my Care Plan... but once it was written up, they didn't adhere to it, so it wasn't worth the paper it's written on, it's pointless". She said, "... (SHFT) just constantly let me down... I was meant to have therapy one week then a talking session the next week... I need that time... it was important, but they failed to phone me...". She said, "I need more intensive support now, because I didn't get the support under the Care Plan and the system has made me worse".⁹⁴³

928. A **carer** told the Panel that in his experience, action plans do not happen and he attributed some of that to the "inconsistency in care because of a change in people and there is no handover when someone leaves". He said, "in our complaint and investigation, a Medical Director put forward an action plan for treatment and regular reviews, which didn't happen and it wasn't carried out. The Team said they had never

⁹⁴⁰ Southern Health NHS Foundation Trust, Inspection Report, CQC, 23 January 2020:
<https://api.cqc.org.uk/public/v1/reports/3bfd1da5-1a89-47cf-8011-1c6ab96495eb?20210114105252>

⁹⁴¹ Ibid

⁹⁴² Southern Health NHS Foundation Trust, Inspection Report, CQC, 3 October 2018
<https://api.cqc.org.uk/public/v1/reports/101eb61f-a20a-4221-8066-808a904b411e?20210117122254>

⁹⁴³ Evidence of a service user, 15 April 2021

received his report, I chased it and it was swept under the carpet, the onus is on Medical Director and more senior people to ensure their recommendations are carried out, but they don't do this. This is the frustration from a carer's view".⁹⁴⁴

929. A **family member** said from his experience, which is not immediately current, "(SHFT's) ability to implement what it agrees is 2 out of 10". He attributes this to there being, "no single line management system at any level and managers and senior clinicians are not accountable (to the Board or senior members for their actions) ... and there is no senior review of clinician's performance".⁹⁴⁵

930. Below are some comments from the sample SHFT End-User Feedback Survey responses following a complaint investigation, which cover the period of 2019 to 2021:

'The Trust is still working to address my complaint. I will have a follow-up discussion with the Trust (...) in 2 to 3 months time to check that appropriate action is really being taken. The proposed solution is acceptable, but it now needs to happen.'

'Our meeting with the Investigation Officer was positive, with a clear action plan and apology.'

'Not getting the resolution to the complaint as hoped for, still lots to do with regards to the actions discussed at the meeting, as they have not had anything in writing (tangible).'

'Not confident – still waiting for the agreed actions. There are signs that improvements have been made.'

'... A lot of effort and time has been put into the complaint and they are grateful – need to see tangible response and commitments, so that staff can be accountable and deliver the actions. (...) has suffered and the family need to be confident re learning.'

'Never mentioned what happened to the member of staff... I should have been informed... that still troubles me today.'

⁹⁴⁴ Evidence of a carer, 6 April 2021

⁹⁴⁵ Evidence of a family member, 14 April 2021

931. As to the responsibility for the implementation of action plans in SHFT, the Panel heard limited evidence of this. The **Patient Safety and Quality Facilitator for the Southampton Division** confirmed that it is not her role to set the actions following an SI investigation and she is there to support the teams to embed it into clinical practice.⁹⁴⁶

Panel's Views on where SHFT are now: implementation of action plans

- The Panel is not satisfied that the action plans they reviewed reached the standards they would expect and that there has been sufficient improvement in this area. For example, without clear timescales and named individuals who are responsible for the implementation of action plans, there is no effective accountability structure in place, so the action plans will simply wither. This is supported by the evidence and feedback from service users, carers and family members, albeit a small sample. It appears to be a widespread problem across SHFT regardless of whether it is a higher level strategic action plan or a more local level action plan following a complaint or SI investigation.
- The lack of confidence that complainants have in SHFT's ability to act on action plans is a cause for concern. SHFT must review this as a priority to move forward on its journey to rebuild trust and confidence.
- The Panel's view is that there must be a move towards, and development of, a robust process to monitor the implementation and impact of recommendations and action plans effectively. This should apply to complaints, concerns, SIs, Red RCAs and incidents that do not go through the full SI investigation process. This must be supported with tangible evidence demonstrating that specific action plans are being following through consistently. The Panel's view is that this does not yet exist universally in SHFT.
- There is also a gap in the evidence to demonstrate the support that is in place for staff to improve in response to issues and implementing recommendations and action plans.
- The Panel's view is that ultimately the responsibility lies with the Board and Chief Executive for the implementation of action plans in SHFT and there was a lack of evidence that this responsibility is being fulfilled.

⁹⁴⁶ Evidence of Patient Safety and Quality Facilitator for the Southampton Division in SHFT, 13 April 2021

Monitoring of Action Plans

932. The Panel received evidence that NHSE/I set up two monitoring, assurance and oversight panels and these were adopted and continued by SHFT. They are now known as the Complex Case Panel and Evidence of Improvement Panel. This Review only received evidence from SHFT participants on this topic and acknowledges that in forming its views, it did not hear from any service users, carers or family members, who may have been involved in a Panel.

933. The **Chief Medical Officer** provided background information about the Panels and the way they practice and he described them as a good assurance mechanism for commissioners too as they attend and can meet the team sometimes. He also acknowledged, when questioned, that there is no method for quality assuring the Panel's work but said that annual reports are an excellent suggestion. He said that at the moment they get internal feedback from those attending.⁹⁴⁷

Complex Case Panels

934. In his statement, the **Chief Medical Officer** explained that SHFT's Clinical Effectiveness Group (2020) reviewed the framework for addressing complex risks in the community and established Complex Case Panels to replace previous risk panel arrangements, which were managerially led.⁹⁴⁸

935. He described the aim of a Complex Case Panel is to provide advice and support to the responsible clinician and wider clinical team in the management of an individual who presents with a complexity of needs and risk, which is beyond that usually found in services and to be supported by the organisation.⁹⁴⁹ He said that the teams have reported the value of the Complex Case Panel. He does not personally attend them.⁹⁵⁰

936. He explained there will be a reference that the Complex Case Panel has happened and the decision of the team in the individual's patient care records and it will be discussed with the patient and their family. Further to that discussion, he said any plans

⁹⁴⁷ Evidence of Chief Medical Officer at SHFT, 12 April 2021

⁹⁴⁸ Statement of Chief Medical Officer at SHFT, 2 February 2021

⁹⁴⁹ Ibid

⁹⁵⁰ Evidence of Chief Medical Officer at SHFT, 12 April 2021

might not be able to be carried forward for a variety of reasons related to the individual patient or family.⁹⁵¹

937. He said the Complex Case Panel agree SMART outcomes that are measurable and are made in discussion with the patient. In the minutes of the Complex Case Panel meetings there is an agreed set of principles, not outcomes, as they do not know if they will be discharged, but the outcome will be determined by whether the patient complies. He said they do not create an action plan but it is a development of what the therapeutic actions will be. He said it is not the process, but the outcome that is the most important. Thus, the outcomes and actions are not monitored as it is not an action plan for the patient, but to enable their care to move forward.⁹⁵²

Evidence of Improvement Panels

938. The **Chief Medical Officer** stated that SHFT has put in place a comprehensive system for monitoring the implementation of action plans arising from SI investigations. All SIs which are graded as 'major' and 'catastrophic' are required to be monitored at an Evidence of Improvement Panel.⁹⁵³

939. He said the Evidence of Improvement Panels take place one to one and a half years after a significant incident and he sits on them with external colleagues. The Evidence of Improvement Panels are particularly for SIs that have gone through external review and it has a set of action plans and the action plan is gone through in meticulous detail with CCG colleagues, who are there for assurance and to see things are improving. He said his role as chair, is to be critical and to say where things are working well.⁹⁵⁴

940. The **Chief Medical Officer** said that the Panel mainly looks at the outcome of the investigation and focusses on recommendations. It's an assurance and quality improvement conversation. They want to see if anything that the investigation has led to can be spread across the organisation to make improvement. Further, he said, that the Evidence of Improvement Panel will review the evidence to see if there is sufficient assurance that the evidence is in keeping with the issue they are seeking to redress. The

⁹⁵¹ Ibid

⁹⁵² Ibid

⁹⁵³ Statement of Chief Medical Officer at SHFT, 2 February 2021

⁹⁵⁴ Evidence of Chief Medical Officer at SHFT, 12 April 2021

Evidence of Improvement Panel will look at evidence to see if actions have been completed and to see what can be done further to make it embedded. He said that if they are not satisfied, it will remain open and they bring it back at the next panel for more evidence, which could be a presentation from the team concerned.⁹⁵⁵

941. He provided the Review with an example of what would need to be shown for the Panel to say there is 'evidence of staff engagement in the changes': "we would probably have a discussion with the team and an Executive or CCG colleague... we want them to demonstrate that there has been reflection in the team, not just from one member, but amongst the team and also the governance structure above it... and to show it was discussed at the (divisional) monthly meeting".⁹⁵⁶

942. A **Clinical Ward Manager** who had direct experience of attending Evidence of Improvement Panels said that when she took over the role two years ago there were outstanding SIs which had gone to investigation, so they had lots of action plans to work on. She worked closely with her senior management and those on the 'shop floor' to embed the action plans and improve. During the ward management meetings, she said they were going through them regularly to ensure they were on track and she gathered everything for the Panel. She said they received really good feedback from the two or three Evidence of Improvement Panels.⁹⁵⁷

Panel's Views on where SHFT are now: the monitoring of action plans

- The Panel is not satisfied that the evidence received showed that the required structures and models are in place at SHFT for the monitoring of action plans at the divisional level and Board level, and what, if any, links there are in place between the frontline, the Board and the managers in the organisation.
- The Panel's view is that the Evidence of Improvement Panels are, overall, positive and unique. They are rigorous and useful for monitoring, reflecting and learning. The Panels also provide an element of scrutiny and assurance as they are attended by the CCG too.
- However, in the Panel's opinion, the Evidence of Improvement Panels could be improved. For example, they are concerned that the current gap of 18 months, from the accident taking place to the Panel commencing, is too long and six months would be preferable. Further, they should be used for all SIs coming through the system, not just for catastrophic events.

⁹⁵⁵ Ibid

⁹⁵⁶ Ibid

⁹⁵⁷ Evidence of Clinical Ward Manager, SHFT, 12 April 2021

Panel's Views on where SHFT are now: the monitoring of action plans continued...

- There is no evidence of feedback being provided to families or record of whether they attend the Evidence of Improvement Panels, as the attendance is not recorded and it should be. The minutes of the panel meetings should be formalised.
- The Panel is concerned that there is a lack of consistency in the recording of the dates for implementation and the actions taken. As a result, records of the Evidence of Improvement Panels do not provide a rigorous monitoring function. Therefore, if an audit trail was carried out, evidence of improvement would not be clear. This is in comparison to the 48-hour Review Panel minutes where the processes and next steps can clearly be seen.
- The Panel did not receive any evidence to demonstrate the impact of the Panels, for example, evidence of improvements in practice as a direct outcome of the Panel's activity.
- The Panel views the Complex Case Panels as a positive step forward and commends the group supervision approach to ensure patients are well supported and safe. The Panel would recommend this approach to other organisations.
- However, the Panel is concerned about the lack of recording of the implementation and responsibility for actions to be taken following the Complex Case Panel discussions. As a result, the impact of actions and recommendations is not measurable. The Panel did not see any evidence of a robust system of monitoring or review in place. The Panel's view is that the action planning following these discussions could be improved.
- The Panel's view is that ultimately the responsibility lies with the Board and Chief Executive for the monitoring of action plans in SHFT and there was a lack of evidence that this responsibility is being fulfilled.

Service user, carer and family member's role in action planning

943. The Panel received limited evidence about the role of service users, carers and family members in the action planning stage. Although the Panel were informed, and indeed it is supported by the SHFT End-User Feedback Survey responses following a complaint investigation, that it is an option for those individuals to request to be kept updated on the implementation of the actions following a complaint or SI investigation.

944. The **Chief Medical Officer** said, "I think we can go further in producing solutions (in investigations) with families, carers and staff".⁹⁵⁸

⁹⁵⁸ Evidence of Chief Medical Officer at SHFT, 12 April 2021

Panel's Views on where SHFT are now: role of service user, carer and families in action plans

- The Panel's view is based on the evidence and feedback which indicates that service users, carers and family members are not actively involved in the action planning stage following SHFT's investigation into a complaint or SI. Instead, action plans are created by the ward or service concerned. The Panel acknowledges SHFT's evidence, which is corroborated, that there is a choice to opt-in to receive updates on the implementation of the action plan. However, the Panel did not receive evidence about how often this takes place or how.
- It was not clear how discussions from Complex Case Panel are shared with the service user (and carer or family member if appropriate) or whether it is documented. It is also unclear what happens if the service user does not agree to the proposals. These should all be formally documented and recorded.

Learning and sharing of actions from action plans

945. There is some overlap with this topic and the learning from events and deaths discussed above.

946. The Panel reviewed the NHS Annual Staff Survey Results to the question: *'When errors, near misses, or incidents are reported, my organisation takes action to ensure they do not happen again'*, which showed that in 2020, 77% of staff said 'yes' to this question (an increase from 2018 when it was 72%).

947. The sample SHFT End-User Feedback Survey responses following a complaint investigation, which cover the period of 2019 to 2021, state:

"Unless people learn from their mistakes, things will not improve."

"Trust (were) open and took on board what had been said, accepted gaps and put measures in place for learning."

"No guidance about how they are addressing the issues raised re learning".

948. The **Deputy Medical Director** acknowledged that, "the other specific area that will benefit from further work is around the issue of learning, I look back over five years and

we have made enormous gains in some areas but not all. One thing we need to get better at is truly understanding what we mean by ‘learning’. Is it merely information sharing with all staff or does it mean we track those changes and find the gap?”⁹⁵⁹

949. The **Patient Safety and Quality Facilitator for the Southampton Division** said when asked if there is obvious room for improvement in actions plans, “there is always room for improvement in everything we do”.⁹⁶⁰

950. The **Chief Executive** was asked about this topic and said, “there is no one single system (for self-assessing our services), because there are so many variations; but there are accreditation processes, inspections by colleges and bodies, buddying arrangements between wards and many services compare with other organisations and different measures can be bought into play... comparing internally with each other is always good and how you drive quality”.⁹⁶¹

Panel’s views on the learning and sharing of actions from action plans

- The Panel’s view is that SHFT needs to ensure that learning is shared widely and systematically throughout the whole of the organisation and at all levels.

Assurance and Governance

951. The Panel acknowledges that the monitoring and oversight functions that SHFT relies on for action plans lie mostly in the implementation of the Evidence from Improvement Panels. However, this only covers SIs that are ‘major’ or ‘catastrophic’ events. There is some overlap in the assurance functions in place for actions plans which are addressed in the assurance part of this Report for ‘independent investigations’, but again, they only cover SIs. The Panel received limited evidence of the assurance, oversight and governance in place for incidents, events, complaints and concerns that do not meet the criteria for a ‘Serious Incident’ or ‘Red RCA’.

⁹⁵⁹ Evidence of Deputy Medical Director at SHFT, 1 April 2021

⁹⁶⁰ Evidence of Patient Safety and Quality Facilitator for the Southampton division, SHFT, 13 April 2021

⁹⁶¹ Evidence of Chief Executive of SHFT, 16 April 2021

952. The **Regional Medical Director for NHSE/I for the South East Region, Dr Lewis**, said if there were continuously poor action plans at SHFT he would be notified but only if others were concerned. He would not necessarily be cited on an action plan, in any organisation, unless it was directly related to an incident that he had been involved in.⁹⁶²

953. The **Chief Medical Officer** explained how, in addition to the public Board meetings, they also have 45 minute seminars. He gave an example from (April 2021) where he presented a review of suicides. He said that in SHFT, 80% of SIs are related to mental health patients, so it is important to have that level of understanding at Board level and of the impact on the wider population, including families and carers.⁹⁶³

954. The **Acting Director of Quality & Nursing at West Hampshire CCG** stated: “the CCG accepts that the review of action plans arising from national reports or local findings has not always been carried through to their completion in the Clinical Quality Review Meeting.”. It is of note that the CQRM has not taken place, save for ‘exceptional reporting’ since February 2020 due to the COVID-19 pandemic.⁹⁶⁴

⁹⁶² Evidence of Regional Medical Director for NHSE/I for the South East Region, Dr Lewis, 6 April 2021

⁹⁶³ Evidence of Chief Medical Officer at SHFT, 12 April 2021

⁹⁶⁴ Evidence of Acting Director of Quality & Nursing at West Hampshire CCG, 5 March 2021

Psychologically and Emotionally Safe Environment for service users, carers, family members and staff

B. Where are SHFT now?

955. The Panel heard from SHFT's Freedom to Speak Up Guardian and asked some participants about this topic directly. The Panel acknowledges that it only received oral evidence from a small sample of individuals.

956. The **Chief Executive** said, "it is fair to say that some clinical teams and individuals have felt scarred by some processes that have been in place and some feel they haven't been supported by the organisation in those processes, or their perspectives have not been adequately represented. The consequence is that they have, to some degree, withdrawn from engagement... they're perhaps more defensive in their practice... and want to put more restrictive practices in place, it's not common across SHFT, but I have come across it".⁹⁶⁵

957. He said he will deal with it if safety concerns arise about a member of staff and described the positive approach, which is to try to get people to push and be the best they can be by enabling them, highlighting exemplars and the success in the organisation. Then there is the professional challenge approach, where he will try to encourage more intellectual debate and be challenging and assertive. He said that if the concern is damaging or potentially harmful to care, he would speak with the Medical Director, speak to the individual himself and a decision as to whether they stay or go would be reached. He said there are no members of staff at a place of danger currently in SHFT that he is aware of (at the time he gave evidence, 16 April 2021).⁹⁶⁶

958. The **Head of Patient and Public Engagement and Experience** said, "when I joined (in summer 2018), there was a lack of confidence in some staff to really get involved with patients. Sometimes people are fearful of inviting people in as they worry it will always be a negative experience. I think by trying things out they have got the benefits and rewards from it, which has increased their confidence". She said they run focus groups, one-to-one interviews, listen to stories and staff feel they can take the time to do it. In

⁹⁶⁵ Evidence of Chief Executive of SHFT, 16 April 2021

⁹⁶⁶ Ibid

her view, good engagement takes time. She acknowledged they have to be flexible, go out to people and that staff have to feel able to do so confidently.⁹⁶⁷

959. The **Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement** said, “we are beginning to see three to four years’ worth of work helping our teams feeling psychologically safe so they feel able and empowered to make decisions about their teams and services, we are beginning to see that and if they feel like that, they’re much more likely to feel confident with their family members using our services”.⁹⁶⁸

960. The **Freedom to Speak-up Guardian** at SHFT, who has been in the role for four years and is the first to hold this position in SHFT, provided extensive and important evidence to the Panel.

961. She said that when she first came into post her remit was to deal with patient safety concerns but this has now changed to anything that gets in the way of providing safe and efficient care for SHFT’s patients. She said her job has grown from 96 concerns in her first year to 382 concerns in the last financial year (2020-2021). She has recently recruited an assistant Guardian.⁹⁶⁹

962. She said the process is that the member of staff should be encouraged to go to their line manager or another manager initially and if the concern hasn’t been resolved, then they should contact her. Alternatively, if a staff member wants to raise a concern with their name in confidence, then they go to her in the first instance. She said she raises all concerns received with the Relevant Director, Chief Operating Officer and Chief Executive and she would raise any issues of professional misconduct with them too.⁹⁷⁰

963. The **Freedom to Speak-Up Guardian** said, “the ideal situation is I that I no longer have a role, as everyone can speak up and raise their concerns in complete safety, without fear of retribution or reprisal. But unfortunately, people do have that concern and want to raise it in confidence. I am there to encourage that compassionate leadership and civility among staff, so hopefully my role will become less needed”.⁹⁷¹

⁹⁶⁷ Evidence of Head of Patient and Public Engagement and Experience at SHFT, 10 March 2021

⁹⁶⁸ Evidence of Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement at SHFT, 29 March 2021

⁹⁶⁹ Evidence of Freedom to Speak-Up Guardian at SHFT, 12 April 2021

⁹⁷⁰ Ibid

⁹⁷¹ Ibid

964. The **Freedom to Speak-Up Guardian** described how 70% of staff come to her in tears, extremely distressed and they often have quite distressing stories. She said that she provides staff with the details of external support organisations.⁹⁷²
965. She confirmed that she does not initiate investigations and is not part of them; they are conducted independently from the Guardian. She avers that she is independent throughout the whole process, although representing the staff member, and confirmed that she does feel totally independent.⁹⁷³
966. She said she gets feedback from staff when she closes a case – “99% are extremely grateful and because they felt supported and saw a change made, or a situation had improved, they decided not to leave their job”. She said that she makes a point of trying to be extremely high profile, to be compassionate and ensure people can trust her.⁹⁷⁴
967. She said part of her role is to look at the themes raised and make sure people are aware and to look at learning to make sure it is transmitted across SHFT. She is accountable to the Chief Executive and said she gets support from him and the Chair when needed and she has a Non-Executive Director that she liaises with fortnightly, sometimes to discuss a concern she does not feel is being addressed properly.⁹⁷⁵
968. The **Freedom to Speak-Up Guardian** said that she raises a concern and escalates it to the appropriate level but does not get automatic feedback, so she is constantly digging and chasing for updates. This is something that she would like to see improved.⁹⁷⁶
969. She explained that she relies on the ‘Freedom to Speak Up Index’, produced by the National Guardian’s Office, drawn from four questions in the NHS Annual Staff Survey. She said that this demonstrates a trend in the speaking up culture in SHFT and an improvement in staff knowing how to raise a concern and who to.

⁹⁷² Ibid

⁹⁷³ Ibid

⁹⁷⁴ Ibid

⁹⁷⁵ Ibid

⁹⁷⁶ Ibid

970. These are some of the responses to the questions posed to staff between 2018 to 2020:

- *'I am confident my organisation would address my concern': 63% said yes in 2020 and 2019 (59% said yes in 2018)*
- *'I would feel secure raising concerns about unsafe clinical practice': 77% said yes in 2020 (76% said yes in 2019 and 73% said yes in 2018)*
- *'If you were concerned about unsafe clinical practice, would you know how to report it': 96% said yes in 2020 (97% said yes in 2019 and 2018)*

971. The **Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement** said they are undertaking work around QI and organisational development to encourage an open approach and philosophy. He said they are working with teams locally to open them up to using stories to learn not to feel threatened, which helps service users to feel psychologically safe to make a complaint.⁹⁷⁷

972. The **Deputy Medical Director** said that she sees support as a tiered approach with immediate psychological help being provided by the clinical service, FLO, Investigating Officer, or a combination and with signposting. The second tier for staff is the peer support in the service and ensuring there is contact with the family so they know SHFT are there if they need. The third tier is the specialist support (counselling services in the community) when it is available and SHFT signpost people to it. She monitors the support provided and said that in her experience it is not uncommon for the Investigation Officer to communicate with a family afterwards to check they are ok and that they have dealt with all the issues. She claimed that they do not just walk away once the investigation is complete.⁹⁷⁸

973. The **Chief Medical Officer** in SHFT said, "psychological safety and just culture can only go so far. You do need to have a disciplined approach to supporting staff and utilising HR and disciplinary processes and I believe there is a degree of engagement required with medical staff... it's a specific accountability going hand-in-hand with a just and safe culture". He stated, he is aware of NHS Resolution Practitioner's Support System and has spoken to them about a doctor who needed support, but not referred

⁹⁷⁷ Evidence of Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement at SHFT, 29 March 2021

⁹⁷⁸ Evidence of Deputy Medical Director, 1 April 2021

anyone himself. He said SHFT will always consider support for doctors going through the GMC process.⁹⁷⁹

974. As to the practices on the ground, the **Clinical Ward Manager** said there is support for staff through reflective practice facilitated by their ward psychologist or she will conduct a case formulation”.⁹⁸⁰

975. Further, a **Matron** said they have support for staff and have increased reflective practice, group supervision and have a debrief at the end of a shift, but she acknowledged that nobody knows the long term impact of working in such a risky area and she believes that it should be measured in the longer term”.⁹⁸¹

976. The **Chair** of SHFT said that the emotional investment in QI is that “it takes aspects of psychological safety, so people can say they’re not happy, or they have done something they’re not proud of, and learn from them all together, so nobody feels compromised about speaking out about what is important to them. Otherwise, our QI programme will not work. The emotional part is to offer a just culture to everyone and if you get things wrong we will help, support and learn with them. Some things they get wrong might be hard to talk about so we all have to invest emotionally in creating safe spaces for people to speak up”.⁹⁸²

977. She was asked where SHFT are on its journey to becoming a truly safe system and she said, “I think there is a little way to go; I think we have the building blocks and that is when you can start to see the incremental shift, which is quite exciting. We have a culture that is opening up, people are speaking up and taking part and people are feeling that buzz”.⁹⁸³

978. The **Clinical Director for Mental Health and Learning Disability for West Hampshire CCG** said, “I think as someone who works alongside (SHFT), there is definitely a difference in cultural processes, so there is a more psychologically safe system. I think the processes are in place and as an organisation they have been through

⁹⁷⁹ Evidence of Chief Medical Officer, 12 April 2021

⁹⁸⁰ Evidence of Clinical Ward Manager, SHFT, 12 April 2021

⁹⁸¹ Evidence of Matron, SHFT, 29 March 2021

⁹⁸² Evidence of Chair of SHFT, 16 April 2021

⁹⁸³ Ibid

a lot of hard learning. From the processes in place now, I can see staff are reporting incidents and processes are being followed as to how they're managed".⁹⁸⁴

979. The Panel reviewed a sample of the Serious Incident Reports and following an incident in September 2020, the 48-hour Review Panel found 'Care and Service Delivery Problems' which included:

'There is no record on RiO that Inpatient clinical staff had discussed a plan of care or potential discharge date with the patient from the time of their admission to the day of the discharge Care Programme Approach meeting... and there were missed opportunities to really get to know the patient and their thinking as an interpreter was accessed for key discussions only whilst they were an inpatient, they was isolating due to the language barrier. They were then reviewed by the Community Services on four occasions post-discharge either face to face or by telephone call during which family members were used for the purpose of interpreting. This did not give the patient the opportunity to speak in confidence'.⁹⁸⁵

Panel's Views on where SHFT are now: creating a psychologically and emotionally safe environment for service users, carers, family members and staff

- There was a culture of fear within SHFT in the past and this had a devastating impact on the organisation and its staff. The Panel is bolstered in its view that evidence from both SHFT and the CCG indicates that the situation has improved.
- There are good examples of SHFT creating a safe environment for its staff, for example, through reflective practice, the Learning from Events Forum, 'safety huddles' and a supportive senior leadership team.
- The Panel acknowledges that it only received oral evidence from a small sample of individuals with direct experience of SHFT.
- However, the Panel is of the firm view that creating such an environment must be considered as a priority for service users, carers and family members, as well as staff. That environment must be maintained and consistent at all times.

⁹⁸⁴ Evidence of Clinical Director for Mental Health and Learning Disability for West Hampshire CCG, 17 March 2021

⁹⁸⁵ Serious Incident Reports, page 356

Panel's Views on where SHFT are now: creating a psychologically and emotionally safe environment for service users, carers, family members and staff continued...

- The Panel is not satisfied, on the evidence it received from a range of participants, that SHFT currently has mechanisms in place to allow them to identify when, and if, a patient feels psychologically or emotionally unsafe. This is acutely important in SHFT, a mental health and learning disability Trust, where a significant proportion of its users may have difficulty communicating whether they feel safe or not. An example of this was seen by the Panel in an incident report which concerned an individual who was Chinese and whose ability to communicate was inhibited by a language barrier.
- The Panel does acknowledge that the CQC's rated SHFT as 'good' in respect of whether its services are safe. However, the Panel heard from service users and carers who, in relation to their engagement with SHFT, reported that they have either, in the past, or currently, not felt safe or they have felt frightened. This is unacceptable and must remain a priority for SHFT to address and continue to improve upon.

Just Culture and Accountability

B. Where are SHFT now?

980. This topic has been briefly addressed in some of the evidence already set out, particularly in the ‘investigations’ section with regard to a culture of reporting and the ‘culture’ sections for complaints handling and communications. The Panel also started this part of the Report with the values that SHFT are seeking to engender in the organisation, which contribute to this discussion.

981. The **Deputy Medical Director** spoke of the cultural shift in SHFT and concluded by saying, “my own experience as a clinician and member of staff (and service user) is that it is a much more open and transparent and inclusive place... there is a sense that we are not here to be in charge or write policies, but see ourselves as members of the community alongside everything else we do”.⁹⁸⁶

982. The Panel heard from the **Deputy Chair of the Learning from Events Forum and Clinical Director** of one of the divisions. She confirmed she has been a Respiratory Consultant since 2010 and had been part of the management structure in SHFT since 2015. She commented on the improvements she had seen in SHFT today and said, “I think that we work really hard to learn... I think the whole of the NHS has moved away from a ‘no blame culture’... and SHFT has moved with it... it has been shown that the more fear in an organisation, the less patient safety there is... I think our learning from really difficult incidents has helped us to learn and focus on where we have harmed people and to understand how to work with carers, families and patients to make care better... I think we have learnt to concentrate more on near misses; if we wait until something bad has happened, then it is too late”.⁹⁸⁷

983. The **Quality & Safety Committee Chair** said he believes there is a strong sense of there being a just culture at SHFT which he defines as, “being fallible and capable of making mistakes, the punishment is not disproportionate but in a learning environment, we can change an individual’s approach, system and environment”.⁹⁸⁸

⁹⁸⁶ Evidence of Deputy Medical Director at SHFT, 1 April 2021

⁹⁸⁷ Evidence of Deputy Chair of the Learning from Events Forum and Clinical Director, SHFT, 1 April 2021

⁹⁸⁸ Evidence of Quality & Safety Committee Chair, SHFT, 9 March 2021

984. The **Chair of SHFT** was asked what the Non-Executives would do in the instance of occasional defensive and restrictive practices of particular staff who cannot see the logic of changing or get in the way of the best interests of the patient. She stated, "... if we see pockets of fear and entrenchment, which often go together, it's a job for us to go in with the organisational development team... and give them the support they need and ask: 'how will we improve this and move it forward?'"⁹⁸⁹
985. She developed this further, "sometimes people see change as being something that will make their life worse or they don't understand it, or their part in it, and those conversations can be reassuring. When you get that right and see staff becoming involved, and getting service users and carers and staff working together, you start to see a big shift. If people are still sitting outside, they are much more visible and it is an uncomfortable place to be and very often they may then leave of their own choice or think they want to get in and be active with the others".⁹⁹⁰
986. The **Deputy Medical Director** informed the Panel that SHFT had been part of a review for the Royal College of Psychiatrists accreditation process in January 2020 and the feedback following a focus group with staff was that they felt SHFT had moved to a place where reporting and investigating incidents is seen as part of their normal day to day work of looking after patients and families and there is no fear or concern in engaging in that. She said they also spoke about the culture of openness and how different it feels to some years ago.⁹⁹¹
987. The **Director of Workforce, Organisational Development and Communications** spoke about promoting SHFT's values in their recruitment process and said that SHFT has a template of their value based approach and questions against them so they are bringing in people with values they want to recognise. He said that the value based assessment for locum staff is not as robust.⁹⁹²
988. He said that if people do not demonstrate the right values, they have tried to be more assertive and have better conversations earlier on, whereas before they would have been left and not challenged. He said, "I'm not saying we have got it right yet and there

⁹⁸⁹ Evidence of Chair of SHFT, 16 April 2021

⁹⁹⁰ Ibid

⁹⁹¹ Evidence of Deputy Medical Director at SHFT, 1 April 2021

⁹⁹² Evidence of Director of Workforce, Organisational Development and Communications, 19 April 2021

is more to do... we have a number of people on conduct plans and we hold them to account for their actions and the way they work, rather than necessarily going into a disciplinary process, which probably would have been the situation before. So, we try and nip it in the bud now and do it in a compassionate but assertive way...".⁹⁹³

989. The **Clinical Director for the Hampshire South-West Division** said that it is useful that Ulysses is in the same form for reporting deaths for all levels of SHFT staff, so that when a junior doctor reports the death, it can be opened and the learning can be extracted and discussed in a group, so they are seeing consultants and leaders as role models. She said that the conversation is so much richer now.⁹⁹⁴

⁹⁹³ Ibid

⁹⁹⁴ Evidence of Clinical Director for the Hampshire South-West Division, SHFT, 1 April 2021

Leadership, Succession and Strategy Planning

B. Where are SHFT now?

990. Within this section the Panel have set out the evidence that they heard about the leadership in SHFT now, specifically the role of the Non-Executives, Governors and long term strategy planning and the processes for auditing risk. There is evidence on these matters throughout the Report too.

Leadership

991. The **Chair of SHFT** described how she thinks that they have got the relationships between herself, the Non-Executive Directors and Executives, about right. She acknowledged that there are times the Board gets frustrated, but they have to work together on those issues to get them right and said that if you listened to the Board and the sub-committees, you would hear open, honest and frank discussions to keep their plan on track and keep SHFT moving.⁹⁹⁵

992. As to the important relationship between the Chief Executive and the Chair, the **Chair** said they are very different and both bring something very different to the organisation. She described how they work very closely and have a very good professional and personal relationship. She said that when they discuss SHFT and where it is going, they have very open and frank discussions and have a united front.⁹⁹⁶

993. As to whether they have ‘the team to take them forward’, the **Chair** said she needed to discuss this with the Chief Executive, as over the last year they had not had the chance to discuss the skills needed, due to the COVID-19 pandemic. She said they have a skills matrix at the Board which needs updating to see what other skills are needed moving forward, particularly with the change in the Medical Director and Chief Executive.⁹⁹⁷

994. A **family member and previous Governor in SHFT** said, “when the new Board came in, it was a breath of fresh air and a different approach was taken by the Chair and others...”.⁹⁹⁸

⁹⁹⁵ Evidence of Chair of SHFT, 16 April 2021

⁹⁹⁶ Ibid

⁹⁹⁷ Ibid

⁹⁹⁸ Evidence of a family member, 14 April 2021

Non-Executive Directors

995. The **Chair of SHFT** spoke of running the Board very differently and that it was opened up so it runs now as part of a public service and not a remote business, which encourages open relationships.⁹⁹⁹

996. A **Non-Executive Director**, who joined SHFT in 2017, described his role: “we have no day-to-day responsibility or accountability. We help ensure the organisation moves forward. We act as eyes and ears for the members; we’re a Foundation Trust, so we have 10,000 members. We are holding the Executive Directors and management team to account and ensure that they have the plans and procedures in place to deliver the best service to our patients”.¹⁰⁰⁰

997. He compared the Board and Committee papers from when he joined in 2017 to now, and said, they were dealing with the past and not addressing the ‘why’ or ‘how’ can we change. He said that after a five day Rapid Improvement Workshop looking at the papers, they are now significantly better and understood.¹⁰⁰¹

998. He said, “our job is to get the Executives to get their heads up and look forward... I say ‘right first time, every time’... there is the right level of tension, support, challenging questions and we are trying to find best way forward to deliver on the strategy”.¹⁰⁰²

999. In terms of access to information, he said, it is about getting out there and that he regularly attends regional, county and national meetings to learn from others what questions to ask. He said they will keep going and asking the questions if they haven’t quite got the answer. He said, “good governance is there if an independent Non-Executive Director can assert to the Board that the organisation abides by the highest standards of business conduct and customer delivery”.¹⁰⁰³

1000. Finally, the **Non-Executive Director** set out a turning point in his mind where during a meeting they asked two Executives, who were presenting at that meeting, “what keeps

⁹⁹⁹ Evidence of Chair of SHFT, 16 April 2021

¹⁰⁰⁰ Evidence of Non-Executive Director and Chair of the Audit, Assurance & Risk Committee at SHFT, 13 April 2021

¹⁰⁰¹ Ibid

¹⁰⁰² Ibid

¹⁰⁰³ Ibid

you awake at night?”. He said they were very sincere and it was all about today’s issues, but then they asked, “what makes you smile?”, he described a phenomenal change of body language. He said, “what showed through, was that most of it was when they were on the wards with patients and families and seeing the experiences and learning from it; and the smiles were tremendous”. He said the learning from that experience was that they have to celebrate, capture and share success more.¹⁰⁰⁴

Governors

1001. In regard to the Council of Governor’s relationship with the Board, the **Chair of SHFT** said that their formal meetings are more structured and open, that they have been given access to a lot more information to carry out their public engagement role, and that they are now invited to the sub-committee of the Board. In regard to the last change, she said that this is not generally required or advisable, but that she thought it was an opportunity to do something different to show a commitment to openness and honesty and to trust them to attend meetings with confidential information about the organisation and to be part of that support structure.¹⁰⁰⁵

1002. She recognised that the Governor’s role is to challenge, but said that it is more of a partnership, with everyone signed up to moving SHFT forward. She is assured that they are not cutting into each other’s domains or becoming too cosy. The performance of the Chair and Non-Executives is reviewed and the Chair is held to account through formal annual appraisals by the Board of Governors, working with a senior independent director and the corporate governance team. Latterly, this appraisal process has included feedback from service users and external views from other Chairs in Hampshire and ICSs.¹⁰⁰⁶

1003. The **Lead Governor** stated that the difference between the two times (2016 to now) is absolutely startling from his perspective. He said that he can now go into, or do, anything he wants and the door is open. He said his interest lies in quality improvement, so he has been heavily involved in those projects, he has done five workshops, and was encouraged to do so by the Board and Chair.¹⁰⁰⁷

¹⁰⁰⁴ Ibid

¹⁰⁰⁵ Evidence of Chair of SHFT, 16 April 2021

¹⁰⁰⁶ Ibid

¹⁰⁰⁷ Evidence of Lead Governor, SHFT, 30 March 2021

1004. The **Lead Governor** said that the problem with his feedback on reports going into the “SHFT ether”, no longer exists and that the Governors are more open, so if they have a question about a report, it is followed up in a professional way and he is able to talk to all of the Non-Executive Directors and Executives. He described an open door to the Chair now.¹⁰⁰⁸

1005. The Governor process has undergone and still is undergoing a review. There is one staff member from each division on the Council of Governors, but there are no doctors. He said the membership sub-committees will be looked at in more detail to understand what members want from them and what they can offer them. He said this review will help them to ensure the staff Governors are better representative of the division and wider organisation.¹⁰⁰⁹

1006. He said that the Governors are encouraged to participate in committee meetings, to ask questions, comment and have changed how they report to the Council of Governors, so in the past the Non-Executive Directors would give presentations, but now the Governors present to the Council of Governors, giving their views on effectiveness and business.¹⁰¹⁰

1007. Further, he explained that Governors can now able to attend public and private Board and Focus Meetings. As an example, he said, the Governors now play a role in the Annual Quality Report and they review the draft, comment on it and write a short report to give their views on SHFT’s performance.¹⁰¹¹

1008. The Council of Governors meet quarterly and have development sessions and the **Lead Governor** said that the Chief Executive and Non-Executive Directors attend, but not the Executives, unless there is a specific item, they need their expertise on. They meet privately before the main meeting. He said they do not want long papers but want short papers, presentations and discussions. The Council of Governors do not produce an annual report, but he accepted it was a good idea and said they could do it.¹⁰¹²

¹⁰⁰⁸ Ibid

¹⁰⁰⁹ Ibid

¹⁰¹⁰ Ibid

¹⁰¹¹ Ibid

¹⁰¹² Ibid

1009. He said about the team of Non-Executive Directors is the one that will get SHFT to where it needs to. He described how he has watched the working relationship between the Non-Executives and Executive Directors develop over three years and there is strong challenge of the Executives. He said the evidence is of a Board that is integrated and of debates about linking strategy to frontline services.¹⁰¹³

1010. In terms of learning and sharing, the **Lead Governor** said he speaks to other Lead Governors from other Trusts and goes to Provider Groups.¹⁰¹⁴

Strategy planning

1011. The Panel heard from a **Non-Executive Director and Chairman of the Audit, Risk and Assurance Committee** who said, “I still do not think the NHS in total looks forward enough and plans, particularly around mental health; statements are made and not followed-up”. He said SHFT has four key strategies that are translated into management action plans and the local divisions know the part that they play.¹⁰¹⁵

1012. The **Chief Medical Officer** said that SHFT, at the moment, reacts to quality planning rather than being forward looking and a change in approach was delayed by COVID-19.¹⁰¹⁶

Auditing risk

1013. The **Chair of the Audit, Risk and Assurance Committee** stated that the Committee is not just about finance, but it is a part of it. He described assurance as the triangulation of what we have heard and seen. He said more than one third of their time is spent on risk across the year and there are 230 risks within SHFT’s corporate risk register, which consolidate up to four strategic risks. He said they look at two of them every meeting and will choose depending on how they perceive the importance or challenges at the time.

¹⁰¹³ Ibid

¹⁰¹⁴ Ibid

¹⁰¹⁵ Evidence of Non-Executive Director and Chairman of the Audit, Risk and Assurance Committee, SHFT, 13 April 2021

¹⁰¹⁶ Evidence of Chief Medical Officer, SHFT, 12 April 2021

He explained that the Board look to the Audit, Risk & Assurance Committee to provide assurance.¹⁰¹⁷

1014. There are four Non-Executives Directors who are members of the Audit, Risk & Assurance Committee and they all chair other committees too (Workforce Committee, Quality & Safety Committee and the Finance and Performance Committee). The committee meet five-to-six times per year.

Panel's Views on where SHFT are now: leadership, succession and strategy planning

- The Panel is acutely aware that the Chief Executive of SHFT has only been in post since June 2020 and that his time since March 2020, and that of a significant number of staff and volunteers, across the organisation, has been occupied by responding to the COVID-19 pandemic. This has led to some redeployment of staff for prolonged periods of time. Therefore, it has not been possible for SHFT to make all of the improvements and changes needed and to implement new strategies and plan for the future in the ways it might have done had COVID-19 not happened.
- The Panel is reassured by the evidence that there are good, professional relationships between the senior leadership team in SHFT and the Board, Non-Executives, Executives and Governors and in particular, between the Chair and the Chief Executive. There has undoubtedly been significant improvement here, which must be commended, but also must continue to improve, develop and grow further.
- The Panel saw evidence of challenge of the Executive Directors at SHFT by the Chair and at divisional level. They heard examples of the Chair leading well and her level of sensitivity expressed towards families and carers - she evoked confidence and a change in the culture of SHFT.
- Overall, however, the Panel's view is that there is a lack of long term strategic planning in SHFT currently, particularly in the areas that they have been investigating. This should be resolved as a priority if SHFT is going to continue positively on its improvement journey.

¹⁰¹⁷ Evidence of Non-Executive Director and Chairman of the Audit, Risk and Assurance Committee, SHFT, 13 April 2021

¹⁰¹⁸ Ibid

¹⁰¹⁹ Ibid

PART 5C: Where should SHFT be?

1. Overall, the Panel's view is that SHFT has a long way to go in putting the patient at the centre of their care. There is evidence that they are on their way, but they are not there yet. Further, there was extensive evidence across all of the topics of a lack of joined-up processes, thinking and overall strategy.
2. The Panel received a lot of suggestions as to 'where SHFT should be' and what it should do to get there, not all of which have not been adopted, but they have been considered and listened to by the Panel. Its focus has always been on making realistic and practical recommendations.
3. A **Non-Executive Director and Chair of the Audit, Risk and Assurance Committee** said, "we will make mistakes, no doubt about it when we have 1.5million service user contacts per year... we hope that they are not catastrophic and that is what we are there to make sure our processes are about preventing".¹⁰²⁰
4. The **Chief Executive** set out what he had identified needed to change, in the short time he has been in this role in SHFT. He said there is no one thing, but the first thing is, "building the organisation's confidence, promotion and realisation of the great stuff being done across the organisation, that is not to say we are not failing in some of what we do, but there are great people doing a great job... that is my biggest challenge... it starts with staff feeling valued by the organisation, comfortable so they can make mistakes and won't be blamed and they're supported as people that work in the organisation and deliver the services...".¹⁰²¹
5. The second thing, he said, is, "the thrust as to where the services are in terms of our national plan and merging into ICSs, which is taking us much closer to populations and to health; working closer with communities and looking at the health of the whole person and community, not treating people according to the mind, body or bits of it. That is fundamentally what this organisation is about... most of what we do is in the community, our close relationships and partnerships with the patients themselves, communities, GPs and local authorities. We have been doing it for 30 years, but it's in a better position than

¹⁰²⁰ Evidence of Non-Executive Director and Chairman of the Audit, Risk and Assurance Committee, SHFT, 13 April 2021

¹⁰²¹ Evidence of Chief Executive at SHFT, 16 April 2021

it's ever been and I am more optimistic now than I have ever been in terms of the potential of that".¹⁰²²

6. The **Chief Executive** discussed SHFT under his leadership: "it is not with a magic wand from an Executive or Board that produces the best of services but it is about how staff feel positive about what they are doing, that they feel in control of it, that the organisation values them and they feel supported in their job and want to do it better. When they are doing that, that is what is important. Whether it receives a 'outstanding' (CQC) rating or not is not the most important bit to me".¹⁰²³
7. He said, "there are organisations that have worked flat out to achieve 'outstanding' (from the CQC) just by ticking the boxes, that is too narrow a focus just to 'pass the exam', the strength has to come from the breadth and depth of what the staff do across the organisation most of the time and you are striving for it to be the case all of the time. It's not about just chasing the rating".¹⁰²⁴
8. The **Deputy Chief Inspector of Hospitals at the CQC, Dr Cleary** said, "a well-led organisation, which has a clear line of sight from the 'ward-to-the-Board' in both directions... is one in which the Executives show a real interest in what is going on in the organisation and have honest conversations with staff... as a senior leader in an organisation people will tell you what they think you want to hear and you have to make people understand that is not what you want, you want to know what the problems actually are, to help and you want to be part of the solution and make it so that the staff in the clinical services can make changes without having to go to the top. Good leaders are transparent about things that are good and painful".¹⁰²⁵
9. The **National Clinical Director for Mental Health in NHSE, Professor Kendall** stated: "some Trusts will always be average, but you can move the average up. That is the ideal... we have to make the average better".¹⁰²⁶

¹⁰²² Ibid

¹⁰²³ Ibid

¹⁰²⁴ Ibid

¹⁰²⁵ Evidence of Deputy Chief Inspector of Hospitals at the Care Quality Commission, Dr Cleary, 19 April 2021

¹⁰²⁶ Evidence of National Clinical Director for Mental Health in NHSE, Professor Kendall, 29 April 2021

10. On 11 February 2021, the White Paper: ‘Integration and Innovation: Working Together to Improve Health and Social Care for All’, was published. The themes are:

- Working towards a *‘truly integrated’* system;
- Moving transactional bureaucracy, in particular, to make better-use of technology and with a focus on *‘population health’*, through the use of *‘collective resources of the local system, NHS, local authorities and voluntary sector’*;
- Making the system more accountable and responsive to the people working in it and people using it, with a focus on ensuring NHSE/I is more accountable; and
- Measures to *‘enhance quality and safety in the NHS, including the creation of an independent statutory body to oversee safety investigations’*.¹⁰²⁷

11. The proposals relating to safety and quality include embedding *‘into the structure and culture of the NHS, via the establishment of an independent Health Services Safety Investigations Body (“HSSIB”), to investigate incidents which have or may have implications for the safety of patients in the NHS’*. The HSSIB is proposed to be an *‘Executive Non-Departmental Public Body, with powers to investigate the most serious patient safety risks to support system learning’*.¹⁰²⁸

12. The proposals recognise that, *‘independence as a concept is fundamentally important to HSSIB as it will be a crucial way of ensuring that patients, families and staff have trust in its processes and judgements’*. It suggests that the HSSIB will produce investigation reports with, *‘recommendations and require organisations to publicly respond to these measures, within a specified timescale’*. The proposals also state that, *‘information held by HSSIB’*, will not be disclosed, *‘save in limited circumstances’*, in order to create a *‘safe space’*. Further, that *‘HSSIB will provide advice, guidance and training to organisations’*.¹⁰²⁹

¹⁰²⁷ <https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-html-version>; <https://www.england.nhs.uk/wp-content/uploads/2021/01/integrating-care-next-steps-to-building-strong-and-effective-integrated-care-systems.pdf>

¹⁰²⁸ Ibid

¹⁰²⁹ Ibid

13. The role of the Medical Examiner will come in under this legislation and will scrutinise all deaths which do not involve a coroner.¹⁰³⁰

14. The stated goal is that the reforms will begin to be implemented in 2022.

¹⁰³⁰ Ibid

Quality Improvement

C. Where should SHFT be?

'Quality Trilogy'

15. The 'Quality Trilogy', or the 'Juran Trilogy' has, underlying it, the concept that *'Managing for quality consists of three basic quality-orientated processes: quality planning, quality control, quality improvement'*. Juran, a quality management expert, *states: 'Each of these processes is universal; it is carried out by an unvarying sequence of activities'*, and *'The quality improvement ("QI") process is superimposed on the quality control process – a process implemented in addition to quality control, not instead of it'*. He refers to the need for *'an infrastructure... for... strategic quality planning'*.¹⁰³¹

Evidence from SHFT

16. The **Chief Medical Officer** at SHFT stated: "I think we are fantastic as an organisation at collecting a lot of data... we have a Tableau system which is highly regarded nationally as a data collection and information system. I think we could use that data far better (and effectively) for knowledge-based analysis. That is where QI measurements come into effect". He said the second stage of the QI methodology is about measurements and data, which will drive and inform their knowledge and lead to wisdom. He explained that he presented this to the Board in March 2021 and the business plan to proceed with this, has been signed off.¹⁰³²

17. The **Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement** said, "one focus this year and there was a workshop on it (recently), is the pulling together of the four domains of quality, which requires us to bring our information, intelligence and stories all together and be more integrated about governance".¹⁰³³

Independent Evidence

¹⁰³¹ The Quality Trilogy: A Universal Approach to Managing for Quality, by J.M.Juran, May 20 1986

¹⁰³² Evidence of Chief Medical Officer at SHFT, 12 April 2021

¹⁰³³ Evidence of Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement at SHFT, 29 March 2021

18. The Panel received evidence from **Dr Bill Kirkup CBE**, who was appointed the Chairman of the Morecambe Bay Investigation in July 2013 and he is leading the independent investigation into the maternity and neonatal services provided by East Kent Hospitals University NHS Foundation Trust. In his statement he said: “from experience of some Trusts that have suffered serious systemic failings and been the subject of major investigations, I believe that there are some general conditions necessary before they are able to remedy problems and show convincing evidence of improvement”.¹⁰³⁴

19. **Dr Kirkup** went on to set out the general conditions he thinks are necessary for improvement in a Trust (emphasis added):

- 1) The Trust and its staff must accept fully and unreservedly, the scale and nature of the problems identified. The extent to which Trusts are capable of persuading themselves that they have been hard done by is remarkable. Problems of this nature generally require changes in deep seated attitudes and behaviours. Until the Trust is prepared to acknowledge that things have gone badly wrong, their effort and attention is more likely to be misdirected toward defensiveness and self-justification than to addressing difficult remedies.
- 2) Effective leadership. Staff, who will need to change attitudes and behaviours, must trust those who lead them, at all levels, and the public need to trust that those who they see as the visible faces of the Trust, will put things right. It is essential that leadership at all levels is assessed to ensure that there is high quality leadership that will inspire confidence in staff and public alike.
- 3) Clinicians need to work together effectively in teams, without interprofessional rivalries or unduly hierarchical relationships. It is an almost universal finding in badly dysfunctional services that poor teamwork, professional jealousies and blame-shifting predominate. These behaviours are typically extremely hard to change, but unless they do change the problems are likely to persist regardless of how the Trust functions at higher level. They are also hard to identify externally.
- 4) Clinicians need to have the confidence to be open when things have gone wrong, both to families to fulfil their Duty of Candour, but also to initiate safety investigations. Without openness from the outset, families are left dissatisfied and

¹⁰³⁴ Written statement of Dr Bill Kirkup, 5 March 2021

systemic problems remain unidentified, so that the same problems recur. Where the clinical culture has been a closed one, it is hard to change and to generate evidence of change, but it is essential as a precursor to genuine improvement.

- 5) The Trust's systems of clinical governance must be effective. The Board must be properly aware of what happens at ward-level and, equally, so that those working at the front end of clinical services have the confidence to report what is happening and know they will be heeded.¹⁰³⁵

20. **Dr Kirkup** spoke about the range of NHS Trusts, from his professional experience: "... there is probably something of a normal distribution of Trusts in relation to many parameters, including overall quality. 5% to 10% will be doing very well and people should be learning from them; 80% are in the middle of the bell-curve, doing what they are meant to and are generally effectively performing; and 10% are in the bottom of the bell-curve, not behaving or learning well and some of their behaviours are pretty incomprehensible to the majority of the curve...".¹⁰³⁶

21. In terms of assessing where a Trust falls in that bell-curve, he said that the recent emphasis on trying to understand organisations from a human factor approach, rather than a statistical viewpoint, is welcomed, but there is progress still to be made there.¹⁰³⁷

22. As to what he would expect from the Board in a Trust in the top 10%, he said they should be ready to recognise where things have gone wrong and they welcome it because they want to improve. They should go out and talk to people and visit clinical areas where staff can talk to them in a less formal way and get feedback and they should want to do that as it is an opportunity to improve.¹⁰³⁸

23. **Dr Kirkup** stated that improvement is measured by talking to people, delivering and receiving the service. He would not recommend embarking on a formal procedure to measure improvement, as it is seen, or could be perceived as, intrusive and self-perpetuating.¹⁰³⁹

¹⁰³⁵ Ibid

¹⁰³⁶ Evidence of Dr Kirkup, 8 April 2021

¹⁰³⁷ Ibid

¹⁰³⁸ Ibid

¹⁰³⁹ Ibid

24. **Dr Kirkup** described how his general approach is to be sceptical about how quickly a Trust can turn itself around and eradicate those behaviours, which are deeply embedded. His view is that it takes a long time and a lot of work to do it.¹⁰⁴⁰
25. He said, "... I won't forget the interviewee, who said they did not realise how bad things had got until they went and worked somewhere else. Very often there is clinical isolation in these units, so practice deviates and they are completely unaware of it until someone holds a mirror up to it, which can be powerfully transformative".¹⁰⁴¹
26. The **Deputy Chief Inspector of Hospitals at the CQC, Dr Cleary** said, "I think QI is extremely important... the organisations that succeed have it as part of their natural DNA and culture of the organisation. It's not an add-on, which some organisations do think of it as, or something that you do sometimes... on the other hand, you have to have quality assurance there too and assure yourself that the quality is there, so it doesn't answer those problems. It is an extra tool to improve the quality of care being provided... having a well embedded QI programme, is probably what gets an organisation (from a CQC rating) of 'good' to 'outstanding', but you need a good quality assurance process to get yourself to 'good'.¹⁰⁴²
27. He said that from his experience as previous Chief Medical Officer at East London NHS Foundation Trust, it took three to four years before there were enough staff trained believing in it and buy-in from the senior level for the QI methodology to become part of the DNA of the organisation. To sustain that he described how you have to never take your eye off the ball, never feel comfortable and that it is a relentless focus by the top of the organisation on quality and regular conversations. He described how he used to meet with Clinical and Divisional Directors once a month to go through the aspects of care in their division.¹⁰⁴³
28. The **National Clinical Director for Mental Health in NHSE, Professor Kendall** said that the CQC top rated mental health Trusts, alongside patient safety, patient experience and clinical effectiveness, also have quality improvement. He said you cannot have a

¹⁰⁴⁰ Ibid

¹⁰⁴¹ Ibid

¹⁰⁴² Evidence of Deputy Chief Inspector of Hospitals at the CQC, Dr Cleary, 19 April 2021

¹⁰⁴³ Ibid

service that is not doing QI but it is “not the panacea, it is a partial answer... it is important, but it is not all we need, by a long shot”.¹⁰⁴⁴

Panel’s Views on where SHFT should be: quality improvement

- The Panel welcomes SHFT’s clear commitment to the QI methodology, but agrees that the QI methodology should not be seen as a panacea and SHFT must not proceed as if it is. In that respect, more needs to be done.
- Dr Kirkup’s suggestions set out in paragraph 22 should form part of SHFT’s strategy for QI if they want to get into the upper centile of the bell-curve, particularly as the Panel have identified in Part 5B that SHFT could improve in all of the areas that Dr Kirkup identifies, specifically in adopting the Human Factors approach and introducing training on it.
- SHFT has, in some respects, acknowledged that it has a way to go in its improvement journey and has identified what it could be doing better. For example, using Tableau and/or Life QI to improve its ability to measure and collect data from its QI projects to monitor implementation and impact. The Panel shares SHFT’s view that there must be improvement in this area and would favour the adoption of Life QI in SHFT as a way to do so.
- SHFT should be able to provide a Trust-wide approach to QI with continuous reflection and a commitment to improvement, which is embedded at every level of their work – receptionists, secretaries, porters, clinicians, senior leaders and managers.
- The Panel is of the firm view that SHFT must ensure that it continues with, and improves upon, its assurance functions, in addition to quality improvement, as per the Juran Trilogy and Dr Cleary’s evidence.
- Overall, the Panel is reassured by the progress being made in SHFT in the area of QI, but it must be recognised by all that the journey is long journey, it is likely to take years and there should always be continuous improvement and a commitment to it from the leadership team at the top of the organisation.

¹⁰⁴⁴ Evidence of National Clinical Director for Mental Health in NHSE, Professor Kendall, 29 April 2021

Complaints Handling

C. Where should SHFT be?

Introduction

Independent evidence

29. The Panel received evidence from independent participants who set out, in general terms, where a Trust should be in regard to complaints handling and how improvements can be measured.

30. The **Director for Experience, Participation and Equalities at NHSE/I, Dr Churchill** said that the pace of improvement for patients to feel involved in their care has been slow. He said there are a number of areas one needs to look at as benchmarks to judge whether the pace of progress has been too slow. These are (emphasis added):¹⁰⁴⁵

- What are the Board doing about complaints and what information are they receiving? Are they just looking at numerical returns, such as response times, when they should look at what the learnings are and go back to them to see what has happened? That is a crucial step.
- Cultures of learning and how complaints and feedback is embedded. When Dr Churchill visits a Trust which is good at this he said he would expect to meet complainants who have made serious complaints about failings in a Trust and for them to be saying that they think progress has been made and he would expect to see that they were using that information in training sessions, creatively, to learn from. He has seen Trusts that dramatise complaints, which he described as very powerful, as you can see the emotional reaction of staff and get a more energised response than you would in a written complaint. He would expect to see it deeply embedded in change.
- The role for commissioners, when they're meeting with NHS organisations, is to discuss quality. A key part needs to be around complaints handling, so whether complainants feel listened to, getting behind the numbers and what has happened in the response.¹⁰⁴⁶

¹⁰⁴⁵ Evidence of Director for Experience, Participation and Equalities at NHSE/I, Dr Churchill, 20 April 2021

¹⁰⁴⁶ Ibid

31. **Dr Churchill** said it is important to think about the professionalisation around complaints handling. He said, “we do not want people to feel they have ended up in that role, on a more junior grade, by a force of circumstances. It should be people who are genuinely motivated by a desire to give people a say, make sure people are listened to, involved and able to contribute to improvement”.¹⁰⁴⁷ This view was echoed by participants, such as the PHSO Chair and Ombudsman. It also arose in the context of the professionalisation of SI investigators and Patient Safety Specialists.

The Complaints Handling Process

32. The current complaints handling process at SHFT focuses on local resolution in the divisions, as quickly as possible, overseen by a centralised team. The alternative would be a centralised team of investigators to investigate complaints, removed from the divisions, as there is for SIs.

Independent evidence

33. The Panel received evidence from the **PHSO Chair and Ombudsman, Rob Behrens CBE**. Mr Behrens was appointed as the Chair and Ombudsman of the organisation on 6 April 2017. He explained how they receive complaints and look at whether or not there has been maladministration or service failures and, if there has, make recommendations for compensation. He said that they are required to be impartial. The PHSO received, on average, 30,000 cases per year prior to the COVID-19 pandemic, but only 10% of those go through the full investigation process.¹⁰⁴⁸

34. The PHSO cannot conduct investigations without a complaint being made, but it does have the power to lay a report before Parliament, if it thinks it is in the public interest to do so and this has been done on a number of occasions. Parliamentary Committees can question a body in the jurisdiction about why the failures have taken place and what they are doing to implement the Ombudsman’s recommendations, but the Ombudsman does not have enforcement powers.¹⁰⁴⁹

¹⁰⁴⁷ Ibid

¹⁰⁴⁸ Evidence of PHSO Chair and Ombudsman, Rob Behrens CBE, 9 April 2021

¹⁰⁴⁹ Ibid

35. For example, the PHSO laid a report before Parliament in 2020 following a two year investigation into complaints handling in the NHS. Their findings were that the system did not work at all and there wasn't really a system. They highlighted three key issues:

- 1) There is no single vision of how staff are expected to handle and resolve complaints, even within the same Trust sometimes there were different approaches to complaints handling.
- 2) Upon meeting many complaint handlers, they found that they had no access to training, had low status in the organisation, felt at the bottom of the hierarchy of merit and were crying out for professional development to do their job effectively. **Mr Behrens** said this is an issue for the leadership of a Trust to address, to ensure that complaint handlers have the skills to recognise what is going on, and have the status to say, it is not acceptable, without fear or favour and the people who do this work are not just used as sub-standard labourers.
- 3) Many Trusts, not all, saw complaints negatively and defensively and felt they did not get the support from senior management in a Trust, who were too far removed from the day-to-day handling to understand the support and investment needed.¹⁰⁵⁰

36. **Mr Behrens** set out four key indicators to signify effective change. The PHSO have tried to incorporate these into the NHS Complaint Standards Framework (emphasis added):

- 1) Do the organisation welcome complaints and recognise them as an important insight into how to improve services? He said it is a big cultural issue which the leadership have to grasp to make sure it is user friendly and people feel confident in interacting with the service and that means citizens need a positive experience, as far as possible, and staff have the discretion to resolve issues without saying it has to go through a bureaucratic process.
- 2) Is it thorough and fair or is it just something that is going through the motions of looking at issues?
He said there is an issue as to how much respect is given to the views of complainants compared to the views of clinicians and there needs to be a balance between those two parties.¹⁰⁵¹

¹⁰⁵⁰ Ibid

¹⁰⁵¹ Ibid

- 3) What is the outcome from the process? Will you be able to state from the start what will be done, how long it will take and the remedies you might get?
- 4) Leadership. He said this is around culture and learning too, so, asking: what does the complaint service tell us about whether learning is a reality and can it contribute to making it a really just culture? He described how there has to be a connection between the leaders of the organisation and those running the services. He gave an example from a Newcastle Trust, where he saw the Chief Executive routinely meeting with complaint staff to understand the issues, make big calls, to demonstrate that she cared and that she had an understanding of the difficulties they were going through. In his view, leadership means connection between all levels of the organisation, not just having a strategic view and he referred to Boards of Trusts, which are full of excellent people, but they do not always have a sufficient understanding of what is going on in the organisation to make an effective contribution.¹⁰⁵²

37. **Dr Kirkup** provided evidence to the Panel, which was generalised and not specific to SHFT. He also acknowledged the influence that the exposure he has had to bad experiences in Trusts has had on his overall viewpoint. Nevertheless, he provided very important and valuable evidence.

38. He described the 'gold standard' for an organisation's complaints handling service would be one that welcomes complaints as feedback, rather than erecting a barrier by which people are criticised, which may make people defensive. It should involve as early resolution as possible, with clinicians, relatives and patients, in a reconciliatory way and not a hostile, confrontational way. It would be an integral part of clinical governance. He observed that most of the commercial sector has moved miles past where the NHS is on this and the NHS could learn a lot from them.¹⁰⁵³

39. Furthermore, **Dr Kirkup** stated that, "complaints are not often seen as a valuable source of information about services, and rarely prompt safety investigations. They are not routinely linked to clinical governance systems as they should be, but run separately... these features require addressing, but this may be a significant national problem...".¹⁰⁵⁴

¹⁰⁵² Ibid

¹⁰⁵³ Evidence of Dr Kirkup, 8 April 2021

¹⁰⁵⁴ Statement of Dr Kirkup, 5 March 2021

40. He described his experience of Trusts when things have gone systemically or systematically wrong and said that there is often a divide between senior Board level and those operating the service at the frontline. He said in the worst cases, people at the frontline are reluctant to identify problems because the response is 'we don't want to hear about them, take them away and deal with them'. He described how this can descend into a bullying culture as people become frightened to report problems because they fear their jobs are in jeopardy, or they will be disciplined, and that fosters a situation where, at senior level, people can say they do not know of any problems and as far as they are concerned, it is working perfectly because they never hear of anything going wrong. He said that disconnect is hard to eradicate.¹⁰⁵⁵

Independence in investigating complaints

41. A **carer** said, "a more independent investigation process would be useful and certainly a more centralised department carrying out the investigations. I compare it to the Police who have a separate unit (to investigate) with a senior officer heading that unit. That could be useful for SHFT: a separate unit, with someone senior overseeing complaint reports and to ensure actions are taken. The handlers in the complaints department now are very nice, but there are no teeth to it and I believe they should have more clout".¹⁰⁵⁶

42. A **carer and family member** suggested that where there are serious complaints, or if it is specifically requested, they need to go to an independent person, perhaps with legal training and a good understanding of the NHS, who was confident enough to know they could go into SHFT and ask to look in any system. They would get to the nub of what people were asking and concerned about.¹⁰⁵⁷

43. The **carer and family member** said that such an investigator should also have the authority to ask if actions have been implemented and for evidence of that. She said this could be someone who worked in SHFT but could not be influenced and was there to work for the patients, carers and services users. She believes this might encourage more people to come forward and make a complaint, which in turn might result in change.¹⁰⁵⁸

¹⁰⁵⁵ Evidence of Dr Kirkup, 8 April 2021

¹⁰⁵⁶ Evidence of carer, 6 April 2021

¹⁰⁵⁷ Evidence of carer and family member, 9 March 2021

¹⁰⁵⁸ Ibid

Panel's Views on where SHFT should be: policy, procedure and process for complaints handling continued...

- The document should be prepared with the PHSO complaints handling guides and frameworks in mind. It should be clear, straightforward and in an easy-to-read format.
- The Complaints Leaflet must also be re-examined and revised as a matter of urgency with the same fundamental principles in mind.
- These documents must be widely available to service users, carers and family members and staff and not only in a digital format.

Centralised or local resolution of complaints

- SHFT should decide whether it currently has a centralised complaints system and whether or not to have a centralised complaints system. Conflicting information was provided by participants as to what system exists at present. A centralised system would be one that reflects the current centralised investigations team for SIs.
- Once SHFT have decided it must be widely shared amongst staff across the organisation and communicated in a simple and straightforward way to service users, carers and families (for example, in the Policy and Procedure document, leaflet and on its website). Consistent language must be used.

PALS

- SHFT should decide whether or not it has a PALS, and if so, decide on what this type of service is to be called and known as in SHFT. Its role, purpose and function in the handling of complaints and concerns needs to be clarified. It must be widely communicated to staff across the organisation and communicated in a simple and consistent way to service users, carers and family members (for example, in the Complaints leaflet and on its website).

Independent investigations

- In the Panel's view, complaints that cannot be resolved locally, or where the complainant requests it, should either be investigated at a more senior level or by a different service. In order to investigate complaints effectively, there must be actual, and a perception of, independence in that process.
- SHFT should have a formalised policy and procedure in place to enable complaints about the complaints process to be brought within the organisation. Once written, it should be shared with complainants and readily available in the Complaints Leaflet and on the website.

Culture in complaints handling

Independent Evidence

47. The **PHSO Chair and Ombudsman, Mr Behrens** said, “the leaders of the organisation (Chief Executive, colleagues and the Non-Executive Board) have the responsibility to

make sure the climate in the organisation is one in which complaints are seen as a positive contribution to learning, rather than seeing them defensively, as a nuisance and pushing them to one side”.¹⁰⁶¹

48. **Mr Behrens** said, “I have been to Trusts where Chief Executives do demonstrate an acute understanding of responsibilities to create an appropriate climate in terms of speaking up, to listen and engage with service users. But that has been the exception rather than the rule”. The example he gave from a Newcastle Trust is set out above.¹⁰⁶²

49. He suggested ways in which a Trust can measure its success in relation to the principles he identified (emphasis added):

- 1) Complaints should not be hidden away and not shared.
- 2) There needs to be oversight to compare and publish how Trusts are performing. The PHSO are going to be doing that through regular published reports over the course of a year. He added that this is not simply a question of the number of complaints, because it is recognised that systems that are trusted tend to attract more complaints than those that are not trusted.¹⁰⁶³

50. The **Director for Experience, Participation and Equalities at NHSE/I, Dr Churchill** explained that, “part of the challenge with complaints handling, is that it’s around the extent to which you have organisational cultures where people are prepared to hear tough feedback, are not overly defensive in responding to it at service delivery level and crucially, at the Board-level, they want to know what’s happening and to learn from mistakes... I wouldn’t expect to see an NHS organisation that is poor at complaints handling, but good at listening to staff concerns and running investigations, the likelihood is that if they’re not listening to patients and families, they’re also not listening to staff or conducting investigations as independently and rigorously as they should; so where there is cluster of those circumstances, it can take time for the culture in an organisation to turn around”.¹⁰⁶⁴

Panel’s Views on where SHFT should be: culture of complaints handling

- In order to re-build the trust and confidence with the population it serves, SHFT must continue to develop a culture of openness and honesty and move away from a closed and defensive culture. There is more work to be done to achieve this. SHFT are not yet in the place they should be, that is, welcoming complaints.
- The Panel’s view is that with the implementation of its recommendations on the production of a new combined Complaints Policy and Procedure and a Complaints Leaflet and better

Panel's Views on where SHFT should be: complaints and concerns

- In the Panel's view, when SHFT amend its Complaints Policy and Procedure it should be explicitly clear about what it defines and treats as a 'concern' and as a 'complaint' and about which procedure/process applies to both. It should also clarify the criteria used to convert a 'concern' into a 'complaint' and vice-versa.
- The revised policy should be explained and shared in a clear and straightforward way in the new Policy and Procedure document, Complaints Leaflet and on the website.
- SHFT must improve and put in place structures to ensure that the recommendations and learning arising from 'concerns' are reviewed, thematically, and are shared and considered for greater improvement and Trust-wide learning.

'Complaints' and 'Concerns'

Independent Evidence

51. The **PHSO Chair and Ombudsman, Mr Behrens** said that if you have a 'concern' in the NHS it means you do not have to write it down and it does not have to be acted upon. He described that as disappointing and not helpful.¹⁰⁶⁵

52. He described how the earlier you can spot or stop something the better, is a key feature of an effective complaints handling process. There will be issues which in NHS terms are 'concerns' and should be addressed. If they go septic, they will become complaints and will have to be addressed at more cost and that is not a good thing. He said if someone has a concern it's an embryonic complaint and should be looked at as if it were a complaint.¹⁰⁶⁶

¹⁰⁶⁵ Evidence of PHSO Chair and Ombudsman, Mr Behrens, 9 April 2021

¹⁰⁶⁶ Ibid

Training for complaint handlers and investigators

Independent Evidence

53. The **PHSO Chair and Ombudsman, Mr Behrens** said that there are serious failings amongst frontline complaint handlers and organisations, not giving appropriate training to people who have to investigate complaints. He described it as a structural problem and said there needs to be professional training provided to case handlers, to make sure they have the skills to do immensely difficult jobs. There are technical skills related to deciding whether or not to investigate and to have the competence to conduct the investigation and produce reports with sensible outcomes.¹⁰⁶⁷
54. He said there are also issues around interpersonal skills and the ability to effectively communicate in an empathetic and understanding way. He said that those skills are hard to develop and obtain; they can take a long time to put in place; and not everyone is capable of receiving them.¹⁰⁶⁸
55. The comprehensive system of training in the PHSO office includes induction training and a training academy where they take new recruits and over months, they introduce them to the system and models. Furthermore, every case handler has to undergo a core process looking at investigative skills, how to scope enquiries, how reports are written, a communication skills module and training about dealing with trauma.¹⁰⁶⁹
56. **Mr Behrens'** evidence was that the PHSO's feedback surveys show that they treat people with respect and dignity. Furthermore, the senior case handlers in the PHSO office are accredited and have to show competence to undertake delegated responsibilities. The PHSO are developing links with universities to ensure that the PHSO can accredit case handlers externally in the next three years.¹⁰⁷⁰

¹⁰⁶⁷ Ibid

¹⁰⁶⁸ Ibid

¹⁰⁶⁹ Ibid

¹⁰⁷⁰ Ibid

57. In his view, there cannot be good decisions if the case handlers are not effectively trained and accredited. Where this does not happen they are more likely to make fewer good decisions.¹⁰⁷¹

Panel's Views on where SHFT should be: training of Investigation Officers for complaints handling

- SHFT need a more comprehensive system of training for its Investigation Officers who investigate complaints in the divisions.
- The training should include: written and oral communication with vulnerable individuals, Duty of Candour and the qualities required to be a good Investigation Officer.
- The training should include a period of supervision, which should be followed by a process of shadowing and assessment, before Investigation Officers are permitted to do their own, unsupervised investigations.
- SHFT should look to NHSE/I and the PHSO examples set out above for examples of good practice to ensure the Investigation Officers are getting it right first time.
- SHFT should move towards professionalising complaint handlers/Investigation Officers, even if they maintain a local resolution approach.

Complaints Standards Framework provides a more workable guidance on the approach that should be taken to complaints handling”.¹⁰⁷³

60. They said that complaints handling is a skill and they endorse the emphasis on training that is set out in the NHS Complaints Standards Framework and the Ombudsman in both Scotland (SPSO) and Wales (PSOW) who have set up internal Complaints Standards Authorities to monitor complaints handling practice, identify trends, promote best practice and encourage co-operation and sharing of best practice among listed authorities.¹⁰⁷⁴

¹⁰⁷¹ Ibid

¹⁰⁷² Evidence of Director for Experience, Participation and Equalities at NHSE/I, Dr Churchill, 20 April 2021

¹⁰⁷³ Statement of Dr Sonia Macleod and Professor Linda Mulcahy, University of Oxford, 18 May 2021

¹⁰⁷⁴ Ibid

Response to complaints, including the engagement of service users, carers and families

Independent Evidence

61. **Dr Kirkup** stated that, “responses to complaints are not generally good across the NHS... I have heard numerous examples and experienced one or two first-hand, where an initial response to a complaint is dismissive at best and hostile at worst... I think the way they are dealt with in many Trusts, is that they are seen as something that has to be fobbed-off and got rid of as quick as they can, not as an opportunity to hear how services could be better...”.¹⁰⁷⁵
62. He said clinicians have to have the confidence and experience to sit down with patients and relatives, say something has gone wrong; say ‘sorry’, ‘this is the reason we think it happened’, ‘this is what we will do now’ and ‘this is how we will investigate’ and welcome their involvement. It is not a quick conversation; you need time and space to do it properly.¹⁰⁷⁶
63. The **PHSO Chair and Ombudsman, Mr Behrens** said, “we need to be more sympathetic and empathetic without losing our ability to be impartial when it comes to decisions”. He described how, “we, as a set of institutions in England, tend to rely on investigations in a way which does not help people who are aggrieved and traumatised

¹⁰⁷⁵ Evidence of Dr Kirkup, 8 April 2021

¹⁰⁷⁶ Ibid

and the hard work to try and mediate where there is value in doing that, has to continue, but both parties have to want to sit in a room and talk, if they don't, it's not mediation. He said if there is even a hint of possibility then it is worth having a go at trying to bring about reconciliation.¹⁰⁷⁷

64. He said that the term 'vexatious', which he defined as, "the behaviour of the person complaining getting in the way of the resolution of the complaint they bring to you", should be spelt out in clear terms in public and people need warnings. Where there is unacceptable behaviour, he said, the Board has responsibility for making sure the policy is known about and there is enough resource to develop people to have the confidence and competence to handle these sensitive issues.¹⁰⁷⁸

65. **Mr Behrens** described how there is a danger that people who bring difficult issues, because they have been so stressed or traumatised, may present them in a non-conventional way and the important thing is not to blame the person for the issue they raise. In his opinion there is no substitute for face-to-face conversation.¹⁰⁷⁹

66. The statement of **Dr Sonia Macleod and Professor Linda Mulcahy** said that any communication should be sincere. This includes apologies which should be genuine apologies, rather than 'we are sorry that you feel...'.¹⁰⁸⁰

67. The **National Clinical Director for Mental Health, NHS England, Professor Kendall**, said his personal view, not that of NHSE, is that there should be an opportunity for service users and carers to be involved at all levels of an organisation, not just investigations, but the way a service is run.¹⁰⁸¹

Evidence of service users

68. A **service user** said that SHFT need to listen to the service user, listen to families, if relevant, and listen to their wider support".¹⁰⁸²

¹⁰⁷⁷ Evidence of PHSO Chair and Ombudsman, Mr Behrens, 9 April 2021

¹⁰⁷⁸ Ibid

¹⁰⁷⁹ Ibid

¹⁰⁸⁰ Statement of Dr Sonia Macleod and Professor Linda Mulcahy, University of Oxford, 18 May 2021

¹⁰⁸¹ Evidence of National Clinical Director for Mental Health, NHSE, Professor Kendall, 29 April 2021

¹⁰⁸² Evidence of service user, 15 April 2021

69. Another **service user** said, “I think they should actually be compassionate... even though the letter does say ‘we are really sorry, we got that wrong’, that could have been accepted if there had been a personal touch, like a meeting...”.¹⁰⁸³

Panel’s Views on where SHFT should be: responses to complaints and engagement

- SHFT should focus on the quality of their complaint response letters, which should be more compassionate, empathetic, respectful and sensitive in the language used.
- SHFT should discuss with complainants how they want their complaint to be handled and agree a timeframe with them, to be more flexible in its response times to ensure quality is not compromised.
- Where unexpected delays arise, SHFT should be swift to communicate and explain the reasons for the delay to the complainant and keep them updated. This should be proactive communication by the Investigation Officer.
- Automated email responses should be avoided. When a response is required, it should be personalised and the language used should avoid thanking the sender for their complaint.
- SHFT should urgently review the structure and content of investigation reports. They should not be de-personalised but the format, tone and language must be user friendly, summarise key judgments and findings must be supported with evidence.
- Use of terms such as ‘upheld/not upheld/partially upheld should be avoided in investigation reports and response letters.
- SHFT should implement consistent and rigorous quality assurance mechanisms for the investigations into complaints and the responses that are sent out.
- Face-to-face meetings must be offered and followed-through, if requested.

Support for making complaints

Evidence of service users and family members

70. A **family member** said that there should be teams who support and encourage people who do not have the confidence or skills to make a complaint to come in with friends or family. He said the teams will need training and may need extra resource to do it, but he

¹⁰⁸³ Evidence of service user, 15 April 2021

thought the teams should want to do this if they want to improve quality. He believes any advocate would have to be from an outside charity unit and not associated with SHFT.¹⁰⁸⁴

71. A **service user** said that if a patient in mental health writes to Patient Experience, it should be shared with their Community Psychiatric Nurse.¹⁰⁸⁵

72. Another **service user** thought that there should be a patient experience representative role to liaise between the complaints department and with the patient's clinical team to check if the patient is ok.¹⁰⁸⁶

Independent Evidence

73. The **PHSO Chair and Ombudsman, Mr Behrens** said complainants are dealing with a large bureaucracy. They have to understand how it works to stand a chance of being effective in bringing an issue forward, which is why in their complaints standards process, there is a requirement on Trusts to publish, in an effective way, what their complaint process means in real terms and how to use it. It should be user friendly, accessible and have people available to explain it, so people do not have to make guesses. He described how the more support a service user can get, the better it is for them and how PALS and advocacy groups often perform a critical role.¹⁰⁸⁷

74. He said there is an inequality in the handling of complaints in mental health services and it puts people in receipt of those services at a disadvantage, but it does not apply just to mental health services. He referred to a study the PHSO undertook about whether elderly people are prepared to make complaints and said it found that a disproportionate number did not want to complain, because they thought they would be victimised, could not operate a computer to make the complaint, or their families did not think it would be worth it, because there would not be an appropriate outcome. He described those findings as chilling.¹⁰⁸⁸

¹⁰⁸⁴ Evidence of family member, 14 April 2021

¹⁰⁸⁵ Evidence of service user, 15 April 2021

¹⁰⁸⁶ Evidence of service user, 4 April 2021

¹⁰⁸⁷ Evidence of PHSO Chair and Ombudsman, Mr Behrens, 9 April 2021

¹⁰⁸⁸ Ibid

75. **Mr Behrens** said that in mental health services, they cannot rely on traditional means of eliciting views, such as surveys, and they have to listen carefully and find different ways to meet service users, which are safe and not threatening. He said that needs investment and training but it is not impossible. He described how Trusts should benchmark themselves against organisations in a similar position: go out and talk to people, look to see how they do it and talk to patient groups.¹⁰⁸⁹

76. **Dr Sonia Macleod and Professor Linda Mulcahy** stated: “Community Health Councils (CHC) still exist in Wales and provide a specific Complaints Advocacy Service to support those wishing to complain. CHCs were independent organisations external to the NHS that were created in 1974 to provide a voice for patients in the NHS in England and Wales. CHCs were abolished in England in 2003 as part of the reforms under the 2000 NHS Plan, they were replaced by PALS”.¹⁰⁹⁰

77. In their informed opinion, appropriate advocacy and support should be available for individuals who wish to make a complaint. They referred to the introduction in Wales, in 2011, of ‘Putting Things Right’, to simplify the process for those raising concerns. In 2014 a review of this was carried out for the Welsh Government by Keith Evans ‘Using the Gift of Complaints: A Review of Concerns (Complaints) Handling in NHS Wales’. They said that there was a clear shift in emphasis towards regarding complaints as a ‘gift’ and supporting individuals to raise concerns.¹⁰⁹¹

Panel’s Views on where SHFT should be: supporting complainants

- SHFT should provide clarity over the role of PALS in relation to complaints and concerns. For example, PALS does not have to be physically located in one place, such as a ‘desk’ or fixed location. It could be a ‘virtual service’ provided by phone, web-chat, text message or email.

Panel’s Views on where SHFT should be: supporting complainants continued...

- The Panel’s firm view is that engagement with the complainant must improve and go further than it has; the impact should be measured and monitored on a regular basis.
- SHFT should ensure that, when required, service users, carers and family members have access to advocacy services. This service may be through a Third sector organisation, to ensure there is independence and the perception of independence. It must be facilitated in a coordinated, joined-up way, which is built-in to the complaints handling process in SHFT.
- SHFT needs to do more to ensure that it is making the complaints handling process accessible for all of its population, including those that are in harder to reach groups or less able to actively engage in the process on their own.

Actions taken following complaints

Independent Evidence

78. The Panel questioned the **PHSO Chair and Ombudsman, Mr Behrens** on the powers of the PHSO to ensure that actions are taken by a Trust following an investigation by the PHSO and recommendations. He confirmed that the PHSO has no coercive powers. He said that they do have a relationship with the CQC, which he said can be challenging and difficult, but it is well managed at the moment. He said they have to work with the CQC to draw their attention to issues arising from the PHSO individual reports, which they can look at in their role as regulator.¹⁰⁹²

79. He described how there comes a time when they have to say that it has gone beyond the time for implementation of the recommendation and it is now up the CQC to see whether or not, over a long period of time, the Trust is operating in a way in which the PHSO had hoped. So there is a responsibility on all of the organisations to be joined up without being in each other's pocket.¹⁰⁹³

80. **Mr Behrens** described the need to ensure symmetry between complaints handling and safety investigations, so that when there is a complaint that looks like a serious incident, it can be moved forward by trained people and there is a proper connection between different parts of the health service.¹⁰⁹⁴

Evidence of a carer

¹⁰⁹² Evidence of PHSO Chair and Ombudsman, Mr Behrens, 9 April 2021

¹⁰⁹³ Ibid

¹⁰⁹⁴ Ibid

81. A **carer** said, "I would like to see people actually helped... and that actions are taken in terms of recommendations and suggestions by the investigation officer".¹⁰⁹⁵

Panel's Views on where SHFT should be: actions taken following a complaint

- SHFT should improve its ability to demonstrate that action and changes have been taken in response to complaints at all levels of the organisation – local, front line, divisional and strategic - ensuring SHFT's slogan, "you said - we did", is meaningful and reflected in everyday practice.
- SHFT should improve its mechanisms and structures for monitoring the implementation of recommendations and action plans made by the investigator of the complaint (this is expanded upon in 'action plans').

Assurance and Governance

Independent Evidence

82. **Dr Sonia Macleod and Professor Linda Mulcahy** stated: "the (PHSO) NHS Complaints Standards Framework specifies that every organisation should have appropriate governance structures in place to ensure that senior staff review information arising from complaints regularly and are held accountable for making sure that the learning is acted on to improve services. Senior staff are defined as, *'those who are responsible for leading the NHS organisation, and/or who have senior responsibility for how the organisation handles feedback and complaints and learns from them.'*"¹⁰⁹⁶

83. They also refer to the 'Independent Medicines and Medical Devices Safety Review ("IMMDS Review")', which considered this issue in the light of the findings from the Mid-Staffs Public Inquiry.¹⁰⁹⁷ The Action for Improvement that the IMMDS Review recommended was that, *'all Organisations who take complaints from the public should designate a non-executive member of the board to oversee the complaint-handling process and outcomes, and to ensure that appropriate action is taken.'*¹⁰⁹⁸

¹⁰⁹⁵ Evidence of carer, 6 April 2021

¹⁰⁹⁶ Statement of Dr Sonia Macleod and Professor Linda Mulcahy, University of Oxford, 18 May 2021

¹⁰⁹⁷

<https://webarchive.nationalarchives.gov.uk/20150407084231/http://www.midstaffspublicinquiry.com/report>

¹⁰⁹⁸ Statement of Dr Sonia Macleod and Professor Linda Mulcahy, University of Oxford, 18 May 2021

84. **Dr Sonia Macleod and Professor Linda Mulcahy** described how the IMMDS Review recommendation goes further than the PHSO NHS Complaints Standards Framework, as it requires an independent person to have oversight of complaints, rather than a member of staff.¹⁰⁹⁹

85. The **PHSO Chair and Ombudsman, Mr Behrens** said that quality assurance is an important issue going to the heart of public confidence in what they do. The PHSO are the only national Ombudsman service in Europe to use an independent firm to ask service users to judge whether they have met the statements in their service charter.¹¹⁰⁰

86. The PHSO will soon be publishing 'Quality Standards' which set out what they consider to be best practice in the quality of decision-making. **Mr Behrens** said the PHSO use an internal system of review and scrutiny to make sure their decisions meet the standards and if there is a deficit in the quality of the work then they hold cases back as a result of that quality review. The PHSO will be publishing quarterly results of this data.¹¹⁰¹

87. **Mr Behrens** said that the PHSO employ a team of clinical advisors inside the organisation and commission external advisors to advise their complaint handlers to ensure they are sticking to the Ombudsman clinical standards, so they ensure that what they do is evidence based.¹¹⁰²

88. The **Director for Experience, Participation and Equalities at NHSE/I, Dr Churchill** said peer review is quite powerful and NHSE have a Regional team that look at complaints and responses from another Regional team to see how effective they are and to provide peer insight into quality. They have found that helpful in improving quality.¹¹⁰³

Evidence of a family member

89. A **family member** said that there should be service standards for complaints handling which should fit the needs of the people using the services and that accountability does

¹⁰⁹⁹ Ibid

¹¹⁰⁰ Evidence of PHSO Chair and Ombudsman, Mr Behrens, 9 April 2021

¹¹⁰¹ Ibid

¹¹⁰² Ibid

¹¹⁰³ Evidence of Director for Experience, Participation and Equalities at NHSE/I, Dr Churchill, 20 April 2021

not mean blame, but it needs to be clear as to who should rectify the problem. He recognised that most problems are caused by a system failure, not individual failings.¹¹⁰⁴

Panel's Views on where SHFT should be: governance and assurance of complaints

- SHFT needs to increase and improve its monitoring of the complaint investigations, the reports and responses to ensure that the quality assurance of them is systematic and rigorous. The system must test the extent to which the outcomes and judgments reached are evidence-based, objective and fair.
- SHFT should consider developing co-produced quality standards for complaints handling, which should form part of the Complaints leaflet, and should be available to the complainant before they decide to make a complaint or raise a concern.
- The Panel is not satisfied that the complaints in SHFT are a sufficient part of the internal clinical governance structure. To reach the 'gold standard' that Dr Kirkup spoke of, they should be.
- In the next reporting cycle and in future, SHFT's Annual Complaints Report should include more analysis, quantitative data and effective reporting on complaints. The Report should be supplemented with an annual action plan, which should state how the QI methodology will be used to maintain quality and to identify and strengthen areas for improvement.
- SHFT should set up a Complaints Monitoring Committee, which should include a representative of the CCG and should consider appointing a Chair, or Deputy Chair, such as a service user or carer, who has experience of making a complaint within SHFT.

Themes in complaints and concerns

Independent Evidence

90. The **PHSO Chair and Ombudsman, Mr Behrens** said they view it as very important to be thinking all the time about what thematic issues need addressing beyond individual complaints. The PHSO have a team dedicated to looking at larger thematic issues.¹¹⁰⁵

91. The **Director for Experience, Participation and Equalities at NHSE/I, Dr Churchill** said, "when you look at reports over the years about complaints handling, very similar issues come forward, so I think the pace of improvement has been slow, which is

¹¹⁰⁴ Evidence of a family member, 14 April 2021

¹¹⁰⁵ Evidence of PHSO Chair and Ombudsman, Mr Behrens, 9 April 2021

frustrating, as we are missing a huge opportunity to learn and to prevent mistakes from recurring”.¹¹⁰⁶

SHFT Evidence

92. The **Chief Executive** stated, “the themes in SHFT are not any different to those in other Trusts, they are the same as the themes arising in national reviews of complaints and incidents. How you bring about change is fundamentally in how we enable people to feel confident and safe to recognise and learn from mistakes and be willing to expose where they feel uncertain or they can learn... there are very positive markers in the NHS Annual Staff Survey of the progress made there over the last two to three years and strong markers about safety culture, which is one of the things which pleases me most”.¹¹⁰⁷

Panel’s Views on where SHFT should be: themes in complaints and concerns

- SHFT must not rely solely on the fact that the top three themes that arise in their complaints are the same as the national top three themes as justification for why it is not improving on these themes.
- A deep dive analysis into these top three themes should be conducted by SHFT promptly, one at a time, using the QI methodology to do so if appropriate, in order to try and improve on them and achieve better outcomes. Any changes that are implemented should be monitored and the impact measured and, if required, more improvement work should be instigated promptly.
- The Panel’s view is that SHFT should be taking a strategic approach to improving on these consistent themes in order for them to be better understood in the context of their population basis.

Number of complaints

Independent Evidence

¹¹⁰⁶ Evidence of Director for Experience, Participation and Equalities at NHSE/I, Dr Churchill, 20 April 2021

¹¹⁰⁷ Evidence of Chief Executive at SHFT, 16 April 2021

93. The two participants from NHSE/I gave general evidence regarding what can, or should, be interpreted from a drop in complaints in an organisation.

94. The **Deputy Director of Patient Safety in NHSE/I, Dr Fogarty** said that if there is a drop in the number of complaints in an organisation then may indicate that an organisation with problems in the past is showing an increased level of satisfaction and a decreased level of dissatisfaction within their services, which is an indicator that an organisation is heading in the right direction. It may also indicate problems with patients being able to complain. He would never advocate for a single metric, but would advocate for multiple metrics to be looked at: what does the patient survey say? Are the patients saying they do not need to complain? Have the opportunities to do so been reduced?¹¹⁰⁸

95. The **Director for Experience, Participation and Equalities at NHSE/I, Dr Churchill** said “we were worried (in NHSE), some time ago, that a small number of complaints would be seen as a positive sign, but actually, the positive sign is having complaints because people know how to complain and there are policies and processes in place for dealing with them and they’re handled well and there is learning”.¹¹⁰⁹

Feedback from complainants

Independent Evidence

96. **Dr Churchill** provided his views on obtaining feedback from complainants: “I am keen on specific questions about people being able to feedback and being heard. For example, two thirds of all patients with a diagnosis complete the cancer patient survey, which demonstrates that people want to share their experience. Over time, the majority of Trusts improve against the majority of those indicators year on year... we add questions at the request of patients and patient groups and you can measure against them”.¹¹¹⁰

97. **Dr Churchill** said it is not just about the ‘willingness to recommend’ score in the Friends and Family Test, but principally, it should be about people who are using a ward or

¹¹⁰⁸ Evidence of Deputy Director of Patient Safety in NHSE/I, Dr Fogarty, 20 April 2021

¹¹⁰⁹ Evidence of Director for Experience, Participation and Equalities at NHSE/I, Dr Churchill, 20 April 2021

¹¹¹⁰ Ibid

service feeding back on their experience and the people working there should look at it every couple of weeks and act on it. He said it is evidenced that wards and services that have a culture of regularly asking for feedback and reviewing it, score better in quality and safety than those wards that do not have that habit. He described how they have been trying to enhance the actions on feedback as success and that it is not about getting a certain number of patients to answer it, but demonstrating what has been done.¹¹¹¹

98. He described a challenge with feedback generally is how it is obtained along a pathway and in a way that supports integrated care. The current focus is around organisations and he said NHSE/I are keen for ICSs to look at this.¹¹¹²

Evidence from SHFT

99. In terms of future improvements in this area in SHFT, the **Director of Nursing & AHP** said it would be helpful to have a patient satisfaction rating for complaints¹¹¹³ and the **Patient Safety and Quality Facilitator for the Southampton Division** said that she understood that there is going to be a new system for providing immediate feedback using a QR code but did not know when that was going to be implemented.¹¹¹⁴

Evidence of service users and family members

100. A **service user** observed that feedback is how you improve and said that if there were an outside organisation doing it in a fair way who produced it as figures, which were declared, it would be fantastic. From her perspective, things need to improve.¹¹¹⁵

101. A **family member** said that SHFT should put into every unit, “high quality customer feedback on their performance in respect of how the patient felt they were being dealt with and how well people were getting as a result of their care”. If somebody were reluctant to give feedback, he said, SHFT could use an external company to obtain the feedback and pass it back to SHFT. In his opinion, a lot of people are afraid to give

¹¹¹¹ Ibid

¹¹¹² Ibid

¹¹¹³ Evidence of Director of Nursing & AHP at SHFT, 9 March 2021

¹¹¹⁴ Evidence of Patient Safety and Quality Facilitator for the Southampton Division, at SHFT, 13 April 2021

¹¹¹⁵ Evidence of service user, 15 April 2021

feedback because they are afraid it will affect their care, but he believes it is a solvable problem.¹¹¹⁶

102. In regards to whom the feedback should be shared with, he stated that the information should be collected by the team and shared with managers above them. It should not be used to beat the teams over the head and they need managerial support to fix their problems, as they are the backline and the team are frontline, and the job of the backline people is to add value to the frontline. They should ask the managers to help them achieve it. He also suggested this would be useful information for the CCG to see.¹¹¹⁷

103. He advocates for teams to produce a rolling annual feedback plan - an action plan to deal with customer feedback - and the managers to look at the plans with them. So, they are moving away from being told what to do, to wanting to be the best team in the programme and he suggests that the complaints system is built into this.¹¹¹⁸

Panel's Views on where SHFT should be: feedback from complainants

- SHFT should continue to utilise different methods of communication in order to gather as much feedback as possible following the closing of a complaint. They should continue to use the telephone as it has proven successful, but they should also explore other methods, such as a QR code, text, email and external web services too. SHFT staff should be encouraged to see feedback as a way to improve, not as a negative.
- SHFT should do more to ensure that it is obtaining feedback from those in harder-to-reach groups, and in that regard, it should continue to develop its relationship with Healthwatch. The work of the Service User Involvement Facilitators and the Head of Patient and Public Involvement and Patient Experience should continue in earnest.

mutual respect.

¹¹¹⁶ Evidence of family member, 14 April 2021

¹¹¹⁷ Ibid

¹¹¹⁸ Ibid

105. A **service user** made six suggestions for the future:

- 1) Staff should follow SHFT's policies;
- 2) Staff should have wider training, including, on legal issues;
- 3) Medical records should include the clinician's thought process and reasons for their decision;
- 4) Complaints should be investigated by an outside, impartial body with authority to request relevant evidence and liaise between the parties;
- 5) The selection and training of Investigating Officers needs to be more robust and comprehensive with accountability and;
- 6) A new national standard (for complaints).¹¹¹⁹

106. A **family member** said, "the key thing is, when something goes wrong, all the families want it put right and before you can do that, you have to understand the root of the failure... the failing can be anywhere in the organisation... or in a number of different parts of the organisation, including the NHS".¹¹²⁰

107. He said that the improvements he would like to see in the complaint procedure would be to raise it with the frontline and they should fix it if they can. There should be one person in charge of the unit. It should be referred up to the Divisional Manager or Chief Executive if it cannot be resolved on the frontline then to the Board, then to NHSE or the CCG. If it is urgent, it should be dealt with within 48 hours.¹¹²¹

¹¹¹⁹ Evidence of service user, 4 March 2021

¹¹²⁰ Evidence of family member, 14 April 2021

¹¹²¹ Ibid

Communication & Liaison and ‘Care for the Carer’

C. Where should SHFT be?

Initiatives and mechanisms for communication and liaison with service users, patients and family members

Evidence from SHFT

108. The **Head of Patient and Public Engagement and Experience** said, “I would like to see a Lead for Engagement in each division. We have Patient Experience Leads in all the service areas, but I would like a permanent position, so it could all be joined-up and any learning and good practice shared, which we do try to do through the Engagement Lead Network. But it is an aspiration to connect with communities to expand it. I think it needs designated roles in each division and some are looking at that”.¹¹²²

Independent Evidence

109. **Dr Kirkup** stated: “communication with families is very often poor in dysfunctional organisations... the inevitable result is loss of trust in the organisation on the part of families and the public... the essential first step is for the organisation to admit its failings fully and frankly. If families are then involved honestly and openly in the improvement work, it is possible to build trust successfully over time. The best evidence of this will come from the families themselves”.¹¹²³

110. In oral evidence he spoke of communication problems stemming from difficulties clinicians have in coming to terms with the fact that things go wrong. He said they must be honest and open about it and involve people in how to put it right, but that does not happen and it erects barriers to open communication.¹¹²⁴

111. The **Director for Experience, Participation and Equalities at NHSE/I, Dr Churchill** discussed the ‘Ladder of Engagement and Participation’.¹¹²⁵ He said that at the limited end of the Ladder the focus is on consultation, where people are given information and

¹¹²² Evidence of Head of Patient and Public Engagement and Experience, SHFT, 10 March 2021

¹¹²³ Statement of Dr Kirkup, 5 March 2021

¹¹²⁴ Evidence of Dr Kirkup, 8 April 2021

¹¹²⁵ <https://www.england.nhs.uk/participation/resources/ladder-of-engagement-2/>

asked for their views, which are taken into account. At the top end, there will be full co-creation and co-production, where people are sitting around the table with a blank piece of paper and working out what they are going to do about problems. He said they would want to see from an NHS organisation that they have skills on each rung of the ladder and they know when to apply them. In the best NHS providers, he said, there are a significant percentage of service users and patients trained in QI and there are 'quality circles' for the services, which service users sit on report that they feel their engagement is meaningful, clear and makes a difference.¹¹²⁶

112. **Dr Churchill** described how the Quality Committee of NHSE/I recently determined that co-production would be the first principle of leading transformational change, which marks a shift in the tide, from this being something the best organisations do, to being consistent across organisations in their services.¹¹²⁷

113. His expectation is that all organisations will understand the 'Ladder of Engagement and Participation', which is at the heart of their engagement network with practitioners in NHS organisations. The point, he said, is that you try and match the technique for the circumstances, for example, he went to a QI conference in a Trust where they played a game around the improvement ladder and the users and staff really appreciated it.¹¹²⁸

114. **Dr Churchill** stated that NHS organisations tend to be most comfortable with the lower rungs of the Ladder, where they have more control, and less so with the higher rungs, in things like co-production. So, he described how part of their goal is to determine how they, and others, can give greater comfort and confidence to professionals. He believes that some of the greatest gains are to be made in that space.¹¹²⁹

115. The **Deputy Director of Patient Safety in NHSE/I, Dr Fogarty** said that healthcare relies on the transfer of information, so there is always a risk that it will not be conveyed in the way the giver intended to give it, or the recipient intended to hear it. Thus, it is an area where risk arises and the more communication, the more risk, and it can be incredibly fraught, as it is such an inherently human process. But equally, he said, it is vital to reducing risk.¹¹³⁰

¹¹²⁶ Evidence of Director for Experience, Participation and Equalities at NHSE/I, Dr Churchill, 20 April 2021

¹¹²⁷ Ibid

¹¹²⁸ Ibid

¹¹²⁹ Ibid

¹¹³⁰ Evidence of Deputy Director of Patient Safety in NHSE/I, Dr Fogarty, 20 April 2021

Panel's Views on where SHFT should be: initiatives and mechanisms for communication and liaison with service users and family members

- The Panel is of the firm view that SHFT should have a focussed Communication Strategy, which is co-produced with service users, carers, family members and staff. It should ensure that there is clarity as to the expectations of service delivery from SHFT: what they can do and what they cannot do (including staff).
- SHFT need to improve the support they provide their service users and family members when seeking advice. Therefore, the Panel suggests that SHFT considers implementing a protocol to address that need. It could be in the form of 'A Team around the Family', which would essentially be a team of professionals around the service user, carer and family to provide care, support and advice when needed and in a form which suits that particular service user, carer and family.

Initiatives and mechanisms for communication and liaison with carers

116. The evidence set out here reflects the mechanisms and initiatives that should be in place for carers to ensure that SHFT are an organisation that 'care for the carers'. It will touch upon the Carer Communication Plans, Triangle of Care and Carer's Action Plan and other points raised during the evidence received at Stage 2. It will also consider the potential for a 'carer's hotline' and other possible initiatives that came out of the evidence, for example, an annual meeting with a carer or family member.

Evidence from SHFT

117. The **Chief Medical Officer** discussed how SHFT identifies carers and said there is a mechanism and process for identifying carers, for having conversations and identifying their needs. He acknowledged that they have a duty under the Care Act and to connect them to the Local Authority. He said he had come across carers needing help and stated that all community teams have significant expertise in supporting them.¹¹³¹

¹¹³¹ Evidence of Chief Medical Officer at SHFT, 12 April 2021

118. The **Community Mental Health Team Manager** said support for carers is limited at the moment in their team and needs to be improved. She said, “ideally, we would recruit people, specifically, to support families: peer carer family support workers, with lived experience and bring people together, so there is common support for carers and family members to have their own peer group for contact and support”.¹¹³²
119. The Panel heard from a **Clinical Ward Manager** who would like to see more groups for carers to get involved in and activities on the ward. In Southampton, she said, more could be done to involve carers in their QI projects.¹¹³³
120. In response to whether the **Chief Medical Officer** would object, in principle, to a telephone ‘hotline for carers’. He responded: “I think it lies directly with the team providing the care, not external to that team... so there are thousands (of people) available for contact, rather than one single point of contact, where potentially the failure point would occur. I would hate to suggest we have a single phone line which is impossible to get through to and does not immediately lead to an effect on the care of their loved one”.¹¹³⁴
121. The **Chief Executive** was also asked for his views on a telephone ‘hotline for carers’, he said, “we would certainly give it consideration”. But said they have in the past had hotlines in mental health services for service users and families and they have not always necessarily been the best way. He said, by its very nature, it goes to one place and that one person who takes the call will probably not know the circumstances in every ward, team or service or the subtleties of what the carer wants and is looking for.¹¹³⁵
122. He suggested that the best way to connect is to connect the person, where possible, directly to the service. However, he agreed that he will explore further the possibility of being able to call, get a quick response and for someone to say, ‘someone will get back to you’, so that if they do leave a message, someone will get back to them.¹¹³⁶
123. The **Community Mental Health Team Manager** did not have a problem with a ‘carer hotline’, but thought that is that it is everyone’s responsibility. They would want to look at

¹¹³² Evidence of Community Mental Health Team Manager, SHFT, 31 March 2021

¹¹³³ Evidence of Clinical Ward Manager, SHFT, 12 April 2021

¹¹³⁴ Evidence of Chief Medical Officer at SHFT, 12 April 2021

¹¹³⁵ Evidence of Chief Executive of SHFT, 16 April 2021

¹¹³⁶ Ibid

whether it is the team or most appropriate person picking up the phone, not just someone passing on a message and then nothing happening.¹¹³⁷

124. The **Clinical Director for the Hampshire South-West Division** was asked for her views on a carer's suggestion of an annual meeting for carers, with clinicians present. She said, "I know how stretched our mental health teams are and that working with carers in the Triangle of Care is part of what they believe to be their role; and care coordination and working with patients should absolutely include families... I think that within appointments and conversations about care needs we should be doing that and I think we are. Whether you could also have the capacity for separate fixed meetings, we could look at it, but it is difficult to put into practice in services that are pushed... it might not be the right approach (for everyone), but if there is that need, we should accommodate that".¹¹³⁸

Evidence from the CCG

125. The **Director of Quality for West Hampshire CCG** spoke highly of the support and social models and thinks that commissioners need to look at how those services can be invested in. She gave the example of 'support lounges', which she had previous experience of. She had seen dementia cafes being held and said that the level of support given to carers of individuals with dementia through the cafes, helped to make them more resilient and better able to care for the person with dementia. She said that having a safe space or crises lounge where people can go when they are feeling unwell and knowing they can access safe support helps them to get early intervention.¹¹³⁹

Evidence from carers and family members

126. The Panel received a number of suggestions as to how SHFT could improve its communication and liaison with carers, from carers and family members. They are underlined below.

¹¹³⁷ Evidence of Community Mental Health Team Manager, SHFT, 31 March 2021

¹¹³⁸ Evidence of Clinical Director for the Hampshire South-West Division, SHFT, 1 April 2021

¹¹³⁹ Evidence of Director of Quality for West Hampshire CCG, 15 April 2021

127. A **carer** suggested an annual telephone call or appointment with the family and patient with long term psychosis, to ask if they need any help, and said that the expectation should be made clear at the time the patient is discharged.¹¹⁴⁰
128. Secondly, he suggested a help line for families to contact for questions and support. He said, “it is very isolating for families caring for a dependent with mental illness. They see potential in their dependent for improved quality of life but are uncertain how best to support them”. He also suggested this could be a regional helpline.¹¹⁴¹
129. He said online helpline would be the most immediate help.¹¹⁴²
130. Further, he said it could be helpful to have a mental health support service for carers on an appointment basis, to provide the chance to talk and ask advice in the GP practice, or to have time reserved with the consultant who saw the patient. He believes that in ICSs in the future, carers should play a massive part and be given support.¹¹⁴³
131. The **carer** also suggested it would be helpful to have a Carers’ Group with a professional as part of the group. He likened it to a tutor group and peer-to-peer learning, with the facilitator there to facilitate the learning.¹¹⁴⁴
132. Another **carer** said that he thought a ‘Carer Hotline’ would be an “absolutely first class idea”. He also said that SHFT did have a Carer Support Worker at one point, which was extremely helpful and she worked hard to get results, but he believed that SHFT had disbanded it. He said he wanted “to be heard and listened to” and the Carer Support Worker had been very effective as she would speak to the team manager to push the case. He described how it felt as if there was someone on your side to do that. He said during the recent discharge they were not contacted and described it as being akin to “pushing someone off the system without realising they would be isolated, housebound and reliant upon the family”.¹¹⁴⁵
133. The **carer** said he needed a Carers’ Group where he could express concerns about treatment and lack of care going forward; a forum to express views and the possibility of

¹¹⁴⁰ Evidence of carer, 31 March 2021

¹¹⁴¹ Ibid

¹¹⁴² Ibid

¹¹⁴³ Ibid

¹¹⁴⁴ Ibid

¹¹⁴⁵ Evidence of a carer, 6 April 2021

involvement with other carers. He stated that some of the ideas about forums and getting people together would be a step forward and he thinks SHFT needs to enforce that.¹¹⁴⁶

134. A **family member and previous carer** stated that one single point of contact for carers would be helpful, but it would need to be prominent as not everyone has access to the internet. She suggested that if for some reason the single point of contact and the carer or family member do not gel, the FLO, if they could not assist, could refer them to someone else or another sector.¹¹⁴⁷

135. A **family member** said that communication plans should be written down and involve the family as good practice. He said that from his experience, this does not happen.¹¹⁴⁸

136. The Panel received samples of the End-User Feedback Survey Responses for the period 2019 to 2020 and one of the prominent comments was:

'She said she is not listened to and feels that a document in which carers can list triggers and list the nice things that help in a trigger situation would be helpful for all, when a loved one is admitted...'. (January 2021)

Independent Evidence

137. The **Chair of Hampshire Healthwatch, Ann Smith** said that one area of that could potentially improve across the UK is in looking after the carers – Carers' Assessments should be taking place. She described it an area that needs improvement and that it has done for some time.¹¹⁴⁹

Panel's Views on where SHFT should be: initiatives and mechanisms available for communication and liaison with carers

- SHFT should adopt, as a starting point, a 'Care for the Carer' approach to its work and communications with carers. This should be pursued as a matter of urgency and pushed forward by the Carers' Strategy Project Officer, supported by the Carer Leads and Carer Support Workers, with input from the Patient Safety Specialists, Patient Safety Partner(s) and the Head of Patient and Public Involvement and Patient Experience.

¹¹⁴⁶ Ibid

¹¹⁴⁷ Evidence of family member and previous carer, 6 April 2021

¹¹⁴⁸ Evidence of family member, 14 April 2021

¹¹⁴⁹ Evidence of Chair of Hampshire Healthwatch, Ann Smith, 6 April 2021

Panel's Views on where SHFT should be: initiatives and mechanisms available for communication and liaison with carers continued...

Carers' Strategy

- SHFT should start by producing and implementing a co-produced Carers' Strategy, led and developed by carers and delivered annually at a large scale event. This may be instead of, or in addition to, the Carers' Action Plan.

Carers' Business Plan

- Additionally, SHFT should produce and implement a co-produced Carers' Business Plan led and developed by carers and monitored by them. It should also be delivered annually at a large scale event. This event should be attended by senior management and the leadership team and it should be chaired by a carer with lived experience.

Carers' Action Plan

- If SHFT continue to use the Carers' Action Plan for more than just internal purposes, it should be amended to represent the fact that it is co-produced and co-owned. It should be made more widely available, for example, on their website and in a non-digital form too.

Triangle of Care

- There needs to be more publicity of the Triangle of Care and all carers identified through the Carer Communication Plan should be informed of it and supported in getting involved.
- The Triangle of Care training should, if it does not already, include an exploration of the term 'carer' and of the different roles and types of carers, including those who care for people who are not current service users.

Carer Communication Plan

- SHFT should ensure that structures, processes and training are in place to encourage wider use of the Carer Communication Plan across the organisation.
- The re-development of the Carer Communication Plan template must be finalised as a matter of priority.
- There should be an option for different methods of communication other than telephone and the carer's preferred method of contact should be recorded.
- The Carer Communication Plan should include a mechanism for a carer to contact a named person within SHFT, recognising that communication works two-ways.

Panel's Views on where SHFT should be: initiatives and mechanisms available for communication and liaison with carers continued...

Carers' Support Groups

- Carers should be seen more widely and nationally as part of the NHS and should be provided with support groups. The Carers' Support Groups should be widely publicised and information provided to the carer as soon as they are identified through the Carer Communication Plan.
- The Groups should be available for carers who may be caring for someone who is not a service user at that specific time.
- The Groups could be part of a localised support network; they could be facilitated by lay members with clinicians; they could include education and advice segments with guest speakers on specialised topics, such as mental health conditions. They should, where possible, be chaired by a carer or someone with experience of caring.
- Each Group should have its own strategy and plan, which is co-produced, directed and monitored by carers. The overarching purpose should be to respond to the needs of carers.

Carer Support Workers

- SHFT should give consideration to the appointment of more peer Carer Support Workers, with lived experience. They should be able to support the carer if they need advice. This should form part of a SHFT protocol/strategy on carers.

Primary and secondary care communication

138. On the topic of primary and secondary care communication and pathways, a **carer** suggested that, “a solution would be a Communication Policy for when SHFT discharges patients, with long term psychosis, to explain to the patient that once a year a follow up appointment with a consultant will be required for them and their family, which will not mean re-admittance to hospital, or forced taking of medication, but help and advice to stay out (of hospital)”.¹¹⁵⁰

139. The **National Clinical Director for Mental Health, NHS England, Professor Kendall** said, “... where you have a patient pathway, you need a clinical director and

¹¹⁵⁰ Evidence of carer, 31 March 2021

service director and I think you should have a service user director working with them to look at patient experience and oversee and ensure high quality patient experience across that pathway... my view is we should be doing that at all levels of our organisation".¹¹⁵¹

140. The **Clinical Director for Mental Health and Learning Disability for West Hampshire CCG** was asked how communications could be improved further. She said, "it is about primary care knowing their team and Lead Consultant and vice-versa... we are working on having a lead GP for each primary care network as a single point of contact... we have trained 19 GPs (in West and North Hampshire) in a primary care mental health diploma".¹¹⁵²

141. As to how SHFT could improve, she said, "I would like to see from SHFT an absolute commitment to clinical staff to be enabled to have the time and capacity to meet with primary care colleagues. It is sometimes an issue and has been missing, but it could be business as usual, as part of the working week or month"¹¹⁵³

142. This topic is explored further below in the discussion around the move to ICSs.

Panel's Views on where SHFT should be: primary and secondary care communication and liaison

- The evidence set out above and earlier in this Report suggests that there is a perceived need to improve the handover between clinicians involved in patient care.
- Therefore, SHFT should ensure that it has in place the training, structures and mechanisms for communication to ensure that care pathway works in practice, in order to reduce either repetition or omissions. There should be a focus on the ways in which technology can assist with improving this.
- SHFT should ensure that staff have the time and capacity to meet with primary care colleagues. They should work collaboratively towards this practice becoming 'business as usual'.

¹¹⁵¹ Evidence of National Clinical Director for Mental Health, NHSE, Professor Kendall, 29 April 2021

¹¹⁵² Evidence of Clinical Director for Mental Health and Learning Disability for West Hampshire CCG, 17 March 2021

¹¹⁵³ Ibid

Recording of information

Independent evidence

143. **Dr Kirkup** commented on how clinical records are taken from one perspective and describe ‘work as imagined, not work as done’, therefore, unless you talk to the people personally involved in those events, you will never get behind that.¹¹⁵⁴

144. The **National Clinical Director for Mental Health in NHSE, Professor Kendall** provided a personal example from his own practice as a psychiatrist for a homelessness and mental health service one day a week. He described how he makes notes in the form of a letter which he gives to the patient and, anything written about them which is sent to anyone else, they are also provided with a copy of. He said that when he starts with a patient, he will ensure there is nothing secret or hidden in the communications and there is nothing in the notes he has not given them. He believes this practice should be more widespread. He said, “we have got to make sure we have a learning culture and can only do that by having it open, transparent and with no blame”.¹¹⁵⁵

Evidence of a service user

145. A **service user** said that communication is key and SHFT need to be better at communicating and sharing information with everyone involved in a person’s life and amongst themselves. He said, in his experience, there have been many times where the notes do not correspond with what was discussed.¹¹⁵⁶

Panel’s views on where SHFT should be: recording of information

- The Panel endorses Professor Kendall’s practice at paragraph 144 above. It encourages SHFT to consider training and supporting its staff to adopt a similar approach. This will ensure note taking is open, transparent and has the patient at the centre of it. The notes should be accessible and penetrable by the patient, their family member or carer, where consent is in place.
- SHFT’s mandatory training must include the recording information in an accurate and consistent way and staff must be allocated sufficient time to do so.

¹¹⁵⁴ Evidence of Dr Kirkup, 8 April 2021

¹¹⁵⁵ Evidence of National Clinical Director for Mental Health in NHS England, Professor Kendall, 29 April 2021

¹¹⁵⁶ Evidence of service user, 15 April 2021

Culture and attitudes in communication and liaison

Evidence of SHFT

146. The **Director of Workforce, Organisational Development and Communications at SHFT** spoke about this topic from a diversity and inclusion perspective. He said, “I would like to do a lot more on diversity and inclusion. We have made great strides but the experience of staff from a characteristics perspective is still not where we would want it to be... we have set a target to be representative across all characteristics by 2024, in our ‘People and Organisation Development Strategy’”. He said they do have an intention to employ more people with disabilities and learning disabilities.¹¹⁵⁷

Evidence of a family member

147. A **family member**, who had experience with SHFT in the past, said she would like to see an open, honest and inclusive culture, which is never demeaning. She asked rhetorically, “if the good things are there, but people are leaving at the rates they are, how do you stop them leaving and ensure the culture encompasses everything and how do different levels communicate with one another and exchange ideas between departments, services and teams?”¹¹⁵⁸

Panel’s Views on where SHFT should be: culture and attitude towards communication and liaison

- In light of the past defensive cultures and attitudes in communications that SHFT has been responsible for, there is a crucial need for SHFT to take a positive proactive approach in all future engagement with families, carers and service users to ensure their needs are met.
- The values that SHFT avers to hold dear and are seeking to invoke must be embedded across the organisation in everything they do and that must include an open and honest culture, which is inclusive and diverse in its views.
- In developing that culture, SHFT must work towards continuing to improve the representation of the population it serves.

¹¹⁵⁷ Evidence of Director of Workforce, Organisational Development and Communications, SHFT, 19 April 2021

¹¹⁵⁸ Evidence of family member, 6 April 2021

Duty of Candour

148. The Panel asked the independent and some expert participants who gave evidence, for their views on the Duty of Candour, including whether they thought it was necessary for it to be on a statutory footing and how it plays out in practice. They received a very rich and informative body of evidence on this topic as a result. Some of this evidence overlaps with the topic of 'just culture' and accountability and investigations.

Independent Evidence

149. **Dr Kirkup** stated, "the gold standard is that as soon as something goes wrong, there is full and open disclosure, which should happen under the Duty of Candour, but that should be done wholeheartedly and not just by paying lip service to it...". He does not think the 'Duty of Candour' should have to be legislated for. He said, "I think we are on a journey and it's about mindset and with that sort of issue - openness, honesty and transparency - you need people to think that it is what they want to do because its right to do, not because someone is telling them externally that it's what they have to do".¹¹⁵⁹

150. He took this further and spoke in general terms when he said, "there is an old adage: the first time is the best opportunity to get it right, and a big problem is that Trusts have not got it right first time. They have been closed, rebuffed people, people have not been given honest and open accounts and the longer it goes on, the more distrustful they become".¹¹⁶⁰

151. Furthermore, he said that you have to be, "as open and honest as you can and sometimes it will work, but it doesn't every time, because if you're an independent investigator, you are never going to agree 100% with what people think of their own case, they will have views that diverge. In my experience, it will be on a minority of issues, but for some people, that is overwhelming unless they are answered in the way they want them to be, then they cannot agree with anything that is less than that".¹¹⁶¹

152. **Dr Kirkup** and other participants spoke generally of a 'sub-culture of impossible perfection' existing amongst clinicians who have very high standards of each other and

¹¹⁵⁹ Evidence of Dr Kirkup, 8 April 2021

¹¹⁶⁰ Ibid

¹¹⁶¹ Ibid

themselves, which makes it very difficult to be open and honest when something goes wrong. He said this can lead to widespread fear that blame will be applied unjustly when an error occurs, which makes it hard to admit errors and they are not properly investigated and learned from as a result.¹¹⁶²

153. The Panel received written and oral evidence from **Dr Ocloo, a Senior Researcher in the Centre for Improvement Science at King's College London**. She stated, "... the Duty of Candour... is a mechanism that can be used to get openness and transparency, but it cannot work properly unless you look at the root of the issue it is trying to address. There is an underlying culture in the NHS, which is fairly systemic and can be the norm in many places, of trying to use a mechanism like the Duty of Candour, in a culture which is not based on openness and transparency... I think this lies at the heart of the issue of why independent investigations are needed - you cannot build openness and transparency on a bed of sand. The right foundations have to be about openness and transparency and you have to get at what is preventing us having those open and transparent foundations in the NHS, before looking at mechanisms like the Duty of Candour".¹¹⁶³

154. **Dr Ocloo** characterised the problems in the NHS system as a whole as being about: "defensiveness and an unwillingness to admit that things have gone wrong... so if that is the norm, you have a default situation where you defend the organisation when harm occurs and families are seen as the problem and have to fight for answers. So, you do not have the roots for a commitment to openness".¹¹⁶⁴

155. She described a system where you have a redress scheme where their remit is based on looking at the facts in an objective way and settling and not about defending your position. She explained that if there is an absence of openness and transparency at the top of an organisation then it sends the wrong signal to the wider NHS system that they are not really committed to transparency. Therefore, in the NHS, she said, there has to be the right balance between openness, accountability and learning and there has to be accountability in public organisations, as this is a way of exposing and addressing corporate and individual failures.¹¹⁶⁵

¹¹⁶² Ibid

¹¹⁶³ Evidence of Dr Ocloo, Senior Researcher in the Centre for Improvement Science at King's College London, 8 April 2021

¹¹⁶⁴ Ibid

¹¹⁶⁵ Ibid

156. **Dr Ocloo** does not think the balance is right currently, nor will it, in her view, be corrected by the Patient Safety Incident Response Framework. She does not think the systems are working appropriately for harmed families to have accountability.¹¹⁶⁶

157. The **Chief Investigator for the Healthcare Safety Investigation Branch (“HSIB”), Keith Conradi** stated, “... I would like to think the ultimate goal is that you don’t need to have (a Duty of Candour) and it should come out of genuine human empathy and it strikes me as fundamental to any investigation”.¹¹⁶⁷

158. The **PHSO Chair and Ombudsman, Mr Behrens** said, “... (the duty of candour) does not work properly at the moment. It should be addressed and it is very important to give people confidence to be able to believe there is a just culture...”. His view is that a ‘safe space’ through HSSIB is not the way to address this. He said, “I have great respect for HSSIB and they are good colleagues making a difference, but if you have a ‘safe space’ where clinicians are told they can disclose without being held to account, it gives the implication that there is an ‘un-safe space’ in the rest of health service...”.¹¹⁶⁸

CCG Evidence

159. The **Interim Director of Nursing and Quality for North Hampshire, South-East Hampshire, Fareham, Gosport and Isle of Wight CCG** said that the most important part of the “SI checklist” they put in for SHFT is the Duty of Candour and developing that relationship. She said that if there is an investigation then it is for learning and to look at what has gone wrong to stop it happening to anyone else, but at the base of that will be the families affected by the serious incident. One of the most important things for her is to be open and honest with the families and involve them in the investigations, as they know their loved ones best from a personal point of view and combining that with the medical expertise, allows a true picture to emerge for the timeline to flow.¹¹⁶⁹

¹¹⁶⁶ Ibid

¹¹⁶⁷ Evidence of Chief Investigator for the HSIB, Keith Conradi, 9 April 2021

¹¹⁶⁸ Evidence of PHSO Chair and Ombudsman, Mr Behrens, 9 April 2021

¹¹⁶⁹ Evidence of Interim Director of Nursing and Quality for North Hampshire, South-East Hampshire, Fareham, Gosport and Isle of Wight CCG, 14 April 2021

Panel's views on where SHFT should be: Duty of Candour

- SHFT should be aiming for, and working towards, the 'gold standard' that Dr Kirkup spoke of (at paragraph 149 above), so that as soon as something goes wrong, there is full and open disclosure. That should be done wholeheartedly and genuinely.
- The Panel draws particular attention to, and endorses, Dr Kirkup's comment that the first time is the best opportunity to get it right.
- SHFT should, throughout the organisation, at all levels, as an absolute, recognise and accept the Duty of Candour as a professional obligation.

The voice of, and engagement with, service users, carers and families

SHFT Evidence

160. The **Chief Medical Officer of SHFT**, who has now left the organisation, said at the top of his list of what SHFT should do is the ongoing engagement with co-production - patients and carers should be co-producing improvement plans - and he would like it to be significantly enhanced in SHFT's QI methodology.¹¹⁷⁰

161. The **Chief Executive** acknowledged that the support and infrastructure for service users to engage is not currently in place in SHFT. He said they are looking to develop independent support for service users and carers and are looking to the Dorset Healthcare University NHS Foundation Trust Mental Health Forum Model to do so. This is, he said, a completely freestanding social enterprise that provides an infrastructure and has professional leadership (chaired by a former PHSO). This is the sort of mechanism and infrastructure SHFT want to build, independent of the organisation, to give service users and carers the voice and strength in order to challenge SHFT even more in what they are doing and to develop that relationship. He said they are one and a half years away, at a minimum, from implementing it as it needs to bring together different voluntary organisations in the county and at least three mental health organisations.¹¹⁷¹

162. The **Chief Executive** described the development as a strategic objective and said they have already started to have discussions and build the support needed, so that

¹¹⁷⁰ Evidence of Chief Medical Officer of SHFT, 12 April 2021

¹¹⁷¹ Evidence of Chief Executive of SHFT, 16 April 2021

people with lived experience can be at the centre of what SHFT are doing in their training, wards, services and interviews.¹¹⁷²

163. He compared the Recovery Colleges (“RC”) in SHFT with the Dorset HealthCare University NHS Foundation Trust. He said that in Dorset they have developed quickly and responsively with service users and families to manage throughout COVID-19. Most of their courses are university accredited so they are professional programmes of support, driven and owned by people with lived experience. In comparison, he said, that the RC in Hampshire has provided some support, but the resources have been too little and he said he is committed to doing more.¹¹⁷³

Evidence of service users

164. A **service user** said, “SHFT need to communicate effectively with service users, families and their wider support network, to find out what care is needed and stick to it where possible. I understand things do go wrong every now and again, but I don’t expect it on a weekly basis”. She expressed how she believes that the system has made her mental health worse and the consequences are that she needs more treatment because she is in a worse place now.¹¹⁷⁴

Independent Evidence

165. The **Director for Experience, Participation and Equalities at NHSE/I, Dr Churchill** said he meets with people who have made complaints to NHSE and want to tell them about their experience of it. This is part of his contact with patients, carers and families to learn about the system. He said he needs to understand if they have had a poor experience and why that is.¹¹⁷⁵

166. The **National Clinical Director for Mental Health in NHSE, Professor Kendall**, said, “whenever I set up a new committee, I try to make sure it is jointly chaired by me and a service user... I had (a national committee based in NHSE overseeing the reduction of restrictive interventions in mental health) co-chaired with a person who had

¹¹⁷² Ibid

¹¹⁷³ Ibid

¹¹⁷⁴ Evidence of service user, 15 April 2021

¹¹⁷⁵ Evidence of Director for Experience, Participation and Equalities at NHSE/I, Dr Churchill, 20 April 2021

been subject to restrictive interventions. He had been homeless for three years and was still a user of mental health services... but was now trained as a therapist in that service”.¹¹⁷⁶

167. He was asked if this approach could be applicable in other situations, such as families who are bereaved following an SI, or when things go wrong. He said it could be, but it would have to be on the basis that they genuinely want to improve things. He could envisage a Trust setting up a small unit to investigate SIs and complaints that would have permanent core staff, which would include relatives. He said it is important that everyone agrees to what is being set out to achieve. His experience is that the service user will need a job description detailing what is expected of them.¹¹⁷⁷

168. Furthermore, **Professor Kendall** said he has developed a Patient Safety Group and has worked with them to set up QI collaboratives across England. They recruit services and start by developing an understanding of local difficulties, working with the users of those services.¹¹⁷⁸

169. The Panel also consulted literature by Don Berwick, who was tasked with setting up a ‘National Advisory Group on the Safety of Patients in England’, which culminated in a report in August 2013.¹¹⁷⁹ It made ten recommendations for improving the safety of patients and some of those are relevant to this Review:

- 1) *The NHS should, continuously and forever, reduce patient harm by embracing wholeheartedly an ethic of learning.*
- 2) *All leaders concerned with NHS healthcare – political, regulatory, governance, executive, clinical and advocacy – should place quality of care in general, and patient safety in particular, at the top of their priorities for investment, inquiry, improvement, regular reporting, encouragement and support.*
- 3) *Patients and their carers should be present, powerful and involved at all levels of healthcare organisations from wards to the boards of Trusts.*

¹¹⁷⁶ Evidence of National Clinical Director for Mental Health in NHSE, Professor Kendall, 29 April 2021

¹¹⁷⁷ Ibid

¹¹⁷⁸ Ibid

¹¹⁷⁹ ‘A promise to learn – a commitment to act’, National Advisory Group on the Safety of Patients in England, August 2014:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf

4) *All organisations should seek out the patient and carer voice as an essential asset in monitoring the safety and quality of care.*¹¹⁸⁰

170. In regards to patient and public engagement, Don Berwick's report¹¹⁸¹ states that:

*'The patient voice should be heard and heeded at all times - Patient involvement means more than simply engaging people in a discussion about services. Involvement means having the patient voice heard at every level of the service, even when that voice is a whisper.... The goal is not for patients and carers to be the passive recipients of increased engagement, but rather to achieve a pervasive culture that welcomes authentic patient partnership... Patients and their carers should be involved in specific actions to improve the safety of the healthcare system and help the NHS to move from asking, 'What's the matter?' to, 'What matters to you?'*¹¹⁸²

Panel's Views on where SHFT should be: the voice of, and engagement with, service users, carers and families

- The Panel strongly recommends SHFT strengthens its links with Hampshire Healthwatch to ensure that the voices of service users and carers are heard nationally and, specifically, to improve SHFT's ability to engage with individuals who may not feel that they are able to engage in the process, or from harder-to-reach groups.
- SHFT should ensure that service users, carers and families are represented at meetings, such as the Patient Safety Group.
- SHFT should do more work to improve its focus on competency and confidence in patient interactions by staff, including temporary staff. Specific mandatory training on communication and liaison skills and reflective practice is required across the organisation. That training should be co-delivered with service users, carers and family members.

¹¹⁸⁰ Ibid

¹¹⁸¹ Ibid

¹¹⁸² Ibid

Investigations

C. Where should SHFT be?

Introduction

171. By way of introduction and background to this topic, this Report will set out in brief detail the proposed amendments to the Serious Incident Framework 2015 (“2015 SI Framework”) and the standards and structures that it is proposed will accompany the new Patient Safety Incident Response Framework (“PSIRF”).

172. The PSIRF is still in the drafting stage. Therefore, the Panel would invite those that are involved in drafting or consulting on it to consider the evidence that was provided during this Stage 2 Review, as it could and indeed should have a wide-ranging and far-reaching impact across the NHS as a whole. The evidence was resoundingly in favour of reform, with the need for patient safety and independence to be at the centre.

Patient Safety Strategy

173. In July 2019, NHSE/I published ‘The NHS Patient Safety Strategy’, which sets out to, *‘build on a patient safety culture and patient safety system’*. It sets-out three strategic aims: *improving insight; improving involvement of patients, staff and partners; and designing and supporting improvement programmes.*¹¹⁸³

Patient Safety Incident Investigations

174. In March 2018, NHS Improvement launched an ‘Engagement Survey’¹¹⁸⁴ to obtain national views on patient safety incidents following a number of reports and studies which suggested that the 2015 SI Framework was not being adhered to. This meant that incidents were either not properly investigated, or where they were investigated the quality was poor and any improvements to prevent recurrence were not effectively implemented. The survey received 400 responses. Some of the ‘engagement topics’ are relevant here and the responses to them are informative:

¹¹⁸³ ‘The NHS Patient Safety Strategy: safer culture, safer systems, safer patients’, NHS England and NHS Improvement, July 2019

¹¹⁸⁴ ‘The future of NHS patient safety investigation: engagement feedback’, NHS Improvement, November 2018

- 1) *Defensive cultures and lack of trust.*
- 2) *Supporting and involving patients, families and carers.*
 - *The most positive response was to the suggestion of: ‘Providing patients, families and carers with clear standardised information, explaining how they can expect to be involved, so they can more easily judge if an organisation is meeting these requirements and, if it is not, raise this with the organisation’.*
 - *The most negative response was to the suggestion of: ‘Asking patients, families, carers to complete a standard feedback survey on receipt of the final draft investigation report that asks whether their expectations were met’.*
- 3) *Misaligned oversight and assurance process.*
 - a. *Support an environment for learning and improvement.*
 - *The most positive response was to the suggestion of: ‘Setting minimum training standards for Boards and those signing-off reports’.*
 - *The most negative response was to the suggestion of: ‘Increased involvement of families at the sign-off stage’.*
- 4) *Lack of time and expertise.*
 - a. *How to ensure sufficient time is devoted to investigations.*
 - *The most positive responses were to the suggestions of: ‘Removing the 60-working day timeframe and instead, allowing the investigation team to set the timeframe for each investigation in consultation with the patient, family or carer’ and ‘Recommending a 60-working day timeframe, but allowing providers some leeway on meeting it and not managing performance against it’.*
 - *The most negative response was to the suggestion of: ‘Keeping the set timeframe at 60-working days but reducing the number of investigations undertaken’.¹¹⁸⁵*

175. In response, NHSE/I have set out for providers ‘Patient Safety Incident Investigation’ (“PSII”) resources and tools for ‘best practice’ to increase the chances of ‘getting it right first time’. These are all available online and include the Patient Safety Incident Response Framework; Duty of Candour; Being Open Policy’ Guidance for working with bereaved families and carers; and a Just Culture Guide.

¹¹⁸⁵ Ibid

National Standards for Patient Safety Investigations

176. The published ‘National Standards for Patient Safety Investigations’ (“the Standards”) include ‘Guiding Principles’: *strategic, preventative, collaborative, fair and just, expert/credible and people focused*.¹¹⁸⁶ Some of those are relevant here:

- 1) *Strategic – Board-level oversight and governance (including an environment of just culture, learning and continuous improvement); proactive planning of each investigation, focus on quality over quantity, timely and responsive, objective, monitored.*
- 2) *Preventative – identify and act on deep-seated contributory or causal factors to prevent or, measurably and sustainably, reduce recurrence.*
- 3) *Collaborative – enable information sharing and action across systems, facilitate development of improvement plans based on more than one similar investigation.*
- 4) *Fair and just – open, honest and transparent.*
- 5) *People focused – patients, families and carers are active and support participants.*
- 6) *Expert/credible – systematic, systems-based and systemic, trustworthy.*¹¹⁸⁷

177. The Standards state that the, ‘*Terms of Reference should outline the degree of independence required*’ and:¹¹⁸⁸

- *All PSIIIs are led or chaired only by those with at least two-days’ formal training and skills development in a ‘systems approach’ to PSII.*
- *PSII training is conducted by those who have attended courses in, and related to, PSII, which amount to more than 30 days; are current in investigation best practice... and have both conducted and reviewed many investigations – the quality of which has been peer reviewed by other national experts.*
- *Patient safety investigators attend update training and networking events with other investigators at least annually to build and maintain their skills and expertise.*¹¹⁸⁹

¹¹⁸⁶ ‘National standards for patient safety investigation: Guiding principles and standards for a local, systems approach to patient safety investigation in NHS-funded care’, NHS England and NHS Improvement, March 2020

¹¹⁸⁷ Ibid

¹¹⁸⁸ Ibid

¹¹⁸⁹ Ibid

178. The Standards require all PSII recommendations, solutions or improvement plans to be monitored for implementation, efficacy (achievable, measurable reduction or prevent of risk or repeat incidents) and sustained improvement. They should not be shared until, *'their efficacy in delivering sustained reduction or prevention of risk or repeat incidents has been established'*.¹¹⁹⁰

179. The Standards suggest that, *'Once systemic, interconnected causal factors are robustly identified, improvements are formally resourced and championed by the Board via a refocus of activity from investigation to implementation, to embed into everyday care and practice sustainable improvements that significantly reduce the risk of repeat incidents.'*¹¹⁹¹

180. The Standards state the organisation must include, *'Promotion of additional or professional support of patients, families and carers and staff, where required to further aid recovery'*. Further, *'Patients, families and carers should be told from the outset what to expect from the process'*.¹¹⁹²

181. The Standards describe how patients, families and carers should be involved in the investigation. They should be:

- *Engaged and given the opportunity to input into the ToR, including the addition of any special questions; and further meeting arrangements.*
- *Given the opportunity to provide evidence (written and/or verbal) to inform and validate the timeline, analysis and improvement plan.*
- *Given the opportunity to be updated at specific milestones in the PSII.*
- *Given the opportunity to review the PSII report with a member of the investigation team while it is still in draft.*
- *Given the opportunity to comment on the PSII report before its completion and publication.*
- *Given the opportunity to feedback on their experience of the PSII.*¹¹⁹³

182. The Standards require that solutions and improvements in investigation reports to be:

¹¹⁹⁰ Ibid

¹¹⁹¹ Ibid

¹¹⁹² Ibid

¹¹⁹³ Ibid

- Targeted towards causal factors (not proximal/superficial factors, problems or themes).
- Designed to be strong and effective.
- SMART (specific, measurable, achievable, realistic, time-based).
- Lead to the prompt development of a plan to support the implementation of improvement.
- Result in a named manager with designated responsibility for delivering the improvement plan within a designated timescale.
- Embedded in work systems, processes and practice.¹¹⁹⁴

183. The Standards require investigation reports to be, and to include:

- Written in a way that professionally and effectively communicates the findings.
- The national investigation report template is used, unadapted, in every PSII.
- Written succinctly in plain English. Each PSII has a single report which can be shared in full (unadapted and unredacted).
- An executive summary sets out the main issues, findings, conclusions and recommendations.
- A summary incident chronology is included in the report to illuminate key points; where the full chronology is included it is attached as an appendix.
- Specific questions from the patient, family or carer, set out in the ToR, are answered and where this was not possible, the reason is explained in the report.¹¹⁹⁵

Patient Safety Incident Response Framework (“PSIRF”)

184. The stated purpose of the PSIRF is to, ‘Outline how providers should respond to patient safety incidents and how and when a patient safety investigation should be conducted’.¹¹⁹⁶ The PSIRF is part of the NHS Patient Safety Strategy July 2019, but work on the development of the PSIRF was put on hold due to COVID-19 and it remains in the pilot stage at the time of writing. Publication is now expected in Spring 2022. Until

¹¹⁹⁴ Ibid

¹¹⁹⁵ Ibid

¹¹⁹⁶ Patient Safety Incident Response Framework: <https://www.england.nhs.uk/patient-safety/incident-response-framework/>

the PSRIF is introduced, the 2015 SI Framework remains in circulation until it is replaced by the PSRIF.

185. The PSRIF has been produced as an introductory version for organisations involved in the pilot, and for organisations that are not, to get an idea of its purpose and aims.

186. In the Foreword it states, *‘This... responds to calls for a new approach to incident management, one which facilitates inquisitive examination of a wider range of patient safety incidents ‘in the spirit of reflection and learning’, rather than as part of a ‘framework of accountability’... it supports a systematic, compassionate and proficient response to patient safety incidents; anchored in the principles of openness, fair accountability, learning and continuous improvement’.*¹¹⁹⁷

187. The key aspects include a move towards:

- *A proactive approach to learning from incidents, away from a reactive approach.*
- *A focus on the quality of safety investigations and clear expectations set for informing, engaging and supporting patients, families, carers and staff involved in patient safety incidents and investigations.*
- *Investigators must be trained and experienced in Patient Safety Incident Investigations.*
- *Flexible timeframes, set in consultation with the patient and/or family, with an average of three-months and not exceeding six-months.*
- *Systems-based PSII, replaces ‘Root Cause Analysis (RCA)’.*
- *The strengthening of governance and oversight by commissioners and local system leaders and Provider Boards signing-off PSII Quality and Safety Improvements.*¹¹⁹⁸

Patient Safety Incident Management System (“PSIMS”)

188. The new ‘Patient Safety Incident Management System’ (“PSIMS”) will replace the current ‘National Reporting and Learning System’ (“NRLS”) and ‘Transfer of Strategic

¹¹⁹⁷ Patient Safety Incident Response Framework 2020: An introductory framework for implementation by nationally appointed early adopters, NHS England and NHS Improvement, March 2020

¹¹⁹⁸ Ibid

Executive Information System' ("StEIS") for the recording of safety events. It will be a central service. It is in the final stages of development, with the full roll-out not before mid-2022.¹¹⁹⁹ This is expected to provide one dashboard for all NHS organisations.

Panel's Views on where SHFT should be: SI investigation process

- SHFT should continue with the accreditation for the Royal College of Psychiatrists' Serious Incident Review Accreditation Network and build upon this work to improve and develop further.
- SHFT's SI Investigation Policy and Procedure document should be reviewed and this should not wait until the PSIRF is rolled-out. The amended Policy and Procedure document should meet the statutory requirements of the 2015 SI Framework. It should also adopt, at its core, the National Standards for Patient Safety Investigations and the PSII resources that are available. This will increase the chances of SHFT 'getting it right first time'.
- Once the PSIRF is introduced, SHFT should review its Policy and Procedure document again and amend it accordingly.
- SHFT should familiarise itself with the National Guidelines on investigations into physical healthcare and mental health and/or learning disability incidents. It should acknowledge that they can be different and require different approaches and revise and improve its approaches to both accordingly.
- SHFT's SI investigations should adopt all of the six characteristics that have been set out by Mr Conradi (at paragraph 190 above) to ensure that they are conducting high quality safety investigations, every time.

the emphasis is on learning. HSIB do not apportion blame or liability – that is the foundation of their investigation. He stated what he considers high quality safety investigations to be characterised by:

- Independence
- Focus on systemic learning
- Family engagement
- Professionally trained investigators
- Timeliness
- Accountability.¹²⁰¹

¹¹⁹⁹ <https://www.england.nhs.uk/patient-safety/patient-safety-incident-management-system/>

¹²⁰⁰ Statement of Deputy Medical Director at SHFT, 2 February 2021

¹²⁰¹ Statement of Chief Investigator for HSIB, Keith Conradi, 5 March 2021

Independence

191. The topic of 'independence' in the context of investigations into SIs and deaths was one that was at the forefront of the Stage 1 Review, therefore, the Panel were unanimous in their approach to ensuring it was properly and forensically examined at Stage 2. The Panel invited specific and focussed evidence on this topic from some of the leaders and experts in the field of investigations, the judiciary, the health sector and academia. As a result, they received a wealth of valuable and insightful evidence, which was contrasting at times, but it has informed the Panel's views on this topic. A summary of the evidence received has been set out below.

192. Some of the key issues the Panel have had to grapple with are what 'independence' means, whether it changes depending on the event that occurs and when it should apply in the context of investigations.

Independence in the Investigation Process

193. The 2015 SI Framework, defines an ‘independent investigation’ as: *‘Investigations (that) should be conducted by people sufficiently independent of the care provided to the patients affected by the incident in question’*. The criteria in the 2015 SI Framework are:

- 1) *Concise investigations - suited to less complex incidents which can be managed by individuals or a small group of individuals at a local level.*
- 2) *Comprehensive investigations - suited to complex issues which should be managed by a multidisciplinary team involving experts and/or specialist investigators.*
- 3) *Independent investigations - suited to incidents where the integrity of the internal investigation is likely to be challenged or where it will be difficult for an organisation to conduct an objective investigation internally due to the size of organisation, or the capacity/capability of the available individuals and/or number of organisations involved.*

194. The **Deputy Director of Patient Safety in NHSE/I, Dr Fogarty** said that the 2015 SI Framework definition applies to all investigations, so if you were the nurse, doctor, or pharmacist providing care to the patient when something went wrong, you should not be conducting the investigation into that patient safety incident/s. That is primarily because, he said, they would not have the level of objectivity required. If a person is considering your own practice, they will consider things from the perspective of that practice, whereas it may be useful in learning terms, to consider the actions undertaken from a distance and have the ability to question why it was done like that.¹²⁰²

195. **Dr Fogarty** said, “I have not seen a satisfactory description (of ‘independence’) that covers all circumstances that would tell me what it does and does not mean and I challenge anyone that claims to be ‘independent’ of anything. There is an interconnectedness of everything we do and you can find a connection if you really look for it”.¹²⁰³

¹²⁰² Evidence of Deputy Director of Patient Safety in NHSE/I, Dr Fogarty, 20 April 2021

¹²⁰³ Ibid

196. He said, “I think the important element is the perception and existence of trust. It is not about independence, but do you trust the individual doing the job and that they are doing it from an objective perspective, or do you not trust them and therefore believe they have an ulterior motive? That trust can exist regardless of who somebody is employed by and cannot exist for reasons of who somebody is employed by. I do not believe that independence in terms of employment is the factor here. It is about trust”.¹²⁰⁴

197. He set out what he interprets the 2015 SI Framework means by the use of the term ‘independent investigation’: “in those circumstances, we would expect it to be commissioned and delivered entirely independently of the body or organisation in which the incident occurred... (we would) advise it is commissioned by the CCG, or if it crosses multiple CCGs, or it is looking into issues under the responsibility of the CCG, it would go to the NHS England Regional Office”. He described investigations that can be undertaken that are internal to an organisation, where the individuals doing it are not involved in the care of the individual, but under the employment of the organisation within which the incident occurred.¹²⁰⁵

198. **Dr Fogarty** said, “I believe (HSIB) are exploring medium-level investigations too, where they could support the NHS in investigations commissioned at regional level. At the moment we go to an independent provider. I think it can only add to the market for HSIB to contribute to those too”.¹²⁰⁶

199. The **Director for Experience, Participation and Equalities at NHSE/I, Dr Churchill** was asked if there are some cases that call for an independent investigation, not directly connected to SHFT. He said that is absolutely the case and the Stage 1 Review Report pointed out the need for independence and the perception of independence, which, he said, were all well-made points.¹²⁰⁷

SHFT Evidence

200. The **Chief Medical Officer** said the criteria he would apply when considering whether an investigation should be externally investigated would be, “where the reputation of the

¹²⁰⁴ Ibid

¹²⁰⁵ Ibid

¹²⁰⁶ Ibid

¹²⁰⁷ Evidence of Director for Experience, Participation and Equalities at NHSE/I, Dr Churchill, 20 April 2021

Panel's Views on where SHFT should be: independence in its internal investigation process continued...

- SHFT should have transparent, objective and clear criteria to determine the degree of independence that is required in an investigation. That will depend on the nature of the incident and what has gone wrong. The criteria should be based on proportionality.
- Where the perception of independence is critical, SHFT should absolutely and straightaway recognise the need for an external independent investigation.
- SHFT should have transparent, objective and clear criteria on who would commission an external investigation should it be required and SHFT's involvement in that decision.

She said, if there is not a perception of independence, there is a problem and one needs to work with families to enable an independent investigation. She suggested there could be a set of investigators in the ICSs that sit independently and could assist.¹²⁰⁹

Panel's Views on where SHFT should be: independence in its internal investigation process

- It is self-evident that every investigation, large or small scale, should be, and should be perceived to be, independent. In Oxford Dictionary terms, that means, '*free from outside control*' and '*not subject to another's authority.*'
- SHFT should improve the processes it currently has in place for Investigation Officers to assure themselves and others that there is no conflict of interest. The new processes must be transparent and the outcome must be recorded.
- SHFT should provide a clear and transparent definition of what it considers 'independent', taking into account the dictionary definition above. It should provide a transparent and open explanation about its processes for ensuring its investigations are in fact 'independent'. That should be widely available to service users, carers, families and staff.

¹²⁰⁸ Evidence of Chief Medical Officer, SHFT, 12 April 2021

¹²⁰⁹ Evidence of Interim Director of Nursing and Quality for North Hampshire, South-East Hampshire, Fareham, Gosport and Isle of Wight CCG, 14 April 2021

An External Independent Body to Conduct Investigations

Independent Evidence

202. The Panel received a written statement and oral evidence from **Dr Kirkup**, a very experienced and well-respected independent investigator.

203. **Dr Kirkup** said, "... safety investigations need to be sufficiently independent of the clinical team involved to be objective and avoid any defensive reaction... and for serious incidents, independent of the organisation."¹²¹⁰

204. He said, "... I think what is important is the degree of separation you need to achieve – it has to be proportionate and that depends on that nature of the incident and what has gone wrong... it may be that for many incidents, it could be someone in the same Trust. But they need to be sufficiently detached from the events to give an objective view... in the more complex, serious or challenging incidents, I think it is absolutely wrong that the organisation itself is involved... there needs to be an external view taken of what can be learnt from this incident" (emphasis added).¹²¹¹

205. **Dr Kirkup** thought it was a good idea for there to be "criterion for deciding an investigation is going to be conducted externally" (emphasis added). He said, "... people often start with the degree of harm caused... but I don't think it should be the only criteria, it is much more usually to do with the systemic nature of what's happened... I think the really difficult ones are where there are systemic failures originating in a lack of teamworking, lack of professional relationships, poor communications, or hierarchical relationships, where nobody feels able to point out a problem... they demand a more external view to be able to (change) people's behaviour".¹²¹²

206. He commented that, "...how external an investigation needs to be, often doesn't become clear until you have commenced the first level, but people need to be ready to

¹²¹⁰ Statement of Dr Kirkup, 5 March 2021

¹²¹¹ Ibid

¹²¹² Evidence of Dr Kirkup, 8 April 2021

say, ‘this isn’t going to be sufficient; we need an external look’”. He said, “what differentiates the good from the not so good units is how ready they are to say it is beyond their capabilities. I think that is quite hard for an organisation to say, but the good ones will ask for external help...”.¹²¹³

207. **Dr Kirkup** said the investigation should be public in the sense of involving patients and families, but not wider than that.¹²¹⁴

208. The **PHSO Chair and Ombudsman, Mr Behrens** spoke of the need for a standing body for very serious issues or exceptional cases that have not been resolved by anybody to ensure the issues do not continue year after year. His desire for such a body arises out of the case of Robbie Powell who died 31 years ago, which he described as going on and on, without resolution.¹²¹⁵

209. **Keith Conradi, the Chief Investigator for the HSIB** said that from an independent perspective, in an ideal world, investigations into safety incidents would be conducted by a professional group of investigators remote from the organisation where it is taking place.¹²¹⁶

210. The Panel received evidence from a retired member of the judiciary, **His Honour Neil Butter QC** as to whether there should be a new independent investigatory process into deaths, serious incidents and complaints. He consulted Sir Robert Francis QC in reaching his views and acknowledged that the Health and Care Bill includes the establishment of an independent ‘Health Service Safety Investigation Body’. In his opinion, this body should investigate major patient safety incidents and deliver investigation reports, recommendations, provide advice and guidance.¹²¹⁷

211. He stated: “Stage 1 of (this) enquiry has clearly shown the need for a new form of investigatory body. Everyone must have genuine confidence in the investigation. The investigatory tribunal must be, and be seen to be, independent, able, fair and swift”. In terms of what he defined as ‘independent’, he said, it should be other than in control of the relevant hospital.¹²¹⁸

¹²¹³ Ibid

¹²¹⁴ Ibid

¹²¹⁵ Evidence of PHSO Chair and Ombudsman, Mr Behrens, 9 April 2021

¹²¹⁶ Evidence of Keith Conradi, the Chief Investigator for the HSIB, 9 April 2021

¹²¹⁷ Statement of His Honour Neil Butter QC, 22 February 2021

¹²¹⁸ Ibid

212. As to the procedure for such an investigation, **His Honour Neil Butter QC** said:

- The investigation should be in private but will normally result in a published report.
- The procedure should be decided by the tribunal and must accord with natural justice, including consultation with grieving relatives.
- Any hospital or entity involved must cooperate fully.
- The investigation should proceed despite other enquiries taking place.
- The report is likely to contain recommendations and the tribunal should be notified within an appropriate timescale by the relevant authorities, whether these recommendations have been implemented.¹²¹⁹

213. He said it might be helpful to have families involved in contributing to the terms of reference. Further, he hoped that a Trust would respond to recommendations and implement them and if it does not do so, it should explain why not.¹²²⁰

214. The Panel received evidence from **His Honour Judge Cutler CBE**. He has held a number of judicial appointments. In deciding whether an investigation should be conducted externally, he said it will often depend on the seriousness of the incident. If there is a death then it might involve the Coroner, Police or CPS and there might be a public interest. However, he said if it is a lesser matter, such as a serious injury, but there is still learning to be taken from it, it may be dealt with internally by the health Trust or hospital with an internal enquiry and he did not think you would need a public enquiry/inquiry in those circumstances.¹²²¹

215. **His Honour Judge Cutler** said it was very important for the families and the professionals who may be at the heart of being criticised, as well as the institution, that the body that is reaching the conclusions should be outside of the 'arena' above it. He stated, "if costs were not an issue, it would be good to have an established small body of investigative people, parallel to the coroner or Police, so when something goes wrong, the NHS in the South East can refer it to a central body, who may have a team of six to twelve judges... there would be an independent person at the head of the investigative

¹²¹⁹ Ibid

¹²²⁰ Ibid

¹²²¹ Evidence of His Honour Judge Cutler CBE, 7 April 2021

group, who would decide if it's an issue of sufficient interest, seriousness and noteworthiness". He averred that the costs of such an enquiry/inquiry would have to be considered in proportion to the issues.¹²²²

216. **His Honour Judge Cutler** said he hoped that the organisation being investigated would say, '... we are happy for it to be investigated fairly and independently rather than one Trust investigating another'. He compared this with the Police where one county investigates another if something goes wrong, which he said, does not look good.¹²²³

217. **Dr Ocloo, a Senior Researcher in the Centre for Improvement Science at King's College London** said 'independence' to her would mean having a mechanism where there are people completely outside of the Trust investigating SIs, which might mean involving independent NHS people with medical experience. She said if this does not exist then Trusts are investigating their own problems or wrongdoing. She averred that the public and families will only get to the facts if an investigation is independent.¹²²⁴

218. In regard to the criteria that should be used to decide if an investigation should be done externally, **Dr Ocloo** said it should happen if someone dies or is seriously harmed or if there is a suspicion that things have not happened properly.¹²²⁵

219. **Dr Ocloo** said, "I think we need an expert group with a balance between system professionals, independent experts, and harmed patients, so you can get at the detail of how it should work at a micro-level... I think you need a truth commission to bring these issues out into the open... people need to finally speak out and ask how we can genuinely build something new and this is what we need a Commission for; to build something fresh in the NHS".¹²²⁶

Evidence of a family member

220. A **family member** said an independent service needs to develop based on the National Independent Medical Examination Service, which is being set up at the moment

¹²²² Ibid

¹²²³ Ibid

¹²²⁴ Evidence of Dr Ocloo, a Senior Researcher in the Centre for Improvement Science at King's College London, 8 April 2021

¹²²⁵ Ibid

¹²²⁶ Ibid

Panel's Views on where SHFT should be: an external independent body to conduct investigations

- As expressed, the Panel shares and adopts the view given by Dr Kirkup: there should be criteria for deciding if an investigation is going to be conducted externally. The criteria should be based on the test of proportionality.
- SHFT should be aiming to be in a position where it has the confidence to acknowledge when an investigation is beyond its capabilities and knows when to ask for external help.
- As to an independent body, the Panel assumes the position suggested by Mr Conradi: external investigations should be done by investigators who are remote from the organisation where it is taking place.

222. He also suggested that there should be an independent investigation unit for more complex cases where expertise might be required. He said that for less serious investigations there should not need to be independence. He believes that if you have a unit receiving continuous customer feedback then the incidents will not get big, but they happen when all of the little things that have gone wrong have built up to a big thing. He considers near misses or complaints should provide a warning sign that something is going wrong. The relevant team should, he thinks, receive this data and information to begin to work on improvements and avoid the big incidents occurring. He said, “the beauty of continuous improvement is that it prevents the big things from happening and going wrong”.¹²³⁰

¹²²⁷ Under the current system, Medical Examiners are employed by Trusts. It forms part of the Health and Care Bill 2021. NHSE/I has been working with the Department of Health and Social Care to support a non-statutory system until legislation could be introduced to put the system on a statutory footing.

¹²²⁸ Evidence of family member, 14 April 2021

¹²²⁹ Ibid

¹²³⁰ Ibid

The Chair and/or Panel of an Independent Investigation

Independent Evidence

223. **His Honour Neil Butter QC** considered whether a retired judge should sit on the tribunal and concluded that they should not, on the basis that there is a public perception relating to age and links to the Establishment and the fact that judges may not exhibit the appropriate degree of empathy or feel at ease with transparency.¹²³¹

224. However, he thought there would be clear advantages in having a lawyer, preferably with tribunal experience, in the Chair with the second person, on the two person tribunal, being a doctor or someone who is medically qualified. He said that in exceptionally serious cases, a three person tribunal might be appointed, the third person's expertise being determined by the issues likely to arise.¹²³² In oral evidence **His Honour Neil Butter QC** stated that it is an advantage to have some legal training and knowledge but he did not think it is absolutely necessary. His view is that there should be a legally qualified chairman, but again, that is not essential.¹²³³

225. He explained that it would cause delay if there were more than two people on the tribunal and it took place in public, as opposed to private.¹²³⁴

226. **His Honour Judge Cutler's** written statement focused on the fact that the incident being investigated may have already been subject to some form of judicial process and findings may have been made by a Judge or judicial views expressed in such proceedings.¹²³⁵ This will not have occurred for all, or even the majority of, patient safety incidents, but may arise in some circumstances where there is a larger investigation.

¹²³¹ Statement of His Honour Neil Butter QC, 22 February 2021

¹²³² Ibid

¹²³³ Evidence of His Honour Neil Butter QC, 7 April 2021

¹²³⁴ Ibid

¹²³⁵ Statement of His Honour Judge Cutler CBE, 22 February 2021

227. He said that in the circumstances of such a large investigation, there is a need for any subsequent investigation to be chaired by a Judge, who will be able to put the earlier Court/Coroner proceedings into context, but will be independent of them.¹²³⁶

228. The Chair must, he said, be independent and needs to have the confidence of any person or institution affected by its terms of reference. He acknowledged that this may seem obvious, but said it is sometimes difficult to achieve. If this does not happen, he said it would allow a person or institution affected by the investigation to down play the findings of the investigation.¹²³⁷

229. **His Honour Judge Cutler** said the qualities required to be a Chair, in any external independent investigation, exist in the judiciary. Judicial office holders are appointed through the Judicial Appointments Commission process and the basic qualities/competencies are at the core of that process.¹²³⁸ He set them out, in summary:

- Exercising judgment – demonstrating independence of mind, ensuring fairness and showing integrity.
- Possessing and building knowledge.
- Assimilating and clarifying information.
- Working and communicating with others – values diversity and shows sensitivity to the different needs of individuals.
- Managing work efficiently.

230. Further, **His Honour Judge Cutler** believes that there are lessons to be taken from the Magistrates appointment process as they are trained to be independent and to work very carefully through the processes, whilst being open and giving full reasons for their decisions.¹²³⁹

231. Therefore, he said, if a Judge or retired Judge were appointed as Chair in an external investigation it would be known that he/she is of the highest intellectual capacity and of the greatest integrity and ability. Any report or finding that is then reached by a panel,

¹²³⁶ Ibid

¹²³⁷ Ibid

¹²³⁸ Ibid

¹²³⁹ Evidence of His Honour Judge Cutler CBE, 7 April 2021

chaired by a Judge, would have the confidence of those who may be impacted by such findings.¹²⁴⁰

232. His view is that the Chair should be provided with expert evidence on best practice. He hoped that would take the heat out of the situation and if they come to the conclusion that the organisation was wrong and should reform itself, then the organisation would say they accept what is said, act on the recommendations and the people who have lost a loved one would accept it, understand it, or can obtain other legal redress.¹²⁴¹

233. **His Honour Judge Cutler** believes it would be sensible for the NHS (or an external investigative body) to have a list of judges with some experience of managing an inquiry/enquiry and knowledge of the background. For example, 50 part time judges from the Mental Health Review Tribunal and 40 judges within the Tribunal Service dealing with health issues. Further, he said, the judge could say they needed panel members and there should be a list of panel members available to consult.¹²⁴²

234. He commented on the role of a panel: “the panel should not give evidence itself. There should be no expert on the panel giving their own views on what was right or wrong. The panel is there to research, gather evidence, and call witnesses to give their views... and they should not have any expertise directly attached to the issue being decided. Then having heard all of the evidence and submissions, (the panel) would come back with (their) full report dealing with the evidence...”.¹²⁴³

235. He thought the panel should be as open and public as possible. He said, “it is fantastically unsatisfactory for the participants to have a major conclusion based on information they do not know about”.¹²⁴⁴

236. In the case of Mark Duggan, **His Honour Judge Cutler** was asked to be Coroner (despite not being local) and the case was presided over by a jury which, he said, came from all walks of life in North London. The jury had all of the facts and evidence and came to their conclusions, so when they reached their verdict, it was widely accepted by all. He said that when the inquiry was being set up they looked at it from the participant’s

¹²⁴⁰ Ibid

¹²⁴¹ Evidence of His Honour Judge Cutler CBE, 7 April 2021

¹²⁴² Ibid

¹²⁴³ Ibid

¹²⁴⁴ Ibid

point of view and asked, ‘what would you, as a participant who was disadvantaged at the end, or part of the health service, or a professional who is criticised by the panel, what would it take for you to take that?’. For him it would be the independence, integrity and hopefully the ability of the panel and the Chair.¹²⁴⁵

237. As to who should lead an external independent investigation, **Dr Kirkup** said there needs to be senior clinical input, but he did not think the investigation had to be led by a clinician and that in many cases it may be better if it were not led by a clinician, in terms of objectivity and detachment. He gave an example of an independent panel he had been on that he said had been very expertly led by the former bishop of Liverpool. He said the former bishop excelled at understanding both the investigation and the human elements involved for those harmed. He agreed that a legal chairman might be sensible in some circumstances.¹²⁴⁶

238. In regards to who should lead an investigation, **Dr Ocloo, a Senior Researcher in the Centre for Improvement Science at King’s College London**, said it should be someone with expertise in holding an investigation. She said there also needs to be some critical independent voices, including members of the public, to bring another perspective, otherwise it can be problematic in terms of openness.¹²⁴⁷

239. The Panel received evidence from **Keith Conradi, the Chief Investigator for the HSIB**, who said that good investigations can be done by those working for the same organisation with the most professional investigator, but there are huge issues, rightly in his view, with perception, which are difficult to overcome.¹²⁴⁸

240. He used his own experience in aviation to explain how they demonstrated independence: “we were all employees of the Department of Transport, so you could ask where the independence was, but we had a Memorandum of Understanding with the Department to demonstrate how we sat separately. Often, we made safety recommendations to the Department, held them to account and we had the legacy of many years of demonstrating, through reports, that we were taking an independent and impartial view”.¹²⁴⁹

¹²⁴⁵ Ibid

¹²⁴⁶ Evidence of Dr Kirkup, 8 April 2021

¹²⁴⁷ Evidence of Dr Ocloo, a Senior Researcher in the Centre for Improvement Science at King’s College London, 8 April 2021

¹²⁴⁸ Evidence of Keith Conradi, the Chief Investigator for the HSIB, 9 April 2021

¹²⁴⁹ Ibid

241. As to who should lead an external investigation, **Mr Conradi** said it does not necessarily have to be an expert in healthcare, but it needs to be someone who can weigh up and balance arguments. Thus, the same qualities a judge possesses would be beneficial. He said this is what happens in the Swedish Investigative Branch. He said the HSIB can assist with local investigations and they are removed from the Trust.¹²⁵⁰
242. The **Chair of the PHSO and Ombudsman, Mr Behrens** said, “I think independence is the key issue... I look, for example, to Dr Bill Kirkup, who has brilliantly co-chaired and sat on panels on very important inquiries. He... has been appreciated for his expertise and humanity to see beyond clinical boundaries. It’s not sufficient to have people with particular backgrounds, they need quality and skills to take people with them”.¹²⁵¹
243. As to who would have the degree of independence necessary to conduct an external investigation, the **Regional Medical Director for NHSE/I for the South East Region, Dr Lewis** said it might be a doctor, but he did not think it had to be a doctor. He said it needs to be someone with an enquiring mind, capable of managing complexity, and able to draw on reports and expert advice of many disciplines. He said it is essential to have an independent clinician and any additional member of a panel, he agreed, could be a lawyer, judge, doctor or come from any sphere.¹²⁵²
244. In the view of the **National Clinical Director for Mental Health in NHSE, Professor Kendall**, there are two groups of people who are best placed to investigate errors in health services: clinicians and those who use the service, as they are the two halves of the experience or conversation that are needed. Further, he said, that if you do not have people who work in health services involved then a lot of things would not be understood and opportunities for learning would be missed.¹²⁵³

SHFT Evidence

245. The **Chief Executive** of SHFT said that the level of independence required of investigators depends on proportionality and the scale of investigation. For example, he said, at the level they commission an internal review using independent people, the

¹²⁵⁰ Ibid

¹²⁵¹ Evidence of Chair of the PHSO and Ombudsman, Mr Behrens, 9 April 2021

¹²⁵² Evidence of Regional Medical Director for NHSE/I for the South East Region, Dr Lewis, 6 April 2021

¹²⁵³ Evidence of National Clinical Director for Mental Health in NHSE, Professor Kendall, 29 April 2021

general direction is to find the right professional expertise. He said he would see the outcome of the review and the Directors, Non-Executive Directors would too.¹²⁵⁴

246. The **Chief Executive** said in an independent review, such as this one, the Chair does not have to be a professional from the respective clinical profession. He referred to his experience of an engineer sitting on a Board who, he said, was very good in understanding risk and quality and was quite against the grain in chairing the Quality Committee, which is usually someone from a medical or nursing background. He said that ultimately this needs to be judged on the events being investigated.¹²⁵⁵

247. He described some events where it should not be investigated by professional people. For example, if there is neglect or sexual abuse of people in SHFT's care and in some other cases, then people from the designated professions should not make those judgments, as there needs to be serious challenge to those professional judgments.¹²⁵⁶

Panel's Views on where SHFT should be: Chair and/or Panel of an independent investigation

- Overall, in the case of an enquiry into a safety incident that requires independent external investigation, the Panel recommends a fully independent and experienced Chair without stipulating any preferred background experience. The choice of Chair should be fact specific.

investigation continued...

- The Panel agrees that one cannot divorce 'independence' from 'perceived independence'. The perception of independence must be borne in mind in the appointment of any Chair and/or Panel. Criteria for such an appointment could be helpful and should be considered. The appointment criteria should dictate the qualities of the Chair (and any panel members) and not their profession or expertise. The qualities that mirror those set out by the Judicial Appointments College are relevant and indeed, imperative. The Nolan Principles of: Selflessness, Integrity, Objectivity, Accountability, Openness, Honesty and Leadership are equally relevant. There should be assurance processes in place to safeguard these requirements.
- A degree of independence should be an integral part of the appointment process for external investigation Chairs. It should ensure that the Chair of an external investigation has a high level of integrity and authority, the ability to be neutral to the organisation being investigated and has a reasonable standing (for example, in public service).
- The case may dictate very specific qualities. For example, if in a very serious case, there have been previous legal proceedings, a current or previous Judge may be better suited for the role of Chair.

Investigation Officers

248. The Panel received evidence from **Keith Conradi, the Chief Investigator for the HSIB**, about how they train their Investigation Officers. It is acknowledged that they are carrying out slightly different types of investigations, however, arguably, the principles that apply will be the same or similar to those carried out by the centralised investigation team at SHFT conducting SI investigations.

249. **Mr Conradi** explained how their investigators have diverse experience of healthcare and other safety critical industries and are trained in Human Factors and safety science. They also consult widely in England and internationally to ensure that their investigations are informed by appropriate clinical and other relevant expertise where needed. They have an extensive interview process focussed on qualities rather than technical experience. They have a three week training course for initial investigators with experts teaching them. They have a training and education department which trains the new investigators and it starts with lots of classroom work before they are allocated to a team. They go out on investigations with a team and an experienced investigator until the HSIB feel that they are ready to do their own investigations. A new investigator would never do an investigation for the first time by themselves.¹²⁵⁷

250. He said you cannot do a good investigation without professionally trained investigators. He believes that the HSIB has an important role in setting the standard

¹²⁵⁷ Evidence of Keith Conradi, Chief Investigator for the HSIB, 9 April 2021

and helping to train other parts of the system to do investigations. He considers it very important that the HSIB see training people to do a better job at local level, where the majority of safety investigations will take place, as part of its success.¹²⁵⁸

251. As to HSIB's wider role in training investigators, **Mr Conradi** explained that they are developing a Learning Pathway for professionalising patient safety investigations, which eventually will educate all NHS staff about patient safety investigations, offer training and professional development for NHS patient safety investigators. He said they have developed a course for local investigators with no investigation experience to allow them to investigate local events professionally. They want to roll it out with the aspiration that you cannot do a safety investigation in a Trust unless they have been through a HSIB accredited course.¹²⁵⁹

252. He said that the skills need to be constantly refreshed. So, if someone is only an investigator every now and again, the quality will not be the same as from those that are doing them consistently.¹²⁶⁰

253. Furthermore, he said, the HSIB are developing a course for Executives in the Trust system, as it is crucial that it is taken up the hierarchy in the system and acted upon, otherwise it is of little use.¹²⁶¹

254. A **family member** said, "when it comes to investigations in SHFT... they need training on how to do investigations with families on minor things. They should look to the HSIB paper on this and they should carry out courses on... the end goal of this is to improve quality".¹²⁶²

Panel's Views on where SHFT should be: Investigation Officers

Job Description

- The Job Description for the Investigation Officer role should be amended to include the qualities required of them and it should include, integrity, objectivity and honesty, at the very least.

Training

- SHFT should implement a robust and rigorous internal training process for an Investigation Officer, beyond the two day training. Thereafter, it should be linked to a shadowing, mentoring and assessment process with a report and sign-off at the end.
- At the heart of the training programme there should be a focus on the qualities and values of the Investigation Officer role: credibility, independence, conflict and integrity. The training should include a focus on the Human Factors approach.
- SHFT should co-produce the training with service users, carers, family members and staff

Investigation Reports

255. The Panel received evidence that SHFT were going to be amending the SI Investigation Report template on Ulysses.

256. The **Incident Investigation Manager at SHFT** said she would like improvements to be made to the SI Investigation Reports to make them more family friendly. She said the timeline is currently very long. They are looking to add the glossary and timeline as an appendix, so the report is not as bulky and daunting for families to read and moving the 'care and service delivery problems' and 'actions' to the start of the report.¹²⁶³

¹²⁶³ Evidence of Incident Investigation Manager for SHFT, 19 April 2021

Panel's Views on where SHFT should be: SI Investigation Reports continued...

- These improvements should reduce the number of reports that the CCG have to return to be re-drafted or amended by SHFT, which causes delay.
- The action plans at the end of the Reports should include a deadline and the name(s) and positions of each individual who is/are responsible for taking the action forward.

Panel's Views on where SHFT should be: SI Investigation Reports

- The SI Report templates must be revised as a matter of priority to ensure:
 - That the individual is at the heart of it
 - The report is personalised
 - The format, contents and length are more accessible to the reader (management speak should be avoided)
 - The focus should be on contributory factors and human factors
 - The family's contribution to the terms of reference should be recorded separately (and state clearly if families did not contribute)
 - A section of the report records 'family involvement' (including if they want no involvement)
 - A section of the report records 'Duty of Candour' and indicates how it is met by SHFT.
- SHFT should implement, as best practice, reports that at a minimum contain:
 - An accurate summary of clinical intervention
 - A timeline that is focused and accessible
 - Balanced and reasoned conclusions
 - Clear recommendations, that conform to the 'SMART' guidance.

¹²⁶⁴ Statement of Deputy Medical Director of SHFT, 2 February 2021

¹²⁶⁵ Evidence of Chief Investigator for the HSIB, Keith Conradi, 9 April 2021

259. **Mr Conradi** said there has to be balance between the complexity of the report with the time that it is going to take to complete. He said that the HSIB provide interim reports, regular updates and are trying to encourage safety actions during their investigations. They are constantly sharing the evidence they find and asking what the organisation are going to do about it and then will carry on with their investigation. Therefore, the organisation is not waiting for the final report and recommendations before making changes and improvements. He said that if the investigation is done too quickly and the focus is too much on the deadline, the benefit from the investigation is compromised as one has to go where the investigation takes them to get the most learning out of it.¹²⁶⁶

260. A **family member** said, "I cannot see why any SI cannot be dealt with (within a few weeks). It should be done in real time with the proper information. Things should change immediately, within days/weeks. They shouldn't wait two weeks to do an investigation... they might have to pause until the family are ready, but there is nothing stopping them going in to carry out the investigation swiftly...".¹²⁶⁷

Panel's Views on where SHFT should be: improving delays in the investigation process

- The Initial Management Assessment Reports that are prepared by the team or service following an incident which go to the 48-hour Panel Review should be of such a quality and level of detail that the panel is able to immediately determine the type of investigation that

Panel's Views on where SHFT should be: improving delays in the investigation process continued...

- SHFT must give consideration to improving its capacity to meet deadlines and should consider whether it needs to allocate funding and resources to recruit more centralised Investigation Officers.
- SHFT may like to consider whether the 48-hour Review Panel is in the best interests of its service users, family members and staff, and whether a move towards a 72-hour Review Panel would be preferable.

Categorisation of harm

Panel's Views on where SHFT should be: categorisation of harm

- SHFT should have a demonstrable decision making process in place regarding the level of investigation required for a SI, based on the risk analysis and impact of the SI.
- Training should be given to clinicians at all levels, on the categorisation of harm when reporting an incident, but in particular and as a priority, to Ward Managers and Matrons. This would promote the 'right first time' approach SHFT should be aiming for.

Service user, carer and family's involvement in the SI Investigation

SHFT Evidence

261. The **Incident Investigation Manager for SHFT** said they could look at improving families being involved in actions set by the teams. She said that she would like to see teams follow up more with families. She said that on occasions they do invite families to meet the team once an investigation has concluded and the team manager will keep them updated on actions and how it benefits patients' care.¹²⁶⁸

Independent Evidence

262. **Dr Kirkup** said that as soon as something goes wrong there should be full and open disclosure. At that point, relatives and patients should be offered the opportunity to be as involved as they want to in the investigation, because people will not generally trust what is being done to investigate it unless they are able to be close to it and they lose trust in the process if they are kept at arm's length. Secondly, he said, it is very hard to get the full picture of what has gone wrong unless the patient and relatives are asked

¹²⁶⁸ Evidence of Incident Investigation Manager for SHFT, 19 April 2021

and if the investigation is done independently of them then often vital information is missed.¹²⁶⁹

263. He went on to give his own experience of doing investigations and said he has read accounts in clinical records and thought one thing then heard the account from the patient's or relatives' perspective and thought something different. He said that neither is 100% correct or incorrect and both need to be taken into account. He said, the clinical records are taken from one perspective, so one will never get behind that unless they talk to the people personally involved in the event.¹²⁷⁰

264. **Dr Kirkup** said that the best examples of Trusts turning themselves around would involve the engagement of families.¹²⁷¹

265. The **Chief Investigator for the HSIB, Keith Conradi** stated that the HSIB places families at the heart of investigations and considers their views and recollections to be as important and valuable as the medical and clinical evidence from healthcare staff, patient care records and subject matter experts.¹²⁷²

266. He expanded this to say that he could not do an investigation without a full understanding and information from the family. He said that the family often know more about the culture in the organisation, so the amount of information and intelligence a family can provide is enormously helpful, and they usually have very insightful views as to where improvements can be made.¹²⁷³

267. **Mr Conradi** explained how the HSIB engage with families during their investigation: "... it involves effective liaison between a family and the investigating team during the complete investigation process. We make sure that families are supported throughout the investigation process. HSIB has a dedicated Head of Family Liaison post (she is an ex-Police FLO), who translates HSIB information materials into native languages and engages regularly with patients and family groups to ensure the HSIB investigators can signpost families to appropriate external support".¹²⁷⁴

¹²⁶⁹ Evidence of Dr Kirkup, 8 April 2021

¹²⁷⁰ Ibid

¹²⁷¹ Ibid

¹²⁷² Statement of Chief Investigator for the HSIB, Keith Conradi, 5 March 2021

¹²⁷³ Evidence of Chief Investigator for the HSIB, Keith Conradi, 9 April 2021

¹²⁷⁴ Ibid

268. He said that as a starting point they will usually interview the family at length about what they want, their expectations and explain what HSIB can offer. He said that one of the key things for HSIB to explain to families up front is about their non-apportioning of blame and liability approach. He said that in response to this, most people are pleased that someone is listening to them and taking the time.¹²⁷⁵

269. Furthermore, he said, “the families and all the players in an investigation have the

Panel’s Views on where SHFT should be: involving the service user, carer and family in the SI Investigation

- SHFT should ensure that the details of a family, service user or carer’s involvement in an SI investigation is properly documented and recorded in the investigation report.
- SHFT should offer meetings to family members, carers and service users, as a matter of course.

270. The National Clinical Director for Mental Health in NHSE, Professor Kendall said, “having service users and families involved (in SI investigations) changes the whole nature of the venture: it puts them at the centre of things and it’s a good lesson for clinical academics and clinicians, to make sure they understand the purpose is to deliver health care for the patients, not for us”.¹²⁷⁷

271. **Professor Kendall** described what a family being involved in an investigation looks like: “as soon as the investigation is invoked that is the point at which a family or service user should be invited to look at the terms of reference. They might refuse, but should be asked from the start... that should be the default...(and) the level of contact should be agreed with them”. He said, “I am always shocked when you see investigations where service users and carers are ignored and delivered a summary verdict... I am still shocked when I hear the Trust haven’t contacted the family or have sent them a standardised later... that is insulting, on top of being painful”.¹²⁷⁸

¹²⁷⁵ Ibid

¹²⁷⁶ Ibid

¹²⁷⁷ Evidence of National Clinical Director for Mental Health in NHSE, Professor Kendall, 29 April 2021

¹²⁷⁸ Ibid

Feedback from service users, carers and family members on the SI Investigation process

SHFT Evidence

272. The **Deputy Medical Director of SHFT** said that by the end of Quarter 4 2020/21, SHFT will instigate a process for systematically capturing feedback from patients and families on their experience of being involved in the investigation process to ensure that they are able to continuously learn from and improve their approach.¹²⁷⁹

Independent Evidence

273. **Dr Ocloo** has published a paper on patient and public involvement in healthcare quality and improvement which concluded that:

*‘Current models of patient and public involvement are too narrow, and few organisations mention empowerment or address equality and diversity in their involvement strategies. These aspects of involvement should receive greater attention, as well as the adoption of models and frameworks that enable power and decision-making to be shared more equitably with patients and the public in designing, planning and co-producing healthcare’.*¹²⁸⁰

274. **Dr Ocloo** developed this before the Panel and said her research for this paper showed that there is widespread discrimination in engagement and involvement processes in patient safety. This is because, “... the patient safety movement does not involve the groups who are most likely to get poor services and at more risk of harm, often those groups are people from Black, Asian and minority ethnic backgrounds, those with disabilities, learning disabilities, or working-class people. The NHS have disproportionately hand picked a small number of individuals to be involved in safety, who are white and middle class to be high profile champions in safety and quality

¹²⁷⁹ Statement of Deputy Medical Director of SHFT, 2 February 2021

¹²⁸⁰ ‘From tokenism to empowerment: progressing patient and public involvement in healthcare improvement’ (Ocloo J, Matthews R. *BMJ Qual Saf* 2016; 25:626–632)

improvement... and their views and experiences can be very different to other parts of the public and wider population".¹²⁸¹

275. The **Director for Experience, Participation and Equalities at NHSE/I, Dr Churchill** said there needs to be a range of ways of listening to people from all communities and groups to ensure better feedback. He said NHSE/I have given a lot of thought to quality checkers and reviewers in learning disability services, so people with learning disabilities visit neighbouring services to talk to users with learning disabilities and providers. They use a toolkit to make recommendations on quality. Where this has been deployed, it has, he said, often made a significant difference and it is also helpful in changing the balance of power, so the service user voice is given greater weight. He explained how the Friends

Panel's Views on where SHFT should be: obtaining feedback from service users, carers and family members on the SI Investigation process

- SHFT should have a mechanism in place to capture their views about the investigation itself, not just the reports. This should be implemented as a priority and then monitored at regular intervals and shared with the central investigations team and the Board for learning purposes. The lessons learnt from obtaining feedback following complaints handling should be extrapolated into this arena.

they are speaking to about their experiences.¹²⁸⁵

277. He stated, "when I look at feedback, I assume that it will exclude certain groups, unless I have made active efforts to find them, listen to them and to give some weight to their feedback, as their numbers will be smaller and they will not necessarily come through in the report presented to the Board".¹²⁸⁴

278. **Dr Churchill** was keen to highlight the Health and Wellbeing Alliance, which is made up of organisations who are deliberately selected to reach different parts of the population. He described how NHSE/I had to adapt some of their approaches to make sure people from disadvantaged backgrounds could participate in some of the listening they do, for example, giving them access to digital devices.¹²⁸⁵

¹²⁸¹ Evidence of Dr Ocloo, a Senior Researcher in the Centre for Improvement Science at King's College London, 8 April 2021

¹²⁸² Evidence of Director for Experience, Participation and Equalities at NHSE/I, Dr Churchill, 20 April 2021

¹²⁸³ Ibid

¹²⁸⁴ Ibid

¹²⁸⁵ Ibid

Reporting culture

279. The **Deputy Director of Patient Safety in NHSE/I, Dr Fogarty** said, “we do still see organisations that are reluctant to report, particularly SIs, as they are seen as a ‘black mark’, so they are worried about the reputation of their organisation, the impact on them personally and the attention they will receive from regulatory and supervisory bodies. It is a constant refrain from us to say that regulators and supervisory organisations cannot use the number of SIs reported by an organisation as a metric for how safe they are and must welcome an increase in incident reporting”. He said that is not universally understood and it is one of the reasons why they are doing work around the patient safety syllabus and specialists.¹²⁸⁶

National and Internal Reporting

280. **Dr Fogarty** explained how, on a periodic basis, batches of data from local risk management systems are uploaded to the NRLS for NHS Trusts in England. This is effectively a national level database that his team operates and it is purely a learning process. It focusses their initial clinical review process on the incidents reported as leading to severe harm and death. He said that when they identify a potentially new or under recognised risk via that review, they will interrogate the wider database to understand more about the issues to determine what, if any, national response would be useful.¹²⁸⁷

¹²⁸⁶ Evidence of Deputy Director of Patient Safety in NHSE/I, Dr Fogarty, 20 April 2021

¹²⁸⁷ Ibid

281. He spoke about the alert system, actions and monitoring that are in place. He explained how approximately one in twenty issues that they identify become a 'national patient safety alert', the most high profile response, which triggers a message to all relevant parts of the NHS stating: 'we have identified a risk, identified some useful effective actions that can be taken to mitigate it, here are the actions and we require you to undertake to do the actions within a certain timeframe to mitigate the risk to patients'.

282. He explained that the 'Central Alert System' has a self-reporting function; the alerts go to the Central Alert System Officer in each organisation and the governance process in each organisation will determine if the alert is relevant to them. If is relevant, they confirm whether they will be undertaking the action required and state on the system if the action is underway or complete, or confirm if the alert is not relevant to them. As part of the CQC regulatory inspection and oversight process they may ask questions about the alert and look to see if the actions have been taken.¹²⁸⁸

283. **Dr Fogarty** stated, "we are very clear that incident reporting is not a suitable metric for understanding the safety of an organisation, other than in identifying extremely worrying cases where incident reporting levels are very low... there is a theoretical idea that as safety improves, you decrease the number of incidents reported with 'significant harm' outcomes and increase the number of incidents of 'low harm' and 'no harm', so you increase the reporting of near misses. I have not seen any evidence for that happening in the healthcare context... our capabilities and expectations change all the time in healthcare, so it is inadvisable to use incident reporting and outcomes and level of harm for a metric for success".¹²⁸⁹

284. **Dr Kirkup** stated, "... there is a huge variation of reporting of incidents nationally, which is completely unjustified by an imaginable difference in the rate in which things go wrong. There is a lot of evidence that says that the places recognising the most incidents, learn the most and provide the best services because they're learning from those incidents".¹²⁹⁰

285. The **Chief Investigator for the HSIB, Keith Conradi** said the HSIB input data into a centralised management system so they can look at themes and trends on a wider

¹²⁸⁸ Ibid

¹²⁸⁹ Ibid

¹²⁹⁰ Evidence of Dr Kirkup, 8 April 2021

national scale. He said there could be such an opportunity at regional level, such as in ICSs.¹²⁹¹

Learning from deaths and events

SHFT Evidence

286. The **Deputy Medical Director at SHFT** said SHFT will improve their clinical engagement in identifying learning and required improvements from investigations (48-hour Panel Reviews, incidents that do not require further investigation, SI investigations and external investigations) to embed these learnings across their services.¹²⁹²

287. The **Patient Safety and Quality Facilitator for the Southampton Division** said that the teams often say they do not know what happened after an incident was reported. So, they are trialling a group with representatives from all teams across the division, including Patient Safety Links and Health Care Support Workers, who will be working within those teams and will attend monthly to discuss learning, as they are on the ground. She described how she wants to hear their good stories, any learning coming from the panels and incidents and from other divisions, which she will share and they can take it back to their teams.¹²⁹³

288. She described how she will be starting to join a different team for one day a week to work with them to find out their concerns, issues and how she can help them to improve. She acknowledged that she cannot do everything on her own at once.¹²⁹⁴

Independent Evidence

289. The **Chief Investigator for the HSIB, Keith Conradi** said, “serious patient safety incidents occur with such relative infrequency... that the opportunity to recognise the systemic patient safety risk is often only possible by an organisation with a view on patterns, trends and themes at a broader level... even when conducted independently, it can be difficult to gain insight into cultural and contributory factors to patient safety risk

¹²⁹¹ Evidence of Chief Investigator for the HSIB, Keith Conradi, 9 April 2021

¹²⁹² Statement of Deputy Medical Director at SHFT, 2 February 2021

¹²⁹³ Evidence of Patient Safety and Quality Facilitator for the Southampton division, SHFT, 13 April 2021

¹²⁹⁴ Ibid

through one off or infrequent independent investigations, especially when these are conducted by private contractors with no system level insight. There are no mechanisms in place for sharing the learning from such investigations more broadly”.¹²⁹⁵

Panel’s Views on where SHFT should be: learning from deaths and events

- The attendance at Learning from Events Forum could be more widely spread and it should be actively encouraged, including extending an invitation to the NHSE/I Regional Team.
- SHFT should consider how it can improve its structures and mechanisms for capturing and sharing learning more widely across the organisation, not just when it is deemed “relevant”, for example, it could be shared on their website or intranet.
- SHFT should have in place regular reporting to the Board on the degree of avoidable harm identified in the formal processes and lessons learned. It should be discussed at Board-level and shared through the Quality Account, Annual Report and with their local population.

291. The Learning Disabilities Mortality Review Programme (“LeDeR”) is funded by NHSE/I. The purpose of the programme is to review deaths and mortality rates of those with a learning disability, with a view to improving the standard and quality of care for them. The programme was reviewed. In March 2021, the Learning from lives and deaths – people with a learning disability and autistic people policy 2021 was published by NHSE/I, which is to be implemented from June 2021.¹²⁹⁷ The policy will now include autism for the first time (from late 2021) and local ICSs will become responsible for ensuring the LeDeR reviews are completed for their local area and that actions are implemented. ICSs will be held to account for the delivery of the actions by NHSE/I.

¹²⁹⁵ Evidence of Chief Investigator for the HSIB, Keith Conradi, 9 April 2021

¹²⁹⁶ Evidence of Dr Ocloo, Senior Researcher in the Centre for Improvement Science at King’s College London, 8 April 2021

¹²⁹⁷ <https://www.england.nhs.uk/wp-content/uploads/2021/03/B0428-LeDeR-policy-2021.pdf>

Patient safety

292. The evidence set out below, which the Panel received on the topic of patient safety, follows on from the discussion above regarding the proposed new Patient Safety Incident Investigation Framework and Patient Safety Specialists and the evident need for patient safety to be at the centre and forefront of everything that SHFT does to improve and develop moving forward.

SHFT Evidence

293. The Panel received some evidence about the further work that SHFT intends to do in the area of Patient Safety.

294. The **Chief Medical Officer** said that the two biggest areas for patient safety improvement are around the capacity of SHFT to have people trained in patient safety and the QI methodology and its spread. He believes they have built the capacity, but it still needs to be engaged in every team.¹²⁹⁸

295. The **Patient Safety and Quality Facilitator for the Southampton Division** said, SHFT will be looking at having Patient Safety Partners: people with lived experience who will be patients and carers and family members. She was not aware of timescales but believes it to be in the pipeline.¹²⁹⁹

Independent Evidence

296. The Panel received evidence as to what a 'safe' healthcare system looks like and how to measure whether a system is safe.

297. The **Deputy Chief Inspector of Hospitals at the CQC, Dr Cleary** provided key indicators for a safe system in mental health settings (emphasis added):

¹²⁹⁸ Evidence of Chief Medical Officer, SHFT, 12 April 2021

¹²⁹⁹ Evidence of Patient Safety and Quality Facilitator for the Southampton division, 13 April 2021

- 1) We would expect an organisation to be transparent about the care it is providing and where something has gone wrong, that they investigate it thoroughly, transparently and fully, in a way in which they can identify the causes of the problems. If they are systemic, the actions that are to be taken to make sure the learning is shared with the relevant parts of the organisation in a way that people can utilise to decrease risk.
- 2) We would expect that to be seen going up to the Board sub-committees and the Board.
- 3) We would expect good oversight from Board-to-Ward.
- 4) We would expect there to be an open reporting culture. So, staff feel free to report without fear, blame or punitive action. This is not easy and it has to be worked at from an organisational cultural point of view if there is going to be progress.¹³⁰⁰

298. The **Deputy Director of Patient Safety in NHSE/I, Dr Fogarty** said there is evidence to show improvement in patient safety across the NHS. He set out some of the metrics used to demonstrate this, including CQC inspection rates and the NHS Annual Staff Survey questions on a safety culture. He said the staff are an omnipresent barometer of safety of care.¹³⁰¹

299. The **National Clinical Director for Mental Health in NHSE, Professor Kendall** said, “I think we are safer; there is a long way to go... it is about continuous QI – you need to monitor outcomes, processes and safety; you cannot suddenly stop...”.¹³⁰²

300. The Panel also heard evidence about the role of Patient Safety Specialists that have been introduced into the NHS.

301. **Dr Fogarty** spoke about how Patient Safety Specialists will fit into the current systems. He said their role is an integral part to what he sees as being the next phase of patient safety improvement across the whole of the NHS. He said this has developed from the co-produced CQC Report, ‘Opening the Door to Change’, and they wanted to identify that every single significantly sized healthcare provider organisation needed one or more experts on patient safety in their organisation, to be the fountain of knowledge,

¹³⁰⁰ Evidence of Deputy Chief Inspector of Hospitals at the CQC, Dr Cleary, 19 April 2021

¹³⁰¹ Evidence of Deputy Director of Patient Safety in NHSE/I, Dr Fogarty, 20 April 2021

¹³⁰² Evidence of National Clinical Director for Mental Health in NHSE, Professor Kendall, 29 April 2021

leader, expert and coordinator, working across all the activities and supporting the organisation to realise the vision set out in the NHS Patient Safety Strategy.¹³⁰³

302. He described their role as ‘captains of the team’, but said, that they are not the only person responsible as patient safety is everyone’s job.¹³⁰⁴

303. **Dr Fogarty** expressed a need to move towards professionalising patient safety and more networking to ensure people can speak to colleagues in different organisations, with regulators and NHSE/I to create communities who understand and want to champion patient safety.¹³⁰⁵

304. In a statement following his oral evidence, **Dr Fogarty** clarified how many Patient Safety Specialists there were as of 23 April 2021: 202 NHS trusts had identified a Patient Safety Specialist (this includes SHFT).¹³⁰⁶

305. **Dr Fogarty** thought there would have been engagement with families by the Patient Safety Specialists when asked by the Panel. A ‘Framework for Involving Patients in Patient Safety’ was created alongside the Patient Safety Specialists and co-produced with a group of patients and carers, as part of the NHS Patient Safety Strategy. He described how there are two halves to the Framework. The first is to support organisations to involve patients and carers in their own safety; how they can interact with healthcare to promote that; and how they should be engaged in patient safety leadership at organisational level. Secondly, there will be Patient Safety Partners who will be helping an organisation to be safer and lead on safety.¹³⁰⁷

306. However, **Dr Ocloo** stated that the role of Patient Safety Commissioner, on their own, will not make a difference, as they are not looking at the broader system.¹³⁰⁸

307. **Dr Fogarty** summarised what a ‘patient safety culture’ looks like under the Patient Safety Strategy (emphasis added):

¹³⁰³ Evidence of Deputy Director of Patient Safety in NHSE/I, Dr Fogarty, 20 April 2021

¹³⁰⁴ Ibid

¹³⁰⁵ Ibid

¹³⁰⁶ Email dated 30 April 2021

¹³⁰⁷ Ibid

¹³⁰⁸ Evidence of Dr Ocloo, Senior Researcher in the Centre for Improvement Science at King’s College London, 8 April 2021

- Just culture, within which people are not afraid of inappropriate blame.
- A culture in which they are psychologically safe to raise concerns, by cultivating a safe environment where you know you can do it as you have seen others do it.
- Leadership is critical - visible leaders who are showing and talking all the time about the importance of safe behaviours and practices and communicating a clear vision about how they want it delivered in their organisation and being present and repeating the message.
- Open and transparent - the information being openly and transparently shared and discussed, which increases the psychological safety and means the organisation is open to scrutiny and constructive challenge so you avoid isolation, which can occur because an organisation is very inwardly focussed, when you want them outwardly focused.
- An interest in data.
- A commitment to continuous quality improvement - the acceptance that this is not a journey with a destination but it is always and everywhere and looking to incrementally get better. The acceptance of that, a laser-like reliance on data to support that and a scientific method of approach to implement it.
- The placement and welcoming of patients, families and carers at the centre of every one of those conversations – they are always present at the discussion, decision making and offer their perspective.¹³⁰⁹

308. The Panel asked **Dr Fogarty** how NHSE/I would know if there were concerns about an area of patient safety in SHFT and he said it would be better to ask the NHSE Regional team.¹³¹⁰

Panel's Views on where SHFT should be: patient safety

- The Panel encourages SHFT to think wider than just the Patient Safety Specialist role, towards implementing a team that is responsible for patient safety and could be led by a Director of Patient Safety.
- SHFT should continue to see investigations and complaints in the context of patient safety.
- There should be a Patient Safety Plan in place at SHFT, which includes recruitment of its Specialists and Partners and a strategy for, and commitment to, continuous improvement. This Plan should be co-produced with the Patient Safety Specialists and Partners.
- Specifically, the Plan should include how the Patient Safety Specialists and Partners can be involved in investigations and complaints.

Role of the Medical Examiner

309. The introduction of the Medical Examiner falls within the White Paper for the Health and Care Bill 2021; therefore, it is not yet on a statutory footing. Although there have been some appointments made by NHS Trusts already. Further, the overwhelming view of the participants who gave evidence to the Panel is that it is a positive step forward and should be endorsed and, indeed encouraged.
310. **Dr Kirkup's** view is that they are an important part of the system that ought to be in operation and would significantly increase people's trust in the system.¹³¹¹
311. The **Deputy Director of Patient Safety in NHSE/I, Dr Fogarty** described it as "the missing piece of the jigsaw in the Learning from Deaths process".¹³¹²
312. He said, "the Medical Examiner... will give an independent medical review of the care provided to someone who has just died in an organisation, the causes of death and provide an opportunity for the loved ones of the deceased to raise any concerns, speak to an independent doctor about the care provided and it is their opportunity to say whether or not there were issues with that care, which the Medical Examiner can use to refer a case into the usual clinical governance processes in an organisation, including patient safety issues. It will provide an in-situ surveillance system that works for every death in the country and it allows the family involvement in the scrutiny, which I think is incredibly powerful".¹³¹³
313. The **Director for Experience, Participation and Equalities at NHSE/I, Dr Churchill** has first-hand experience of the Medical Examiner. He said, "in my personal case, which had nothing to do with my service area, when my father died in hospital in September, on the day it happened, the clinician asked if I had any questions and I was too numb to work out what they might have been. So, it was very helpful, a couple of weeks later, to

¹³¹¹ Evidence of Dr Kirkup, 8 April 2021

¹³¹² Evidence of Deputy Director of Patient Safety in NHSE/I, Dr Fogarty, 20 April 2021

¹³¹³ Ibid

get a call from the Medical Examiner, to ask if I had questions. I did have questions and I was able to get them answered... in my experience, the Medical Examiner had nothing to do with the service area and I felt I was getting an authoritative clinical view".¹³¹⁴

314. **Dr Ocloo, Senior Researcher in the Centre for Improvement Science at King's College London** stated that the Medical Examiner role should be independent and might be able to pick up some of the critical issues for families at an early stage which can then provide the basis for further investigation, where necessary.¹³¹⁵

315. A **family member** said that the key is to stop deaths and improve quality and safety so that you no longer need investigations. He believes there is too much thought on how the investigation process can be improved and very little thought on how the existing

Panel's Views on where SHFT should be: assurance and wider learning

- SHFT should implement training for managers on extracting data from Tableau and then it should be shared for learning and quality improvement more widely across SHFT.
- SHFT should develop the potential for wider learning between organisations at the Quality Safety Group meetings, which currently involve regional level representatives and local authorities. This can be achieved by inviting participants to bring issues, examples of good practice and other learning to meetings and by holding 'themed' meetings to consider specific issues.
- SHFT should implement an Annual Report on SI Investigations to be submitted to the Board.

Assurance and wider learning

317. The **Chief Investigator for the HSIB, Keith Conradi** said they believe that they have some competence and could provide some quality assurance to local investigators. For their own assurance they look at feedback received. He said it is difficult because there are no standards set in healthcare at national level and these need to be built for the future. Norway has one, so they may have to quality assure each other.¹³¹⁸

¹³¹⁴ Evidence of Director for Experience, Participation and Equalities at NHSE/I, Dr Churchill, 20 April 2021

¹³¹⁵ Evidence of Dr Ocloo, Senior Researcher in the Centre for Improvement Science at King's College London, 8 April 2021

¹³¹⁶ Evidence of family member, 14 April 2021

¹³¹⁷ Evidence of Chief Medical Officer at SHFT, 12 April 2021

¹³¹⁸ Evidence of Chief Investigator for the HSIB, Keith Conradi, 9 April 2021

Support, advocacy and representation for family members, carers and service users in the investigation of serious incidents

318. The subject of advocacy and representation during an investigation for those either left behind following a SI, or in some cases, for those involved in a SI was considered by the Chair of this Review at Stage 1. Therefore, the Panel were interested to pursue this further at Stage 2 and welcomed evidence from independent participants on the topic. In this regard, the Panel considered the evidence set out in Part 5B regarding the work of the FLO within SHFT, the appointment of a Family Liaison Support Officer to assist the current FLO and the suggestion that they are developing a Patient and Carers Support Service.

Evidence of family members

319. A **family member** told the Panel how she would have welcomed contact from a FLO when her daughter died in 2013. She said, "... a FLO should be trained to think when to step forward and maybe a letter would come first, so they can take it slowly rather than on the phone... it needs to be within a fortnight, but the FLO should know within hours of someone dying and should be one of the first to know... then there should be regular contact which does need them to be proactive, as a lot of people do not bother to read, or might not know what is available, or what they will get out of it". She said the FLO should be asked to attend any investigation meetings.¹³¹⁹

¹³¹⁹ Evidence of family member, 6 April 2021

320. Another **family member** said, “I think we should move away from legal involvement, but there should be support and advocacy for those with difficulties representing themselves or explaining what they need”.¹³²⁰

Independent Evidence

321. **Dr Kirkup** said, where needed, a family should have legal support provided. He recalled instances where he had seen a Trust lined up on one side, with very high-level and expensive support, making it look like an adversarial process, even if it is not supposed to be, and the families are left to their own devices. He said that is completely wrong.¹³²¹

322. However, he said, “in my experience, if you have a more informal investigation where nobody is legally represented, it may be easier in some circumstances, to foster constructive dialogue...”. He believes there is a role for advocacy on behalf of a family involved in an investigation, particularly where harm resulted but does not think they necessarily have to be legally qualified and, in some circumstances, it might be best not to be.¹³²²

323. **His Honour Neil Butter QC** said he could see the force of the argument and thought it would be possible, but difficult in practice, for families to have representation at an inquest, or smaller enquiry, where there has been an unexpected death and for the Trust to contribute to the costs of such representation.¹³²³

324. In regard to representation for families in small scale enquiries conducted by SHFT and who should pay for that representation if the family cannot afford it and need to be heard, **His Honour Judge Cutler** suggested that it would be helpful if there could be an arrangement between the Trust and a local firm of solicitors, who would be independent, and refer people to them from time to time to represent them at an enquiry. He expressed that this kind of arrangement would give those parties a friend to go to, who is on their side, can explain the law and procedures, help them present their case and give their evidence, as required.¹³²⁴

¹³²⁰ Evidence of family member, 14 April 2021

¹³²¹ Evidence of Dr Kirkup, 8 April 2021

¹³²² Ibid

¹³²³ Evidence of His Honour Neil Butter QC, 7 April 2021

¹³²⁴ Evidence of His Honour Judge Cutler CBE, 7 April 2021

325. **Dr Ocloo** said that families should have access to representation and independent advocacy, if there is going to be an internal investigation or enquiry, an external investigation or enquiry. In her view, you cannot have a democratic system where one side have all the resources and the poor grieving families have nothing. She said, “the average person who is grieving following an adverse event is going to need support so what is it like for the most disadvantaged families who do not have that support?”. In terms of who should represent the families in an NHS Trust, she said, solicitors who that Trust use cannot do it.¹³²⁵

326. The **National Clinical Director for Mental Health in NHSE, Professor Kendall** said

Panel’s Views on where SHFT should be: advocacy and representation for family members, carers and service users in the investigation of SIs

- 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. SHFT should signpost family members, carers and service users to the local organisations.
- SHFT should prepare and implement a strategy for the role of the FLO and its expansion and future. This would be a key determinate for SHFT’s success.

328. In terms of whether they should be inside or outside SHFT he said that having a relationship with an organisation allows you to navigate it quicker, but an external person could be seen as more independent. In terms of who should pay for such representation, he said, “... in a way we do currently pay for external investigations, so it might be thinking about how resources are used. We can end up with multiple investigations in a complex case, which cannot be the best use of resource”.¹³²⁸

¹³²⁵ Evidence of Dr Ocloo, Senior Researcher in the Centre for Improvement Science at King’s College London, 8 April 2021

¹³²⁶ Evidence of National Clinical Director for Mental Health in NHSE, Professor Kendall, 29 April 2021

¹³²⁷ Evidence of Chief Medical Officer in SHFT, 12 April 2021

¹³²⁸ Ibid

Ongoing reconciliation and mediation

329. The subject of reconciliation and mediation was one that was initiated by Dr Kirkup following his experience in Morecambe Bay and it was discussed with the PHSO Chair and Ombudsman too. Following their evidence, the Panel were keen to explore this idea with the Chief Executive of SHFT.

Independent Evidence

330. **Dr Kirkup** spoke of his experience in Morecambe Bay where he said mediation was volunteered in dialogue with the families, the Trust concerned and a couple of families accepted the invitation. Therefore, they arranged one to two individual conciliation sessions with a professional qualified mediator between clinicians and family members. The families were involved in planning the improvement of services and they built a new maternity unit, which was not a recommendation, but a tangible sign of improvement and they involved the families in that. He reported that at least one found it extremely valuable.¹³²⁹

331. However, he said that mediation is something both parties have to want to go into and see value in it for it to work.¹³³⁰

332. **The PHSO Chair and Ombudsman, Mr Behrens** said, "...we... have to continue to work hard to try and mediate where we think there is a value in doing that. But we need people who are skilled and know what to do, as it is a very challenging role to perform. It needs specialist training and money behind it".¹³³¹

¹³²⁹ Evidence of Dr Kirkup, 8 April 2021

¹³³⁰ Ibid

¹³³¹ Evidence of PHSO Chair and Ombudsman, Rob Behrens CBE, 9 April 2021

333. He said, "... if there is not sufficient common ground, it is a waste of time, but if there is a hint of possibility it is worth having a go at in terms of trying to bring about a reconciliation".¹³³²

334. The **Director for Experience, Participation and Equalities at NHSE/I, Dr Churchill** was asked what steps a Trust could take to rebuild public confidence where it has been properly criticised for historical failures to rebuild public confidence. He said, "a number of people who have been vocal critics of aspects of NHS care will talk powerfully about what has been done to address those concerns. It is very powerful (and credible) to hear from that individual what has changed (and improved) ... I think that is a very important thing for a Trust to demonstrate: that it has made a lasting difference".¹³³³

SHFT Evidence

335. The **Chief Executive** said, "I am always open to see if there are ways we can try and address the issues that grieving individuals and family groups have". He said it needs to be established on the basis of what can be done and is there a way of finding a resolution?¹³³⁴

336. He said that before he arrived, SHFT had tried to engage with the families and was not suggesting fault, but for whatever reason, it had not been possible to establish the grounds to make progress or clarify what it was in terms of outcome that SHFT would be doing. He said several clinicians and managers had spent several hundred hours with the family members to try and make progress and it had not been successful.¹³³⁵

337. In his view, "there will always be a number of families with good cause and justification who will be angry or hostile towards SHFT because of their experience of what happened or what they believe happened. We must do everything we can to try and build bridges, work with those individuals, but there will always be a group who have a bad experience and death is always a shock. Sometimes there isn't always the

¹³³² Ibid

¹³³³ Evidence of Director for Experience, Participation and Equalities at NHSE/I, Dr Churchill, 20 April 2021

¹³³⁴ Evidence of Chief Executive of SHFT, 16 April 2021

¹³³⁵ Ibid

understanding and a belief something could have been done, so we cannot always get to a position of resolution".¹³³⁶

Panel's Views on where SHFT should be: ongoing reconciliation and mediation

- SHFT should consider the possible use of recognised mediation services to resolve outstanding issues with families who have disengaged within the last two years, or where there are protracted complaints.
- This service should be available on the following terms:
 - As separate and independent from the organisation/SHFT
 - If all remedies within SHFT have been exhausted
 - The purpose should be to avoid persistent confrontation
 - This should be part of the investigation process, as the last stage
 - It should be professional, constructive and active in nature
 - All of the parties must have expressed a commitment to mediate and to do so on the basis that they will work towards looking forward, not back.
- SHFT should define and share widely what amounts to 'vexatious' in their SI Policy and Procedure document.

of NHSE/I which are set out below.

Move to Integrated Care Systems

¹³³⁶ Ibid

339. The moved to ICSs was set out in the NHS Long Term Plan, to be established by April 2021 and there is currently a White Paper going through Parliament for ICSs to be established in law.¹³³⁷ The vision for this approach is for decisions about how services are arranged to be made as close as possible to those who use them.

340. The White Paper for the Health and Care Bill 2021 includes proposals for statutory ICSs, made up of an '*ICS NHS Body*' and an '*ICS Health and Care Partnership*'. The ICS NHS Body will have responsibility for strategic planning and allocation decisions, including financial allocation and will be accountable to NHSE/I for spending. Therefore, it will merge some of the strategic functions currently being fulfilled by non-statutory ICSs or sustainability and transformation partnerships ("STPs") with the functions of CCGs, which will be abolished, with their staff transferring over to the ICS NHS Body. However, it will not have powers to direct NHS Trusts or Foundation Trusts.¹³³⁸

341. ICS Health and Care Partnerships will have responsibility for '*developing a plan to address the system's health, public health and social care needs, which the ICS NHS body and local authorities will be required to 'have regard to' when making decisions.*' Local areas will have flexibility in who it appoints as members. They are likely to include, Healthwatch and other voluntary sector providers.¹³³⁹

342. The White Paper also recognises that '*place-based partnerships*' are an important part of the delegation expected of ICS NHS Body and of '*provider collaboratives*'.¹³⁴⁰

CCG Evidence

343. The **Interim Director of Nursing and Quality for North Hampshire, South-East Hampshire, Fareham, Gosport and Isle of Wight CCG**, who has the portfolio for developing the local ICS, is hopeful that this will have a positive impact on the patients and families so that they will only have to do things once and it will stop duplication.¹³⁴¹

¹³³⁷ NHS Long Term Plan, January 2019

¹³³⁸ <https://www.Kingsfund.org.uk/publications/health-social-care-white-paper-explained>

¹³³⁹ Ibid

¹³⁴⁰ Ibid

¹³⁴¹ Evidence of Interim Director of Nursing and Quality for North Hampshire, South-East Hampshire, Fareham, Gosport and Isle of Wight CCG, 14 April 2021

344. She said that with separate CCGs, there was an opportunity for things to be missed, so coming into one big CCG, forming ICSs and collaborating with partners – NHS providers and local government – is really going to help move things along for people in their daily lives. Thus, she hopes there will be a system with localised care at the point of needing receipt and people in the population who are tailored to care for those people and their families. She recognised that COVID-19 has shown health inequalities and said that is a huge thing they need to tackle.¹³⁴²

345. She acknowledged that with the switch to ICSs, there will be movement and, with that, the need to make sure there is organisational memory which is not lost. Therefore, there must be robust record keeping.¹³⁴³

346. The **Director of Quality for West Hampshire CCG** said, “there is an opportunity with ICSs because we will have all of the data and information at scale, it might help us to identify earlier issues that would benefit from patient engagement, as we will be able to triangulate the data from each of the areas without having the artificial divide between commissioners and providers”.¹³⁴⁴

347. The **Clinical Director for Mental Health and Learning Disability for West Hampshire CCG** said, “I hope we can move to a place of equity... there are benefits and negatives of making things place-based. When you make something place-based, there is a risk that one area will do a great deal of work, potentially to the detriment of another area nearby and another area might focus on a speciality, but lose focus on other areas... I hope that with a wider system, we can look at things more broadly and it doesn't matter where you live in Hampshire you can expect to have the same response and support for mental health needs. But it is a new development and there is a lot of work we need to do to make sure we have close connections to the local population”.¹³⁴⁵

SHFT Evidence

348. The **Chief Medical Officer at SHFT** said that to make effective change, ICSs would have to be a part of finding solutions. Currently, he said, this exists with the NHSE/I

¹³⁴² Ibid

¹³⁴³ Ibid

¹³⁴⁴ Evidence of Director of Quality for West Hampshire CCG, 15 April 2021

¹³⁴⁵ Evidence of Clinical Director for Mental Health and Learning Disability for West Hampshire CCG, 1 April 2021

Regional South-East team to some extent, but he felt that it is a bit removed from making changes Hampshire-wide.¹³⁴⁶

Independent Evidence

349. **Dr Kirkup** spoke of some of the potential positives from a move to ICSs and said, "... if they foster a closer way of working between the different parts of the system, then a lot of good could come out of it, including a more integrated approach to how improvement is looked at and when things go wrong; investigations that are detached from the point they occurred, so they are more objective; and to ensure action plans are not just tick-box exercises but produce change on the ground".¹³⁴⁷

350. **Dr Ocloo, a Senior Researcher in the Centre for Improvement Science at King's College London** had concerns about the extent to which 'harmed patients and families' had been involved in developing the new ICSs, so questioned whether or not it would actually improve patient safety.¹³⁴⁸

351. The **Chief Investigator for the HSIB, Keith Conradi** said that with the move to ICSs there is, "an opportunity to structure a more organised safety system – nationally, locally and at the geographical footprints in-between... I think there is the potential for a regional model, where we can have more day-to-day connection with local investigations going on at a training, guidance and advice level and feed that in at a national, regional and local level as you start to see themes, evidence and data...". He said, "if you want to make safety recommendations at a national level... it needs the general collation of data to a national body, such as the HSIB, to evolve that into an evidence based safety recommendation". He observed that this is happening at various geographical levels across the system but believes it could be more effective than it currently is.¹³⁴⁹

352. The **National Clinical Director for Mental Health in NHSE, Professor Kendall** said, "I am a firm believer in local services... the idea of integrated health and social care and better education around health, where we aim not just for therapeutic communities,

¹³⁴⁶ Evidence of Chief Medical Officer at SHFT, 12 April 2021

¹³⁴⁷ Evidence of Dr Kirkup, 8 April 2021

¹³⁴⁸ Evidence of Dr Ocloo, a Senior Researcher in the Centre for Improvement Science at King's College London, 8 April 2021

¹³⁴⁹ Evidence of Chief Investigator for the HSIB, Keith Conradi, 9 April 2021

but to make communities therapeutic. It is an important step for the NHS and the nation to take and integrated care is great for us to all aim for".¹³⁵⁰

353. He explained that ICSs are not a commissioning body, but will get the funding and will broadly be a 'provider collaboration'. However, he is, very keen that mental health do not lose out which he said has happened in the past.¹³⁵¹

Panel's Views on where SHFT and the CCG should be: ICSs

- The design and development of ICSs in Hampshire must be co-produced with local populations. In line with any legislative provisions, ICSs should be subject to consistent and regular review, to ensure that the appropriate assurances are in place.

Role in commissioning

354. The **Interim Director of Nursing and Quality for North Hampshire, South-East Hampshire, Fareham, Gosport and Isle of Wight CCG** recognised that there needs to be equity and parity between mental health services and transformation funding of disability services and physical health services.¹³⁵²

355. She said, "I think the Learning Disability Mortality Review Programme has really helped us to increase our visibility of people who have died with a learning disability... but there is the inequality in COVID-19 mortality rates of people with learning disabilities and that needs to be addressed".¹³⁵³

356. Further, "there is a focus in ICSs around mental health transformation programmes. There are things we can do at scale... but we need to work out what is unwarranted variation and what is the variation we need... there is a number of different enquiries coming to the fore and the themes are the same: truly listening to our families, patients, hearing and understanding what they have to say to say is absolutely crucial to this and

¹³⁵⁰ Evidence of National Clinical Director for Mental Health in NHSE, Professor Kendall, 29 April 2021

¹³⁵¹ Ibid

¹³⁵² Evidence of Interim Director of Nursing and Quality for North Hampshire, South-East Hampshire, Fareham, Gosport and Isle of Wight CCG, 14 April 2021

¹³⁵³ Ibid

to co-designing services, otherwise we won't get anywhere, because they know their families and conditions".¹³⁵⁴

Relationship between SHFT and the CCG

357. **Dr Kirkup** stated: "supervision of patient safety by CCGs has been problematic in many NHS systems. This appears to originate in the nature of the relationship between service providers and commissioners, the former preferring to keep their commissioners at arm's length and the latter finding it difficult to obtain meaningful information about service quality."¹³⁵⁵

358. A **family member** suggested that the CCG should make public any papers that set out what they are doing, the structure should be known and it should be confirmed as to whether checks will be made on SHFT.¹³⁵⁶

Assurance and oversight function of the CCG

359. The **Interim Director of Nursing and Quality for North Hampshire, South-East Hampshire, Fareham, Gosport and Isle of Wight CCG** said she would like to see, "...divisional sections linked in with Integrated Care Providers and local place-based systems, to ensure they have the right coverage in each area... and we need to make sure it goes from Board-to-floor and floor-to-Board and continue that governance structure across the area".¹³⁵⁷

360. She developed this further and described two areas of monitoring they need to

Panel's Views on where the relationship between SHFT and the CCG should be

- The CCG should be in the position to show its independence from SHFT when required.

finance assurance process and up-to the Board.

¹³⁵⁴ Ibid

¹³⁵⁵ Statement of Dr Kirkup, 5 March 2021

¹³⁵⁶ Evidence of family member, 6 April 2021

¹³⁵⁷ Evidence of Interim Director of Nursing and Quality for North Hampshire, South-East Hampshire, Fareham, Gosport and Isle of Wight CCG, 14 April 2021

2) We are developing as an ICS (and we are double-running our reporting to the Region until the new legislation is passed), so we are looking at place-based

Panel's Views on where the CCG should be: oversight and contractual management of the complaints handling process in SHFT

- The CCG should have a robust process in place to monitor the standard of complaints handling within SHFT. This could be achieved by setting up a Complaint Monitoring Committee, which includes representation from the CCG.
- The CCG should work harder to ensure its assurance functions demonstrate how SHFT is being challenged and how they are monitored. Additionally, SHFT should be more precise in its documented responses to concerns raised by the CCG.
- SHFT should consider what mechanisms it can implement to allow the CCG to 'dip sample' complaint responses and investigation reports, for quality assurance purposes.

actions are assigned to individual(s) and state their role, with deadlines for completion and clear evidence of monitoring and implementation.

Oversight or contractual management of the complaints handling process in SHFT

Oversight or contractual management of the SI investigations process in SHFT

¹³⁵⁸ Evidence of Interim Director of Nursing and Quality for North Hampshire, South-East Hampshire, Fareham, Gosport and Isle of Wight CCG, 14 April 2021

361. The **Interim Director of Nursing and Quality for North Hampshire, South-East Hampshire, Fareham, Gosport and Isle of Wight CCG** said, “when the Patient Serious Incident Review Framework... (which) all providers will be expected to move to, comes out, that is where you will get the qualifications for a Patient Safety Incident Investigator, a set of standards and a framework to work within to look at individual and thematic investigations... the CCG will work with the providers to look at their plan for the year, including, prevention, response and governance”.¹³⁵⁹

362. Furthermore, she said, “I would like to see how we can take away some of the bureaucracy when there are multiple providers. I find the domestic homicide reviews very clear, because there is an independent person coming in and all of the organisations provide timelines and they are brought together in a very formalised way... but when there are multiple providers coordinating, it is quite difficult. We have a standard approach agreed with providers across ICS areas, where it is a multi-agency SI framework and the CCGs coordinate it, which is working. I think we need to refine it and ensure it is adopted alongside the HSSIB and Patient Serious Incident Response Framework”.¹³⁶⁰

363. She explained how they liaise with the police and local authority on a regular basis for safeguarding and recognised that they should also be doing it for SIs.¹³⁶¹

Service user, carer and family member’s voice in the commissioning of services

CCG Evidence

364. The **Interim Director of Nursing and Quality for North Hampshire, South-East Hampshire, Fareham, Gosport and Isle of Wight CCG** stated, “I think it is our duty to make it clearer for service users and families to navigate through the system. When I returned from the USA, I couldn’t navigate it and I was the Deputy Director of Nursing”. She said this should be done by setting out clearly what they are doing and having

¹³⁵⁹ Ibid

¹³⁶⁰ Ibid

¹³⁶¹ Ibid

Panel's Views on where the CCG should be: the voice of service users, carers and families in the commissioning of services

- The CCG should prioritise the engagement, co-production and promotion of the service user, carer and family member's voice in the development of, and move towards, the new ICSs.

it has also shown the need for having access to easy read documents, not only for service users, but as tools for staff to use too.¹³⁶³

Family Member's Evidence

366. A **family member** said that if support is required, you should be able to go to SHFT,

Panel's Views on where NHSE/I (Regional level) should be: support/supervisory role of SHFT

- The outcomes of the Quality Surveillance Governance meetings and the process in place for the follow-up of actions or issues arising from them should be properly documented and shared.
- SHFT should consider inviting NHSE/I to their Learning from Events Forum.

NHSE/I Regional level

368. **Dr Kirkup** said that it was the role of NHSE/I to ensure there is effective leadership but that he did not think it had been as effective or thorough as it might have been.¹³⁶⁶

¹³⁶² Ibid

¹³⁶³ Ibid

¹³⁶⁴ Evidence of family member, 14 April 2021

¹³⁶⁵ Evidence of Dr Kirkup, 8 April 2021

¹³⁶⁶ Ibid

Action Plans

C. Where should SHFT be?

Introduction

369. There is considerable overlap between the topic of Action Plans and the evidence that the Panel received on Quality Improvement so the evidence should be considered as a whole.

370. A **family member** put it very concisely when he said that trust is obtained through integrity and integrity is doing what you say you are going to do.¹³⁶⁷

371. The **Director for Experience, Participation and Equalities at NHSE/I, Dr Churchill** recognised that action plans have limitations. He said it is easy to set out what is to be done but harder to show progress has been made against them. This is where he believes more of the emphasis needs to go: what has changed as a result?¹³⁶⁸

372. The **Interim Director of Nursing and Quality for North Hampshire, South-East Hampshire, Fareham, Gosport and Isle of Wight CCG** said that in order to put things into action it is about getting out and doing. She said an action plan can be about working with leaders and how to implement change, which may be done by meeting or relationship building, but it is in the monitoring and assurance stages when the change happens.¹³⁶⁹

373. The **Chief Medical Officer at SHFT** stated that “long term solutions for viability of an improvement system comes from a culture of quality improvement; staff having psychological safety to openly report problems; an organisational structure to use data and to make it widely available; and staff engagement in a shared desire to pursue safety and effectiveness”.¹³⁷⁰

¹³⁶⁷ Evidence of family member, 14 April 2021

¹³⁶⁸ Evidence of Director for Experience, Participation and Equalities at NHSE/I, Dr Churchill, 20 April 2021

¹³⁶⁹ Evidence of Interim Director of Nursing and Quality for North Hampshire, South-East Hampshire, Fareham, Gosport and Isle of Wight CCG, 14 April 2021

¹³⁷⁰ Statement of Chief Medical Officer at SHFT, 2 February 2021

Implementation of Action Plans

Independent Evidence

374. The overwhelming evidence received from the independent participants on this topic was that the responsibility for the implementation of action plans, ultimately, lies with the Board.

375. In regard to safety investigations, **Dr Kirkup** said in his written statement, "... resulting actions must be escalated appropriately to Board-level with a process to ensure implementation".¹³⁷¹

376. He said, "the usual NHS way of assessing the extent to which recommendations have been implemented is for a Trust to establish an action plan... the principal danger is that this becomes a box-ticking exercise operated at high-level in a Trust and real change at service level lags behind or is absent... effective leadership at every level, complete acceptance of the need for change and full engagement of clinical unit staff, are all essential".¹³⁷²

377. He described how, "on paper you can have a very satisfactory process, but in reality, it might not be reflected in what is happening on the ground... action plans, which look like a whole series of boxes with 'complete' against them, worry me. I think they are too likely to be superficial and do not reflect reality".¹³⁷³

378. **Dr Kirkup** said, "for the more far-reaching and difficult problems it makes sense for regulators to make sure there is some external scrutiny". Therefore, he said there ought to be a key role for the commissioners representing the local population, but acknowledged that the exchange of information in relation to the quality of services between commissioners and providers, is sometimes not as good as imagined.¹³⁷⁴

379. The **Chief Investigator for the HSIB, Keith Conradi** said, "the safety recommendations we make are not mandatory and people have a choice, but we ask

¹³⁷¹ Statement of Dr Kirkup, 5 March 2021

¹³⁷² Evidence of Dr Kirkup, 8 April 2021

¹³⁷³ Ibid

¹³⁷⁴ Ibid

people to respond to them with the actions they intend to take, including ‘no action’ if they say that’s appropriate and we make that public... but with so many bodies in healthcare we can make the recommendations but (the question is) who is checking that work is being done? That is still work in progress and no obvious body takes that responsibility”.¹³⁷⁵

380. However, **Mr Conradi** said, “... (the HSIB) have a large maternity programme and do local investigations into incidents and make safety recommendations to a Trust. The Trusts in which they’re most successful and have the best outcomes, are those where there is interest at Board-level... Board interest in safety is critical to the success and implementation of safety recommendations”.¹³⁷⁶

381. He stated, “at local level, HSIB maternity investigations have found that Trusts demonstrate their accountability by commitment to fulfilling their Duty of Candour requirements, taking action early on any safety issues identified by either their own 72 hour analysis or the HSIB’s safety investigations, and by incorporating findings and recommendations from the HSIB investigations in their Board-level reporting and feedback to staff”.¹³⁷⁷

Panel’s Views on where SHFT should be: action plans

- All action plans SHFT creates at any level of the organisation must include a deadline and the name of the individual(s) and their role, or team, who is responsible for the action.
- SHFT must move towards and develop a robust process for monitoring the implementation and impact of recommendations and action plans effectively. This includes investigations into complaints, concerns, all SIs and Red RCAs and incidents which do not go through the full SI investigation process.
- SHFT should implement a system of monitoring or review for the Complex Case Panels and ensure that it is clear who has the responsibility for any actions to be taken following the panel discussion.
- Evidence of Improvement Panels should be held six months after the relevant incident and should be more widely used for all serious incidents. There should be feedback to families, a record of whether they attend the Panels and consistency in the recording of the dates for implementation and actions taken.

¹³⁷⁵ Evidence of Chief Investigator for the HSIB, Keith Conradi, 9 April 2021

¹³⁷⁶ Ibid

¹³⁷⁷ Statement of Chief Investigator for the HSIB, Keith Conradi, 8 March 2021

Assurance processes for action plans

382. **Dr Kirkup** discussed the quality assurance processes that need to be in place to be assured that recommendations will be implemented and sustained: “you need a proper assurance process, not the Board, but a quality assurance committee... their job is to assure the Board that the right things are being done and that needs to go into quite a lot of detail... and in intractable cases it needs to call people in and grill them... you need to talk to people and call them in to ask what has been done to put it right and implement the checklist and not disregard it. You need to go into quite a lot of detail...”.¹³⁷⁸

383. The **Chief Investigator for the HSIB, Keith Conradi**, said, “I think there could be a (representative) on a quality and safety committee (and their) role should be strengthened. If the Chief Executive sits on that committee then... it is a signal from the Chief Executive and Board members in the way they interact with the organisation, that can make a huge difference”.¹³⁷⁹

Service User feedback

384. A **service user** gave her strong views on this topic, from her own personal experience. She said, “feedback is how you improve. Before I wasn’t well, I owned two businesses and feedback was very important to help me continuously improve. If you had an outside organisation doing that in a fair way, it would be fantastic and produced to them as figures, which I think they should declare. Things need to improve”.¹³⁸⁰

¹³⁷⁸ Evidence of Dr Kirkup, 8 April 2021

¹³⁷⁹ Evidence of Chief Investigator for the HSIB, Keith Conradi, 9 April 2021

¹³⁸⁰ Evidence of service user, 15 April 2021

Psychologically and Emotionally Safe Environment for service users, carers, family members and staff

C. Where should SHFT be?

385. The Panel received independent evidence on the subject of a psychologically and emotionally safe environment for service users, carers, family members and staff. The majority of the evidence on this topic has already been set out above, in relation to the Duty of Candour, the reporting of SIs and patient safety and below, concerning a just culture and accountability. This demonstrates the pervasiveness and importance of this topic and the sections should be read as a whole.

386. In addition to the evidence already set out, **Dr Kirkup** said, "... I do sympathise with what people intended by (the Duty of Candour) and that is that people have to feel able to own-up to things that they find difficult to own-up to themselves and others. Unless we can foster a culture of that, we are stuck with some of the imperfect processes and outcomes that we have at the moment".¹³⁸¹

387. **Dr Ocloo, a Senior Researcher in the Centre for Improvement Science at King's College London** said that if we move towards a psychologically safe system that respects all those involved then the foundations can be built upon and in her view, it is in the interests of the whole system to do so.¹³⁸²

388. The **Chief Investigator for the HSIB, Keith Conradi** said he does see an improving culture in the areas of the NHS that HSIB have visited, which he recognised is limited. He said that with an improvement in culture the NHS will become a safer place to work.¹³⁸³

¹³⁸¹ Evidence of Dr Kirkup, 8 April 2021

¹³⁸² Evidence of Dr Ocloo, a Senior Researcher in the Centre for Improvement Science at King's College London, 8 April 2021

¹³⁸³ Evidence of Chief Investigator for the HSIB, Keith Conradi, 9 April 2021

Panel's Views on where SHFT should be: developing a psychologically and emotionally safe environment for service users, carers, families and staff

- The Panel is clear that SHFT must provide a psychologically and emotionally safe environment for service users, carers and family members, as well as staff.
- SHFT should set up a Trust-wide QI project/workshop, which should include service users, carers, family members and staff from across all levels of the organisation, but specifically, clinical staff and the Director of Workforce, Organisational Development and Communications. The question to be answered should be: what actions can be done to improve the psychological and emotional safety in this organisation?
- Following the workshop there should be a co-produced strategy, which should include any suggestions arising from the workshop. The aim of the strategy is to ensure SHFT is a more psychologically and emotionally safe environment for all. The strategy should be monitored and reviewed annually.
- Specifically, SHFT should work towards ensuring there is compassionate leadership that permeates throughout the entire organisation.

Just Culture and Accountability

C. Where should SHFT be?

Introduction

389. NHSE/I take the definition of a ‘just culture’ from Professor Sir Norman Williams’, ‘Review into Gross Negligence Manslaughter in Healthcare Report (June 2018) which stated, ‘*A just culture considers wider systemic issues where things go wrong, enabling professionals and those operating the system to learn without fear of retribution*’.¹³⁸⁴

390. The Report said, ‘... *Generally in a just culture inadvertent human error, freely admitted, is not normally subject to sanction to encourage reporting of safety issues. In a just culture, investigators principally attempt to understand why failings occurred and how the system led to sub-optimal behaviours. However, a just culture also holds people appropriately to account where there is evidence of gross negligence or deliberate acts.*’¹³⁸⁵

391. NHSE/I have produced a ‘Just Culture Guide’ to be used when ‘*There is a suspicion that a member of staff requires support or management to work safely, or as part of an individual practitioner performance/case investigation*’.¹³⁸⁶

392. Sidney Dekker¹³⁸⁷ has written about a ‘just culture’ on numerous occasions. In one paper he considers the balance between a ‘just culture’ and the line between acceptable and unacceptable behaviour. Some of his observations in this paper are relevant here:¹³⁸⁸

- *A just culture, is particularly concerned with the sustainability of learning from failure through the reporting of errors, adverse events, incidents.*

¹³⁸⁴ ‘Just Culture Guide’, NHS England: <https://www.england.nhs.uk/patient-safety/a-just-culture-guide/#what-do-we-mean-by-just-culture>; <https://www.gov.uk/government/groups/professor-sir-norman-williams-review>

¹³⁸⁵ Ibid

¹³⁸⁶ Ibid; https://www.england.nhs.uk/wp-content/uploads/2021/02/NHS_0932_JC_Poster_A3.pdf

¹³⁸⁷ Sidney Dekker founded the Safety Science Innovation Lab at Brisbane University, Australia. He was also professor of human factors and system safety at Lund University in Sweden, where he founded the Leonardo da Vinci Laboratory for Complexity and Systems Thinking.

¹³⁸⁸ ‘Just culture: who gets to draw the line?’ Sidney W. A. Dekker, Cogn Tech Work, 14 January 2008

- *A ‘no-blame’ culture is neither feasible nor desirable. Most people desire some level of accountability when a mishap occurs.*¹³⁸⁹
- *Holding people accountable and blaming people are two quite different things... blame-free or no-fault systems are not accountability-free systems. On the contrary: such systems want to open up the ability for people to hold their account, so that everybody can respond and take responsibility for doing something about the problem. If... we see the act as an indication of an organisational, operational, technical, educational or political issue, then accountability can become forward-looking.*¹³⁹⁰
- *Creating the basis for a just culture: The first steps involve a normalisation of incidents, so that they become a legitimate, acceptable part of organisational development... then... empowering and involving the practitioner him-or her-self in the aftermath of an incident is the best way to maintain morale, maximise learning, and reinforce the basis for a just culture....*¹³⁹¹

‘Just Culture’ and Accountability

Independent Evidence

393. The questions asked by the Panel of most participants which produced the answers below were based on whether they think it is possible to strike a balance between a ‘just culture’, a culture of accountability, responsibility and learning. Then, whether there should be a ‘no-blame culture’ in the NHS.

394. The **Chief Investigator for the HSIB, Keith Conradi** stated, “an open and just culture is one in which incidents and failures are openly and honestly discussed by staff, patients and families, creating an environment where the causes of serious events can be established and lessons can be widely learned. This approach... has enabled (other) industries to shift the focus of safety investigations from attributing individual blame to understanding the underlying risks and contributory factors inherent within the design or implementation of work systems”.¹³⁹²

¹³⁸⁹ Ibid. GAIN (2004) Roadmap to a just culture: Enhancing the safety environment. Global Aviation Information Network (Group E: Flight Ops/ATC Ops Safety Information Sharing Working Group)

¹³⁹⁰ Ibid. Sharpe VA (2003) Promoting patient safety: an ethical basis for policy deliberation. Hastings Center Report Special Supplement 33(5): S1–S20

¹³⁹¹ Ibid

¹³⁹² Statement of Chief Investigator for the HSIB, Keith Conradi, 8 March 2021

395. **Mr Conradi** said the HSIB identify the contributory factors that have led to harm or have the potential to cause harm to patients. Furthermore, although the HSIB do not apportion blame or liability, they can apportion accountability. He said they look at it from a system perspective and conduct an analysis by looking at the interaction between all of the players and parts and considering a person given a task, with the tools, working in an environment within a wider organisation.¹³⁹³
396. He explained how the HSIB always start from the premise that nobody comes into work to make a mistake or do a bad job and they start with the assumption that people come to do a good job and try to understand what the circumstances were leading to an adverse event happening, despite people coming in to do a good job. He said they do not suggest just culture is about blaming individuals for mistakes which were honest mistakes. He believes accountability and compassionate leadership can work together.¹³⁹⁴
397. He said, "... people will often find reasons why the event does not require a safety investigation, which is part of the difficulty people have in accepting something has gone wrong. This should not happen but as long as people find difficulty in this and fear they will be blamed unjustly, there is still a huge gap between what ought to be investigated and what is investigated".¹³⁹⁵
398. **Mr Conradi** described said that following a HSIB investigation, it usually comes down to the regulators, someone who sets the regulations and standards for what happens and the processes that take place. The HSIB will make safety recommendations to those who they think can address the deficiencies identified – that is the level of accountability. He said that ultimately, in healthcare, it lies with the Department of Health and the many regulators which is where the focus of improvements can take place, so they do apportion accountability.¹³⁹⁶
399. **Dr Ocloo** spoke of needing a 'just culture' for harmed patients, which, in her view, does not exist now. She was asked whether there can genuinely be a culture shift and

¹³⁹³ Ibid

¹³⁹⁴ Evidence of Chief Investigator for the HSIB, Keith Conradi, 9 April 2021

¹³⁹⁵ Ibid

¹³⁹⁶ Ibid

discussed how this should be evaluated: “if you had an individual Trust... where families had been harmed, in which there was evidence of genuine contrition and a willingness to change then ultimately the judge of whether this was genuine could only come from the individuals and families who had been harmed”. However, she said it is difficult to get these shifts unless there is a real commitment from the top to addressing the issues, in partnership with ‘harmed patients’ and family members.¹³⁹⁷

400. The **Chair of the PHSO and Ombudsman, Mr Behrens** believes a just culture can live alongside a culture of accountability as accountability does not mean vindictive blaming of individuals, but it means a proper account of institutions to make sure they learn from the process. He said if that is adhered to then it is perfectly possible to have a just culture which is accountable. He believes there should not be an obsession and he said there isn’t one, with trying to hold individuals to account when the issues are really systemic and the individuals carrying out the actions are doing what the system requires of them, or hasn’t done to support them. He described how there is a discipline required on the Ombudsman to make sure there is no vindictiveness in the decision making.¹³⁹⁸

401. He said, “... it cannot be right for doctors in hospitals to come to me and say they cannot complain because they will be disciplined if they do so. That is very serious.” He explained the need for support to be in place for doctors in this position and for those on the receiving end of a complaint or making a mistake. He could not immediately recall any such support that was available.¹³⁹⁹

402. **Dr Cleary, Deputy Chief Inspector of Hospitals at the CQC** said, “the first thing you have to do is consistently take the same approach to incidents when something goes wrong. Be honest where there is a systemic problem and admit at Board-level that any system problems are your responsibility and ensure those systemic problems are dealt with... it is about not blaming the most junior members of staff, but taking appropriate responsibility at the appropriate level of the organisation”.¹⁴⁰⁰

403. The **Deputy Director of Patient Safety in NHSE/I, Dr Fogarty** said, “I would challenge the juxtaposition of ‘just’ and ‘no blame’, as they are different things. A just

¹³⁹⁷ Evidence of Dr Ocloo, a Senior Researcher in the Centre for Improvement Science at King’s College London, 8 April 2021

¹³⁹⁸ Evidence of Chair of the PHSO and Ombudsman, Rob Behrens CBE, 9 April 2021

¹³⁹⁹ Ibid

¹⁴⁰⁰ Evidence of Dr Cleary, Deputy Chief Inspector of Hospitals at the CQC, 19 April 2021

culture is one in which people do not fear inappropriate blame. A no-blame culture is one in which there is no blame. We are not in pursuit of a no-blame culture. There are a small number of cases where blame is an appropriate and justified response”. He stated, “we should be aiming for a just culture, which is the case in other high-risk and high-reliability industries”. But acknowledged that a just culture is difficult to generate as blame is a natural and normal human reaction. He said blame is very destructive to improvement and learning because it generates fear and fear leads to people not openly exploring where they can improve.¹⁴⁰¹

404. **Dr Fogarty** said, “the pursuit of a just culture is important... we are attempting to engender that culture across the system... we have the ‘Just Culture Guide’. Furthermore, he explained how looking at the individual is detrimental to safety and said, “we need to look at the potential for anyone to be in that situation and make improvement based on that. That is where accountability comes in: everyone in healthcare is accountable to make those changes that we have identified through the process of learning, to drive the improvement of quality across the system and that is what they should be held accountable for”.¹⁴⁰²

SHFT Evidence

405. The **Chief Executive** said that a blame-free culture and accountability, “have to be seen together... quite often we are clear about not blaming, but we do not address the accountability issue and get to the root cause of the problem to support them to move on... so they go hand in hand”. He stated, “it is really important that we do not resort to blaming behaviour, it is really difficult sometimes not to, but it is absolutely crucial we do not have a blame culture in that respect”.¹⁴⁰³

406. The **Chair** said SHFT does not have a just culture for all; not for the people outside of the organisation and particularly not for carers and service users. She recognised that this is an area of work that she wanted to drive forward.¹⁴⁰⁴

407. The **Patient Safety and Quality Facilitator for the Southampton division** said, “I have just started a project to develop and embed a ‘just culture’ in the Southampton

¹⁴⁰¹ Evidence of Deputy Director of Patient Safety in NHSE/I, Dr Fogarty, 20 April 2021

¹⁴⁰² Ibid

¹⁴⁰³ Evidence of Chief Executive of SHFT, 16 April 2021

¹⁴⁰⁴ Evidence of Chair of SHFT, 16 April 2021

division, so we can have an open and learning relationship... someone in the central governance team is supporting me and we are completing a needs analysis this week”. She defined ‘just culture’ as “...being completely honest, open and transparent and not just using those as buzz words... it does not matter what has happened, it is about how we move on with it... we can turn it into something positive and learn something from it”.¹⁴⁰⁵

408. The **Director of Workforce, Organisational Development and Communications at SHFT** said a ‘just culture’ and accountability of actions, “come hand-in-hand... it is important that there is clarity in accountability and the right processes and culture, to support staff to do their job. We need people to understand what they are responsible for and to take it seriously, I think the vast majority of our staff do that”.¹⁴⁰⁶

409. He spoke about a culture of ‘fear to report’ when he joined three years ago and said, “... our NHS Annual Staff Survey results say we are in a better place. But accountability needs to come with it. Where people do get it wrong, we will dismiss them. It is not something we will be doing lightly, but we had to dismiss someone this month as they had to be held accountable for their actions”.¹⁴⁰⁷

Family Member’s Evidence

410. A **family member** said, “accountability does not mean blame, but you need to know who should rectify the problem. Most problems are caused by system-failure not individual failings”. He said, a ‘just culture’ to him means, “everyone would be happy to speak up and in fact, they knew it was their duty to speak up and would be praised for it”. He said there should be defined accountability every level of management.¹⁴⁰⁸

¹⁴⁰⁵ Evidence of Patient Safety and Quality Facilitator for the Southampton division, SHFT, 13 April 2021

¹⁴⁰⁶ Evidence of Director of Workforce, Organisational Development and Communications at SHFT, 19 April 2021

¹⁴⁰⁷ Ibid

¹⁴⁰⁸ Evidence of family member, 14 April 2021

Panel's Views on where SHFT should be: developing and balancing a 'just culture' and accountability

- It is crucial that SHFT gets the balance right: there should be a culture that balances accountability and responsibility, with meeting the Duty of Candour and admitting mistakes. To do this, there needs to be in place:
 - A culture where people feel able to admit to making a mistake
 - A focus on Human Factors
 - A move away from a focus on the individual and a move towards focussing on the systems in which that individual practices
 - A culture where individuals are encouraged to improve and punitive action will only be taken when absolutely necessary.
- SHFT should absorb and implement the 'Just Culture' Guide on the NHSE/I website.
- SHFT should continue with the work it is has already started to reduce the culture of blame and fear that has existed in the organisation in the past. The message should be shared and permeate all levels of the organisation.
- The Panel acknowledges the challenges of achieving this balance, but SHFT must not shy away from it for that reason. It should embrace it and develop it across the whole organisation, using QI methodology where appropriate and relevant.
- By developing an open and honest culture, SHFT will re-build the trust and confidence with the population it serves.

Leadership, Succession and Strategy Planning

C. Where should SHFT be?

411. **Dr Kirkup** spoke about the continuing presence of senior leaders in an organisation that has faced problems in the past and he said, “it is difficult for someone who has been an integral part of a previously closed process and tried to fend off evidence of problems to convincingly say they will behave properly now. It is not impossible, but it is very difficult”.¹⁴⁰⁹
412. He went further and said, “I... have not seen it applied successfully, where an existing senior management team involved in that degree of systemic problems, which I have been involved in investigating, have been able to change to the extent necessary”.¹⁴¹⁰
413. A **family member and ex-Governor** does not think that the Non-Executive Directors have the scope to implement real change. He is unwavering in his view that the focus should not be on SHFT, as it is limited as to what it can radically reform, because of the way the NHS overall, operates.¹⁴¹¹

Panel’s Views on where SHFT should be: leadership, succession and strategy planning

- The Panel acknowledges that SHFT has strengthened its leadership at the Board and is further developing the Council of Governors under the leadership of the Chair of SHFT.
- The development of divisions with strong clinical and managerial leadership provides the local focus required. It is hoped that this will be reinforced and developed further by the ICS approach.
- The Panel recognises that there is an organisational strategy in place and would suggest this is revisited and further enhanced to ensure it is communicated across SHFT, its service users, carers and family members to demonstrate SHFT’s commitment.

¹⁴⁰⁹ Evidence of Dr Kirkup, 8 April 2021

¹⁴¹⁰ Ibid

¹⁴¹¹ Evidence of family member and ex-Governor, 14 April 2021

Wider National Reporting

C. Where should SHFT be?

414. The ability of the NHS to report incidents of harm at the ward or outpatient level is a unique process and it is commonly seen as the global exemplar. It is also a good indicator of the reporting and safety culture of staff, when they are involved in, or see, harm caused to a patient.
415. The NHS has the ability to report easily through an integrated system onto the NRLS, which is now collecting more than two million incidents annually across the NHS. This allows the NHS to identify key themes, to send appropriate alerts (National Patient Safety Alerting System) and interventions can be put in place to prevent or reduce future harms (National Patient Safety Improvement Programme).
416. Participants that the Panel have heard from have described the use of a variety of processes to report incidents, which they have said demonstrate an improving reporting culture where a 'fear to report' has been reduced in recent years.
417. The development of the Patient Safety Information Management System will provide an opportunity for SHFT to engage with the national system and will offer an opportunity to integrate its incident reporting systems.

Panel's Views on where SHFT should be: wider national reporting

- SHFT should ensure that all of its staff are aware of and trained in the link between local reporting and its value to the national system of reporting and learning.
- SHFT needs to evaluate and reconsider the method(s) it employs to categorise the degree of harm for reported incidents and to explain the low numbers assessed as 'moderate' and 'low' harm. Similarly, there are very few deaths or severe harms reported in comparison to the numbers of such reported incidents from other mental health trusts.
- SHFT should provide further support and training to staff to improve the timeliness of reporting and the appropriate categorisation of incidents.
- All incidents and deaths reported through SHFT's Learning from Events and SI process should be available to be reported on STEIS and the subsequent replacement of the NRLS.

Panel's Views on where SHFT should be: wider national reporting continued...

- SHFT should ensure it has joined-up processes and mechanisms in place for sharing and learning across the organisation from information that is uploaded to the SI reporting system, the STEIS, the Learning from Events programme and the incidents reported through to the NRLS
- The development of the Patient Safety Information Management system provides an immediate opportunity. It should be adopted in SHFT and throughout the NHS.

PART 6: Recommendations and Learning Points

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, 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.
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 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.

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 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 representation. Therefore, it should look to Third sector organisations that it can to facilitate access or signpost their availability for 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 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.

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 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.
11. 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.
12. 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.

Support for Service Users, Carers and Family Members

13. 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.

Information Sharing

14. 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.

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 physical health, mental health and learning disability and 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, which includes 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 quantitative 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.

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 perceived independence.

35. The establishment of the newly formed Integrated Care Service 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 implanted 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, overall, increase its annual and quarterly reporting by committees and divisions to be accessible to the public it serves.

PART 7: 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:

Dr Mike Durkin OBE MBBS FRCA FRCP DSc

Professor Hilary McCallion CBE

Priscilla McGuire

23 July 2021

Appendix 1: Terms of Reference Stage 2

Stage 2 Investigation - Southern Health NHS Foundation Trust Review

Terms of Reference

Introduction

This paper sets out the scope and terms of reference for stage 2 of the independent review into the quality of investigations and implementation of the resulting recommendations relating to the deaths of various patients who were in receipt of care provided by Southern Health NHS Foundation Trust (“the Trust”) and as recommended for further investigation by the stage 1 report, authored by Nigel Pascoe QC.

Details on the format and procedure for stage 2 will be set out by the Panel in a separate paper.

Stage 2 Terms of Reference

Stage 2 will comprise two distinct investigations:

1. Subject to the consent of Edward Hartley’s family and the agreement of the Panel, the factual circumstances of the death of Edward Hartley will be investigated in line with the Terms of Reference for stage 1. If the investigation is so agreed, it will be subject to separate Terms of Reference, which will themselves be agreed with the family and the Panel;

2. A limited public investigation that is specific and focused in nature, addressing some of the thematic issues identified in the stage 1 report, which could not be determined fully on paper. Following discussion with the families and agreement from the Chair and the Chief Nursing Officer for England, it is agreed that the key concerns from those identified in the report are in relation to:
 - a. The implementation of a robust, efficient and effective complaints handling procedure at the Trust
 - b. The structures and procedures now in place at the Trust for communication and liaison with patients’ families, both during a patient’s life and afterwards

- c. The establishment of a totally independent, robust investigative structure and process to conduct transparent and fair investigations into serious accidents, deaths and complaints at the Trust
- d. The supervision structure that has been in place since 2011 by the Clinical Commissioning Group (who shall provide the relevant evidence) and how it has been exercised towards the Trust in relation to complaints and investigations, and of any planned changes in the light of public concerns
- e. How the outcome of sub-paragraphs (a) and (d) above might be extrapolated across the NHS in England, and
- f. The extent to which recommendations from previous investigations referred to in the Stage 1 report have been developed, implemented and monitored by the Trust (including in its Action Plans and by providing illustrations of effective Action Plans in the recent past) and whether areas for further improvement have been identified and actioned.

Purpose and aims of the Stage 2 investigation

The Stage 2 investigation is subject to the purpose and aims as set out in the Terms of Reference for the Review (see Appendix 2).

These are as follows:

The participating families have unresolved questions and concerns relating to the care provided, as well as the circumstances leading up to their death and how these have been investigated to date by the parties concerned.

Specifically, the families' aims are to achieve to their satisfaction the following:

- acknowledgement by the parties concerned of the evidenced facts;
- acknowledgement by the parties concerned of clear failings, be they failings of the systems and procedures or be they failings in the application of those systems and procedures by individual staff members;
- acknowledgment of the wider consequences of the failing to both the patient's family and involved members of staff;
- to determine accountability and responsibility at an individual level for identified failings in systems, processes and people;
- to make recommendations for remedial action and to assign accountability for their completion; and

- to provide demonstrable proof through appropriate outcome measures that the actions completed have successfully addressed the identified failing.

The Trust and NHS Improvement aim to ensure that lessons from any identified failing are learned by both the Trust and the wider NHS.

Stage 2 Investigation process and scope

The Stage 1 report recommended a limited public investigation that is specific and focused in nature.

The Stage 2 investigation will therefore investigate and address those issues identified in the report as set out in paragraphs 2a-f above in order to evaluate and comment on the Trust's progress to date and to conclude and recommend lessons for learning, but it will not further investigate specific facts of any of the cases considered in stage 1 (unless a separate investigation into the death of Edward Hartley is agreed by his family in line with paragraph 1 above) or consider new cases. The investigation will not name or hold individuals personally responsible for any failings but it will identify where there have been any failings, as appropriate, by the Trust or by another relevant organisation and the investigation will recommend where accountability for its recommendations should lie at an individual organisational level.

The Stage 2 investigation will be focused and result in clear recommendations. The investigation will:

- Consider relevant evidence submitted during stage 1 which touches directly on the specific policy issues identified in paragraph 2a-f above, which have been selected for public investigative examination
- Invite evidence from the family members who participated in stage 1 specifically on the thematic issues to give effect to their wishes to promote constructive and effective reform of the Trust's processes
- Invite evidence from existing staff at the Trust and the CCG who can provide in-depth knowledge of the topics identified and set out also the extent to which the Trust has implemented previous recommendations or put new policies / practices in place to address previous failures and concerns
- Consider evidence on existing and proposed NHS complaints handling and investigatory practices from the relevant regulators (NHS Improvement/England, the

CQC) which may further the Panel's understanding of the concerns identified in the Stage 1 report and to explain national proposals to address those concerns

- Invite evidence from service users of the Trust on their experience of complaints handling and investigations. The investigation will not investigate individual cases but it may consider evidence of experiences from services users and suggestion on how they might improve. The Panel will share this evidence with the Trust and invite the Trust to respond, where relevant
- Invite evidence from others (such as specialist experts), as deemed by the Panel to be necessary and proportionate, to provide insight into how the complaints and investigation systems may be improved
- Evaluate and draw conclusions on the steps taken by the Trust to date and on its plans for improvement
- Make reasonable, proportionate, achievable and targeted recommendations for the Trust on lessons to be learned in relation to the areas identified
- Include the findings within the stage 2 report to the family, Trust, CCG and NHS Improvement/England

The investigation Panel and the key principles of the investigation

The investigation will be carried out by a Panel, which shall be appointed by NHS Improvement in agreement with the Chair. Panel Members shall be suitably independent and qualified to fulfil their roles. NHS Improvement will conduct due diligence on any panel member candidates to ensure that they meet these criteria and that there are no conflicts of interest which would put their position on the Panel at risk.

The investigation will consist of a public hearing (in virtual form, given the social distancing restrictions which are in place during the COVID-19 pandemic). The hearing will be a fact-finding process and will not be adversarial or accusatorial.

The hearing will be conducted by the Panel Chair in a fair, independent, impartial and objective manner.

The hearing will take place in public as a virtual hearing unless there is sufficient cause for evidence to be given in private.

The Panel will not have powers to compel persons to participate. Those who do participate will be expected to attest to the truth of what they say and to co-operate with the reasonable requests of the Hearing Panel.

The Panel's findings will be based only on evidence submitted to it in advance of the relevant hearing date or during the hearing on that topic.

Required output of the investigation

The Panel will prepare a comprehensive and concise written report covering the areas identified above, making clear recommendations for the trust and, where relevant, the wider NHS. This will conclude the overall review.

The report will be made public. Whilst the key audiences for the report are the family members and the trust, it is accepted that the report may have wider public relevance, including any recommendations which may inspire change across the wider NHS, and will contribute to the development of national changes in the approach to NHS complaints handlings and investigations.

The report will be published by NHS Improvement/England and will also be shared with local CCGs and any other relevant organisation.

The written report is the responsibility of the Panel. Before publication of the report, where the Panel considers it necessary, the Panel will conduct a factual accuracy checking exercise. It will be entirely in the discretion of the Panel how to conduct the exercise and any amendments to the report will remain solely within the discretion of the Panel based on the evidence submitted to it.

The Panel will agree with participants where their information is considered for publication and where the Panel form the view that any significant criticism should be notified to any relevant participant before publication, they will inform the organisation or person concerned who will be given an opportunity to respond within 14 days. The investigation will not name or hold individuals personally responsible for any failings.

The timing and arrangements for release of the report and its publication will be agreed between the Chair and NHS Improvement.

Access to documents

All relevant NHS organisations and any relevant regulators are expected to co-operate with the investigation as is normal, professional practice, including supplying relevant documentation when requested by the Panel.

Timescale

The investigation should be undertaken with sufficient pace to enable resulting recommendations to be implemented as quickly and effectively as possible. It is expected the Panel will complete the hearing over the course of 4 weeks (not necessarily continuous weeks) and will complete the report within a further 6 weeks.

On the basis of current information, it is expected that the Panel will make its best endeavours to complete the work and produce its report by the end of December 2020. After a period of factual accuracy checking, it is expected that the final report for publication will be produced within a further 4 weeks.

Resources

Resources for the investigation will be provided by NHS Improvement. A Panel Secretary will be appointed by NHS Improvement with the Chair's agreement to support the Panel. NHS Improvement will provide proofreading support before publication.

The hearing will take place virtually. NHSE/I will provide the necessary resources to enable a virtual hearing and will ensure that the hearing is publicised so that members of the public may observe the public elements of the hearing.

Data Protection

The Panel and Panel Secretary will process personal data and confidential information in accordance with relevant data protection laws and the common law duty of confidentiality.

Appendix 2: Terms of Reference Stage 1

Stage 1 Investigation - Southern Health NHS Foundation Trust Review

Terms of Reference

Introduction

This programme of work will be carried out in two stages as summarised below.

The work will be commissioned by NHS Improvement and Stage 1 will be chaired by Nigel Pascoe QC.

Stage 1 Overview

An independent review of the quality of investigations carried out to date¹⁴¹², and implementation of the resulting recommendations, relating to the deaths of five patients who were in receipt of care provided by Southern Health NHS Foundation Trust (“the Trust”). The five deaths occurred between October 2011 and December 2015. The scope of this Stage is described in more detail below.

Stage 2 Overview

Where the independent review undertaken in stage 1 identifies deficiencies in the investigations carried out to date, and where such action is merited, NHS Improvement will commission a further investigation. This will be on the basis of new terms of reference specific to the death to be investigated.

Shared purpose and aims for the review

The families of the five patients concerned have unresolved questions and concerns relating to the care provided as well as the circumstances leading up to their death and how these have been investigated to date by the parties concerned.

¹⁴¹² Based on accepted NHS best practice at the time. Documentation relating to these standards will be provided to the Chair of the review and the families.

Specifically, the families' aims are to achieve to their satisfaction the following:

- Acknowledgement by the parties concerned of the evidenced facts;
- Acknowledgment by the parties concerned of clear failings, be they failings of the systems and procedures or be they failing in the application of those systems and procedure by individual staff members;
- Acknowledgment of the wider consequences of the failing to both the patient's family and involved members of staff;
- To determine accountability and responsibility at an individual level for identified failings in systems, processes and people;
- To make recommendations for remedial action and to assign accountability for their completion; and
- To provide demonstrable proof through appropriate outcome measures that the actions completed have successfully addressed the identified failing.

The Trust and NHS Improvement aim to ensure that lessons from any identified failing are learned by both the Trust and the wider NHS.

Scope and purpose of Stage 1

In respect of each of the deaths covered by this programme of work, the review will undertake to:

- Review the quality of the investigations undertaken by the Trust, other NHS bodies and/or external organisations¹⁴¹³ (including the resulting reports) in relation to care received by the five patients;
- Identify whether the investigations appropriately acknowledged and addressed the relevant concerns and issues arising following the deaths, including governance issues;
- Establish if recommendations were accepted and appropriate actions implemented by the Trust and other NHS bodies, within timescales identified, and whether the intended outcomes were achieved;
- Consider how the families and friends of the patients were engaged by the Trust, other NHS bodies and/or external organisations during those investigations and subsequently (including inquest proceedings);

¹⁴¹³ External organisations include the Parliamentary and Health Service Ombudsman.

- Reserve the right to undertake a second-stage review of primary cases if recommended by Stage 1 of the review;
- Draw conclusions and make recommendations on any lessons to be learned for both the Trust and the wider NHS to secure the delivery of high quality care; and
- Present a report of the findings of the review to families of the deceased, the Trust and NHS improvement.

The review will actively engage and communicate with families and friends relevant to the specified cases, where they have expressed a preference for such engagement.

The review will focus on the actions, systems and processes of the Trust. The review will also consider the actions of regulators and commissioners insofar as they appertain directly to care received by the five patients.

Access to documents

All relevant NHS organisations, regulators and the Department of Health and Social Care are expected to cooperate with this review as is normal professional practice, including supplying documentation as and when requested by the review chairman.

Timeframe

The Stage 1 review should be undertaken with sufficient pace to enable resulting recommendations to be implemented as quickly and effectively as possible. It is expected, based on current information, that the Stage 1 review will complete work and produce its report by December 2019. NHS Improvement will publish the report of the review.

Scope and Purpose of Stage 2

To be determined following the completion of Stage 1. Any Stage 2 investigation will be carried out on the basis of new terms of reference specific to the death to be investigated.

NHS Improvement is committed to resourcing Stage 2 of the programme of work, should this be required following the Stage 1 review.

Appendix 3: Participant List

Southern Health NHS Foundation Trust participants	
Chief Executive	
Chair	
(previous) Chief Medical Officer	
Deputy Medical Director	
Deputy Director of Nursing	
Director of Nursing & Allied Health Professionals	
Deputy Director of Nursing and Clinical Director for Patient Safety and Quality Improvement	
Head of Patient and Public Involvement and Patient Experience	
Clinical Director for South West Hampshire Division, Deputy Chair of the Learning from Events Forum	
Director of Workforce, Organisational Development and Communications	
Patient Safety and Quality Facilitator for the Southampton Division	
Quality & Safety Committee Chair	
Chair/Lay member of Working in Partnership Committee	
Deputy Chair/Lay member of Working in Partnership Committee	
Non-Executive Director and Chair of the Audit, Assurance & Risk Committee	
Carers Strategy Project Officer and Triangle of Care Project Lead	
Lead Governor, Chair and appointed Governor for Carers Together	
Service User Involvement Facilitator	
Family Liaison Officer	
Community Mental Health Team Manager	
Consultant Psychiatrist	
Matron	
Freedom to Speak Up Guardian	
Clinical Ward Manager	
Incident Investigation Manager	

West Hampshire Clinical Commissioning Group participants	
Director of Quality and Board Nurse	
Acting Director of Quality & Nursing	
Senior Quality Manager	
Clinical Director for Mental Health and Learning Disability	
Interim Director of Nursing and Quality for North Hampshire, South-East Hampshire, Fareham, Gosport and Isle of Wight	

NHS England and NHS Improvement participants	
National Clinical Director for Mental Health	Professor Tim Kendall
South East Regional Medical Director	Dr Vaughan Lewis
Director for Experience, Participation and Equalities	Dr Neil Churchill
Deputy Director of Patient Safety (Policy and Strategy)	Dr Matthew Fogarty

Independent participants	
Hampshire Healthwatch, Chair	Ann Smith
Retired member of the judiciary	His Honour Neil Butter QC
Member of the judiciary	His Honour Judge Keith Cutler CBE
Experienced Investigation Chair and Panel Member	Dr Bill Kirkup CBE
Senior Researcher in the Centre for Improvement Science Fellow at King's College London	Dr Josephine Ocloo
Health and Safety Investigative Branch, Chief Investigator	Keith Conradi
Parliamentary and Health Service Ombudsman Chair and Ombudsman	Rob Behrens CBE
Care Quality Commission, Deputy Chief Inspector Mental Health and Community Services	Dr Kevin Cleary
Researcher in Civil Justice Systems at University of Oxford	Dr Sonia Macleod
Professor of Socio-Legal Studies and Director of the Centre for Socio-Legal Studies at University of Oxford	Professor Linda Mulcahy

Service users, carers and family members participants	
Service users: 3	
Family members: 4	
Carers: 2	