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### Performance

**Purpose: To provide Governors with further information on the Trust’s performance**

| 5. | Trust Performance Report - Overview by CEO (based on cover report to Board) | Acting Chief Executive Officer and Executive Team | Paper | Discussion |
| 6. | Business Planning/Trust objectives | Director of Corporate Governance | Verbal | Discussion |
| 7. | Hampshire and Isle of Wight Sustainability and Transformation Plan (STP) | Director of Strategy | Verbal | Discussion |

**Purpose: To gain an understanding from NEDs as to current issues facing the Trust and to hold them to account in their role**

| 8. | Board Committee Report (Overview by Committee Chairs) | NEDs | Paper/Verbal | Discussion |

### Governance

**Purpose: To support Governors in fulfilling their role**

| 9. | Approval of Acting Chief Executive | Deputy Chair | Paper | Decision |
| 10. | Lead Governor appointment | Company Secretary | Paper | Decision |
| 11. | Update on Chair appointment process | Deputy Chair | Verbal | Information |
| 12. | NED appointment process | Deputy Chair | Paper | Information |
| 13. | Membership Report | Associate Director of Communications | Paper | Discussion |
| 14. | Corporate Governance Report | Company Secretary | Paper | Information |
| 15. | Patient Story | Company Secretary | Paper | Decision |
| 16. | Governor Issues Log | Company Secretary | Paper | Discussion |
| 17. | Governor consideration of legal advice provided by Blake Morgan on resolutions contained in agenda items 18, 19 & 20 | Blake Morgan | Verbal | Discussion |
| 18. | Resolutions submitted by Public Governor, Peter Bell and those submitted by John Green and adopted by Public Governor, Peter Bell | Peter Bell, Public Governor | Paper | Decision |
| 19. | Resolution to establish a committee of the Council of Governors to be known as the Governors Public Consultation and Communication Strategy committee | Peter Bell, Public Governor | Paper | Decision |
| 20. | Resolution to consider the adoption of a purported amendment to the Code of Conduct for Directors and Governors | Peter Bell, Public Governor | Verbal | Decision |

**Final Administration**

| 21. | Any Other Business | Deputy Chair | Verbal | Noting |
| 22. | Close | | | |

**Date of Next Council of Governors’ meeting:** 31 January 2017  
**Venue:** Development & Training, Tatchbury Mount, Calmore, Southampton SO40 2RZ

**Quorum**

No business shall be transacted at meetings of the Council unless at least one third of the total number of Governors is present and the majority of those Governors present are members of the public constituency of the Trust.

_The Trust will take an audio recording of Board meetings held in public and of Council of Governors’ meetings held in public. The recording will be held on file with the meeting documentation and published following the meeting. In accordance with Standing Order 4.1.2 of the Trust’s Constitution and Standing Orders, any other audio recordings of the proceedings of Board meetings held in public or of Council of Governors’ meetings held in public will require the prior agreement of the person chairing the meeting._
Southern Health NHS Foundation Trust
Minutes of the Council of Governors’ Meeting held in Public
Tuesday 26 July 2016
14:05 - 17:00
Hurstwood Room, Havant Borough Council, Public Service Plaza,
Havant PO9 2AX

Members:

Tim Smart   Interim Chair
John Beaumont  Public Governor, South West Hampshire
Peter Bell   Public Governor, Rest of England
Andrew Jackman  Public Governor, Southampton
Cllr Andrew Joy  Appointed Governor, Hampshire County Council
Richard Mandunya  Public Governor, Oxfordshire & Buckinghamshire
Josie Metcher  Public Governor. South West Hampshire
Arthur Monks   Public Governor. South East Hampshire
Nick Sargeant  Staff Governor, North Hampshire
Sue Smith   Public Governor. North Hampshire
Adrian Thorne  Appointed Governor, Carers Together
Paul Valentine  Staff Governor. South East Hampshire

In attendance
Jon Allen   Non-Executive Director (part)
Paula Anderson  Interim Finance Director
Chris Ash   Director of Integrated Services (MCP) West
Malcolm Berryman  Non-Executive Director
Julie Dawes   Director of Nursing & Allied Health Professionals
Tracey Faraday-Drake Non-Executive Director (part)
Claire Feehily  Non-Executive Director
Dr Chris Gordon  Director of Patient Safety (Chief Operating Officer)
Gethin Hughes  Director of Integrated Services (MCP) East
Mark Morgan  Director of Operations (Mental Health, Learning Disabilities & Social Care)
Katrina Percy  Chief Executive Officer
Jane Pound   Interim Head of People Strategy
Judith Smyth  Non-Executive Director
Trevor Spires Non-Executive Director
Dr Lesley Stevens  Medical Director
Paul Streat Provider Development Director
Anna Williams  Company Secretary & Head of Corporate Governance

Present
Clare Bundy   Staff member
Anne Daneshvar  Member of public
Louisa Felice   Staff member
Ian Hartley  Member of public
Jane Hartley  Member of public
Geoff Hill  Member of public
Chair’s Welcome and Meeting Protocol

1.1. Tim Smart, Interim Chair welcomed members to the meeting, which he opened at 14:05. He noted that an audio recording of the meeting would be made by the Trust which would be available via the website. Tim added that he had received a number of requests that no further recordings, or photographs be taken and asked that this be complied with. Tim commented that he hoped his chairmanship would enable everyone to feel able to participate in the meeting.

1.2. The Interim Chair noted apologies from Professor Clive Holmes, Appointed Governor, University of Southampton; Cllr Paul Lewzey, Appointed Governor, Southampton City Council; Vicky Melville, Staff Governor, South West Hampshire; Susie Scorer, Public Governor, Southampton; Alia Sidki Gomez, Staff Governor, Southampton and Tom Whicher, Public Governor, Southampton.

1.3. There were no declarations of interest relating to items on the agenda or any other matters.

Minutes of Last Meeting (26.04.2016)

2.1. The minutes were agreed as a true and fair record of the meeting held on 26.04.2016 and would be signed outside of the meeting.


2.3. In addition, updates were provided as follows:

2.4. CoG 27.01.2016/15.3 - still being progressed.

2.5. CoG 05.01.2016/5.22 - proposed flowchart implemented, item to be closed.
2.6. CoG 26.01.2016/12.9 - further discussion required as to how patient stories would be presented to future Council meetings.

2.7. Peter Bell, Public Governor, Rest of England enquired as to when a presentation on Tableau would be provided to Governors. Anna noted that this was on the agenda framework and that the date for presentation would be agreed by the Interim Chair and Lead Governor.

2.8. In response to an enquiry from Peter Bell, Anna Williams advised that the Agenda Planning Group had not met for some time and that the process for agreeing items on the agenda was through the Interim Chair, with discussion with the Lead Governor. Tim Smart commented that this was the usual procedure for setting agendas for Council meetings, and that the Lead Governor represents the views of the governors in putting forward items for the agenda. There was an opportunity for further items to be suggested when the draft agenda was circulated to Governors.

3. Update from Interim Chair

3.1. Tim Smart noted that he had been appointed by NHS Improvement to ensure that the issues which had given rise to public and patient concern about the Trust were resolved and that the future of the services provided by the Trust were secured. He reported that he had reviewed multiple sources of evidence and had commissioned a Board capability review. Tim noted that he had shared his recommendations with the Minister of State at the Department of Health, Alistair Burt on 30.06.2016, and that there had been system-wide support for these recommendations. He added that he had been due to meet again with Alistair Burt but that following Mr Burt’s resignation as Minister, and subsequent departure from post, consideration was being given as to how to update Jeremy Hunt, Secretary of State, who had assumed Mr Burt’s portfolio, of the plans.

3.2. Tim reminded members that the principal role of the Council of Governors was to hold the Board to account for the performance of the Trust and this was achieved through the appointment by Governors of Non-Executive Directors, including the Chair. He noted the proposal within Item 9 to establish two Governor Working Groups and brought Governors’ attention to the opportunity to put themselves forward for membership of the Appointment Committee.

3.3. Tim thanked Anna Williams and Andrew Jackman, Lead Governor for their input to the process of selecting independent legal advisers to advise the Council on discharging their duties relating to the performance of the Non-Executive Directors. He also brought the Governors’ attention to the work of Executive team in ensuring that the national access targets had been achieved and noted that the Trust had a sound financial future.

3.4. Arthur Monks, Public Governor, South East Hampshire requested further details in respect of the evidence which the Interim Chair had reported he had reviewed. Tim noted that this information had been included in the annex to the paper circulated on 30.06.2016. In response to a further enquiry from Arthur, Tim Smart confirmed that he had studied both the ‘Mazars’ (Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with...
Southern Health NHS Foundation Trust April 2011 to March 2015 report and the report produced by Mike Holder.

3.5. Arthur Monks referred to the Governors’ conference call with Tim Smart held on 30.06.2016 and commented that from reading social media messages later that day, the information shared with Governors during the call did not appear to be a true reflection of the meeting with families. Arthur also questioned the comment made by Alistair Burt that this was ‘by no means over’. Tim Smart noted that during the call with Governors, he had advised that there was support for the proposal for considering the future of the services provided by the Trust and acknowledged that there had been a great deal of emotion with regard to the continued employment of Katrina Percy. He added that he had agreed with Alistair Burt to reflect upon the feedback and to meet with the Minister again when he returned from annual leave. He added that as Mr Burt was no longer in post that he hoped to be able to report back to the Secretary of State.

3.6. Arthur Monks requested that Governors be provided with a report as to what Alistair Burt’s comments meant following the meeting on 30.06.2016.

4. Board Committee Report (Overview by Committee Chairs)

4.1. Malcolm Berryman, Non-Executive Director and Chair of the Serious Incident Oversight & Assurance Committee (SIOAC) reminded Governors that the SIOAC had been established to provide oversight of and assurance to the Trust Board regarding the delivery of the Mortality and SIRI action plan which addressed the recommendations arising from the Mazars Report. Malcolm noted that Niche and Grant Thornton had reviewed the action plan and had requested that the plan be updated to reflect all issues raised by the Mazars report. Malcolm noted that at each meeting the committee reviewed a patient story and all the statistics in respect of the delivery of the outcomes. He highlighted that further information had been included in the CEO report.

4.2. John Beaumont, Public Governor, South West Hampshire and Governor observer for the SIOAC noted that he had raised concerns that: there was still no patient representative on the committee; a particular incident which the committee was aware of should have been reported as a serious incident; he considered Mark Morgan, Director of Operations (Mental Health, Learning Disabilities & Social Care) should be a member of the committee.

4.3. In response to John Beaumont’s observations, Anna Williams reported that Julie Dawes, Director of Nursing & Allied Health Professionals would be meeting with Healthwatch in order to agree a public representative for the Mortality Working Group which was more appropriate than the SIOAC. Furthermore, she noted that the Terms of Reference for the SIOAC, which included membership of the committee, had been agreed by the Board. Anna noted that it was not appropriate to comment on an individual serious incident at this meeting. Malcolm confirmed that this had been raised.
4.4. Richard Mandunya, Public Governor, Oxfordshire & Buckinghamshire referred to paragraph 2.03 of the CEO report relating to Mortality reporting and learning and requested that the data be presented in an easier to read format.

4.5. Malcolm Berryman, Non-Executive Director and Chair of Service Performance & Transformation Committee (SPTC) reminded Governors that the SPTC was responsible for monitoring the overall performance of the Trust including monitoring the strategic financial performance, overseeing the Trust's financial strategy, and for ensuring that patient and service user experience was effectively monitored. Malcolm reported that at the SPTC on 25.07.2016 items identified for escalation to the Board related to the use of agency staff and out of area beds. The Committee had also highlighted the requirement for further Board discussion in respect of the Multispecialty community provider (MCP) particularly with regard to finance.

4.6. In response to an enquiry from Peter Bell as to the highest strategic risks, Malcolm noted that for the SIOAC this was to ensure that all changes identified were delivered and embedded throughout the Trust. Malcolm noted that a major concern for SPTC was to ensure the delivery of the action plans at the same time as developing services in line with the Better Local Care plans across Hampshire.

4.7. Adrian Thorne, Appointed Governor, Carers Together reiterated his previous request that the third sector and social care be included in the discussions regarding partnership working. Malcolm acknowledged this request and suggested this would be achieved through strategic leadership.

4.8. Trevor Spires, Non-Executive Director and Chair of Audit, Assurance & Risk Committee (AARC) noted that the Annual Report, Quality Report and Accounts for 2015/16 had been finalised. He reported that the Trust's financial position had improved since the previous year but that there remained significant financial pressures within the NHS.

4.9. Trevor reported that items reviewed by AARC on 11.07.2016 included:

4.9.1. Whistleblowing, discussions concluded that further work was required in respect of culture to ensure everyone felt able to speak up;

4.9.2. the use and control of management consultants, agency staff, off payroll interim employees and had identified additional controls relating to the Trust’s Standing Financial Instruction and Scheme of Delegation which had been presented to the Board for ratification today;

4.9.3. the funding received by the Trust in respect of the MCP;

4.9.4. Working Capital Facility (WCF) - the AARC agreed that the Trust did not require a WCF. Trevor assured Governors that there was an emergency facility available from the Department of Health should this be required;

4.9.5. Board Assurance Framework (BAF) and risk management, Trevor noted that the AARC was overseeing the current review of these;
4.9.6. the independent review of health and safety, he noted that the review had been completed and that when the final report had been received this would be shared with Governors.

**Action:** Review of Health & Safety report to be circulated to Governors  
**Date:** 25.10.2016

4.10. In response to an enquiry from Arthur Monks, Public Governor, South East Hampshire, Paula Anderson, Interim Finance Director noted that the 2015/16 financial position was a deficit of approximately £700,000 normalised but that there had been exceptional items which had increased the figure.

4.11. Arthur Monks enquired as to use of an off payroll employee bearing in mind the regulations. Trevor confirmed that the proper processes had been followed and that the appropriate declaration had been made in the Annual Report & Accounts.

4.12. Richard Mandunya noted that the financial position of the Trust had been reported as good and enquired as to whether this took account of the current position within Oxfordshire and Buckinghamshire particularly in respect of unfilled vacancies. Trevor Spires assured Governors that the position within Oxfordshire & Buckinghamshire had been included in the financial forecast and acknowledged that whilst there were vacancies in this area, that this was not necessarily a local position.

*Tracey Faraday-Drake joined the meeting*

4.13. Claire Feehily, Non-Executive Director and Chair of Charitable Funds Committee (CFC) reported that the CFC had not met since the last Council meeting and that there was therefore no formal report. Claire noted that a workshop had been held on 06.06.2016 which had discussed and agreed the future plans including the recruitment of a new Head of Charity.

4.14. Jon Allen, Non-Executive Director and Chair of Quality & Safety Committee (QSC) reported that at the meeting held on 09.05.2016 items reviewed by the QSC had included the Quality Report & Accounts 2015/16, the Quality Strategy and the Quality Improvement Plan. He highlighted that the QSC had been assured that the Trust had in place effective arrangements in respect of safeguarding vulnerable children and adults.

4.15. Jon noted that the QSC had also met on 07.07.2016 and highlighted that:

4.15.1. the committee had considered the risks on the Board Assurance Framework (BAF), and had acknowledged that a review of the BAF was currently underway;

4.15.2. a proposed new quality governance structure comprising existing and new sub committees had been considered and agreed, he noted that this would enable the QSC to receive assurance, particularly in respect of CQC compliance and that one of the new committees would be an Executive Risk Management committee;

4.15.3. the QSC would meet monthly for the foreseeable future;
4.15.4. the committee had received assurance that all but one of the actions in respect of the CQC warning notices were on track for completion and that the one behind plan was in respect of the proposed new quality governance structure already reported on;

4.15.5. that information in respect of the CQC action plan was reported within the CEO report;

4.15.6. the Infection Prevention & Control Annual Report 2015/2016 had been reviewed and it was noted that there had been one incident of MRSA in Romsey Hospital;

4.15.7. the committee had received a report on the use of Ravenswood, he noted that it was not compliant with the standards set for medium secure units by the Royal College of Psychiatrists and that it was agreed this should be raised with commissioners;

4.15.8. the Complaints, Concerns and Compliments Annual Report 2015/16 was reviewed and the committee was assured that the processes in place were robust, had been followed and that there was good evidence of learning from complaints;

4.15.9. a contract performance notice 2016/17 raised by commissioners had been addressed and closed.

4.16. Peter Bell, Public Governor, Rest of England noted that the number of complaints reported had reduced and suggested that it was preferable to see an increase in complaints but with a decrease in their severity. Tim suggested that a response to this point should be provided by the Executive under agenda item 5.

4.17. Judith Smyth, Non-Executive Director and Chair of Strategic Workforce Committee (SWC) brought Governors' attention to paragraph 2.11 and in particular to the temporary closure of the PICU ward at Antelope House and a ward at Bluebird House due to staff shortages. She noted that the SWC continued to review recruitment and retention levels and highlighted that turnover and sickness and absence had reduced. Judith reported that at the SWC meeting on 18.07.2016, the committee had received a report on Safer Staffing and she noted that this had now been developed for use within community services. She added that the SWC had reviewed the use of bank and agency staff and in particular to provide assurance to the Board that the staff used were fit for work. Judith commented that the SWC reviewed staff training and development and would continue to do so in order to provide evidence to the Board that this was improving the quality and safety of services delivered.

4.18. Arthur Monks enquired as to how the Trust managed the use of contract staff. Judith Smyth noted that there were a number of controls in place including the requirement for all nurses to be qualified, annually accredited and be fit to nurse; the contract with the agency and for line managers to be responsible for discussions with the staff. Judith invited Arthur to discuss with her outside of the meeting should he have any further concerns. Tim Smart advised that this question would be responded to by the Executive at item 5.
4.19. In response to an enquiry from Paul Valentine, Staff Governor, South East Hampshire, Mark Morgan confirmed that Bluebird House was compliant with the standards set by the Royal College of Psychiatrists.

4.20. Arthur Monks referred to the information he had received following his Freedom of Information request (FOI844) relating to the security of confidential patient records. He noted that Trevor Spires, Chair of AARC had previously indicated that the risk was residual and enquired as to whether any progress had been made to encrypt patient data. Trevor Spires noted that, as reported at the previous Council meeting, an audit had been carried out by the Information Commissioners’ Office (ICO) which had included a review of the handling of information. He noted that whilst the audit identified areas for improvement it did not raise any concerns in respect of processes or controls. Trevor commented that this would be more regularly reviewed by the AARC.

4.21. Tracey Faraday-Drake, Non-Executive Director and Chair of Nomination & Remuneration Committee (NRC) reported that an Extraordinary meeting of the NRC had been held on 28.06.2016 to discuss the executive team structure. She noted that the Trust was currently recruiting to two posts, Director of Mental Health & Learning Disabilities and Director of Finance.

Jon Allen left the meeting

5. Trust Performance Report: Overview by CEO (based on cover report to Board)

5.1. Katrina Percy, Chief Executive Officer noted that the paper included the CEO reports for May, June and July but that she intended to focus primarily on the July report. Katrina highlighted the progress made against key actions resulting from the CQC Warning notice; that the Trust had met the national access and performance targets; that the contract between Brune Medical Centre and the Trust was signed on 01.07.2016 and highlighted the work currently being led by Dr Lesley Stevens, Medical Director in respect of the Mental Health Alliance through the Hampshire and Isle of Wight.

5.2. Julie Dawes, Director of Nursing & Allied Health Professionals referred to Peter Bell’s comment regarding the number of complaints reported. She commented that whilst there had been a reduction this month that the number of complaints received was generally static. Julie noted that whilst complaints were reported on a monthly basis, the complaints received could refer to care which had been received during the previous six months. She acknowledged that the information provided did not show severity of complaints but reassured Governors that there were only a small number which were showing as amber/red. Julie commented that concerns/informal complaints were also received which had to be addressed by the Trust but were often resolved within a shorter time period. Julie noted that a review of the complaints process had identified areas which required strengthening and that these would be addressed by a Task & Finish Group and an update provided to the next Council meeting.
Action: Director of Nursing & AHPs to provide an update on the work of the Complaints Task & Finish Group  
Date: 25.10.2016

6. Governor questions and discussions

6.1. Peter Bell suggested that the Trust should have a target to increase the number of complaints received in order to demonstrate that the organisation was listening to patients’ concerns. Julie Dawes noted that a Patient Involvement Strategy was being developed to ensure the Trust received feedback via many different methods. She noted that the national guidance was not to set targets. Tim Smart commented that he believed there was a high incident reporting culture within the Trust and highlighted the importance of dealing with complaints in a timely and efficient manner. Katrina added that the Executive team monitored the complaints received and if a team was identified as receiving significantly low number of reported incidents compared with similar teams, this was investigated. Peter Bell suggested that the Trust should monitor opportunities for improvement, the number of times the issue had been raised and whether the person was happy with the change which had been implemented as a result of the issue raised. Julie noted Peter’s suggestion and acknowledged the need for more ‘rounded’ feedback.

6.2. Arthur Monks referred to the Trust’s use of Survey Monkey as a method of receiving feedback from patients, he noted that he had asked a number of questions regarding this for which he had received a response and that he had requested further details. Julie Dawes noted that a report had been prepared outlining the various methods by which the Trust received patient and staff feedback. She suggested that this report should be shared with Governors.

Action: Report on feedback from patients to be shared with Council of Governors  
Date: 25.10.2016

6.3. Richard Mandunya enquired as to how the Executive team ensured that all members of staff felt part of the Trust. Katrina acknowledged that this was a challenge for a dispersed organisation but that it was not necessarily the location which made teams feel isolated. She noted that there were a number of ways in which teams were engaged including enabling them to influence the business plan and providing them with the skills to engage with their local healthcare. She added that following receipt of feedback from staff, the Trust would be investing in team development. Katrina reported that Sara Courtney, Associate Director of Nursing & Allied Health Professionals continued to visit Evenlode on a weekly basis to support them through their team improvement plan. Katrina reported that, in line with best practice, the staff survey would be sent to one-twelfth of the workforce every month, which should help to highlight any issues at an earlier stage.

6.4. Tim Smart noted that following his review of the Trust, which had included visiting many of the sites and speaking with staff and patients, he had made a number of recommendations in respect of the future of the services provided. He suggested that approximately 70% of the current services could be delivered through Better Local Care/Multi-speciality Community Provider (MCP) but that consideration
needed to be given as to which organisations would be best to deliver the other 30% of the Trust’s services. Tim noted that a Steering Group would be established to design a plan and business case for the future of the Trust’s services and he provided an outline of the process.

6.5. Nick Sargeant, Staff Governor, North Hampshire commented that the process outlined by the Interim Chair would impact many members of staff and enquired as to the timeframe anticipated. Tim commented that he expected to share the process and timetable with staff shortly and anticipated that the plan would be concluded by the end of his tenure as Interim Chair. He assured Governors that the focus was on how best to organise the services currently delivered.

6.6. Richard Mandunya commented that where multiple providers delivered services within the same setting this created confusion for patients. Tim acknowledged that this was an issue for both staff and patients but that it was commissioners who decided service providers. He stressed the importance of clinicians and patients being involved in discussions around services.

6.7. John Beaumont, Public Governor, South West Hampshire raised a number of concerns, including the apparent lack of engagement with the Trust’s membership, he noted that the current member newsletter had only been circulated electronically and considered it should be posted to those members who did not have an email address. Tim Smart acknowledged that communication with members was an issue for many Foundation Trusts and noted the importance of enabling Governors to engage with their membership. Councillor Andrew Joy, Appointed Governor, Hampshire County Council suggested that GP practices could be used to promote membership. He mentioned outstanding problems with service users which he wished to see resolved by the Trust. John referred to the reported increased usage of out of area beds and suggested that the Trust should look to open beds at Woodhaven. Dr Lesley Stevens, Medical Director confirmed that a number of options were currently being considered in respect of the use of Woodhaven. He expressed concern that, from his observation at the SIOAC meetings, there was a tendency on occasion to deal with systems before people. Tim commented that whilst everyone within the Trust put the patient first, due to the requirement to monitor performance, it was necessary to use data and information systems to achieve this.

6.8. Arthur Monks, Public Governor, South East Hampshire commented that a number of Governors had recently resigned from the Council and suggested that exit interviews were carried out by an external organisation. Arthur noted that John Green had recently stood down as Public Governor, South West Hampshire and requested that thanks be recorded for the considerable contribution John had made to both the Council and the Trust. Tim wished thanks be recorded to all past and present Governors for the valuable service they provided to the Trust on a voluntary basis.

Malcolm Berryman left the meeting

6.9. Peter Bell, Public Governor, Rest of England noted that the Charitable Funds Committee (CFC) had not met recently and enquired as to the current position in respect of patient Wi-Fi. Chris Ash, Director of Integrated Services (MCP) West
noted that the patient Wi-Fi details were being finalised and that the application would be submitted to the next CFC. With regard to Peter's concern that there appeared to be a lack of staff within the IT department to carry out training, Chris noted that in addition to substantive IT staff, contractors were employed as required to meet the demands of individual projects.

7. Governor Issues Log

7.1. Tim Smart referred to the Governor Issues Log report and expressed concern at the large number of issues noting that many of them neither focussed nor affected the quality of care provided to patients. Anna Williams drew Governors’ attention to line 26 and noted that whilst the position stated that this would be considered at this meeting, this had been addressed by the proposal within the Corporate Governance report. Anna noted that with regard to line 97, a response had been provided within a week of the request but acknowledged that Arthur had submitted further questions on 07.07.2016 which would be added to the issues log.

7.2. John Beaumont, Public Governor, South West Hampshire requested that his thanks be recorded to the Corporate Governance Team for the support they had provided to him since becoming a member of the Council.

8. Appointment of External Auditors

8.1. Trevor Spires, Non-Executive Director and Chair of AARC presented the Appointment of External Auditors report. He outlined the tender process which had been carried out and reported that two Governors, Andrew Jackman and Adrian Thorne, had been members of the evaluation panel. Andrew and Adrian both confirmed that a robust process had taken place and were confident of the outcome of the tender process. In response to an enquiry from Arthur Monks, Paula Anderson, Interim Finance Director confirmed that the cost was approximately £1,000 less than the previous year.

8.2. Councillor Andrew Joy proposed that as Andrew Jackman and Adrian Thorne had been selected to represent the Council that the Governors therefore approved the decision in the report. The Council of Governors ratified and approved the recommendation of the Audit, Assurance & Risk Committee in appointing the bidder who scored the highest score in the External Audit procurement process. It was also agreed that the appointment would be for an initial three year period, commencing November 2016, with the possibility of two further one year extensions.

9. Corporate Governance Report

9.1. Anna Williams, Company Secretary & Head of Corporate Governance presented the Corporate Governance Report and brought Governors’ attention to a number of items.

9.2. Anna noted that the election process had commenced and reported that two nominations had been received for the Public Governors vacancies in North Hampshire and three nominations had been received for the two South East Hampshire vacancies, she noted that following validation of the nominations voting
would commence on 05.08.2016. Anna noted that no nominations had been received for the Public, Oxfordshire & Buckinghamshire vacancy or the Staff, Oxfordshire, Buckinghamshire & Rest of England and a further election would therefore be held which would include the public vacancy in South West Hampshire. Anna noted the request for improved member recruitment and engagement and acknowledged that the election process may need to be delayed in order to address this.

Post meeting note – Validation of nominations resulted in one nomination received for the South East Hampshire vacancy and four nominations for the North Hampshire vacancies

9.3. Anna noted that as Tim Smart’s tenure was until early 2017 it was necessary to shortly begin the appointment process of a substantive Chair. She commented that NHS Improvement had confirmed that the normal process for the Appointment of Trust Chair would be followed. She brought Governors’ attention to Appendix B, an excerpt from the Trust’s Constitution outlining the process for the Appointment of Chair and Non-Executive Directors; Appendix C, the Terms of Reference for the Appointment Committee and Appendix D, the Appointment Committee Self-Nomination Form - It was noted that the first line of the statement should read ‘I wish to be a member of the Appointments Committee for the duration of 2016/17’. It was agreed that the deadline for receipt of nominations for the Appointment Committee should be the end of August.

Action: Corporate Governance team to circulate the Appointment Committee nomination form and Terms of Reference to Governors

Date: 28.07.2016

9.4. In response to an enquiry from Arthur Monks, Tim Smart noted that the Appointment Committee would develop the person specification for the Chair, with advice from the Senior Independent Director.

9.5. Governors approved the Terms of Reference for the Appointment Committee as set out in Appendix C.

9.6. Anna Williams referred to Appendix E, the outline Terms of Reference (ToR) for the Council of Governors’ Patient Experience & Engagement Group and Appendix F, the outline Terms of Reference for the Council of Governors’ Membership Engagement Group and enquired whether any Governor had any comments on these two ToRs.

9.7. Peter Bell noted that he had submitted a formal proposal to the Council of Governors; Anna noted that this proposal had been circulated to members of the Council of Governors, but no comments received. Peter asked why this proposal had not come forward to the Council of Governors; Anna responded that this was during the tenure of the previous Chair but that she would look into this.

9.8. The Terms of Reference in respect of the two Governor Group as outlined in Appendices E and F were approved subject to any comments being received by the Corporate Governance Office by the end of August. Peter Bell asked regarding the
quorum requirements; he noted the inclusion of the Trust representatives meant that if these individuals were unable to attend then Governors would be unable to meet. Anna confirmed that this was the case, as currently stated, and that the proposal set out for Trust officers to attend in order to support the Groups. It was noted that Peter Bell had voted against the approval of the Terms of Reference.

**Action:** Corporate Governance team to circulate the Terms of Reference for the CoG Patient Experience & Engagement Group and the CoG Membership Engagement Group to Governors for comment by 24.08.2016

**Date:** 02.08.2016

10. **Any other business**

10.1. Sue Smith, Public Governor, North Hampshire reported that she had met with Dr Juanita Pascual at Alton Community Hospital to learn more about how patients in rural areas accessed services. She noted that it had been a very useful meeting and was reassured by the work currently underway in respect of Better Local Care.

10.2. Anna Williams noted that Richard Mandunya had recently taken part in a Peer Review and suggested that consideration be given as to how Governors could provide feedback to the Council of activities which they had taken part in.

10.3. Arthur Monks, Public Governor, South East Hampshire enquired as to the current situation with regard to the appointment of Blake Morgan, and asked for clarification on next steps. Arthur noted that he did not believe that this was a good use of Trust funds. Tim Smart noted that had the Governors proceeded with the resolution previously proposed, the costs would have been significantly higher. He added that he was confident that this was the correct procedure if the Governors wished to undertake a review of the performance of the Non-Executive Directors. Peter Bell enquired as to the date he had asked for legal advice; Tim Smart indicated that he believed it was at around the time he arrived. Peter noted that he believed it was indeed earlier than this, and noted that at that time he requested assistance in preparing a resolution.

10.4. Anna Williams reported that she had advised Blake Morgan of the decision of the Council of Governors and that their recommendation was that a statement of legal privilege be circulated to Governors. Anna noted that subject to agreement of the statement, a date would be arranged in mid-August for Governors to meet with Blake Morgan.

**Action:** Corporate Governance team to circulate Doodle poll for Governor availability to meet with Blake Morgan

**Date:** 29.07.2016

10.5. Peter Bell enquired as to whether the Trust subscribed to NHS Providers and as to whether Governors were able to access training and advice from NHS Providers. Anna Williams confirmed that NHS Providers held the national contract for the provision of Governor training and she suggested that NHS Providers be invited to provide a training session to Governors at a forthcoming Development
Day. She added that where Governors had requested specific training this would be looked at on an individual basis having regard to the budget available for Governor training.

10.6. John Beaumont, Public Governor, South West Hampshire commented that he had suggested to Alan Yates, Improvement Director that taking questions from the public at the end of the Council meeting was not appropriate and that a better way of hearing concerns should be found. Tim Smart indicated his agreement to this point.

11. **Questions from the public**

11.1. Geoff Hill made a statement in which he raised a number of concerns, including the allegation of lack of reporting of a serious incident, the process for validation of Governors and determination of members, Ravenswood house, staff shortages, concerns regarding individual Directors, and a letter from NHS Improvement regarding the conduct of the Interim Chair. Geoff Hill asked Tim Smart whether he had received correspondence from NHS Improvement on this matter; Tim Smart noted that he would ask NHS Improvement to resend any communications regarding this.

11.2. Russell Stevens expressed his thanks to the Public Governors for their hard work in difficult circumstances and for putting the points across to the NEDs and trying to improve services. He also expressed thanks to individual Governors for raising matters.

11.3. Diane Small addressed the Council and described the circumstances of her son’s death. She said that what she had particularly wanted from the Trust and what she had still not received was a sincere apology for the failings in her son’s care. Tim Smart noted that he recalled her expressions of grief at the meeting with Alistair Burt MP. He reiterated his personal expressions of regret and apology on behalf of the Trust.

11.4. Peter Bell noted that the examples voiced by these individuals were the reason that he had stood as a Governor, and that he was committed to ensure that we learn from experiences, change and ensure it does not happen to others. Tim added that this was the view of all Governors.

12. **Close**

12.1. Tim Smart reminded Governors that the Annual Members’ Meeting would be held at 18:00 on Tuesday 6 September 2016 at Tatchbury Mount and the next Council of Governors meeting would be held on Tuesday 25 October 2016.

12.2. The Interim Chair thanked members for their attendance and closed the meeting at 17:00.

Certified as a true record of the meeting
<table>
<thead>
<tr>
<th>Meeting</th>
<th>Date</th>
<th>Action Ref</th>
<th>Action NB from Minutes</th>
<th>Raised By</th>
<th>Owner</th>
<th>Target Closure Date</th>
<th>How Action will be closed</th>
<th>Current Position</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>CoG</td>
<td>27/01/2015</td>
<td>15.3</td>
<td>The Communications Team to update the current status of Katrina Percy’s Twitter account and to arrange for Sue Harriman’s Southern Health Twitter account to be closed.</td>
<td>Arthur Monks, Public Governor, South East Hampshire</td>
<td>CoSec</td>
<td>30/01/2015</td>
<td>The Trust to ensure the status of Katrina Percy’s Twitter account is up to date and to close Sue Harriman’s Southern Health Twitter account</td>
<td>Update to be provided at meeting</td>
<td>In progress</td>
</tr>
<tr>
<td>CoG</td>
<td>05/01/2016</td>
<td>2.30</td>
<td>A presentation on Tableau to be provided to Governors</td>
<td>CoSec</td>
<td>CoSec</td>
<td>By 31/07/2016</td>
<td>A presentation on Tableau to be provided to Governors</td>
<td>Presentation on Tableau provided at Governor Development Session held on 06.09.2016</td>
<td>Proposed for closure</td>
</tr>
<tr>
<td>CoG</td>
<td>26/01/2016</td>
<td>12.9</td>
<td>Patient story to be included at every Council of Governors’ meeting</td>
<td>CoSec</td>
<td>CoSec</td>
<td>27/04/2016</td>
<td>Patient story to be added to the Council of Governors agenda framework</td>
<td>Proposal for Patient Story at Council of Governors’ meetings on agenda 25.10.2016</td>
<td>In progress</td>
</tr>
<tr>
<td>CoG</td>
<td>26/04/2016</td>
<td>3.4</td>
<td>Report to be presented to the Council of Governors on the transition to business as usual post the Serious Incident Oversight &amp; Assurance Committee</td>
<td>CoSec</td>
<td>CoSec</td>
<td>25/10/2016</td>
<td>Report to be presented to the Council of Governors on the transition to business as usual post the Serious Incident Oversight &amp; Assurance Committee</td>
<td>Committee continues to meet; regular reports provided to Council of Governors</td>
<td>In progress</td>
</tr>
<tr>
<td>CoG</td>
<td>26/04/2016</td>
<td>5.2</td>
<td>Feedback from Audit, Assurance &amp; Risk Committee on further assurance sought on Health &amp; Safety to be provided to Council of Governors</td>
<td>CoSec</td>
<td>CoSec</td>
<td>26/07/2016</td>
<td>Update to be provided by AARC Chair</td>
<td>Update provided by AARC Chair at 26.07.2016 Council meeting. Report shared with Governors</td>
<td>Proposed for closure</td>
</tr>
<tr>
<td>CoG</td>
<td>26/04/2016</td>
<td>5.22</td>
<td>Governor session on Workforce Strategy (post Board seminar)</td>
<td>CoSec</td>
<td>CoSec</td>
<td>tbc</td>
<td>Governor session on Workforce Strategy to be arranged</td>
<td>Board seminar deferred - date to be rescheduled</td>
<td>In progress</td>
</tr>
<tr>
<td>CoG</td>
<td>26/04/2016</td>
<td>9.3</td>
<td>Governors to provide feedback on the Process for handling questions to Governors</td>
<td>CoSec</td>
<td>CoSec</td>
<td>03/05/2016</td>
<td>Governors to provide feedback on the Process for handling questions to Governors</td>
<td>No feedback received from Governors - the process as outlined to be adopted</td>
<td>Proposed for closure</td>
</tr>
<tr>
<td>CoG</td>
<td>26/07/2016</td>
<td>5.2</td>
<td>Director of Nursing &amp; AHPs to provide an update on the work of the Complaints Task &amp; Finish Group</td>
<td>CoSec</td>
<td>CoSec</td>
<td>25/10/2016</td>
<td>Update to be provided</td>
<td>Update to be provided by Acting CEO</td>
<td>Proposed for closure</td>
</tr>
<tr>
<td>CoG</td>
<td>26/07/2016</td>
<td>6.2</td>
<td>Report on feedback from patients to be shared with Council of Governors</td>
<td>CoSec</td>
<td>CoSec</td>
<td>25/10/2016</td>
<td>Report on feedback from patients to be shared with Council of Governors</td>
<td>Report circulated via the Governor Briefing on 20.10.2016</td>
<td>Proposed for closure</td>
</tr>
<tr>
<td>Meeting</td>
<td>Date</td>
<td>Action Ref</td>
<td>Action NB from Minutes</td>
<td>Raised By</td>
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<td>Target Closure Date</td>
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</tr>
<tr>
<td>CoG</td>
<td>26/07/2016</td>
<td>9.3</td>
<td>Corporate Governance team to circulate the Appointment Committee nomination form and Terms of Reference to Governors</td>
<td>CoSec</td>
<td>CoSec</td>
<td>28/07/2016</td>
<td>The Appointment Committee nomination form and Terms of Reference to be circulated to Governors on 28.07.2016</td>
<td>The Appointment Committee nomination form and Terms of Reference circulated to Governors on 28.07.2016</td>
<td>Proposed for closure</td>
</tr>
<tr>
<td>CoG</td>
<td>26/07/2016</td>
<td>10.4</td>
<td>Corporate Governance team to circulate Doodle poll for Governor availability to meet with Blake Morgan</td>
<td>CoSec</td>
<td>CoSec</td>
<td>28/07/2016</td>
<td>Doodle poll circulated for Governor availability to meet with Blake Morgan</td>
<td>Doodle poll circulated to Governors on 29.07.2016; meeting held 16.08.2016</td>
<td>Proposed for closure</td>
</tr>
</tbody>
</table>
## Executive Director Overview

The Chief Executive Officer and Directors’ reports are presented to each Board meeting* to provide an update on key issues.

The reports have been taken from **25 October 2016** and **27 September 2016** meetings and are the main reports only - the appendices are available on the Trust Board meetings page of the Trust’s website (http://www.southernhealth.nhs.uk/about/who/board/board-meetings/). They contain information from the Chief Executive and the Executive Team, as well as divisional updates, financial information and performance data.

## Action Required

The Council is asked to note the reports and to ask any questions of the Executive team.
<table>
<thead>
<tr>
<th><strong>REPORT TO THE TRUST BOARD</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date</strong></td>
</tr>
<tr>
<td><strong>Agenda Item</strong></td>
</tr>
<tr>
<td><strong>Title</strong></td>
</tr>
<tr>
<td><strong>Author(s)</strong></td>
</tr>
<tr>
<td><strong>Purpose</strong></td>
</tr>
<tr>
<td><strong>Previously Considered by</strong></td>
</tr>
<tr>
<td><strong>Sponsoring Director</strong></td>
</tr>
<tr>
<td><strong>Executive Director Overview</strong></td>
</tr>
<tr>
<td><strong>Action Required</strong></td>
</tr>
</tbody>
</table>
1. **Chief Executive’s Overview**

1.1. **Quality improvement and CQC reports**

1.1.1. During the week commencing 12 September CQC carried out a follow up inspection looking into progress against the requirements of the March 2016 Warning Notice. The Trust is awaiting receipt of the draft report but feedback from CQC verbally and via email, indicates that CQC saw enough improvements and progress to lift the Warning Notice. However, the Trust and CQC acknowledge that there are still further improvements which are required.

1.1.2. We have received draft findings from the review of the experience of families in the investigation process which has highlighted significant improvements needed. The findings will be presented to the Board at this meeting.

1.1.3. Good progress continues to be made against the CQC and Serious Incident action plans. Full detail of these plans and progress is set out in a separate paper to this Board meeting.

1.1.4. The Trust has appointed to the role of Family Liaison Officer. This is a new role to support families and loved ones through the difficult process of an investigation into a serious incident or a serious complaint. The Trust has also made its appointment to the Freedom to Speak Up Guardian role.

1.2. **Access and performance target achievement**

1.2.1. All national targets and NHS Improvement stretch targets to secure access to Sustainability and Transformation funding in 2016/17 have been met within tolerance.

1.2.2. Medisec Ambulance Services Limited’s CQC registration was suspended by CQC on 13 October following concerns over a lack of recruitment checks on employees. The service predominantly provides transport for section 136 suites whilst awaiting mental health assessment. SHFT sites impacted are Antelope House, Elmleigh, and Parklands. Alternative arrangements have been made until a formal contract re-tender exercise can be undertaken.

1.3. **Month 6 financial performance**

1.3.1. The financial performance in September was £77k ahead of the six month plan to date. The surplus realised in month 5 was due to a one-off credit linked to rates rebates and pressures in this month reflect the continued use of out of area beds for mental health and overspends within the East ISD. The forecast deficit for the year has increased to £3,079k deficit. This increase has been agreed with NHS Improvement and relates to technical items. We still forecast to meet the cash deficit within the planned control total of £1.7m

1.3.2. The agency cap for 2016/17 is £7.5m (set by NHS Improvement). For the five months to September the spend cap was £4,271k and the Trust spent £5,736k, an adverse variance of £1,465k.

1.4. **Trust Strategy**
1.4.1. The Clinical Services Strategy programme has been established to support the Board in a fundamental review of the Trust’s clinical strategy, with particular focus on mental health and learning disability services in the context of Better Local Care and the wider Hampshire and Isle of Wight Sustainability and Transformation Plan. Full details are set out in a separate paper to the Board meeting.

1.4.2. We continue to work with other health and care agencies across Hampshire & Isle of Wight to develop the area’s Sustainability and Transformation Plan (STP), which will be submitted to NHS England in late October. We are taking care to ensure full alignment between key programmes within the STP (notably the ‘New Care Models’ and ‘Mental Health Alliance’ work streams) and the Clinical Services Strategy review being undertaken by the Trust.

1.4.3. Learning Disability services in Oxfordshire will transfer from Southern Health to a new NHS provider in 2017. Subject to final discussions with Oxfordshire commissioners, Oxford Health will take over the running of the community services from mid-2017, with the exact date of transfer to be confirmed. The secure Learning Disability Services provided at Evenlode do not form part of this planned transfer. Southern Health is working very closely with NHS England, who separately commission the care at Evenlode, to determine the future shape of services for this group of patients.

1.5. Media attention

1.5.1. The Trust announcement on 7 October that Katrina Percy would step down from her advisory role was the focus of media coverage this month, resulting in national, local and trade coverage.
2. Integrated Executive Performance Report

2.01 CQC Warning Notices and inspection reports

CQC carried out an unannounced inspection of mental health and learning disability services during week commencing 12 September 2016. The focus of the inspection was to review progress against the actions related to the Warning Notice. The inspection took place in inpatient units and concentrated on environmental patient safety including ligature risks, environmental risk assessments, fire safety and estates works carried out.

The Trust is awaiting receipt of the draft report but feedback from CQC verbally and via email, indicates that CQC saw enough improvements and progress to lift the Warning Notice. However, the Trust and CQC acknowledge that there are still further improvements which are required.

Full detail of the action plan and progress is set out in a separate paper to this Board meeting.

2.02 Mortality and serious incident reporting and learning

Analysis and quality assurance of the data provides the following information:

Compliance detail:

- 701 out of 705 reported deaths since 1 December 2015 have been reviewed as of the 30 September: 99.4% compliance.
- 91% (58 of 64 deaths) were reviewed within the 48hrs. This is a continued improvement on the previous month. The six delayed cases occurred on the week of the 12 September and were in the Mental Health Division (3) and West Integrated Service Division (3). The other three divisions were 100% compliant. Although the internal target of 95% has not yet been reached, progress is actively monitored through the Mortality Forum (previously known as the Mortality Working Group) with divisions
- In September, seven, (11%) of the 64 deaths reviewed were reported as serious incidents.
Quality assurance:

The audit of the Ulysses held records of the mortality panels and the clear decision making surrounding whether a death requires investigation has been undertaken.

In September the result was 87% which pertained to 3 of the 23 records not containing the correct information to explain the decision making. These cases were in Mental Health Division (1) and West Integrated Service Division – community and Romsey Hospital (2).

100% of serious incident investigation reports due in September were uploaded to StEIS (the national database) within the 60 days required timeframe. This improvement has been sustained for a four months period.

A process has been agreed with the CCG Commissioner for Mental Health, Older Persons Mental Health and Learning Disabilities for serious incident report closure on the national StEIS the system. Data collection has occurred since the 31 August and a 90% key performance indicator has been agreed. In August 94% and in September 90% was achieved.

Number and type of serious incidents (SI’s requiring investigation):

<table>
<thead>
<tr>
<th>Division</th>
<th>No. of SI’s reported in September 2016 (Aug16 in brackets)</th>
<th>Type of Incident</th>
</tr>
</thead>
<tbody>
<tr>
<td>East ISD</td>
<td>0 (6)</td>
<td></td>
</tr>
<tr>
<td>West ISD</td>
<td>4 (1)</td>
<td>1 Suicide</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 Grade 4 Pressure Ulcers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Grade 3 Pressure Ulcer</td>
</tr>
<tr>
<td>Mental Health (includes Specialised Services)</td>
<td>11 (8)</td>
<td>3 Community Patient Deaths</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 Probable Community Patient Suicides</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 In-patient death whilst on Section 17 Leave</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Absence Without Leave (AWOL)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Medicines Management</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 Serious Self Harm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Adult Safeguarding</td>
</tr>
<tr>
<td>Learning Disabilities</td>
<td>0 (0)</td>
<td></td>
</tr>
<tr>
<td>QTtwentyone</td>
<td>1 (0)</td>
<td>1 Accident/Injury to a Patient</td>
</tr>
<tr>
<td>Children and Families Division</td>
<td>0 (0)</td>
<td></td>
</tr>
<tr>
<td>Corporate</td>
<td>0 (0)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>16 (15)</td>
<td></td>
</tr>
</tbody>
</table>

Deaths:
Seven deaths were reported in this period:

Four deaths requiring further investigation were identified;

- One from Andover and Winchester Community Treatment Team (CTT)
- One from New Forest CTT
- One from South Central Adult Community Mental Health Team (AMH) and
- One patient who as on Section 17 Leave from Kingsley Unit at Melbury Lodge.

Three of the deaths appear to be probable suicide;

- One from Eastleigh and Romsey CTT
- Two in Fareham and Gosport CTT.

It should be noted that this data may change following the outcomes of investigations and Coroner's inquests into the seven deaths identified above.

Pressure Ulcers:

Three pressure ulcers were reported:

- One grade 3 pressure ulcer in Waterside Community Care Team (CCT)
- One grade 4 pressure ulcer in Waterside CCT
- One grade 4 pressure ulcer in Andover One CCT.

Self-Harm:

Two serious self-harm incidents were reported: both occurred within South Central AMH CMHT.

Other Serious Incidents:

The remaining four serious incidents related to:

- An absence without leave (AWOL) from Beech Ward, Southfield Unit
- An injury to a patient requiring hospital treatment within Hamilton Road TQ 21 social care unit
- An adult safeguarding incident on the Kingsley Unit at Melbury Lodge
- A medicines management incident on Hawthorns 2 Ward at Parklands Hospital.

The lessons learned from serious incidents have been extracted from those serious incident and red graded investigation reports reviewed and approved at corporate panels during September 2016. Ten reports were heard, with an additional 11 pressure ulcer reports approved through the divisional panel approval process. The key themes were extracted for sharing and learning:

Key learning themes from the reported pressure ulcers identified three key areas of learning:

- Education - timely and effective education to the patient or their carers in pressure ulcer management to prevent further deterioration of wounds and education to staff on the impact of patient’s existing multiple pathologies on tissue viability and tissue resistance.
- Communication - externally with the equipment stores to ensure that the patient's needs are met for timely delivery of equipment. Internal communication between team members, MDT members and other SHFT teams to ensure robust handovers, forward diary planning and equipment/dressing ordering to support safe seamless care to patients.
- High risk patients - pressure relieving education to be holistically focused ensuring every pressure area is given due consideration where patient are at high risk due of pressure damage due to tissue perfusion, lack of sensation and deformity.
Key learning themes from the reported falls identified:

- Documentation - to ensure there is sufficient documentation for completing patient body maps.
- Risk assessment - to ensure that where a patient is identified as having a number of falls that an assessment is carried out by the physiotherapist and for nursing staff to develop more critical thinking in relation to night time ward care.

Key learning themes from reported deaths (mental health and older persons mental health) identified:

- A recognised framework is to be used to ensure clear communication and documentation of conversations between nursing staff and out of hours GP service when caring for a deteriorating patient.
- Crisis and contingency plans - a number of themes have emerged including that clear plans are developed to ensure that the patient, their family and health professionals are aware of how to manage complex patients in difficult situations. The plans were identified as being not up to date.
- Risk continues to be a theme with inadequate interagency communication regarding risk factors, failure to take account of dynamic and demographic risk.
- Key learning identified from a service user abscondment links into the risk learning above, in that risk assessments should be completed immediately a patient is admitted to the ward.

One Trust-wide safety alert was published in September:

- Following review of an incident through the Serious Incident process a Trust wide alert was issued in regards to a situation a situation that occurred where a leaflet was locally designed and published that contained incorrect information about the dosage in regards to Vitamin D. This information was then made widely available and distributed to patients. In this case this error did not result in any harm, but it is clear in another case it could easily have resulted in serious harm. It is essential that any client and patient information is necessary, clear and accurate and that has been appropriately signed off. A vital message from this incident is that generic information leaflets should not include information about specific dosages of medication and patients should be signposted to where they can get further information.

Hotspots and Learning Matters circulations have been produced in all of the divisions and circulated to the clinical teams. Assurance that these publications are discussed at team meeting is gained through ‘Peer Review’ and ‘Back to the Floor’ visits.

Family engagement (duty of candour) continues to be documented from those investigation reports reviewed and approved at corporate panels during September. It is recognised that the Trust needs to increase the level of support and communication offered to families and loved ones to ensure that they understand the investigation process for incidents. A Family Liaison Officer role has been created following the model used by the police and is currently being recruited to.

Incidents:

1744 incidents were reported in September 2016. This represents an overall decrease of 9% (176 incidents) from the previous month. The largest overall decrease is of 121 incidents: 772 to 651 within the Mental Health Division. This can be attributed in the main to the closure of Hamtun Ward at Antelope House.

The East ISD saw the second largest decrease of 64 incidents: from 355 to 291.

The top three incident cause groups remain unchanged from 2015:

- Assault, abuse or threats to staff
- Self-harm or self-injurious behaviour, and disruptive or dangerous behaviour
Slips, trips and falls.

Incidents relating to self-harm or self-injurious behaviour have been on a downward trajectory for the last five months, with a reduction from 169 to 116 from August to September 2016. The closure of Hamtun Ward at Antelope House and the transfer of the Ridgeway Centre has had the greatest overall impact on the reducing numbers.

2.03 Outcomes from inquests

There were eight inquests held by the Coroner for patients in September 2016. Of the 8 inquests that were held, the conclusions of four have not been fully reported.

A high profile inquest for the MH East division concluded in Southwark during October with the Jury finding a conclusion of suicide due to neglect, constituted by the gross failure to provide basic medical care. This was with regards to a Mental Health Act assessment carried out by Trust Doctors and an AMHP from Hampshire County Council. The Coroner is considering whether a regulation 28 will be issued in the light of the Clinical Director for the Trust supplying extensive change evidence.

2.04 Complaints / Concerns / Compliments

There were 34 complaints received in September 2016 compared to 21 in August, although this looks like a significant increase, it actually brings numbers of complaints back up the average level after a very low month in August. Concerns have remained steady, with 56 received in September and 52 received in August. There was an increase in the number of compliments recorded; 208 compared to 176 in August, with the highest number (137) entered by the Children’s Division – this area has consistently high numbers of compliments recorded and the Division have embraced the web based compliments reporting module.

Complaint categories/themes:
The top three categories, reported using the national KO41a reporting category types for September were:

- Clinical Treatment/Patient Care (9)
- Communication (6)
- Values and Behaviours (Staff) (5)

Complaints relating to clinical treatment and patient care:
Mental Health (6)
- Questioning the decision to cut back her sister’s care.
- Regarding the lack of interaction from staff; low levels of staffing.
- Complainant feels the CMHT have failed in their duty of care toward her.
- Clinician failed to turn up for appointments and the service user did not receive a constructive care plan, as promised.
- The service did not provide enough support when complainants’ father reported suicidal thoughts.
- Complainant feels lack of support contributed to husband trying to take his life.

Integrated Services Divisions (3)
- Complaint regarding alleged misdiagnosis by General Practitioner
- Alleged poor care and attention from district nurses in last hours of mother’s life.
- Complainant questioning the ability of out of hour’s service to provide nursing care to patient requiring a drain bag replacement out of hours.

Complaints relating to communication:

Integrated Services Divisions (3)
- Complainant unhappy with letter from occupational therapist.
- Complainant was given conflicting information when she called the district nurses, following her mother passing away in the night.
- Lack of information given to parents regarding safeguarding issues for new born son by the GP surgery.

Mental Health (2)
- Complainant feels a report prepared about him is inaccurate.
- Complainant disputes details of a report about her.

Complaints relating to values and behaviours (staff): These have increased from two to five this month.

Mental Health (1)
- Unhappy with inappropriate comments and actions of staff member.

Integrated Service Divisions (4)
- Patient unhappy about attitude of staff member who explained they did not meet the criteria for a home visit.
- Concerns about GP consultation and onward referral.
- Doctor was abrupt and impolite.
- Manner of doctor was rude, felt concerns were ‘brushed off’.

Acknowledgement of complaints within three working days:
100% achieved for September 2016.

Final Response Letters sent within agreed timeframe:
32 final responses were sent in September however only 59% were sent within the agreed time frame compared to 89% in August. This is disappointing result pertaining to 13 response letters and is Trust-wide:
- Seven for Mental Health (1 North, 5 East, 1 West)
- One for Learning Disabilities
• Five for the Integrated Service Divisions (1 East, 3 South West, 1 North East).

Reasons for delays in completing the complaints process include:
• Delays in appointing investigating officers
• Delays in the investigation being completed
• Delays in approval of response letters – both within the division and at corporate level

The Working Group for complaints management and improvement had its inaugural meeting on 26 September and will be focusing on the recommendations from the thematic review of the customer experience pathway June 2016. The working group, which has representatives from staff, governors, members of the Trust and complainants, will review the current complaints policy and procedures with the aim to have a simple timely process which best meets the needs of the complainant.

2.05 Parliamentary and Health Service Ombudsman (PHSO) and Local Government Ombudsman (LGO) open cases

There are four cases currently open;
• East ISD (1) is under investigation.
• West ISD (1)) is under investigation (1) is awaiting the final report
• Specialised Services (1) is under investigation.

Two cases have recently been closed for Mental Health.

They are considering re-opening one further case, which they had originally declined to investigate, at the request of the complainant.

2.06 Peer reviews

Eight peer reviews were completed during September 2016. These were all scheduled comprehensive peer reviews.

<table>
<thead>
<tr>
<th>Division</th>
<th>Children's/Learning Disabilities Division</th>
<th>West Hampshire &amp; Southampton ISD</th>
<th>East Hampshire ISD</th>
<th>Children's &amp; Families</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Division</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Learning Disabilities Division</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>West Hampshire &amp; Southampton ISD</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>East Hampshire ISD</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Ratings have been received for four of the peer reviews completed. The other four reports are currently being finalised.

Results for the comprehensive peer review report received:

<table>
<thead>
<tr>
<th>Division</th>
<th>Service</th>
<th>Date</th>
<th>Overall rating</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children's</td>
<td>Lymington Health Visiting Team</td>
<td>07/09/2016</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Outstanding</td>
</tr>
<tr>
<td>West Hampshire ISD</td>
<td>Endoscopy &amp; Day Case, Lymington NF Hospital</td>
<td>01/09/2016</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Outstanding</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Children's</td>
<td>Fleet Health Visiting</td>
<td>14/09/2016</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
</tr>
<tr>
<td>West Hampshire ISD</td>
<td>Basingstoke Integrated Community Team</td>
<td>15/09/2016</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
</tr>
</tbody>
</table>
Areas for improvement from August 2016’s peer reviews:

<table>
<thead>
<tr>
<th>Team</th>
<th>Areas for improvement</th>
</tr>
</thead>
</table>
| Alver and Lee Health Visiting Team, Children’s Division | **Safe:**  
  • Staff not currently accessing clinical supervision.  
  **Responsive:**  
  • Patient experience forms were not offered to clients at every observed contact.  
  **Well-led:**  
  • Several staff members had training that was out of date. |
| MAU & Forest Assessment Centre, West Hampshire ISD | **Safe:**  
  • Fridge temps were recorded but maximum temp was too high on several sequential occasions.  
  **Caring:**  
  • Patients unaware of care plans or how long they would be there.  
  **Responsive:**  
  • Higher than expected readmission rate. |
| Andover Integrated Community Team & MSK, West Hampshire ISD | **Safe:**  
  • Concerns highlighted with staff knowledge and application safeguarding concerns.  
  **Responsive:**  
  • Resuscitation training out of date. No evidence of equipment being checked by staff.  
  **Well-led:**  
  • Training days frequently being cancelled.  
  • There is no structured induction to the service. |
| Southampton East Community Mental Health Team, Mental Health Division | **Safe:**  
  • Trust policy not followed regarding medication changes.  
  • Process to be put in to check when service users have not attended for medication.  
  **Effective:**  
  • Service users on Care Treatment Orders do not have appropriate care plans in place.  
  **Caring:**  
  • All service users to be offered up to date copy of their care plans. |
| Eastleigh South Health Visiting, Children’s Division | **Safe:**  
  • The follow up of families who DNA is inconsistent.  
  **Caring:**  
  • Staff need to utilise feedback forms to capture the work they are doing.  
  **Responsive:**  
  • Care plans are not always shared with families despite being co-written with them. |
2.07 Infection control

<table>
<thead>
<tr>
<th>Condition</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA bacteraemia &gt;48hrs post admission</td>
<td>0</td>
</tr>
<tr>
<td>New MRSA positive results &gt;48hrs post admission</td>
<td>0</td>
</tr>
<tr>
<td>MSSA bacteraemia &gt;48hrs post admission</td>
<td>0</td>
</tr>
<tr>
<td>Clostridium Difficle Toxin positive results &gt;72hrs post admission</td>
<td>0</td>
</tr>
</tbody>
</table>

There have been no infection control related ward closures during September.

2.08 Safer staffing

September 2016 data shows 6 sites reported as red in the national publication data:

- Antelope House – Registered Nurse day shifts – 72.9%
  - Unregistered staff used to ensure total working hours of 101% of planned*.

- Bluebird House – Registered Nurse day shifts 66.2%
  - Unregistered staff used to ensure total working hours of 95% of planned*.

- Melbury Lodge – Registered Nurse day shifts 75.7%
  - Unregistered staff used to ensure total working hours of 91% of planned*.

- Parklands Hospital – Registered Nurse day shifts – 76.9%
  - Unregistered staff used to ensure total working hours of 107% of planned*.

- Western Community Hospital – Registered Nurse day shifts - 63.2%
  - Unregistered staff used to ensure total working hours of 111% of planned*.

- Emleigh – Registered Nurse night shifts – 75.9%
  - Unregistered staff used to ensure total working hours of 103% of planned*.

* Skill mix dilution provides a potential safer staffing risk, which is carefully managed on a shift by shift and day by day basis.

13 wards have had staffing under-establishment fill rate challenges for at least 3 out of the past 4 rolling months. These are monitored on a shift by shift/daily/weekly basis and staff redeployed flexibly across units to ensure wards are staffed appropriately.

The safer staffing report is set out at Appendix 3.

2.09 Teams requiring intensive support

As reported to the Board in previous months, a number of teams across the Trust are under intensive support. The list of these teams is highlighted below and a short update is noted where there have been material changes since last reported.

Mental Health, Specialised and LD:
• Antelope House, (Southampton)
• Evenlode (Buckinghamshire)
  • Final environmental works have now commenced.
• Kingsley Ward, Melbury Lodge (Winchester)
  • Environmental works will commence on 17th November which requires ward decant; beds have been identified at Woodhaven and private local provider.
• Ridgeway Centre (Buckinghamshire)
  • Service is now closed with the last two last patients being safely discharged on 30th September. Work is now underway to close down the site.

Integrated Service Divisions:
• Southampton East (OPMH) Community Mental Health Team
• North Hampshire Integrated Care Teams
• Dryad Ward, Gosport War Memorial Hospital
• Petersfield Integrated Community Team (ICT)
• Romsey Ward, Romsey Hospital
  • There is a new Ward Manager in place with a new Ward Sister commencing in November. Further focussed support is in place with the ward.

ACCESS

2.10 Access and performance targets
Access and performance target performance remained strong in September. The Trust performance dashboards are set out in detail in Appendix 2. Key points to note:

Performance:
• The Trust was compliant with most of the NHS Improvement (Monitor) Access to Care and Outcome Standards in August; with the exception of the 18-week RTT Target sustainability and transformation target which was missed by 0.62%. The Trust is within tolerance level across Q2 at 93.93% so should secure funding for this period. It also exceeded the national target of 92%.

• Delayed Transfers of Care (DTOC) rose to 2.5% in September from 2.2% reported in August, but remain below the NHS Improvement threshold of 7.5%. OPMH inpatient services are experiencing increased pressures with DTOCs in September and returned a % DTOC figure of 8%. This is an increase on August’s figure of 6%. A permanent Bed Manager has been recruited to provide a consistent, coordinated response to DTOC blocks and to liaise with Social Services to reduce delays.

• Waiting times to Therapy pathways in the community teams continue to experience pressure. There are regular reviews of waiting times, planned referrals for classes and group sessions, plus
the way that inter-discipline referrals are captured are being considered.

- There has been a significant rise in waiting times within Outpatient MSK services since March. A Recovery Plan has now been introduced incorporating a robust referral triage system. An additional Physiotherapist has been recruited.

Quality:
- The proportion of moderate or above severity incidents for Management of Violence and Aggression still remains higher than historical months, following the increase during July 2016. The largest volume continues to be experienced within an Older Persons Mental Health ward relating to specific patients.
- Whilst the number of reported incidents of Service User Falls decreased in September 2016 to 92 incidents, as did the proportion of incidents that were graded as moderate or above severity; there are units that are still having incidents. There are high numbers of patients being admitted to some wards who are at high risk of falls. These are assessed on admission, and reviewed weekly. Fall sensors are also used.
- Whilst the overall number of Grade 2-4 Pressure Ulcers decreased in September 2016, those incidents that have been reviewed are showing a trend of patients with more complex requirements are those affected. It has highlighted a need for key working and an integrated approach between OPMH and Primary Care.

Finance:
- The Trust has maintained the Financial Sustainability Risk Rating (FSRR) of 3, and forecasts 3 for the end of the year
- The activity and financial targets are still on track, which if continue to be delivered throughout the year will allow the Trust to access the £2.7m sustainability and transformation funding from NHS Improvement

Patient Experience:
- Patient experience surveys: the percentage of respondents recommending the Trust’s services to friends and family risen from 76.2% in August to 94% in September.

Workforce:
- Across the Trust, appraisal compliance rate for the rolling 12 months to September is at 92.9% against the target of 95% of appraisals undertaken.
- The rolling 12 month vacancy rate dropped to 7.7% to September; absence rate is stable at 4.8%, whilst turnover reduced slightly to 17.5%.

2.11 Medisec patient transport contract

Medisec Ambulance Services Limited’s CQC registration was suspended by CQC on 13 October following concerns over a lack of recruitment checks on employees.

The service predominantly provides transport for adults and children with mental health disorders, as well as the transport and supervision of people in, section 136 suites whilst awaiting mental health assessment. SHFT sites impacted are Antelope House, Elmleigh, and Parklands.

Alternative arrangements have been made until a formal contract re-tender exercise can be undertaken. The Trust has been working with commissioners to provide an alternative transport service for MH patients. The matter is subject to daily calls with commissioners and NHS England to ensure patient safety is maintained.
2.12 Year to Date (month 6) financial summary

<table>
<thead>
<tr>
<th></th>
<th>Mth</th>
<th>Mth</th>
<th>Mth</th>
<th>YTD</th>
<th>YTD</th>
<th>YTD</th>
<th>Budget</th>
<th>Full Yr</th>
<th>Full Yr</th>
<th>Forecast</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
</tr>
<tr>
<td>Income</td>
<td>27,380</td>
<td>27,082</td>
<td>(298)</td>
<td>162,806</td>
<td>161,342</td>
<td>(1,464)</td>
<td>318,732</td>
<td>317,386</td>
<td>(1,346)</td>
<td></td>
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<tr>
<td>Income - STP</td>
<td>225</td>
<td>225</td>
<td>-</td>
<td>1,350</td>
<td>1,350</td>
<td>-</td>
<td>2,700</td>
<td>2,700</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pay</td>
<td>(19,540)</td>
<td>(19,143)</td>
<td>397</td>
<td>(116,255)</td>
<td>(115,230)</td>
<td>1,025</td>
<td>(226,081)</td>
<td>(223,592)</td>
<td>2,489</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non Pay</td>
<td>(6,520)</td>
<td>(7,054)</td>
<td>(534)</td>
<td>(39,095)</td>
<td>(40,110)</td>
<td>(1,015)</td>
<td>(76,343)</td>
<td>(79,685)</td>
<td>(3,342)</td>
<td></td>
<td></td>
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<tr>
<td>Reserves</td>
<td>(250)</td>
<td>(0)</td>
<td>250</td>
<td>(1,500)</td>
<td>(1,500)</td>
<td>-</td>
<td>(3,000)</td>
<td>(2,178)</td>
<td>822</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EBITDA</td>
<td>1,295</td>
<td>1,110</td>
<td>(185)</td>
<td>7,306</td>
<td>7,351</td>
<td>45</td>
<td>16,098</td>
<td>14,631</td>
<td>(1,377)</td>
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<tr>
<td>I&amp;D</td>
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<td>(1,281)</td>
<td>10</td>
<td>(7,656)</td>
<td>(7,624)</td>
<td>32</td>
<td>(15,408)</td>
<td>(15,410)</td>
<td>(1)</td>
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<tr>
<td>Normalised Surplus/(Deficit)</td>
<td>5</td>
<td>(171)</td>
<td>(176)</td>
<td>(350)</td>
<td>(273)</td>
<td>77</td>
<td>600</td>
<td>(779)</td>
<td>(1,379)</td>
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<td></td>
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<tr>
<td>Exceptional Items</td>
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<td></td>
<td></td>
<td>(474)</td>
<td>37</td>
<td>510</td>
<td>(2,300)</td>
<td>(2,300)</td>
<td>0</td>
<td></td>
<td></td>
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<tr>
<td>Non Normalised Surplus/(Deficit)</td>
<td>5</td>
<td>(171)</td>
<td>(176)</td>
<td>(823)</td>
<td>(236)</td>
<td>587</td>
<td>(1,700)</td>
<td>(3,079)</td>
<td>(1,379)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The financial performance in September was a normalised deficit of £171k, an adverse variance of £176k compared to the period budget but £77k ahead of the six month plan to date. The surplus realised in month 5 was due to a one-off credit linked to rates rebates and pressures in this month reflect the continued use of out of area beds for mental health and overspends within the East ISD. Overall the CIP has been achieved for the month, although with an element of non recurrent delivery. The forecast for the year has increased to £3,079k deficit. This increase has been agreed with NHS Improvement and allows the Trust to deliver the cash deficit within the planned control total of £1.7m. The planned expenditure on impairments £1.2m and depreciation on donated assets £120k are not included for the purposes of calculating achievement of the control total.

The deficit has been increased to take account of the Trust’s commitment to develop at pace the clinical strategy for Trust services and to work through the financial, system and organisational implications of this. The activity target (A&E and RTT) and financial target (achievement of financial control total) are still on track to date. If maintained throughout the year, it will allow the Trust to access £2.7m of sustainability and transformation funding.

The cash position remains strong due to temporary working capital benefits with a cash holding of £35.1m as at the 30.9.16 (against an initial plan of £20.7m). This will reduce during October as payments are agreed with NHS Property Services. The Financial Sustainability Risk Rating (FSRR) for the month was a 3, in line with our annual plan.

At a divisional level:

- The East ISD is beginning to reduce its overspend but it continues to be high. The overspend in September of £255k (August £302k) has been driven by a one off refit of a building (£40k), continued agency and locum costs in OPMH and Calthorpe Ward and unidentified CIP schemes.
- The Mental Health division is £386k overspent (August £444k), mainly due to the ongoing use of out of area beds (£425k) following the temporary closure of Hamtun Ward. The underlying demand for beds, in particular PICU, continues to be in excess of available beds. There was a marginal offset by non-recurrent benefits and income.
- The overspends within the Learning Disabilities division are caused by the closure of the Ridgway Centre and will reduce significantly in October as the final patients have now moved out of the unit.
TQ21, Children’s, Estates and Corporate Services delivered in month underspends. The West ISD significantly reduced its in month deficit but continues to have an underlying pressure. All divisions which are overspending are currently assessing the actions which need to be taken during quarter 3 to bring their run rates back to budgeted levels for the start of quarter 4.

Pay budget performance

<table>
<thead>
<tr>
<th></th>
<th>Mth Budget £'000s</th>
<th>Mth Act £'000s</th>
<th>Mth Var £'000s</th>
<th>YTD Budget £'000s</th>
<th>YTD Act £'000s</th>
<th>YTD Var £'000s</th>
<th>Budget Full Yr £'000s</th>
<th>Full Yr Forecast £'000s</th>
<th>Variance Full Yr £'000s</th>
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</thead>
<tbody>
<tr>
<td>Substantive</td>
<td>(19,338)</td>
<td>(17,442)</td>
<td>1,896</td>
<td>(114,608)</td>
<td>(104,622)</td>
<td>9,986</td>
<td>(223,703)</td>
<td>(206,592)</td>
<td>17,111</td>
</tr>
<tr>
<td>Bank</td>
<td>(74)</td>
<td>(628)</td>
<td>(554)</td>
<td>(1,096)</td>
<td>(4,873)</td>
<td>(3,777)</td>
<td>(1,401)</td>
<td>(7,475)</td>
<td>(6,074)</td>
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<tr>
<td>Agency</td>
<td>(128)</td>
<td>(1,073)</td>
<td>(945)</td>
<td>(550)</td>
<td>(5,736)</td>
<td>(5,185)</td>
<td>(976)</td>
<td>(9,524)</td>
<td>(8,548)</td>
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<tr>
<td>Pay</td>
<td>(19,540)</td>
<td>(19,143)</td>
<td>397</td>
<td>(116,255)</td>
<td>(115,230)</td>
<td>1,025</td>
<td>(226,081)</td>
<td>(223,592)</td>
<td>2,489</td>
</tr>
</tbody>
</table>

The total pay expenditure for month 6 is underspent by £397k (August underspend £153k). Overall there is an increase of £124k in the total pay bill from last month partly due to a correction to Junior Doctors banding. An element of underspend is linked to income reductions as described previously. Vacancies have increased in September at 8.4% (August 7.7%); the staff turnover has remained steady around 17.5% and the overall sickness rate has increased from 4.6% to 4.8%

Temporary Staffing Costs

The position in September 2016 saw bank staff costs decrease by £229k compared to last month and agency costs increase by £147k. Excluding TQ21, agency costs have increased from £747k to £896k due to coding corrections rather than increased use. Agency use within TQ21 has remained steady this month but will decrease in quarter 3 as services transfer. Overall this year there has been no significant change in the use of agency although this will be variable within teams. Further run rate analysis will be carried out to ensure targeted actions are considered. Looking at overall % of costs, the East ISD remains at 11%, Learning disabilities is at 7% and all other teams are at 5% or below.

The agency cap of £7.5m for 2016/17 (set by NHS Improvement) continues to be breached as shown in the graph below. For the five months to September the spend cap was £4,271k and the Trust spent £5,736k, an adverse variance of £1,465k. Detailed reporting to NHS Improvement has been put in place from October to enable targeted support where Trusts are finding it difficult to deliver sustained reductions. The pressures within Southern continue to be linked to difficulty in appointing and retaining permanent staff and the requirement for short term capacity to facilitate our action plans linked to quality and governance. There are very specific pressures for medical locums in OPMH services and Calthorpe Ward in Fleet.
Cost Improvement Plans (CIPs)

The cost reduction plan included within our annual plan is £10.2m, performance against this is shown in the table and graph below including narrative where there has been in-year slippage. Delivery is currently above plan but supported by non recurrent solutions. Of the annual target the majority of schemes have been identified and the quality impact assessment has been signed off by the Director of Nursing and Medical Director. However there is slippage within the East and West ISD which will need to be resolved prior to quarter 4 in addition to schemes identified for 2017/18, this is a significant challenge and an action plan is being developed. The graph shows a summary below:

Non pay expenditure

There are overspend on the Purchase of Healthcare Services mainly driven by mental health out of area beds due to current ward closure and bed pressures. Premises costs are over budget largely due to CIP under-achievement on the Estate Rationalisation Programme.

The procurement team have an extensive work programme linked to the divisions to ensure that value for money is achieved on non-pay expenditure. During September contracts were awarded for the MCP Evaluation (funded by NHS England), the additional capacity required to develop our clinical strategy, the Occupational Health contract and the continence contract moved into implementation stage.

Progress has been made with the supplier of the resuscitation (trust designed) bag and an order has now been placed for the initial 77 bags. Significant tenders that will be finalised during the Autumn include: Bluebird education provision and the decontamination service. In addition a number of estates related contracts are being tendered including pest control, asbestos management, ventilation, fire alarm system testing and security guarding.

Clinical contracts and tendering (income related)

Contract values have been agreed with all Commissioners. Work has begun as part of the STP to consider how operating plans for 2017-2019 can be established for each organisation within the footprint and contracts signed prior to the end of the calendar year.

During October we were asked to attend the IAPT presentation to support the bid we submitted. The Health Visiting Contract award is anticipated during October.

Balance Sheet

The Month 6 cash balance is temporarily higher than planned at £35.1m, a decrease of £1.4m in
September and against an initial plan of £20.7m. Good progress has been made during October on moving forward the discussions with NHS Property Services and payments on account are planned in October 2016. Whilst giving a temporary benefit to the Trust’s cash holding the consequence is an increase in the level of creditor accruals.

Current receivables increased by £2.2m in the month to stand at £12.5m. The over 90 days debt has decreased to £1.5m to £1.4m with progress across several customers. Further senior effort will be required to resolve points of principle with two local NHS Organisations, PHT and Solent.

The balance sheet and statement of cashflows are set out in full in Appendix 1.

NEW CARE MODELS

Trust Strategy

2.13 Clinical Services Strategy

The Clinical Services Strategy programme has been established to support the Board in a fundamental review of the Trust’s clinical strategy, with particular focus on mental health and learning disability services in the context of Better Local Care and the wider Hampshire and Isle of Wight Sustainability and Transformation Plan.

The programme will first identify how services can be best delivered to meet the needs of our communities in the future and then consider whether the current organisational arrangements need to change to support the delivery of these services.

The approach will be shaped by clinical leaders in the Trust, supported by an external expert reference group to develop the strategy, in partnership with people who use services and their families.

The approach will also ensure that local commissioners and system partners are a central part of the governance structure, enabling the Trust Board to be in a position to consider clear recommendations on a way forward by January 2017.

Detail of the programme of work is set out in a separate paper to this Board meeting.

2.14 Sustainability and Transformation Plan

Southern Health has been working with the other health and care agencies across Hampshire & Isle of Wight to develop the area’s STP, which will be submitted to NHS England in late October. The document sets out a strategic framework for improving health and care outcomes and within which services can remain clinically, financially and operationally sustainable for the next five years and beyond. The plan builds on a variety of policy and projects across the constituent geographies and organisations, all of which has been the subject of local engagement and/or consultation. Southern Health is also taking care to ensure full alignment between key programmes within the STP (notably the ‘New Care Models’ and ‘Mental Health Alliance’ work streams) and the Clinical Services Strategy review being undertaken.
by the Trust. The next stage of the process will result in more joint working, across agencies and in partnership with local people, to address the challenges and develop more detailed shared plans.

<table>
<thead>
<tr>
<th>Better Local Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2.15 MCP Evaluation</strong></td>
</tr>
<tr>
<td>With a growing number of Vanguard projects having now completed, or in the process of writing up, formal evaluations of their outcomes Better Local Care is reaching a crucial point in terms of being able to scale up and replicate areas of best practice that are being shown to have tangible impact on patient outcomes and the working of extended primary care services. PACEC have been selected to lead the formal evaluation of Better Local Care, with their work feeding into a national evaluation of the Vanguard schemes.</td>
</tr>
</tbody>
</table>

| **2.16 Integrated Intermediate Health & Social Care** |
| Southern Health has commenced work with colleagues in Hampshire County Council, aimed at the establishment of a fully integrated intermediate care service that optimises the support for clinically stable patients with recovery potential. The new offer will aim to formally bring together a range of domiciliary and bed-based services, tailoring care around individuals’ needs as opposed to who is responsible for providing or paying for the care, and moving towards common and equitable service standards across the county. |

| **2.17 MCP Technology Projects** |
| Implementation of the Medical Interoperability Gateway (MIG), which will allow GPs and Integrated Community Teams to view each other’s data within their own records systems, is now live. At the time of reporting, 68 of the 112 practices in Hampshire have signed up to use the service, and 41 practices are live, with primary care data records visible to staff from within RiO. Phase 2 of the project will enable community and mental health records to be available to primary care and is being tested. |

<table>
<thead>
<tr>
<th>Better Specialist Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2.18 Oxford Health</strong></td>
</tr>
<tr>
<td>Learning Disability services in Oxfordshire will transfer from Southern Health to a new NHS provider in 2017. Subject to final discussions with Oxfordshire commissioners, Oxford Health will take over the running of the community services from mid-2017, with the exact date of transfer to be confirmed. However, the secure Learning Disability Services provided at Evenlode do not form part of this planned transfer. Southern Health is working very closely with NHS England, who separately commission the care at Evenlode, to determine the future shape of services for this group of patients.</td>
</tr>
</tbody>
</table>

| **2.19 STP Mental Health Alliance** |
| Within the STP, the Mental Health Alliance is establishing work streams that will address a number of priorities faced by the main providers of care (SHFT, Solent and Isle of Wight). These include workforce, acute care, crisis care, and out of area placements. CCG and Local Authority mental health commissioners have formed a mental health commissioning group to support the work of the Alliance. The Alliance itself has constituted a multiagency Clinical Reference Group, which will also play an important role aligning the Alliance and the Clinical Services Strategy work in
SHFT, and is currently in the process of appointing an independent chair.

## ENABLERS

<table>
<thead>
<tr>
<th>Developing People</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2.20 Workforce resourcing</strong></td>
</tr>
<tr>
<td>For the rolling 12 months to September 2016, the Trust’s overall vacancy rate and staff turnover reduced slightly to 7.7% and 17.5% respectively. New arrangements for the recruitment of Registered Nurses started during September, with fortnightly selection panels being implemented both within Mental Health/LD services and the ISDs. Early indications are positive with conversion rates of candidates and more timely appointments being made. A more comprehensive report will be provided when the process is fully embedded.</td>
</tr>
<tr>
<td>Temporary staffing costs amounted to 8.6% of the total pay bill. Internal controls around agency usage remain in place and the emphasis continues to be on bank worker placements through NHS Professionals. There is a noticeable trend in off framework agency usage which is both expensive and uncontrolled in terms of non PO payments. We have contacted these agencies to inform them that we will not use them, and these instances of use will be followed up on a case basis.</td>
</tr>
</tbody>
</table>

| **2.21 Absence** |
| The rolling 12 month average for sickness absence remained stable at 4.8% this month. HR Managers continue to support managers in hotspot areas with assistance from Occupational Health and the Health and Wellbeing plan to help prevent absence due to ill health and also to facilitate the return to work for individuals as soon as possible. |

| **2.22 Appraisal** |
| Engagement with the appraisal process had increased throughout the period to September 2016, with 92.9% of staff having participated in an annual performance review and personal development planning meeting by this time. |

| **2.23 Freedom to speak up Guardian** |
| The Trust has made its appointment to this important role. Elizabeth Kerridge-Weeks will start her duties shortly. |

| **2.24 Family Liaison Officer** |
| The Trust has appointed Elaine Ridley to the Trust in the role of Family Liaison Officer. This is a new role to support families and loved ones through the difficult process of an investigation into a serious incident or a serious complaint. |

| **2.25 Staff Survey** |
| This year’s survey was launched at the start of October and will run until 2nd December 2016; the results will then be made available in the spring of 2017. We |
are encouraging staff to complete the survey as part of our wider programme of staff engagement.

### 2.26 Junior Doctor Contract
Despite the ongoing debate within the Junior Doctor community and the BMA, we continue to focus on our implementation plan for the new contract, the first of which will be implemented 1\(^{st}\) December 2016.

<table>
<thead>
<tr>
<th>Infrastructure</th>
<th>2.27 Hampshire Health Record</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Single sign on to the Hampshire Health Record (HHR) from RiO is in progress, with a technical go live is planned for 21st October 2016. This will save clinical time operating between different systems when accessing information to support direct patient care.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Infrastructure</th>
<th>2.28 Child Protection Information System</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The CP-IS is a national register of children subject to child protection plans. The CP-IS includes looked after children, or pregnant women where there is a child protection plan for an unborn child. Local authorities will submit core information each night via the National Spine Service to the national register and this information can be viewed as a new ‘tab’ on the Summary Care Record (SCR). Unscheduled and urgent care staff can access this information using a standalone viewer or through functionality embedded within their clinical systems. Use of CP-IS by urgent care settings will be mandatory by March 2018. Southern Health plans to use the service from the end of October 2016. Included in scope, will be the Minor Injuries Units (MIU) at Lymington and Petersfield and Children’s Services are also very keen to have access to this information as part of the ‘Think Family’ approach. Hampshire County Council are planning to go live with submitting information to CP-IS at the beginning of October 2016. Southern Health has formally signed up to deliver this project with NHS Digital.</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Infrastructure</th>
<th>2.29 Store and Forward</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The project to pilot the ability for staff to use RiO off line and to synchronise the data when they have connectivity is underway. The Technology Transformation Team are working closely with the clinical teams to ensure they are well supported and are able to consider how the software can help improve and support the availability of information at the point of care. The pilot will include a benefits review.</td>
</tr>
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<table>
<thead>
<tr>
<th>Infrastructure</th>
<th>2.30 Cleaning</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>22 audits were undertaken in September to check the standard of cleaning within high risk, significant risk and low risk areas. Of these 22 audits, two, both high risk, were not at the required standard and action plans have been put in place and completed. Internal feedback has confirmed there are ongoing issues with cleaning within our units and further actions have been initiated as part of the management of the contract including a change to our auditing approach and the inclusion of the clinical team in the process.</td>
</tr>
</tbody>
</table>

The Estates auditing team also conducted a review called “a Day in the Life of” with frontline members of housekeeping staff to enable a more comprehensive view to
be formed of the effectiveness of cleaning on the ward. This review will be used to challenge and work with the cleaning contractor.

2.31 PLACE headlines

In the 2016 PLACE assessment, 8 activities were assessed. These were:
- Cleanliness,
- Overall food,
- Organisational food,
- Ward food,
- Privacy dignity and wellbeing,
- Condition appearance and maintenance of buildings,
- Dementia
- Disability

The directive from the Health and Social Care Information Centre (HSCIC) is that the Trust should aim for year on year improvements regards scoring achieved. 7 out of 8 categories improved from the 2015 audits with cleanliness falling by 1.1%. The main points that were identified were corners of floors, high and low level dusting, chair legs and table legs.

There was a 77% increase in overall food scores from 2015 in 17 out of the 22 sites. The organisational food score achieved an improvement of 8%.

Continued investment in the infrastructure resulted in 16 sites (72%) improving their score for condition, maintenance and appearance. Most noteworthy is Ravenswood which improved by 16%, reflecting the significant capital investment made at this location.

No sites were below the national average for dementia, with the Trust trending in excess of 10% above the national average score. The internal target to improve PLACE scoring by 2% in all domains was achieved in 5 out of 7 domains [no score for disability last year so unable to compare]. We will use the PLACE data to build on a focussed approach in prioritising our estate programme of work

PLACE reports together with working action plans have been sent to site responsible clinical and non-clinical colleagues. All outstanding actions will be tabled for approval at the, Patient Environment Group (PEG) which is scheduled to meet on the 19th October. It is anticipated that any remaining PLACE actions will be uploaded onto Share point workplans after this date.

2.32 Capital investment programme

The Trust has £9m of capital funding available for 2016/17 with particular emphasis on the action plans arising from the CQC reports, patient safety and statutory requirements.
The capital programme continues to gain pace and is on target to deliver the schemes agreed earlier in the year. There are a number of substantial schemes where the contractor arrangements have been finalised through procurement tendering. The scheme at Melbury Lodge is due to begin in November and will require Kingsley Ward to be emptied with patients either being treated in Woodhaven or outside of the Trust but locally at the Priory in Marchwood. Although there have been some delays on the IM&T schemes it is anticipated they will be finalised as planned before the end of the year.

All planned anti-ligature works at Evenlode have been completed including the vent grills and radiator covers. The works around the seclusion room at Antelope House are due to complete during October but have been delayed slightly due to 2 minor issues. The order has been placed for the anti climb guttering for the courtyard at Saxon Ward. A change in the planned approach for Southfields has been agreed which will see further work carried out to determine whether to support an extension to the unit. In advance of this decision a temporary solution has been identified for the seclusion rooms and quotations are due back in September for planned completion by the end of December.

Originally it was planned that we would start the tendering process during September for the works required at Parklands, however there have been a number of changes to the project scope which have extended the detailed design stage. These changes will significantly improve the physical environment and it is likely the project will overrun into April 2017. The work to the bathrooms and bedrooms in Elmleigh are also at planning stage and are expected to complete during the Spring.

The capital planning process for 2017/2018 is underway with peer reviews planned in mid-November.

### Helping You to Do Your Job

#### 2.33 Media attention

The Trust announcement on 7 October that Katrina percy would step down from her advisory role was the focus of media coverage this month, resulting in national, local and trade coverage. The majority of stories focused on the financial settlement.

At a local level the Trust’s ‘Knowing Me, Knowing You’ project received positive coverage having been shortlisted for a patient experience award. The scheme is a perinatal support scheme for women who have low mood and anxiety issues after giving birth. ITV Meridian have filmed the service and we are awaiting a date for broadcast.

Local events to promote World Mental Health Day on 10 October were promoted widely through social media but unfortunately received little pick up through local media.
2.34 Freedom of Information (FOI)

The Trust received 54 requests in September 2016, (compared with 32 in September 2015).

There were no internal reviews requested, but there were seven breaches of the 20 working day deadline due to the Trust seeking legal advice concerning the wording of the responses.

One request was closed without being responded to because we did not receive clarification of the points being raised.

Appendices:

Annexe 1: Balance Sheet & Cash Flow Forecast

Annexe 2: Performance Dashboards

Annexe 3: Safer Staffing Report
# REPORT TO THE TRUST BOARD

<table>
<thead>
<tr>
<th>Date</th>
<th>27.09.2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agenda Item</td>
<td>08</td>
</tr>
<tr>
<td>Title</td>
<td>Chief Executive’s Report</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Julie Dawes, Acting Chief Executive</td>
</tr>
<tr>
<td>Purpose</td>
<td>To update the Board on delivery of the Trust’s strategic objectives and for discussion.</td>
</tr>
<tr>
<td>Previously Considered by</td>
<td>Trust Executive Group (TEG)</td>
</tr>
<tr>
<td>Sponsoring Director</td>
<td>Julie Dawes, Acting Chief Executive</td>
</tr>
<tr>
<td>Executive Director Overview</td>
<td>To update the Board and for discussion</td>
</tr>
<tr>
<td>Action Required</td>
<td>The Board is asked to note and comment on this report.</td>
</tr>
</tbody>
</table>
1. Chief Executive’s Overview

1.1. Quality improvement and CQC reports

1.1.1. During the week commencing 12 September the CQC carried out a follow up inspection looking into progress against the requirements of the March 2016 Warning Notice. No formal feedback has been received at the time of writing. A verbal update will be provided to the Board.

1.1.2. Good progress continues to be made against key actions resulting from the CQC Warning notice. Full detail of the action plan and progress is set out in a separate paper to this Board meeting.

1.1.3. The first phase of the Niche/Grant Thornton review of the action plan is complete and the Trust has been issued with an ‘unqualified reasonable assurance opinion’, stating the Action Plan is ‘properly prepared in all material aspects set out in the criteria’.

1.2. Access and performance target achievement

1.2.1. The Trust has received the 2016 National Community Mental Health User Survey findings. The report shows positive performance by the Trust in relation to both prior year performance and peer services. The report authors found that the Trust ‘is making excellent progress across the board and the Trust should be commended for this’.

1.2.2. All national targets and NHS Improvement stretch targets to secure access to Sustainability and Transformation funding in 2016/17 have been met within tolerance.

1.3. Month 5 financial performance

1.3.1. The financial performance (normalised) is £252k ahead of plan to date for the year. The position has strengthened overall but this was due to one off benefits; the underlying position continues to reflect financial pressures within the divisions. Of particular concern are CIP slippage and the use of out of area mental health beds. An assumption on the redundancy risk for the Ridgeway Centre has been included in month.

1.3.2. The agency cap of £7.5m for 2016/17 set by NHSI is a pressure, with a month 5 adverse variance of £966k. NHSI has confirmed that the agency cap will not form part of the success criteria for accessing the STF.

1.4. Better Local Care

1.4.1. The Waterside Practice and Stoke Road transaction continue to move forwards with expected completion by the end of October. Two further practices in the Gosport area are exploring options with us.

1.5. Better Specialist Care

1.5.1. The MBI review of progress against the 2014 Learning Disabilities Improvement Plan has been completed. MBI’s opinion is that the 2014 improvement plan has been effectively implemented and continues, where
appropriate, to be embedded by the leadership team. Full detail of report is set out in a separate paper to this Board meeting.

1.6. **Workforce**

1.6.1. Staff turnover remains challenging but the positive trend has continued. For August 2016, the Trust’s overall vacancy rate reduced to 7.7% (rolling 12 months at 8.3%) and staff turnover fell slightly to 17.4%, the lowest level for 12 months.

1.7. **Media attention**

1.7.1. The Trust has undergone a sustained period of media coverage in recent weeks. The announcement of Katrina’s decision to step down as Chief Executive on 30 August resulted in widespread coverage across national and local media outlets in the days that followed.

1.7.2. On 7 September BBC Inside Out (regional) aired a documentary focusing on recent criticisms of the Trust and our response to them. The communications team had worked with the BBC and provided access to our clinical services to demonstrate the improvements being made.

1.7.3. Tim Smart’s resignation as Interim Chair on 19 September also attracted interest from national and local media outlets.
2. Integrated Executive Performance Report

2.01 CQC Warning Notices and inspection reports

There were no formal CQC inspections during August 2016. During the week commencing 12 September CQC carried out a follow up inspection looking in to progress against the requirements of the March 2016 Warning Notice. No formal feedback has been received at the time of writing. A verbal update will be provided to the Board.

Summary of progress against the CQC action plan resulting from the Warning Notice:

- Piloting the new Exception reporting framework (through use of summary recovery plans) for all actions that are “at risk” or “not on track”.
- Cyclical process put in place to audit sites with regards to security management
- Evidence of improvement panels now in place for incidents graded as 4 or 5, to gain assurance of completion of action plans.
- Further environmental improvements completed within inpatients wards as per Estates plan.

As of 12 September there are 13 actions flagged as ‘Red’. Nine of these relate to warning notice and ‘Must Do’ actions. Full detail of the action plan and progress is set out in a separate paper to this Board meeting.

2.02 Mortality and serious incident reporting and learning

Good progress continues to be made in delivering the Serious Incident and Mortality action plan in response to the Mazar’s report.

The first phase of the Niche/Grant Thornton of the action plan is complete and the Trust has been issued with an ‘unqualified reasonable assurance opinion’, stating the Action Plan is ‘properly prepared in all material aspects set out in the criteria’. We will be working in next month on agreeing terms of reference and criteria for Phase 2 which will give assurance on the output of the plan.

Compliance with mortality process:
Compliance with mortality reviews is tracked through the Trust’s live Business Intelligence reporting system.

Data relating to the period 01/08/2016 through 31/08/2016 inclusive:

Analysis of the 48 hour mortality panels since 1st December which have been completed shows:

- 536 deaths do not require further investigation
- 22 required local investigation
- 63 have been declared as serious incidents
- 1 incident was voided as a duplicate report of a death
- 1 remains pending review within the 48 hours

There are no cases shown as ‘pending’ in relation to whether an investigation should be undertaken or not.

Of the 50 deaths reported in August 7 deaths requiring investigation were identified from the mortality panels:

- 1 Southampton EIP (probable suicide)
- 1 Southampton EIP
- 1 South West AMH CMHT
- 1 Andover and Winchester CTT (probable suicide)
- 1 Havant and Waterlooville CTT
- 1 patient transferred from Sultan Ward GWMH to Queen Alexandra Hospital
- 1 patient transferred to Calthorpe Ward Fleet from Frimley Park Hospital

This is the second death that the Havant and Waterlooville CTT reported within Q2 however from early
indications there appears to be no repeating factors.

Of those deaths reported in August there were no immediate safety concerns raised.

The lessons learned from serious incidents have been extracted and Red graded investigation reports heard and approved at corporate panels during August 2016:

- There is inconsistency in the skills of staff to recognise the signs and symptoms of a deteriorating patient. This increases the risk to the patient not receiving the necessary medical care in a timely manner. This is being addressed by a task and finish group within Adult Mental Health who are reviewing physical health education for all clinical staff.
- Collection of accurate and timely risk assessments recorded on RiO.
- A second incident was heard where there was no clear guidance in place as to who should be treated within a nurse practitioner clinic. Although this was not the root cause of the incident it was considered as a care and service delivery problem. A Trust-wide alert was issued that requires all patients currently within a Nurse-led practitioner clinic lists are reviewed to ensure that new or undiagnosed patient are placed within appropriate clinics.

There has been one Trust-wide alert was issued (to date) in September. This was a reminder alert which was issued to all staff to ensure that the next of kin are being correctly recorded on the patient administration systems and the information checked at each attendance.

**Quality assurance:**

| Ensure there is evidence of rationale of the decision making process of whether to conduct an investigation into a death and this is clearly recorded |
|---|---|---|---|---|---|---|---|---|---|
| Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 |
| 94% | 100% | 100% | 71% | 83% | 85% | 81% | 82% | 91% |

There has been an increase in the sample size of the regular audit of the Ulysses held records of the mortality panels and the clear decision making surrounding whether a death requires investigation. The sample has increased from 20% to 50% in order to improve understanding and learning to improve. This, combined with work undertaken by the Mortality Working Group has stimulated improvement.

**Serious Incidents:**

| % of all Serious Incident investigation reports submitted to StEIS within 60 working days |
|---|---|---|---|---|---|---|---|---|---|
| Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep |
| 27% | 44% | 22% | 25% (7/24) | 46% (10/22) | 86% (25/29) | 100% (24/24) | 100% (22/22) | 100% (18/18) |

The Trust continues 100% compliance with serious incident investigation reports being uploaded to StEIS (the national database) within the 60 days required timeframe.

There were 15 Serious Incidents (SI) reported during August 2016. This is a decrease on the previous month; these remain within normal statistical control (SPC) at present but will require monitoring if this becomes a continuing trend.

<table>
<thead>
<tr>
<th>Division</th>
<th>No. of SI's reported in August 2016 (July 2016 in brackets)</th>
<th>Type of Incident</th>
</tr>
</thead>
<tbody>
<tr>
<td>East ISD</td>
<td>6 (3)</td>
<td>2 deaths 1 high harm fall</td>
</tr>
</tbody>
</table>
1 grade 2 pressure ulcer  
1 grade 3 pressure ulcer  
1 grade 4 pressure ulcer

<table>
<thead>
<tr>
<th>West ISD</th>
<th>1 (4)</th>
<th>1 high harm fall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health (includes Specialised Services)</td>
<td>8 (9)</td>
<td>3 deaths</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 probable suicides</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 assault</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 serious self-harms</td>
</tr>
<tr>
<td>Learning Disabilities</td>
<td>0 (0)</td>
<td></td>
</tr>
<tr>
<td>TQtwentyone</td>
<td>0 (0)</td>
<td></td>
</tr>
<tr>
<td>Children and Families Division</td>
<td>0 (0)</td>
<td></td>
</tr>
<tr>
<td>Corporate</td>
<td>0 (0)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>15 (16)</td>
<td></td>
</tr>
</tbody>
</table>

Top serious incident themes currently under investigation:

- The requirement for a ‘deep dive’ thematic review of falls in OPMH ward area following three falls which had occurred within a two month period of high patient acuity.
- Updating of crisis contingency plans when the clinical presentation changes.
- There is continuing work to improve the standard of the risk assessments and this is being monitored by the tableau reports.

### 2.03 Outcomes from inquests

There were 10 inquests held by the Coroner for patients in August 2016. The Central Governance Team has not been notified of informal commentary recorded by the Coroner.

### 2.04 Complaints

There were 21 complaints received in August 2016 compared to 33 in July, this was a significant decrease (the lowest in the last 20 months); whilst there was a slight increase in the number of concerns (52 received in August compared to 46 in July).

There was a decrease in the number of compliments recorded; 176 compared to 206 in July, with the highest number (78) entered by the Children’s Division – this area has consistently high numbers of compliments recorded and the Division have embraced the web based compliments reporting module.

The top three categories, reported using the national reporting category types were:

- Clinical Treatment/Patient Care (11)
- Access to treatment or drugs (3)
- Values and Behaviours (Staff) (2)
The remaining five complaints were classified as: “Appointments”, “Communications”, “Privacy, Dignity and Wellbeing”, “Admissions and Discharges” and “Prescribing” with one complaint in each category.

Complaints relating to clinical treatment and patient care have decreased in August with 11 compared to 13 in July 2016. There were three for Mental Health, two for Children’s and six for the ISDs.

Mental Health (three)

- Patient’s mother needs help to get the right therapy for her daughter who has only been seen twice this year
- Patient’s father does not feel his son is safe, lost property as well as poor communication and clinical care issues
- Insufficient care from the community mental health team as well as pain and orthopaedic services

Children’s (two)

- Cancelled appointment, lack of care
- Challenges around initiation of the bruising protocol

ISDs (six)

- Father fell out of chair and was not found for some hours
- Care and treatment of father whilst an inpatient on an OPMH ward impacted on his general health and subsequent deterioration
- Concerns around end of life care (East ISD)
- Concerns about being sectioned (OPMH) and loss of driving licence
- Concerns around end of life care in final days before father’s death (West ISD)
- Concern about care pathway, patient left in pain for two months following an urgent referral

Complaints relating to access to treatment or drugs, all three were for Mental Health

- Unhappy with contact from care coordinator, lack of support when needed
- Patient’s father complained about the lack of service for his son
- A number of concerns about the provision of care, this has not met expectations

Complaints relating to values and behaviours (staff), both were for Mental Health

- Actions of care coordinator led to a Mental Health Act assessment
- Support provided inadequate

Acknowledgement 100% of complaints were acknowledged within three working days
and 83% of final response letters were sent within agreed timeframe for August 2016. Of the 28 final responses sent, there were five that fell outside the timeframe agreed: three were AMH and two East ISD.

2.05 Parliamentary and Health Service Ombudsman (PHSO) and Local Government Ombudsman (LGO) open cases

There are seven open cases currently being reviewed by the PHSO or LGO – No change in numbers this month but slight changes in the stage of the complaint.

- Four are in the investigation stage (1 AMH, 3 West ISD), one of which the draft report is now being prepared, with a possible recommendation of financial remedy, which we have agreed to in principle.
- One is pending PHSO review as complainant has appealed to them following a decision not to investigate (East ISD).
- One is re-opened to allow a member of staff, who was out of the country and not able to be contacted for the initial investigation, to contribute, this case has previously been investigated and partially upheld. (AMH)
- One case: papers have been provided and the Ombudsman is deciding whether or not to take forward and investigate. (MH Leigh House)
- One closed case where complainant has approached the Ombudsman to advise he is unhappy with our response letter to him; this is currently being reviewed with the Executive Team.

2.06 Peer reviews

Each division is expected to complete a minimum of two peer reviews a month with the exception of the Learning Disabilities Division who are smaller and expected to complete a minimum of one per month.

Seven peer reviews were completed during August 2016. These were all scheduled comprehensive peer reviews.

<table>
<thead>
<tr>
<th>Division</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Division</td>
<td>2</td>
</tr>
<tr>
<td>Learning Disabilities Division</td>
<td>0</td>
</tr>
<tr>
<td>West Hampshire &amp; Southampton ISD</td>
<td>3</td>
</tr>
<tr>
<td>East Hampshire ISD</td>
<td>0</td>
</tr>
<tr>
<td>Children’s &amp; Families</td>
<td>2</td>
</tr>
</tbody>
</table>

The East ISD had to cancel their two scheduled peer reviews in August 2016. This was a result of clinicians pulling out at short notice due to the pressure of annual leave impacting on patient visits.

The Learning Disabilities Division completed 2 peer reviews (as opposed to the expected 1) in July 2016 as the pressures of annual leave had been forecasted and prevented a peer review from taking place in August 2016.

Ratings have been received for 3 of the peer reviews completed in August 2016. The other 4 reports are currently being finalised.

Areas for improvement from July 2016’s peer reviews:

<table>
<thead>
<tr>
<th>Team</th>
<th>Areas for improvement</th>
</tr>
</thead>
</table>
| Southampton - OPMH Teams - East, Safe: | Majority of clinicians do not take their laptops out with them as there is poor
### West & City (West Hants ISD)

Remote access to RiO. This will be discussed at the team meeting and resolved as a clinical staff must have access to the comprehensive record.

**Responsive:**
- Concerns were raised about out of hour’s crisis access for OPMH patients. There is work underway to obtain this service from adult mental health.

**Wilverley 2 Ward – Lymington (West Hants ISD)**

**Safe:**
- Clinical supervision not currently in place due to vacancies causing shifts which NHSP is unable to fill. There is a recruitment drive in place to fill the permanent vacancies and cover from the other wards is being reviewed to enable this to take place.

**Winchester Health Visiting (Children’s & Families Division)**

**Safe:**
- Record-keeping – it was observed that some care plan were not up to date and SNOMEDS codes were not always used.

**Responsive:**
- Some staff unclear on how to find out telephone number for booking interpreters and not all sure on whether family members could be used for this. This has now been addressed.

**Basingstoke Town 1 Community Team (West Hants ISD)**

**Safe:**
- The conversations they were having at shift handover were not formally structured. This would be a concern for agency nurses who had no knowledge of the team or the caseload. This has been addressed.

### 2.07 Infection control

<table>
<thead>
<tr>
<th>Infection</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA bacteraemia &gt;48hrs post admission</td>
<td>0</td>
</tr>
<tr>
<td>New MRSA positive results &gt;48hrs post admission</td>
<td>0</td>
</tr>
<tr>
<td>MSSA bacteraemia &gt;48hrs post admission</td>
<td>0</td>
</tr>
<tr>
<td>Clostridium Difficle Toxin positive results &gt;72hrs post admission</td>
<td>0</td>
</tr>
</tbody>
</table>

There have been no infection control related ward closures during August.

### 2.08 Safer staffing

August 2016 data shows 5 sites reported as red in the national publication data:

- Antelope House – Registered Nurse day shifts – 77.1%
  - Daily staffing meetings and cross unit working to ensure safe staffing levels are maintained and skill mix is utilised where appropriate. Long term placements from non-framework agencies have been sourced and continue to provide support. Hamtun Ward data is included due to previous months data, however this ward is currently closed.
  - Unregistered staff used to ensure total working hours of 110% of planned*.
- Bluebird House – Registered Nurse day shifts 60% and Registered Nurse night shifts – 76.5%
• This is due to vacancy. Focus on recruitment and retention continues, however registered
nursing recruitment continues to be challenging. Additional resource is being provided from
long term agency staff and from within the Division, with senior staff working clinically as
required to ensure safe staffing levels are maintained. Bluebird House has over-recruited
substantively to unregistered staff as part of its recruitment strategy.

• Unregistered staff used to ensure total working hours of 121% of planned*.

• Melbury Lodge – Registered Nurse day shifts 71.6%
  • This is due to vacancies. An improving picture this month compared to previous months.
    Recruitment for Band 5 nurses continues.
  • Unregistered staff used to ensure total working hours of 138% of planned*.

• Parklands Hospital – Registered Nurse day shifts – 75%
  • This is due to vacancies. Skill mix and regular temporary staffing is being utilised in order to
    facilitate risk mitigation. Vacancies are actively being recruited into, although this continues
to be a slow process. Qualitative data continues to be monitored in order to identify any
impact on patient care.
  • Unregistered staff used to ensure total working hours of 110% of planned*.

• Western Community Hospital – Registered Nurse day shifts 73.2%
  • This is due to vacancy, sickness and maternity leave. Skill mix utilisation in order to
    ensure safe staffing levels. Staffing levels are monitored on a shift by shift basis to ensure safe
    staffing. Vacancies remain higher than expected due to applicant withdrawal. Two newly
    qualified staff commencing in post in September. Improved position within August 2016
    data.
  • Unregistered staff used to ensure total working hours of 107% of planned*.

* Skill mix dilution provides a potential safer staffing risk, which is carefully managed on a shift by shift
and day by day basis.

15 wards have had staffing under-establishment fill rate challenges for at least 3 out of the past 4 rolling
months. These are monitored on a shift by shift/daily/weekly basis and staff redeployed flexibly across
units to ensure wards are staffed appropriately.

The safer staffing report is set out at Appendix 3.

2.09 Teams requiring intensive support

As reported to the Board in previous months, a number of teams across the Trust are under intensive
support. The list of these teams is highlighted below and a short update is noted where there have been
material changes since last reported.

Mental Health, Specialised and LD:

• Evenlode (Buckinghamshire)
  • Final environmental works due for completion week commencing 12 September.

• Kingsley Ward, Melbury Lodge (Winchester)
  • Environmental improvements have been made to roof and vistamatic door fittings. Further
    environmental works to commence on 17th November which requires ward decant; beds
    have been identified at Woodhaven and private local provider.

• Antelope House, (Southampton)
• Skill mix review has been undertaken and new roles to be introduced to support reopening of Hamtum ward with safe staffing. Monitored through weekly staffing meeting.

• Ridgeway Centre (Buckinghamshire)

• Service is due to close. Two patients remain at the service. We are working closely with commissioners on move-on plans and still fully expect that no patients will remain at the end of September.

Integrated Service Divisions:

• Southampton East (OPMH) Community Mental Health Team

• Romsey Ward, Romsey Hospital

• North Hampshire Integrated Care Teams

• Dryad Ward, Gosport War Memorial Hospital

• External appointment is in process for the Ward Manager anticipated to take up post by October. Activity continues on delivery of the action plan and includes the development of a programme of internal rotation with Daedalus ward — a model already embedded in the other Inpatient Units.

• Petersfield Integrated Community Team (ICT)

• Recruitment to the Community Matron post is underway and anticipated to take up post by October. Recruitment to all other posts has been made. It is anticipated that subject to final review the team will exit intensive support in November.

ACCESS

2.10 2016 National Community Mental Health User Survey

The results of the annual survey, organised by CQC, allow the Trust to assess its progress and compare performance against other providers of community mental health services. The interviews were carried out in October 2015.

The survey company highlighted Southern Health as making excellent progress across the board. The summary findings are set out below:
2.11 Access and performance targets

Access and performance target performance remained strong in August.

The Trust performance dashboards are set out in detail in Appendix 2. Key points to note:

- **Key Scores in 2016 (1)**
  - Q03. Seen NHS Mental Health Services often enough: 62% (2015), 63% (2016), All 62%
  - Q10. Agreed that care was very well organised: 80% (2015), 81% (2016), All 83%
  - Q14. Had a formal review in the last year: 67% (2015), 70% (2016), All 72%
  - Q21. Knows who to contact out of hours if in a crisis: 61% (2015), 67% (2016), ↑ 70%
  - Q41. Treated with respect and dignity: 87% (2015), 89% (2016), All 83% ↑

(SHFT scores in blue compared to National figures)

- **Overall**
  - Overall Rating of Experience (scale 0-10): 69% (2015), 72% (2016), All 70%
    - Poor (0-2): 7% (2015), 5% (2016), 9%
    - Satisfactory (3-5): 22% (2015), 19% (2016), 18%
    - Good (6-7): 20% (2015), 21% (2016), 20%
    - Very Good (8-10): 51% (2015), 55% (2016), 53%
  - Treated with dignity and respect: 87% (2015), 89% (2016), All 83% ↑

**Southern Health NHS Foundation Trust is making excellent progress across the board and the Trust should be commended for this.**

**ISSUES FOR ACTION**
- Ensure that services users’ views are taken into account at all points in their care – make this explicit. Specifically in ensuring service users feel involved in decisions on treatments and therapies.
- Continue excellent work around crisis care and ensure all service users have access to the out-of-hours support telephone number.
- Information is key – strong link to health outcomes
Performance:
- The Trust was compliant with all NHS Improvement Access to Care and Outcome Standards in August.
- The Trust was compliant with the NHS Improvement stretch targets for access to funding within tolerance. The A&E target which was missed by 0.12% but was within the 1% tolerance level for Q2.

Quality:
- The proportion of moderate or above severity incidents for Management of Violence and Aggression still remains higher than historical months. The largest volume continues to be experienced within an Older Persons Mental Health ward in South East Hampshire due to 5 acutely unwell admissions in a short period of time, and in a Learning Disabilities ward related to one high acuity service user.
- Medicines Management: A reduction in reported Medicines Management incidents combined with an increase the reported severity has been identified. Of the 6 moderate severity incidents, 2 related to Medicines Storage and 4 related to Medicines Administration.
- Whilst the number of reported incidents of Service User Falls decreased in August 2016 to 122 incidents, the proportion of incidents that were graded as moderate or above severity increased to 9.0%; the 5th consecutive monthly increase. There was one major severity fall in LD community. A full root cause investigation is being undertaken.

Finance:
- The Trust has maintained the Financial Sustainability Risk Rating (FSRR) of 3, and forecasts 4 for the end of the year
- The activity and financial targets are still on track, which if continue to be delivered throughout the year will allow the Trust to access the £2.7m sustainability and transformation funding from NHS Improvement

Patient Experience:
- Patient experience surveys: the percentage of respondents recommending the Trust’s services to friends and family dropped from 80.7% to 76.2%. The percentage rating the service as poor remained at 0.8%.
- Mental Health decreased to 69.6% from July’s 79.2%.
- Learning Disability increased from 76.0% from 96.0%, although the service has small numbers of questionnaires returned compared with other services.
- Of the other areas, there was either stability or increased satisfaction shown in August.

Workforce:
- Across the Trust, appraisal compliance rate for August is at 91.0% against the target of 95% of appraisals undertaken
- The vacancy rate dropped from 8.4% to 7.7% in August; absence rate has decreased to 4.6%, whilst turnover dropped slightly at 17.4%.
### 2.12 Year to Date (month 5) financial summary

<table>
<thead>
<tr>
<th>Aug-16</th>
<th>Mth</th>
<th>YTD</th>
<th>Budget</th>
<th>Act</th>
<th>Var</th>
<th>Forecast</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>£'000s</td>
<td>£'000s</td>
<td>£'000s</td>
<td>£'000s</td>
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<tr>
<td>Income</td>
<td>27,145</td>
<td>27,002</td>
<td>(143)</td>
<td>139,426</td>
<td>134,340</td>
<td>(1,086)</td>
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<tr>
<td>Income - STP</td>
<td>225</td>
<td>225</td>
<td>-</td>
<td>1,125</td>
<td>1,125</td>
<td>-</td>
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<tr>
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<td>(15,019)</td>
<td>153</td>
<td>(96,715)</td>
<td>(96,087)</td>
<td>628</td>
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<tr>
<td>Non Pay</td>
<td>(6,581)</td>
<td>(6,620)</td>
<td>(99)</td>
<td>(32,575)</td>
<td>(33,056)</td>
<td>(481)</td>
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<tr>
<td>Reserves</td>
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<td>0</td>
<td>250</td>
<td>(1,250)</td>
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<tr>
<td>EBITDA</td>
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<td>1,554</td>
<td>186</td>
<td>6,011</td>
<td>6,241</td>
<td>231</td>
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<tr>
<td>I&amp;D</td>
<td>(1,296)</td>
<td>(1,270)</td>
<td>16</td>
<td>(6,865)</td>
<td>(6,844)</td>
<td>22</td>
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<tr>
<td>Normalised Surplus/(Deficit)</td>
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<td>279</td>
<td>199</td>
<td>(954)</td>
<td>(102)</td>
<td>252</td>
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<tr>
<td>Exceptional Items</td>
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<td>(406)</td>
<td>2</td>
<td>(474)</td>
<td>37</td>
<td>510</td>
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<tr>
<td>Non Normalised Surplus/(Deficit)</td>
<td>(327)</td>
<td>(126)</td>
<td>201</td>
<td>(828)</td>
<td>(60)</td>
<td>763</td>
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The financial performance in August was a normalised surplus of £279k, which is £199k better than budget for the period and £252k ahead of plan to date for the year. The month 5 position contains a significant benefit linked to the recovery of a rates rebate but also includes pressures around income reduction for services which are closing and increased use of out of area beds linked to the temporary closure of a MH Psychiatric Intensive Care Unit in Southampton and general demand and acuity pressures. Costs relating to redundancy risk for staff at the Ridgeway Centre have also been assumed within the exceptional items.

The cash performance has remained strong due temporary working capital benefits; we closed the month with a balance of £36.5m up from £30.9m. The Financial Sustainability Risk Rating (FSRR) for the month was a 3, in line with our annual plan.

At a divisional level:

- Mental Health will continue to overspend on the use of out of area beds until Hamtun is able to be reopened, however the use of beds was higher than planned and led to an overall overspend against budget of £444k. The Division is working on a mitigation plan to reduce the cost pressures they are currently experiencing.

- In the East the overspend continues to be high and increased further on the position in month 5 (£302k) which is a combination of unidentified CIP, agency pressures due to vacancies and medical costs across the division. Work has begun with the CCG to identify whether service changes are required to deliver cost reductions to the overall system.

- The Learning Disabilities Division overspent further in August (£85k) caused by the impact of the Ridgeway Centre closure and therefore not able to accept new admissions. This known risk was a planned use of contingency.

- The West division month 5 overspend of £48k showed an improvement on previous months following the successful redeployment of TQ@Home staff. The overspend continues due to CIP slippage and reduced income for non-contracted activity which is reconciled on a quarterly basis. The division is taking action to identify CIP plans which can be implemented in the current year.

Estates, TQ21, Children’s and Corporate Services delivered in month underspends.

### 2.13 Pay budget performance
The total pay expenditure for month 5 is underspent by £153k, a cost decrease of £193k in month across substantive and agency staff; budgets decreased slightly this month reflecting the profile linked to CIP assumptions. Vacancies have decreased in August to 7.7%; the staff turnover has reduced to 17.4% and the overall sickness rate has increased to 4.6%.

### 2.14 Temporary Staffing Costs

The position in August 2016 saw bank staff costs stay the same as July and agency costs reduce by £40k. Excluding TQ21, agency costs have decreased from £846k to £747k, due to the temporary closure of Hamturn Ward reducing the resource requirement. There was an increase within TQ21 of £59k in agency staff costs in the period, in part due to holiday cover, new clients and the recruitment freeze pending service transfer. As a percentage of TQ21’s overall staff costs, agency is now running at 35% (17% for July). The East ISD remains at 11% whilst all other teams are at 5% or below.

The agency cap of £7.5m for 2016/17 (set by NHS Improvement) requires a significant run rate reduction during 2016/17 and all divisions are introducing a number of measures to facilitate compliance with this target. For the five months to August the spend cap was £3,697k and the Trust spent £4,662k which is an adverse variance of £966k.

There continues to be significant risk that we will not be able to achieve this target partly due to transfers of services but also linked to our ability to recruit and retain staff at this time. In addition it is likely we will require short term capacity to facilitate our action plans linked to quality and governance. It will be important to demonstrate all the work we are doing to minimise unnecessary agency spend and to move towards the March 2017 targets.

### 2.15 Cost Improvement Plans (CIPs)

The Cost Improvement Plan included in the annual plan is £10.2m with a target year to date of £3,471k. Delivery against the plan is £3,391k with continued slippage experienced in the East and West Integrated
Service Divisions. Other divisions are planning for non-recurring over performance which is partially mitigating the risk. Of the annual target the majority of schemes have been identified and the quality impact assessment has been signed off by the Director of Nursing and Medical Director. Overall there is a forecast underperformance of £150k but this will reduce over the coming months as division identify further CIP schemes.

![Cost Improvement Plans](image)

2.16 Non pay expenditure

The procurement team have an extensive work programme linked to the divisions to ensure that value for money is achieved on non-pay expenditure. During August the contracts were awarded for Continence product and delivery and well as occupational health. Savings will be delivered from both of these procurements. Significant tenders that will be finalised during the Autumn include: Bluebird education provision, the decontamination service, Clinical Strategy and organisational form and local strategic capacity. In addition a number of estates related contracts are being tendered including asbestos management, ventilation, fire alarm system testing and security guarding.

2.17 Clinical contracts and tendering (income related)

Contract values have been agreed with all Commissioners. Work has begun as part of the STP to consider how operating plans for 2017-2019 can be established for each organisation within the footprint and contracts signed prior to the end of the calendar year.

During August we submitted a bid for the Health Visiting and Family Nurse Partnership services tender and resubmitted our IAPT tender.

2.18 Balance Sheet

The Month 5 cash balance is temporarily higher than planned at £36.5m, an increase of £5.6m in August and against an initial plan of £20.6m. Despite agreement being reached with NHS Property Services in relation to 2015/16 charges, to date they have not enacted the transaction adjustments which will allow the Trust to process the payment agreed. Whilst giving a temporary benefit to the Trust’s cash holding the consequence is an increase in the level of creditor accruals.

Current receivables and other debtors reduced by a further £2.7m in the month (having reduced in July by £2.7m) to stand at £12.7m. The over 90 days debt has decreased to £1.5m from £2.2m with progress across several customers. Further senior effort will be required to resolve points of principle with two local NHS Organisations, PHT and Solent.
The balance sheet and statement of cashflows are set out in full in Appendix 1.

### NEW CARE MODELS

#### Better Local Care

##### 2.19 Gosport primary care

The Waterside Practice and Stoke Road transaction continue to move forwards with expected completion by the end of October. Two further practices in the Gosport area are exploring options with us.

##### 2.20 Better Local Care

Work continues apace to develop the Multi-disciplinary Community Provider (MCP) model of care across Hampshire, aligned with the Hampshire & Isle of Wight STP. Particular focus has been placed on development of the national pilot MCP contract of which South East, Fareham & Gosport CCG and Better Local Care are one of six national fast implementer sites. There is close working between the CCG, Southern Health and local GPs to assess how the contract could work. It is expected that the contract will be developed through the remainder of 2016/17 with a contract award during 2017/18.

##### 2.21 STP: New Care Models

Chris Ash is supporting the New Care Models work stream to ensure alignment between Hampshire & Isle of Wight work streams and that of Better Local Care. There are five clear work streams that align with the emerging Better Local Care clinical model. The work stream is projecting an investment requirement to achieve net projected savings. The STP is working through assumptions and evidence base with clinicians across the Hampshire & Isle of Wight with a particular focus on components of investment relating to mental health.

#### Better Specialist Care

##### 2.22 MBI Review of Learning Disabilities Services

Since 2014, LD Services entered a period of quality and performance turnaround that has delivered results, in the face of on-going operational and regulatory challenges. In 2015 and 2016 MBI were asked to review and provide assurance that the appropriate actions identified in the 2014 Learning Disability Improvement Plan continue to be embedded and to highlight any further gaps. The key lines of enquiry are taken from all of the original 2014 improvement plan actions and themed so they could be categorised according to previous reviews.

The 2016 review is now complete. MBI concluded that significant progress has been made and issues identified in the 2015 review have been addressed.

MBI’s opinion is that the 2014 improvement plan has been effectively implemented and continues, where appropriate, to be embedded by the leadership team.
2.23 Workforce resourcing

For August 2016, the Trust’s overall vacancy rate reduced to 7.7% (rolling 12 months at 8.3%) and staff turnover fell slightly to 17.4%. New arrangements for the recruitment of Registered Nurses take effect from September, with fortnightly selection panels being implemented both within Mental Health/LD services and the ISDs. This collaborative process is designed to ensure that offers of employment are made to all suitable candidates within two weeks of applying.

Temporary staffing costs amounted to 8.5% of the total pay bill. Internal controls around agency usage remain in place and the emphasis continues to be on bank worker placements through NHS Professionals. New collaborative arrangements for framework agencies have recently been implemented and we are working closely with suppliers to ensure they comply with NHSI limits on both pay rates and overall costs.

2.24 Absence

Sickness absence for August was 4.6% (rolling 12 months at 4.8%). Our main hotspot areas for sickness absence are the ISDs (East and West) and TQtwentyone. Ongoing support is being provided to managers to help prevent absence due to ill health and also to facilitate the return to work for individuals as soon as possible.

2.25 Appraisal

Engagement with the appraisal process had increased throughout the period to 31st August 2016, with 91% of staff having participated in an annual performance review and personal development planning meeting by this time.

2.26 Junior Doctors contract

We are pleased to have appointed the Guardian of Safe Working Hours for the Trust as part of the overall contract implementation plan. Further industrial action has been announced by the BMA and whilst the planned 5-day strike during September was cancelled, preparatory work is underway to ensure there is no adverse impact upon service delivery during the further periods of activity scheduled for October, November and December.

In terms of operational impact, clinical directors are talking to consultants, and we are confident there will be safe medical cover. The main risk around cancellation of services is in Lymington and we’re working to minimise this. There are robust business continuity plans in place that we report into NHSE.

2.27 Staff Survey

This year’s survey is due to be available for all staff to participate throughout October and November; the results will then be made available in the spring of
2017. An emphasis has been placed upon encouraging feedback throughout this mechanism as part of the wider staff engagement programme.

2.28 Freedom to Speak Up Guardian

We are currently appointing to the role of Freedom to Speak Up Guardian; this will support the Board to create a more open, transparent culture, ensuring that staff are listened to and supported with raising concerns. The Guardian will be part of the national network, helping to develop best practice in this area.

2.29 Staff Health and Well-Being

The Health and Well-Being CQUIN has been launched and covers;

- a health and well-being plan to encourage physical activity and support for mental health;
- promotion of healthy nutrition and ensuring that high fat, high salt and high sugar foods are not advertised; and
- a stretch target for staff flu vaccinations.

The CQUIN has been approved by our local commissioners and Public Health England and we work towards meeting the milestones attached.

A number of teams have requested support at Team Away Days to focus discussions on Team Health and Well-Being. Each team designed a team ‘Health and Well-Being Charter’ which summarised the commitments the team would have to Health and Well-Being. Fast track services are in place for; MSK (Musculoskeletal problems) and IAPT (Improving access to Psychotherapy)

The Occupational Health contract ceases in January 2017 and a retender exercise has been completed. The service specification has been redrafted to ensure that the service provided is fit for purpose.

2.30 Catering – Gosport Central Production Unit (CSU)

Capital schemes are being considered for the CPU at Gosport which provide meals for many of our inpatient units. This scheme would enable the unit to expand and be in a position to extend its coverage. It was recently visited by the Environmental Health Officer and awarded a 5 star rating for food hygiene.

2.31 Cleaning

19 audits were undertaken in August to check the standard of the cleaning within high risk, significant risk and low risk areas. Of these 19 audits, 4 were not at the required standard and action plans have been put in place and all actions have been completed. It is of significant concern that both audits in high risk areas were just below the standard required. Internal feedback has confirmed there are ongoing issues with cleaning within our units and further actions have been initiated as part of the management of the contract.

2.32 Capital investment programme
The Trust has £9m of capital funding available for 2016/17 with particular emphasis on the action plans arising from the CQC reports, patient safety and statutory requirements.

The plan year to date has been refreshed to reflect the current view on timing of the schemes. Additional project managers have been successfully appointed to ensure schemes are run successfully to plan.

All planned anti-ligature works at Evenlode have been completed including the vent grills and radiator covers. The works around the seclusion room at Antelope House have begun and are on track for planned completion. The clinical team in Saxon Ward are reviewing the quote received for CCTV coverage for the courtyard. We are currently finalising the arrangements for the Kingsley Ward works including going out to tender for the contractor to complete the work at Melbury Lodge, ensuring the decant area at Woodhaven is ready and arranging for the purchase of additional beds locally. The current timescale is on track to begin in November.

A change in the planned approach for Southfields has been agreed which will see further work carried out to determine whether to support an extension to the unit. In advance of this decision a temporary solution has been identified for the seclusion rooms and quotations are due back in September.

Originally it was planned that we would start the tendering process during September for the works required at Parklands, however there have been a number of changes to the project scope which have extended the detailed design stage. These changes will significantly improve the physical environment but are not expected to cause a delay to the overall completion of the programme. We are currently four weeks behind our original timescales.

The capital planning process for 2017/2018 is underway with all proposed schemes due for submission in September.

2.33 Team and trust level performance dashboards

The Informatics team, working with the Director of Nursing, has developed a new live dashboard for quality data that can be drilled down from Trust level, to division and on to team, which went live in August.

The roll out of the weekly Southern Health Performance ‘Pops’ has continued apace. All inpatient MH, OPMH, LD and Specialised services, Adult Mental Health...
Community Teams and Health Visiting and Integrated Care Teams now have weekly access to performance data benchmarking teams against peers on quality, access, finance and workforce measures.

Next stage of roll out will cover community LD and OPMH teams and specialised nursing services.

The performance team are developing an improved Integrated Performance Report building on this increased richness of performance data that will be rolled out during Q3.

2.34 Media attention

The Trust has undergone a sustained period of media coverage in recent weeks. The announcement of Katrina’s decision to step down as Chief Executive on 30 August resulted in widespread coverage across national and local media outlets in the days that followed. The Trust’s Annual Members meeting on 6 September received some coverage in local and regional press.

On 7 September BBC Inside Out (regional) aired a documentary focusing on recent criticisms of the Trust and our response to them. The communications team had worked with the BBC to ensure the programme contained balance and provided access to our clinical services to demonstrate the improvements being made.

Tim Smart’s resignation as Interim Chair on 19 September also attracted interest from national and local media outlets.

Annexe 1: Balance Sheet & Cash Flow Forecast

Annexe 2: Performance dashboards

1. Quality Dashboard
2. NHS Improvement (Monitor) access targets Dashboard
3. Finance Dashboard
4. Patient Experience Dashboard
5. Workforce Dashboard

Annexe 3: Safer Staffing Report
### REPORT TO THE COUNCIL OF GOVERNORS

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<td><strong>Agenda Item</strong></td>
<td>08</td>
</tr>
<tr>
<td><strong>Title</strong></td>
<td>Board Committee Report</td>
</tr>
<tr>
<td><strong>Author(s)</strong></td>
<td>Anna Williams, Company Secretary &amp; Head of Corporate Governance</td>
</tr>
<tr>
<td><strong>Purpose</strong></td>
<td>To gain an understanding from Non-Executive Directors as to current issues facing the Trust and to hold them to account in their role</td>
</tr>
<tr>
<td><strong>Previously Considered by</strong></td>
<td>Trust Board</td>
</tr>
<tr>
<td><strong>Sponsoring Director</strong></td>
<td>Trevor Spires, Audit, Assurance &amp; Risk Committee Chair</td>
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| **Executive Director Overview** | Reports from Board Committees are provided as a standing item in the Board papers, which are made available to all Governors.  
  
  Trevor Spires, Non-Executive Director and Chair of Audit, Assurance & Risk Committee (AARC) is unable to attend the Council meeting; this report is a summary of the AARC meeting held on 11.10.2016.  
  
  Verbal reports will be provided to the Council of Governors by the respective Chairs of all other Board Committees. |
| **Action Required** | The Council is asked to note this report and ask any questions of the Non-Executive Directors |
Audit, Assurance & Risk Committee Summary Report 11.10.2016

Board Assurance Framework
The Committee received and reviewed the refreshed Board Assurance Framework. The Committee accepted the monitoring of the refreshed strategic risks SR2 and SR7, and approved use and presentation of the framework to Trust Board for approval in November.

Talentworks and Consilium Internal Audit Review
A report was received by the Committee which provided the history of the procurement and contract management of TalentWorks and Consilium, including recommendations to improve controls and agreed actions. The Committee discussed next steps regarding publication of the review and agreed that an update on procurement training would be brought back to the Committee.

Whistleblowing Tracker
The Committee received a progress update in respect of actions following the Whistleblowing audit undertaken in 2015, an overview of current whistleblowing concerns and actions to support the improvement of ‘Speak Up’ processes within the Trust. It was agreed an update on compliance would be brought to the next meeting.

Health & Safety External Review
The Committee received a report providing an external review on the strategies, processes and policies for Health and Safety within the Trust, and took assurance from the report with respect to the Health and Safety function and the subsequent action plan and recommendations.

Risk Appetite Statement/Risk Management Policy
The Committee received and reviewed the draft Risk Appetite Statement and Risk Management Strategy and Policy prior to their submission to Trust Board on 25.10.2016.

Off payroll engagements
A report was received by the Committee advising of off payroll engagements and management consultancy agreements active to August 2016. It was agreed that an update on proposals around engagements would be presented to the Committee in January 2017.

Procurement Compliance
The Committee considered a report updating on all areas of procurement compliance including process waiver, challenges to tender process, contract overspends, purchase order and standing order compliance and actions from the 2015 procurement audit. The Committee took assurance on the detail within the report and the actions being taken to ensure compliance with the Trust’s Standing Orders. An update on findings would be presented to the Committee in January 2017.

Disaster Recovery and Business Continuity
The Committee received a report updating on EPRR activities, took assurance on EPRR Core Standard Improvement Plan progress, approved the 2016/17 NHS EPRR Core Standards self-assessment and Improvement plan, and approved the draft EPRR work plan, subject to confirmation with West Hampshire CCG.

Accounting for MCP
The Committee received an update report on the accounting process for MCP Vanguard funding.

**Review of Terms of Reference**

The Committee reviewed the Audit, Assurance & Risk Committee Terms of Reference and the Executive Risk Management & Assurance Group Terms of Reference, noting the need to build in linkages with the refreshed Board Assurance Framework where appropriate.

**Review of Constitution and Standing Orders**

The Committee received an update on the proposed approach and timetable for review of the Trust’s Constitution and Standing Orders.
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<td><strong>Author(s)</strong></td>
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<td><strong>Purpose</strong></td>
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<tr>
<td><strong>Sponsoring Director</strong></td>
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<tr>
<td><strong>Executive Director Overview</strong></td>
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<td><strong>Action Required</strong></td>
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APPROVAL OF ACTING CHIEF EXECUTIVE APPOINTMENT

1. Purpose
1.1. The NHS Act 2006 sets out that the appointment of a Chief Executive of an NHS Foundation Trust requires the approval of the Council of Governors. This paper seeks the approval of the Council of Governors for the appointment of Julie Dawes as Acting Chief Executive Officer for Southern Health NHS Foundation Trust.

2. Context
2.1. Katrina Percy resigned as Chief Executive Officer from Southern Health NHS Foundation Trust with effect from 31 August 2016. The Chief Executive Officer of an NHS Foundation Trust is designated as the accounting officer, as set out in the NHS Act 2006.
2.2. The legislation sets out that the appointment of the Chief Executive Officer is undertaken by the Non-Executive Directors and that this appointment requires the approval of the Council of Governors. Guidance from NHS Improvement (“Your statutory duties: A reference guide for NHS Foundation Trust Governors” published by Monitor in 2013) sets out the role of governors in relation to this duty, and factors to consider in the approval of an appointment.
2.3. In light of Katrina’s resignation, the Nominations & Remuneration Committee considered temporary arrangements to cover this role, whilst a substantive successor was identified. On this basis, the Committee agreed to appoint Julie Dawes as Acting Chief Executive Officer. Given the sensitive and confidential nature of the negotiations with the outgoing Chief Executive Officer, the proposal for the Acting Chief Executive Officer appointment was not brought to the Council of Governors for approval prior to the public announcement of Katrina’s resignation.
2.4. In the interests of good governance, the Trust is seeking approval from the Council of Governors for the appointment of Julie Dawes as Acting Chief Executive Officer. Both the legislation and the Trust’s constitution are silent on interim arrangements, but given that the Trust is required to have a statutory Chief Executive (who is the accounting officer) the acting post-holder will be holding this statutory role. It is anticipated that this will be a short-term appointment, and that the appointment of a substantive Chief Executive Officer will commence once a substantive Chair is appointed.
2.5. The Council of Governors should note that the Trust is subject to additional licence conditions in respect of governance from NHS Improvement, and that NHS Improvement had been engaged in this process.

3. Next Steps
3.1. Once a substantive Chair has been appointed, the process for appointing a substantive Chief Executive Officer will commence. It is anticipated that the Council of Governors will be appropriately consulted and involved in this appointment process from the outset, as set out in the guidance document “Your statutory duties: A reference Guide for NHS Foundation Trust Governors” published by Monitor in 2013.

4. Recommendation
4.1. The Council of Governors is asked to approve the appointment of Julie Dawes as Acting Chief Executive Officer.

CoG 25.10.2016
Agenda Item 09 – Appointment of Acting CEO
**REPORT TO THE COUNCIL OF GOVERNORS**

<table>
<thead>
<tr>
<th>Date</th>
<th>25.10.2016</th>
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<tbody>
<tr>
<td>Agenda Item</td>
<td>10</td>
</tr>
<tr>
<td>Title</td>
<td>Lead Governor Appointment</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Sarah Anderson, Company Secretary Interim Support; Anna Williams, Company Secretary &amp; Head of Corporate Governance</td>
</tr>
<tr>
<td>Purpose</td>
<td>To seek approval from the Council of Governors for the role description and person specification and appointment process of the Lead Governor role for Southern Health NHS Foundation Trust.</td>
</tr>
<tr>
<td>Previously Considered by</td>
<td>n/a</td>
</tr>
<tr>
<td>Sponsoring Director</td>
<td>Malcolm Berryman, Deputy Chair</td>
</tr>
<tr>
<td><strong>Executive Director Overview</strong></td>
<td>This report sets out the role of the Lead Governor and the process to be adopted to appoint a new Lead Governor.</td>
</tr>
</tbody>
</table>
| **Action Required** | The Council is asked to  
  - Comment on and approve the role description for the Lead Governor  
  - Approve the process for receiving nominations and completing the process  
  - Confirm that no Deputy Lead Governor will be appointed |
LEAD GOVERNOR APPOINTMENT

1. Purpose

1.1. The purpose of this paper is to set out the role of Lead Governor and a process to fill the post. In addition, the paper proposes that the role of Deputy Lead Governor is withdrawn and covered in a different manner.

2. Context

2.1. The NHS Improvement (NHSI) Code of Foundation Trust Governance on pages 59-60 recommends to all Foundation Trusts that they should have a Lead Governor who can be a point of contact for NHSI and can liaise with them, on behalf of all Governors, in the rare set of circumstances where it would be inappropriate for NHSI to contact the Chair, or Company Secretary, or vice versa.

2.2. Andrew Jackman, Public Governor Southampton has been undertaking the Lead Governor role as reported to the Council of Governors on 27 January 2015.

2.3. Vicky Melville, Staff Governor South West Hampshire was appointed as the Deputy Lead Governor but this role was not back-filled following her going on maternity leave.

3. The Role of Lead Governor

3.1. It is not usual for there to be regular direct contact between NHSI and the Council of Governors during the ordinary course of business. If communication is required, it would be expected to be via the Chairman and/or Company Secretary & Head of Corporate Governance which are considered to be the normal channels of communication.

3.2. However in certain limited circumstances, the role of Lead Governor will facilitate direct communication between NHSI and the Council of Governors. This might be where communication via the Chairman or Company Secretary & Head of Corporate Governance would be inappropriate, for example if there are concerns about Board leadership or the appointments process for Board positions. Similarly, where individual Governors wish to contact NHSI, this would be expected to be done through the Lead Governor.

3.3. It was not NHSI’s original intention that the ‘lead governor’ should ‘lead’ the governors. However, many trusts, including ourselves, have developed an enhanced role for the lead governor.

3.4. The proposed role description of the Lead Governor role is attached at Appendix A. This also includes the proposed person specification.

4. The Role of Deputy Lead Governor

4.1. Previously the Council of Governors has appointed a Deputy Lead Governor. Current good practice indicates that this role can cause confusion and should not be appointed to. The rationale is that the role requires some duplication in effort to ensure that both the Lead Governor and the Deputy Lead Governor are fully briefed on the current position.

4.2. It is therefore proposed that when the Lead Governor will be unavailable to fulfil their role for a period of time that the Lead Governor nominates a deputy from among one of the chairs of the other Council of Governor Committees/Groups. The Chair, Company Secretary & Head of Corporate Governance and Governors will be aware of this situation as it occurs but NHSI will not formally be informed.

CoG 25.10.2016
Agenda Item 10 – Lead Governor Appointment
5. **Proposed Nomination Process**

5.1. There is no prescribed means of nominating a Lead Governor and equally there is no process set out in the Trust’s Constitution. Therefore we propose to use the same process previously used for nomination to the role of Lead Governor for consideration by the Council of Governors.

5.2. All Public and Staff Governors will be invited to express an interest in seeking appointment as Lead Governor. (Across the foundation trust sector it is generally considered that Appointed Governors are precluded from becoming the Lead Governor due to a potential conflict of interest in representing their own organisation.)

5.3. Governors wishing to be considered for appointment to the role will complete an Expressions of Interest Form for Role of Lead Governor (provided at Appendix B) and submit this to the Company Secretary & Head of Corporate Governance by 5pm on Friday 11.11.2016.

5.4. The information contained in these Expressions of Interest forms will be circulated by Friday 18.11.2016.

5.5. The Council of Governors will vote for the Lead Governor virtually by 02.12.2016.

5.6. The Governor with the most votes will be elected as Lead Governor and this result will be declared on 05.12.2016.

5.7. The term of office of the Lead Governor will be two years or until the end of a Governor’s term – whichever is the shorter.

5.8. Following termination of the period of office, the post-holder will be able to stand for re-election alongside new candidates.

6. **Recommendation**

6.1. The Council of Governors is asked to

- Comment on and approve the role description and person specification for the Lead Governor
- Approve the process for receiving nominations and completing the process
- Confirm that no Deputy Lead Governor will be appointed.
PROPOSED LEAD GOVERNOR ROLE DESCRIPTION

The NHS Improvement Code of Foundation Trust Governance recommends to all Foundation Trusts that they should have a Lead Governor who can be a point of contact for NHS Improvement and can liaise with them, on behalf of all Governors, in the rare set of circumstances where it would be inappropriate for NHS Improvement to contact the Chair, or Company Secretary & Head of Corporate Governance, or vice versa.

Foundation Trusts may also choose to enhance the role of Lead Governor with other duties, as at Southern NHS FT.

Main duties:

1. To act as a point of contact with NHS Improvement on behalf of the Council of Governors in those circumstances where it would be inappropriate for NHS Improvement to contact the Chair or Company Secretary & Head of Corporate Governance directly
2. To chair the Council of Governors meetings in the rare circumstances where it would be inappropriate due to conflict of interest for either the Chair or any of the Non-Executive Directors to do so
3. To assist the Chair in the agenda planning for Council of Governor meetings, seeking the views of Governors in advance of meetings, to ensure their interests are represented
4. To seek and collate the views of Governors on the annual appraisal of the Chair and Non-Executive Directors, and feed these in to the Senior Independent Director (who coordinates the Chair’s appraisal) or to the Chair for the Non-Executive Directors
5. To act as a point of contact and liaison for the Chair and Senior Independent Director on all matters relating to the Council of Governors
6. To act as a point of contact on behalf of the Council of Governors for the CQC
7. To lead the Council of Governors in holding the Non-Executive Directors to account for the performance of the Board
8. To lead the Council of Governors in discharging its responsibility to represent the interests of members and the wider public
9. To seek the views of Governors on a range of issues where the Trust may request the input of Governors
10. To undertake a role in problem solving issues which may arise relating to the Council of Governors or individual Governors, by mediating and raising issues with the Chair, Chief Executive or Company Secretary & Head of Corporate Governance as necessary
11. To work closely with the Chair, Chief Executive and Company Secretary & Head of Corporate Governance on the development needs of the Council of Governors and individual Governors, to ensure there is access to appropriate training to enable Governors to fulfil their statutory roles
12. To report regularly to the Board of Directors on the work of the Council of Governors and on any issues the Governors wish to be conveyed to the Board
PROPOSED LEAD GOVERNOR PERSON SPECIFICATION

1. A skilled communicator, with the ability to influence and negotiate, and present issues effectively on behalf of the Council of Governors
2. The ability and desire to work constructively with colleagues both internal and external to the Trust
3. To be able to commit the time necessary to undertake the role effectively
4. A commitment to the success of Southern Health NHS Foundation Trust
5. Be able to demonstrate a good understanding of the Trust’s Constitution and the wider context within which the Trust operates
6. Be a Public or Staff Governor (while it is permissible for an Appointed Governor to be Lead Governor, this can cause a possible conflict of interest)
**APPENDIX B**

**EXPRESSIONS OF INTEREST FORM FOR ROLE OF LEAD GOVERNOR**

<table>
<thead>
<tr>
<th>I would like to express an interest in the role of Lead Governor</th>
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<tbody>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Constituency:</td>
</tr>
<tr>
<td>Date:</td>
</tr>
<tr>
<td>Information about why you are interested, what you will bring to the position and any relevant experience (NB this information will be circulated as part of the ballot process):</td>
</tr>
<tr>
<td>Signature:</td>
</tr>
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</table>

Please return this form to the Company Secretary & Head of Corporate Governance, Southern Health NHS Foundation Trust, Sterne 7, Tatchbury Mount, Calmore, Southampton, SO40 2RZ by 5pm Friday 11.11.2016
<table>
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<tr>
<th><strong>REPORT TO THE COUNCIL OF GOVERNORS</strong></th>
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<td><strong>Author(s)</strong></td>
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<td><strong>Purpose</strong></td>
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<td><strong>Previously Considered by</strong></td>
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<td><strong>Sponsoring Director</strong></td>
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<tr>
<td><strong>Executive Director Overview</strong></td>
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<td><strong>Action Required</strong></td>
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</tbody>
</table>
1. Purpose
1.1. This paper sets out the terms of office for the Trust’s Non-Executive Directors, and outlines the process to be taken for appointment, and consideration of reappointment, in accordance with the Trust’s Constitution.

2. Background
2.1. In accordance with the NHS Act 2006, the Council of Governors is responsible for appointing the Non-Executive Directors, and setting their terms of office. This responsibility remains unchanged by the implementation of the Health & Social Care Act 2012.

2.2. The Trust’s Constitution sets out the process for appointment of Non-Executive Directors to the Board of Directors (Appendix A). Paragraph 27 of the Constitution sets out that any existing Non-Executive Director nearing the end of his or her term of office shall be considered for a further term of office, subject to the following conditions:

- A satisfactory appraisal that he / she continues to be effective;
- He / she continues to demonstrate commitment to the role;
- He / she is willing to complete a further term of office;
- He / she is not precluded by virtue of time already served as a Non-Executive Director.

3. Terms of Office for Non-Executive Directors
3.1. The table below sets out when the term of office for each of the Trust’s Non-Executive Directors comes to an end:

<table>
<thead>
<tr>
<th>Non-Executive Director</th>
<th>End date of current term of office</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jon Allen</td>
<td>28.02.2018</td>
</tr>
<tr>
<td>Malcolm Berryman</td>
<td>08.08.2017</td>
</tr>
<tr>
<td>Tracey Faraday-Drake</td>
<td>30.11.2017</td>
</tr>
<tr>
<td>Claire Feehily</td>
<td>31.12.2017</td>
</tr>
<tr>
<td>Judith Smyth</td>
<td>30.11.2017</td>
</tr>
<tr>
<td>Trevor Spires</td>
<td>31.08.2018</td>
</tr>
</tbody>
</table>

3.2. It should be noted that the term of office for four of the Trust’s Non-Executive Directors comes to an end in 2017, and for a further two Non-Executive Directors in 2018. Consideration will therefore need to be given, in advance of the term of office expiring, to the process of appointment or reappointment, subject to eligibility criteria being met.

4. Composition of the Appointment Committee
4.1. At the Council of Governors meeting held on 27.07.2016 the Council reviewed and approved the Terms of Reference for the Appointment Committee (Appendix B). The Terms of Reference set out the composition of the Appointment Committee for the
appointment of Non-Executive Directors (it should be noted that this differs to the composition for the Appointment Committee for the Chair).

5. **Recommendation**

5.1. The Council of Governors is asked to:

5.1.1. Note that the terms of office for four Non-Executive Directors come to an end in 2017, and the remaining two Non-Executive Directors in 2018;

5.1.2. Note the need to commence the process of appointment (including consideration of eligibility for reappointment for a further term of office, for those Non-Executive Directors whose terms of office expire in 2017) for Non-Executive Director positions on the Board of Directors.

6. **Appendices**

Appendix A – Constitution excerpt: Appointment and Removal of Chairman and other Non-Executive Directors

Appendix B – Terms of Reference for the Appointment Committee for the Chair and Non-Executive Directors
Appendix A – Constitution excerpt: Appointment and Removal of Chairman and other Non-Executive Directors

27. **Board of Directors – Appointment and Removal of Chairman and Other Non-Executive Directors**

27.1. The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chairman of the Foundation Trust and the other Non-Executive Directors.

27.2. During any meeting of the Council of Governors at which the Chairman may be suspended or removed, the Deputy Chairman shall preside, or if the Deputy Chairman is absent from the meeting or is absent temporarily on the grounds of a declared conflict of interest, another Non-Executive Director, as shall be appointed by the Council of Governors, shall preside.

27.3. Removal of the Chairman or another Non-Executive Director shall require the approval of three-quarters of the members of the Council of Governors.

27.4. The Chairman or other Non-Executive Director in question shall be given the opportunity to respond to such reasons at the meeting of the Council of Governors which the resolution is to be considered and voted upon. If the individual in question fails to attend the meeting without due cause, the meeting may proceed in their absence. The decision to proceed in these circumstances will be at the sole discretion of the person chairing the meeting in question.

27.5. If any resolution to suspend or remove either the Chairman or a non-Executive Director is not approved at a meeting of the Council of Governors in accordance with paragraph 27.4 above, no further resolution can be put forward to remove such Non-Executive Director, or the Chairman which is based on the same reasons within 12 calendar months of the meeting of the Council of Governors at which the resolution mentioned in paragraph 27.4 above was considered.

27.6. The process for appointing new Non-Executive Directors and the Chairman will be as follows:

27.6.1. the Chairman and other Non-Executive Directors shall be appointed in accordance with a process agreed by the Appointments Committee on behalf of the Council of Governors.

27.6.2. An existing Chairman or Non-Executive Director, nearing the end of his term, shall be considered for a further term of office, subject to the following:

27.6.2.1. a satisfactory appraisal that he continues to be effective;

27.6.2.2. he continues to demonstrate commitment to the role;

27.6.2.3. he is willing to complete a further term of office;

27.6.2.4. he is not precluded by virtue of time already served as a Non-Executive Director.

27.6.3. Should the Appointments Committee decide to advertise externally for a Non-Executive Director, a specification shall be drawn up and approved by the Appointments Committee that shall set out the personal and professional qualities needed.

27.6.4. Where paragraph 27.6.3 applies, the Appointments Committee shall follow a process which involves advertising for the vacancy, shortlisting against
the specification and interviewing candidates. In the case of appointing a Non-Executive Director, the interview panel will include at least one Public Governor and the Chairman. In the case of appointing the Chairman, the interview panel will include at least one Public Governor and the Senior Independent Director.

27.6.5. Before the end of the term of office of the Chairman or a Non-Executive Director (as the case may be), the Council of Governors will appoint an Appointment Committee to seek a suitable replacement. The Appointment Committee will be constituted as set out below.

27.6.6. The Appointment Committee for the Chairman will consist of the Senior Independent Director (unless the Senior Independent Director is standing for the appointment of Chairman in which case another Non-Executive Director will replace him/her), three Public Governors, one Staff Governor and one Appointed Governor. If the number of Governors prepared to serve on the Appointment Committee is greater than the number of places available, the committee members will be selected by election by their peer Governors. The Senior Independent Director will chair the Appointment Committee (unless the Senior Independent Director is standing for the appointment of Chairman in which case another Non-Executive Director will replace him/her). Each member of the Appointment Committee will have one vote.

27.6.7. The Appointment Committee for the Non-Executive Directors will consist of the Chairman, two Public Governors, one Staff Governor and one Appointed Governor. The Chief Executive will attend in an advisory capacity only. If the number of Governors prepared to serve on the Appointment Committee is greater than the number of places available, the committee members will be selected by election by their peer Governors. The Chairman will chair the Appointment Committee. Each member of the Appointment Committee will have one vote.

27.6.8. The Appointment Committee will make recommendations to the Council of Governors, including recommendations about pay.

27.6.9. The Appointment Committee will be supported by appropriate advice from the Foundation Trust’s Director of Human Resources on the qualifications, skills and experience required for each position.

27.6.10. The Council of Governors will not consider nominations for membership of the Board of Directors other than those made by the appropriate Appointment Committee.
Appendix B – Terms of Reference – Appointment Committee

Southern Health NHS Foundation Trust
Appointment Committee for the Chair and Non-Executive Directors

Terms of Reference

1. Constitution

1.1. The Council of Governors is authorised by the Constitution para 27.6.5. to establish an Appointment Committee (‘the committee’).

1.2. These terms of reference reflect the provisions set out within the Constitution paragraph 27. In any case where there is or appears to be a different interpretation of the arrangements for appointment of the Chair or other Non-Executive Directors between these terms of reference and the Constitution, the Constitution shall prevail.

1.3. The committee is appointed and authorised by the Council of Governors to undertake the recruitment and selection of the Chair and Non-Executive Directors of Southern Health NHS Foundation Trust and to recommend their appointment to the Council of Governors, including recommendations on remuneration.

1.4. All proceedings of the Appointment Committee shall be confidential.

1.5. In undertaking its duties the committee shall:

- Be mindful of the best practice governance guidance on Board appointments provided by Monitor within the Code of Governance;
- Seek such external independent advice as it requires;
- Request the Chief Executive and Director of Workforce & Communications to advise on issues as required.

1.6. The process which shall govern the way that the committee shall undertake its work is set out in Appendix B and is a facsimile of the relevant constitutional provisions in Paragraph 27.

2. Purpose

2.1. To undertake the recruitment and selection process for the Chair and Non-Executive Directors and making recommendations for appointment to the Council of Governors.

3. Membership (including quorum)

3.1. The Appointment Committee for the Chairman will consist of the Senior Independent Director (unless the Senior Independent Director is standing for the appointment of Chairman in which case another Non-Executive Director will replace him/her), three Public Governors, one Staff Governor and one Appointed Governor. The Senior Independent Director will chair the Appointment Committee (unless the Senior Independent Director is standing for the appointment of Chairman in which case another Non-Executive Director will replace him/her).
3.2. The Appointment Committee for the Non-Executive Directors will consist of the Chairman, two Public Governors, one Staff Governor and one Appointed Governor. The Chairman will chair the Appointment Committee.

3.3. If the number of Governors prepared to serve on the Appointment Committee is greater than the number of places available, the committee members will be selected by election by their peer Governors. For instance, to elect one Public Governor from two Public Governor candidates willing to serve on the committee; each Governor from all Constituencies shall have one vote. Such a vote shall be administered by the Company Secretary, using a first past the post system.

3.4. The Chief Executive Officer and the Director of Workforce, Development & Communications will attend the committee in an advisory capacity only.

3.5. Each member of the Appointment Committee will have one vote.

3.6. The quorum for the Committee shall be 3 members, including at least one public governor and the Chair or Deputy Chair of the Committee or a nominated deputy.

3.7. A Member of the Committee shall be regarded as being in attendance for the purpose of counting towards the quorum and the transaction of business if at the point at which the Chair of the committee opens the meeting, he / she is able to hear the voices of the other Members and his / her own voice can be heard by the other Members. This may be by telephone conference call or video / Skype link.

4. Meeting arrangements

4.1. The Company Secretary shall provide support to the committee. The Company Secretary will make arrangements for formal interviews and assessments of shortlisted candidates to be conducted by the Appointment Committee, ensuring that the Board of Directors has an opportunity to meet with candidates and provide its views on their suitability to the Appointment Committee.

5. Frequency

5.1. The frequency of meetings will be determined by Trust requirements.

6. Authority

6.1. The Committee is authorised by the board to take action in respect of any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

6.2. The Committee is authorised by the board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

7. Duties

7.1. The Appointments Committee will meet to:

(a) Consider any relevant information provided to the committee by the Chair or other Non-Executive Director regarding the Board’s views on any appointment;

(b) Consider any additional advice from the CEO and Director of Workforce, Development & Communications;
(b) Decide on the terms of the appointment, including the time commitment required and remuneration;
(c) Consider and amend if required the role description and person specification for the position, taking into account any advice published or provided privately by Monitor;
(d) Agree the manner in which candidates will be assessed against the role description and person specification;
(e) Agree the timetable and action plan for the appointment including the need for, identification of and fees payable to any external adviser required to support the appointment
(f) Agree the manner in which the position may be advertised.
(g) Authorise the Company Secretary to advertise the position and seek applications.

7.2. The committee plays no role in any decision by the Council to remove an incumbent Chair or other Non-Executive Director.

7.3. When considering whether to propose to the Council the reappointment of an incumbent Chair or Non-Executive Director, there shall be two resolutions for the committee to consider:
(a) To make a recommendation to the Council that a re-appointment of an incumbent shall be made without open competition; or
(b) To make any recommendation for appointment or re-appointment only after a process of open competition has been completed.

8. Reporting
8.1. The minutes of the meetings of the committee, once approved, shall be available on request to any Governor, unless he / she has not signed or appears to be acting or likely to act in contravention of the Code of Conduct.

8.2. The Chair of the committee shall provide a report to the Council of Governors at the next formal meeting of the Council, to explain to Governors the work which the committee is undertaking, and progress on a particular appointment.

9. Monitoring
9.1. The Terms of Reference shall be reviewed annually by the Council of Governors.

9.2. During this review the Committee will be assessed to ensure it has performed in accordance with these terms of reference, specifically that:

9.2.1. The Committee has carried out the duties required
9.2.2. The Committee has reported to the board and other committees as required
9.2.3. Membership, frequency of meetings and attendance has been as stated
9.2.4. The Committee has been quorate each time it has met
## REPORT TO THE COUNCIL OF GOVERNORS

<table>
<thead>
<tr>
<th>Date</th>
<th>25.10.2016</th>
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<tbody>
<tr>
<td>Agenda Item</td>
<td>13</td>
</tr>
<tr>
<td>Title</td>
<td>Membership Report</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Liz Pusey, Head of External Communications</td>
</tr>
<tr>
<td>Purpose</td>
<td>To provide an update on current membership figures and lay out next steps for the recruitment and engagement of members.</td>
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<tr>
<td>Previously Considered by</td>
<td>n/a</td>
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<tr>
<td>Sponsoring Director</td>
<td>n/a</td>
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<tr>
<td>Executive Director Overview</td>
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</tr>
<tr>
<td>Action Required</td>
<td>The Council of Governors is asked to note this report.</td>
</tr>
</tbody>
</table>
Membership update

1. Purpose
1.1. This paper gives an overview of membership activity to the Council of Governors.

2. Background
2.1. Historically, the Membership and Engagement Strategy has given details on the recruitment and engagement of members of the Trust, including specific activity to be carried out, involvement of Governors, and which demographic groups will be targeted.
2.2. Throughout 2015/16 Southern Health has received an unprecedented level of media interest and public scrutiny. Publication of the Mazars report, the CQC inspection and warning notice, the subsequent resignations of the Chairman, Chief Executive and Interim Chair, as well as other high profile stories, have all had a significant impact on the capacity of the Communications Team.
2.3. As a result the level of membership recruitment and engagement activity has dropped, and communication has been limited to providing email updates on key Trust developments and an invitation letter to all members for the Annual Members Meeting in September.

3. Current membership figures and planned activity
3.1. The table below shows our current public membership figures per constituency in comparison to the same time last year.

<table>
<thead>
<tr>
<th>Area</th>
<th>September 2015</th>
<th>+/-</th>
<th>September 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out of Area</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>North Hants</td>
<td>2095</td>
<td>-102</td>
<td>1993</td>
</tr>
<tr>
<td>Ox and Bucks</td>
<td>259</td>
<td>-10</td>
<td>249</td>
</tr>
<tr>
<td>South East Hants</td>
<td>1437</td>
<td>-99</td>
<td>1338</td>
</tr>
<tr>
<td>South West Hants</td>
<td>2849</td>
<td>-81</td>
<td>2768</td>
</tr>
<tr>
<td>Southampton</td>
<td>2152</td>
<td>-42</td>
<td>2110</td>
</tr>
<tr>
<td>Rest of England</td>
<td>920</td>
<td>-15</td>
<td>905</td>
</tr>
<tr>
<td>Total</td>
<td>9712</td>
<td>-349</td>
<td>9363</td>
</tr>
</tbody>
</table>

3.2. The figures show that the unprecedented level of public scrutiny and criticism has not led to a dramatic decrease in members, and that the number of members leaving the Trust is proportionate to the size of the constituency. There are no obvious geographic areas where membership efforts would have to be increased above efforts in other areas.

3.3. We recognise that in order to move forward a renewed focus on membership recruitment and engagement is needed. The following activities are planned or already underway:

3.3.1. Revival of the action group involving Governors and members of the Communications and Engagement Team in order to review the Membership Recruitment...
and Engagement Strategy and to develop an ongoing activity plan. Our aim is to involve Governors in membership recruitment and membership events in order to strengthen the link between Governors and the constituents they represent.

3.3.2. Develop more accessible membership recruitment material (including adverts for GP surgery screens and social media) that can be used by staff, Governors, and existing members, and which clearly articulates benefits for members.

3.3.3. Review the development of a Membership Champion scheme across the Trust – a team of dedicated staff within key teams who can lead on recruitment locally.

3.3.4. Renew the printing of the Southern Health Insider membership magazine, which previously had to be reduced to an online version due to budgetary constraints (due for publication in November).

3.3.5. In addition to the quarterly membership magazine, we are working on launching a regular email newsletter (likely to be monthly) highlighting press releases we sent out, campaigns to look out for, introducing and signposting to services, and things to get involved in, with the aim to provide members with brief and more timely information.

3.3.6. Refresh the Medicine for Members events (themed, informative events open to the public), working with partners such as Solent NHS Trust, GPs, universities, police, fire service and relevant local charities in order to widen our reach across the Trust area.

3.3.7. Consulting our members on the current Trust website as part of a redesign project.

3.4. The above activities will form part of the Trust’s engagement plan for the next twelve months, and topics and events will be aligned to key issues and themes identified in the Trust’s overarching Communications and Engagement Strategy that is currently being developed by the team.

3.5. The membership strategy will be refreshed over the next four months, and we are keen to work with Governors through the Communications Action Group to ensure their input into the above activities as well as the wider strategy.

4. **Recommendation**

4.1. The Council is asked to note the content of this report.
**REPORT TO THE COUNCIL OF GOVERNORS**

<table>
<thead>
<tr>
<th>Date</th>
<th>25.10.2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agenda Item</td>
<td>14</td>
</tr>
<tr>
<td>Title</td>
<td>Corporate Governance Report</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Anna Williams, Company Secretary &amp; Head of Corporate Governance</td>
</tr>
<tr>
<td>Purpose</td>
<td>This report is to summarise items requiring approval by the Council and matters that the Council should note.</td>
</tr>
<tr>
<td>Previously Considered by</td>
<td>N/A</td>
</tr>
<tr>
<td>Sponsoring Director</td>
<td>Anna Williams, Company Secretary &amp; Head of Corporate Governance</td>
</tr>
<tr>
<td>Executive Director Overview</td>
<td>Governors are asked to review the report in its entirety.</td>
</tr>
<tr>
<td>Action Required</td>
<td>The Council is asked to agree the recommendations in the report, and note the points reported</td>
</tr>
</tbody>
</table>
CORPORATE GOVERNANCE REPORT

1. Purpose
1.1. This report is to summarise matters for the Council to note and to highlight items requiring approval.

2. Changes to the Trust Board
2.1. Katrina Percy resigned as Chief Executive Officer and Accountable Officer, with effect from 31.08.2016.
2.2. Julie Dawes, the Director of Nursing & Allied Health Professionals, has been appointed as Acting Chief Executive Officer from 01.09.2016, subject to approval by the Council of Governors.
2.3. It is proposed that the appointment process for the substantive Chief Executive Officer commence following the appointment of a substantive Chair.
2.4. Tim Smart, Interim Chairman, tendered his resignation with immediate effect on 15.09.2016.
2.5. The Trust is expecting to receive a “Notice of Requirement to appoint an Interim Chair” from NHS Improvement in line with the powers under s.111 of the Health & Social Care Act 2012. In the meantime the Trust’s Deputy Chair, Malcolm Berryman, will ensure that the duties of the Trust Board are carried out.
2.6. The Nominations & Remuneration Committee approved the secondment of Dr Chris Gordon to NHS Improvement, and of Sandra Grant, to work with the local Sustainability Transformation Plan until the end of the financial year.
2.7. Following a formal, rigorous and transparent process, the Nomination & Remuneration Committee appointed Paula Anderson as Director of Finance, and Mark Morgan as Director of Operations (Mental Health & Learning Disabilities).
2.8. The Nomination & Remuneration Committee approved the proposal for Sara Courtney to assume the role of Acting Director of Nursing, during the period whilst Julie Dawes is acting Chief Executive Officer.
2.9. Pending the appointment of a substantive Chief Executive Officer and further consideration of the Board structure, the Nomination & Remuneration Committee considered and approved proposed changes to the portfolios of the Executive team; these changes were considered to be transitional arrangements.
2.10. The Council of Governors has formed an Appointment Committee to progress with appointing a substantive Chair. After a nomination process held in August the Governors serving on this Committee are Adrian Thorne, Andrew Jackman, John Beaumont, Richard Mandunuya and Nick Sargeant. The Appointment Committee will commence the appointment process for a substantive Chair following clarity around the interim Chair position.

3. Changes to the Council of Governors
3.1. Following resignations from a number of governors the Trust held elections for seats on the Council of Governors in July / August 2016; the results of the elections were as follows:
<table>
<thead>
<tr>
<th>Constituency</th>
<th>Seats</th>
<th>No. of Candidates</th>
<th>Elected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public – Oxfordshire &amp; Buckinghamshire</td>
<td>1</td>
<td>0</td>
<td>Vacant seat remains</td>
</tr>
<tr>
<td>Public – South East Hampshire</td>
<td>2</td>
<td>1</td>
<td>Anne Daneshvar</td>
</tr>
<tr>
<td>Public – North Hampshire</td>
<td>2</td>
<td>4</td>
<td>David Lee Venus Madden</td>
</tr>
<tr>
<td>Staff – Oxfordshire, Buckinghamshire &amp; Rest of England</td>
<td>1</td>
<td>0</td>
<td>Vacant seat remains</td>
</tr>
</tbody>
</table>

- As such, a number of vacancies remain on the Council of Governors, as follows:
  - Public Governors – Oxfordshire & Buckinghamshire (1), South East Hampshire (1), South West Hampshire (1);
  - Staff Governor – Oxfordshire, Buckinghamshire & Rest of England;
  - Appointed Governor – Age Concern Hampshire, Mencap

- A proposal was provided to the Audit, Assurance & Risk Committee outlining the intention to undertake a full review of the Trust’s Constitution, with a view to presenting the full revised Constitution to the Board of Directors and Council of Governors in April 2017. This was supported, with some reservations expressed regarding management capacity to undertake the work. It is intended that members of the Board of Directors and members of the Council of Governors would be invited to engage in this process. External legal advice would be sought to support this process.

- At the Board meeting in September a constitutional amendment to remove MENCAP from the Trust’s Constitution was considered and supported in principle, subject to engagement to seek alternative voluntary sector representation. It is therefore proposed that full consideration to this be given as part of this review.

4. **Governance items**

4.1. The Council has established two new governor groups as follows:

4.1.1. Patient Experience and Engagement Group: Membership will be Peter Bell, David Lee, Josie Metcher, Susie Scorer, Sue Smith, Adrian Thorne and Paul Valentine from the Council and Lesley Stevens (Medical Director). It is intended that Sara Courtney (Acting Director of Nursing) and Chris Woodfine (Interim Head of Patient Engagement and Experience) will also attend. The first meeting will be on 31 October 2016.

4.1.2. Membership Engagement Group: Membership from the Council of Governors is John Beaumont, Peter Bell, Adrian Thorne, Richard Mandunya and Susie Scorer. A date for the first meeting has yet to be determined due to lack of mutual availability.
5. **Information provided to the Council between meetings**
   5.1. A log of information that has been sent to Governors between meetings is attached at Appendix A.

6. **Recommendation**
   6.1. The Council is asked to:
       6.1.1. Note the content of this report.

7. **Appendices**
   Appendix A: Information sent to Governors between meetings
### Appendix A: Information sent to Governors between meetings

<table>
<thead>
<tr>
<th>Date</th>
<th>Subject</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>21/07/2016</td>
<td>Peer Review Schedule</td>
<td>Schedule</td>
</tr>
<tr>
<td>21/07/2016</td>
<td>Trust Board Meeting – 26.07.2016</td>
<td>Agenda &amp; link</td>
</tr>
<tr>
<td>21/07/2016</td>
<td>Board Part 2 Minutes (Redacted) - 24.05.2016</td>
<td>Minutes</td>
</tr>
<tr>
<td>21/07/2016</td>
<td>Update on transition of TQ21 social care services</td>
<td>Briefing</td>
</tr>
<tr>
<td>21/07/2016</td>
<td>Better Local Care Latest newsletter</td>
<td>Newsletter</td>
</tr>
<tr>
<td>21/07/2016</td>
<td>Extraordinary Council of Governors’ meeting</td>
<td>N/A</td>
</tr>
<tr>
<td>22/07/2016</td>
<td>Instruction of independent legal advice to the CoG</td>
<td>Update</td>
</tr>
<tr>
<td>28/07/2016</td>
<td>Actions arising from CoG meeting 26.07.2016</td>
<td>ToRs</td>
</tr>
<tr>
<td>29/07/2016</td>
<td>BBC report on consultancies used by the Trust</td>
<td>Links</td>
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<tr>
<td>05/08/2016</td>
<td>Article in Mail on Sunday</td>
<td>Briefing</td>
</tr>
<tr>
<td>16/08/2016</td>
<td>Elections update</td>
<td>Information</td>
</tr>
<tr>
<td>16/08/2016</td>
<td>HSE investigation post Mazars</td>
<td>Information</td>
</tr>
<tr>
<td>16/08/2016</td>
<td>Peer Reviews Schedule</td>
<td>Schedule</td>
</tr>
<tr>
<td>16/08/2016</td>
<td>Changes to Inpatient LD Services in Oxon and Bucks</td>
<td>Briefing</td>
</tr>
<tr>
<td>16/08/2016</td>
<td>HSJ Article re. Southern Health</td>
<td>Information</td>
</tr>
<tr>
<td>16/08/2016</td>
<td>NHS Providers - Governor focus newsletter</td>
<td>Newsletter</td>
</tr>
<tr>
<td>22/08/2016</td>
<td>Executive Team changes</td>
<td>Information</td>
</tr>
<tr>
<td>25/08/2016</td>
<td>AMM 06.09.2016 - Papers</td>
<td>Papers</td>
</tr>
<tr>
<td>30/08/2016</td>
<td>Message from Interim Chair</td>
<td>Press release</td>
</tr>
<tr>
<td>31/08/2016</td>
<td>Governor Development Day</td>
<td>Agenda</td>
</tr>
<tr>
<td>31/08/2016</td>
<td>Appointment Committee Nominations</td>
<td>Information</td>
</tr>
<tr>
<td>31/08/2016</td>
<td>Governor Working Groups</td>
<td>Information</td>
</tr>
<tr>
<td>31/08/2016</td>
<td>Governor Induction training</td>
<td>Information</td>
</tr>
<tr>
<td>31/08/2016</td>
<td>Elections update</td>
<td>Attachments</td>
</tr>
<tr>
<td>31/08/2016</td>
<td>Response on concern raised at CoG meeting re. incident</td>
<td>Information</td>
</tr>
<tr>
<td>31/08/2016</td>
<td>Legal advice to Governors</td>
<td>Presentation slides</td>
</tr>
<tr>
<td>31/08/2016</td>
<td>Guardian of Safe Working appointment</td>
<td>Information</td>
</tr>
<tr>
<td>31/08/2016</td>
<td>Demfest 25.09.2016</td>
<td>Poster</td>
</tr>
<tr>
<td>05/09/2016</td>
<td>Process for approval of Acting CEO</td>
<td>Draft paper</td>
</tr>
<tr>
<td>07/09/2016</td>
<td>Message from Tim Smart, Interim Chair</td>
<td>Information</td>
</tr>
<tr>
<td>10/09/2016</td>
<td>Alert re media interest</td>
<td>Information</td>
</tr>
<tr>
<td>15/09/2016</td>
<td>Governor Development Day</td>
<td>Information</td>
</tr>
<tr>
<td>15/09/2016</td>
<td>CoG &amp; AMM</td>
<td>Presentations</td>
</tr>
<tr>
<td>19/09/2016</td>
<td>Statement from the Board of SHFT: Tim Smart resignation</td>
<td>Information</td>
</tr>
<tr>
<td>22/09/2016</td>
<td>Privileged and confidential advice for the CoG</td>
<td>Legal advice</td>
</tr>
<tr>
<td>23/09/2016</td>
<td>Recent CQC inspection</td>
<td>Briefing</td>
</tr>
<tr>
<td>23/09/2016</td>
<td>Notification of publication of Trust board papers</td>
<td>Link</td>
</tr>
<tr>
<td>04/10/2016</td>
<td>Governor Induction training 22.11.2016</td>
<td>Information</td>
</tr>
<tr>
<td>04/10/2016</td>
<td>Membership Engagement Group</td>
<td>Link to Poll</td>
</tr>
<tr>
<td>04/10/2016</td>
<td>Patient Experience &amp; Engagement Group</td>
<td>Information</td>
</tr>
<tr>
<td>04/10/2016</td>
<td>Query re. Appointment of External Auditors</td>
<td>Information</td>
</tr>
<tr>
<td>04/10/2016</td>
<td>Better Local Care Latest newsletter</td>
<td>Newsletter</td>
</tr>
<tr>
<td>07/10/2016</td>
<td>All Staff Briefing re. Katrina Percy</td>
<td>Briefing</td>
</tr>
</tbody>
</table>
**REPORT TO THE COUNCIL OF GOVERNORS**

<table>
<thead>
<tr>
<th><strong>Date</strong></th>
<th>25.10.2016</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Agenda Item</strong></td>
<td>15</td>
</tr>
<tr>
<td><strong>Title</strong></td>
<td>Patient Story Report</td>
</tr>
<tr>
<td><strong>Author(s)</strong></td>
<td>Anna Williams, Company Secretary &amp; Head of Corporate Governance</td>
</tr>
<tr>
<td><strong>Purpose</strong></td>
<td>This report is to make a proposal as to the inclusion of a standing item on the agenda for Council of Governors’ meetings relating to a “Patient Story” and to determine what this item might look like</td>
</tr>
<tr>
<td><strong>Previously Considered by</strong></td>
<td>Council of Governors’ meetings 26.01.16, 26.04.16 and 26.07.16</td>
</tr>
<tr>
<td><strong>Sponsoring Director</strong></td>
<td>Paul Streat, Director of Corporate Governance</td>
</tr>
<tr>
<td><strong>Executive Director Overview</strong></td>
<td>Governors have requested that they receive a patient story at the Council of Governors’ meetings. There is some challenge in how the Council can progress this in a way that enables Governors to fulfil their role and not compromise their position. This paper sets out some options for the Council to consider in setting a framework for gaining a deeper understanding of the views of service users and their experience of the Trust’s service.</td>
</tr>
<tr>
<td><strong>Action Required</strong></td>
<td>The Council of Governors is asked to consider the approach set out in the paper and determine the preferred option so that this item can be added to the agenda framework for the Council of Governors, to take effect from January 2017.</td>
</tr>
</tbody>
</table>
PATIENT STORY REPORT

1. Purpose
1.1. This paper sets out some options for the Council to consider in setting a framework for gaining a deeper understanding of the views of service users and their experience of the Trust’s services.

2. Background
2.1. The request to include a standing item entitled ‘Patient Story’ on the Council of Governors’ agenda first arose at the January 2016 meeting. This suggestion was made by a Governor in response to issues raised by members of the public.
2.2. At the July Council of Governors the need to discuss the format that this could take was noted.

3. Role of the Council of Governors
3.1. The 2012 Health and Social Care Act sets out the role of the Council of Governors, which includes representing the interests of the members of the Trust as a whole and the interests of the public. How this is fulfilled is not defined and therefore it is for Trust’s to determine, in accordance with the regulatory framework and good practice advice, how to achieve this.
3.2. The Monitor Guide: Your statutory duties: A reference guide for NHS foundation trust governors (August 2013) provides examples of activities that governors may become involved in that are not set out in legislation, but reiterates that governors do not have an operational role within the Trust and neither have a right to inspect services or undertake quality reviews nor a duty to meet patients and conduct quality reviews.

4. Options
4.1. Generally governors could be sighted on the views of patients and the public through a number of mediums such as patient/public drop ins, comments/feedback on a website, members’ days and surveys. The Trust is developing ways in which it can seek and receive feedback and will consider how Governors might be involved in this.
4.2. In receiving a patient story due consideration needs to be given to maintaining the confidentiality of patients (given that it would be intended that this item would be taken in public) and also protect Governors from becoming involved in individual cases and operational issues, which is outside their role.
4.3. There are various approaches that could be considered, as follows:
   4.3.1. One approach might be for the Council of Governors to hear about the work of a service area illustrated by case studies (positive and negative, where available);
   4.3.2. An alternative approach might be to hear about an anonymised patient’s experience of a service. This could be presented by a manager or by a service user/carer (if they feel able to speak in public). A balance of positive and negative experiences should be heard over time and there would be no context of the service area.
4.4. The Council of Governors has recently established a Patient Experience and Engagement Group, which will hold its inaugural meeting on 31 October 2016 and has the primary duty to support Governors in fulfilling their statutory duty to represent the interests of Trust members and the public, specifically in relation to patient experience and engagement. This Group could be responsible for identifying items for this part of the agenda.

5. Recommendation

5.1. The Council of Governors is asked to consider the approaches set out above and determine which of the proposed options are preferred so that this item can be added to the agenda from the January 2017 meeting:

5.1.1. Focus on the work of a service area illustrated by case studies (positive and negative, where available); or

5.1.2. A patient’s experience of a service, anonymised as appropriate.
### GOVERNOR ISSUES LOG

<table>
<thead>
<tr>
<th>ID</th>
<th>Date Raised</th>
<th>Raised By</th>
<th>Subject</th>
<th>Question/Comment/Action Requested</th>
<th>Response/Current Position</th>
<th>Closed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>24.03.2016</td>
<td>Arthur Monks</td>
<td>Update on action taken regarding Mike Holder letter dated 13 February 2012</td>
<td>Requested sight of the documents relating to Mike Holder report and paper requested by AARC</td>
<td>Documents sent to Arthur Monks by Recorded mail on 08.04.2016 - Documents to be returned to Trust</td>
<td>Closed</td>
</tr>
<tr>
<td>2</td>
<td>24.03.2016</td>
<td>Arthur Monks</td>
<td>Recording of CoG meeting held on 26.01.2016</td>
<td>Requested recording of CoG 26.01.2016</td>
<td>Data stick sent to Arthur Monks. Data stick returned to Trust. [Note: Recordings of CoG meetings now available on website]</td>
<td>Closed</td>
</tr>
<tr>
<td>7</td>
<td>15.04.2016</td>
<td>John Beaumont</td>
<td>Lymington New Forest Hospital</td>
<td>Enquiry regarding air conditioning</td>
<td>JB advised that this is being progressed by the Lymington Patient Forum.</td>
<td>Closed</td>
</tr>
<tr>
<td>21</td>
<td>26.04.2016</td>
<td>Peter Bell</td>
<td>Request for information</td>
<td>A copy of the Holden (Holder) Report</td>
<td>Documents sent to Peter Bell by Recorded mail on 06.05.2016 - Documents to be returned to the Trust</td>
<td>Closed</td>
</tr>
<tr>
<td>26</td>
<td>27.04.2016</td>
<td>Peter Bell</td>
<td>Council of Governors - proposal for new committee of governors</td>
<td>Proposal that the Council of Governors pursuant to article 6.1.2 of the Standing Orders considers creating a new committee of governors to be called the Public Participation committee of governors (or similar). Additional proposals regarding membership and terms of reference, and administrative support.</td>
<td>Agenda item: CoG 25.10.2016</td>
<td>Closed</td>
</tr>
<tr>
<td>41</td>
<td>04.05.2016</td>
<td>Peter Bell</td>
<td>Annual declaration and revisions to code of conduct</td>
<td>Objection to the purported amendment of the Code of Conduct placed on the agenda for forthcoming CoG</td>
<td>Added to list of agenda items to be considered for forthcoming CoG (October)</td>
<td>Open</td>
</tr>
<tr>
<td>44</td>
<td>08.05.2016</td>
<td>Peter Bell</td>
<td>Governor training</td>
<td>Request for meeting with Head of Learning. Additional request for details of budget and spending for Governor training and development</td>
<td>No dedicated budget allocation for Governor training. Governor training strategy is being developed</td>
<td>Closed</td>
</tr>
<tr>
<td>51</td>
<td>11.05.2016</td>
<td>Peter Bell</td>
<td>Requisition of meeting - assistance with drafting</td>
<td>Requested assistance in drafting requisition for meeting</td>
<td>No further action</td>
<td>Closed</td>
</tr>
<tr>
<td>93</td>
<td>16.05.2016</td>
<td>John Beaumont</td>
<td>Serious misbehaviour of two SHFT governors'</td>
<td>Letter to Interim Chair re Governor behaviour</td>
<td>Fact finding investigation undertaken. This issue was not substantiated due to lack of TV footage evidence.</td>
<td>Closed</td>
</tr>
<tr>
<td>117</td>
<td>13.06.2016</td>
<td>Peter Bell</td>
<td>FOI request 1293 - why the delay?</td>
<td>Request that response to an FOI request is placed on the agenda for a future Council of Governors meeting</td>
<td>To be added to list for Interim Chair / Lead Governor to consider for future CoG agendas</td>
<td>Open</td>
</tr>
<tr>
<td>123</td>
<td>18.06.2016</td>
<td>Peter Bell</td>
<td>Role of Lead Governor</td>
<td>Request for copy of the resolutions which broadened the powers of the Lead Governor and a copy of the resolution where the Lead Governor was appointed.</td>
<td>On CoG agenda 25.10.2016</td>
<td>Closed</td>
</tr>
<tr>
<td>125</td>
<td>23.06.2016</td>
<td>Peter Bell</td>
<td>Governors Issue list</td>
<td>Request for a copy of the Governors Issue list together with a list of those raised by Governors not on issue list and the reasons why not on issue list</td>
<td>Issues log forms standing part of CoG papers Minor and quick to respond to issues are not recorded</td>
<td>Closed</td>
</tr>
<tr>
<td>126</td>
<td>24.06.2016</td>
<td>Peter Bell</td>
<td>Council of Governors - effectiveness</td>
<td>Request for a copy of the questionnaire and the results of this and a copy of the Governor development and training plan produced as a result</td>
<td>Last CoG effectiveness undertaken October/November 2015 and circulated via the Governor Briefing on 19.01.2016.</td>
<td>Closed</td>
</tr>
<tr>
<td>136</td>
<td>14.07.2016</td>
<td>Peter Bell</td>
<td>Who is Portland?</td>
<td>Enquiry as to whether sufficient notice of the meeting had been given</td>
<td>18.07.2016 Response provided</td>
<td>Closed</td>
</tr>
<tr>
<td>137</td>
<td>20.07.2016</td>
<td>Peter Bell</td>
<td>Council of Governors' meeting 26.07.2016</td>
<td>Enquiry as to whether sufficient notice of the meeting had been given</td>
<td>20.07.2016 Response provided</td>
<td>Closed</td>
</tr>
<tr>
<td>138</td>
<td>20.07.2016</td>
<td>Peter Bell</td>
<td>Council of Governors' meeting</td>
<td>Enquiry as to why proposed items including resolution to create a committee of the CoG were not on the agenda</td>
<td>Given limited time available at CoG priority was given to statutory items. Items have been carried forward for consideration for inclusion on the next CoG agenda</td>
<td>Closed</td>
</tr>
<tr>
<td>139</td>
<td>26.07.2016</td>
<td>Peter Bell</td>
<td>Peer Review schedule</td>
<td>Request for Peer Review schedule</td>
<td>02.08.2016 Response provided advising latest Peer Review schedule circulated via Governor Briefing on 21.07.2016</td>
<td>Closed</td>
</tr>
<tr>
<td>140</td>
<td>26.07.2016</td>
<td>Peter Bell</td>
<td>Recording of CoG by the public of press</td>
<td>Please explain clause 4.1.2 in the Standing Orders re. recording of Board/Council</td>
<td>Decision to allow audio recording is to be made by the Chair at each meeting</td>
<td>Closed</td>
</tr>
<tr>
<td>ID</td>
<td>Date raised</td>
<td>Raised By</td>
<td>Subject</td>
<td>Question/Comment/Action requested</td>
<td>Response/Current Position</td>
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<tr>
<td>141</td>
<td>27.07.2016</td>
<td>Peter Bell</td>
<td>Amendment of Governors Code of Conduct</td>
<td>Enquiry re. how Governors may access independent legal advice</td>
<td>Response provided 27.07.2016</td>
<td>Closed</td>
</tr>
<tr>
<td>142</td>
<td>27.07.2016</td>
<td>Peter Bell</td>
<td>Hardcover of board papers</td>
<td>Request for Board papers to be posted and a copy of the papers for the 2015 AMM</td>
<td>03.08.2016 Response provided advising papers would be posted</td>
<td>Closed</td>
</tr>
<tr>
<td>143</td>
<td>27.07.2016</td>
<td>Peter Bell</td>
<td>AMM</td>
<td>Request for information in respect of 2016 AMM</td>
<td>Acknowledgement sent 28.07.2016 / Response provided 01.09.2016</td>
<td>Closed</td>
</tr>
<tr>
<td>144</td>
<td>28.07.2016</td>
<td>Peter Bell</td>
<td>Meridian broadcast</td>
<td>Request to circulate footage to Governors</td>
<td>10.08.2016 email sent advising footage not circulated as it was out of context</td>
<td>Closed</td>
</tr>
<tr>
<td>145</td>
<td>29.07.2016</td>
<td>Peter Bell</td>
<td>Extraordinary CoG</td>
<td>Request for date to be arranged for Extraordinary CoG and for assistance on a written resolution</td>
<td>Superseded</td>
<td>Closed</td>
</tr>
<tr>
<td>146</td>
<td>29.07.2016</td>
<td>Arthur Monks</td>
<td>BBC report re consultancies</td>
<td>Suggestion that the deliberations of the AARC be provided</td>
<td>AAARC reports to Board and therefore key considerations and all decisions/actions have been shared</td>
<td>Closed</td>
</tr>
<tr>
<td>147</td>
<td>29.07.2016</td>
<td>Peter Bell</td>
<td>BBC report re consultancies</td>
<td>Request for legal name of Talent Works</td>
<td>03.08.2016 Response provided</td>
<td>Closed</td>
</tr>
<tr>
<td>148</td>
<td>30.07.2016</td>
<td>Peter Bell</td>
<td>Recording of CoG</td>
<td>Enquiry re. the recording of CoG meeting</td>
<td>04.08.2016 Response provided</td>
<td>Closed</td>
</tr>
<tr>
<td>149</td>
<td>03.08.2016</td>
<td>Arthur Monks</td>
<td>NHS Off Payroll pay</td>
<td>Request to circulate article about NHS Off Payroll pay</td>
<td>03.08.2016 – Email circulated to Governors</td>
<td>Closed</td>
</tr>
<tr>
<td>150</td>
<td>04.08.2016</td>
<td>Peter Bell</td>
<td>Advice from Blake Morgan</td>
<td>Suggestion re. session with Blake Morgan</td>
<td>Session with Blake Morgan held on 16.08.2016</td>
<td>Closed</td>
</tr>
<tr>
<td>151</td>
<td>04.08.2016</td>
<td>Peter Bell</td>
<td>Doodle poll for session with Blake Morgan</td>
<td>Enquiry as to dates offered and whether a doodle poll would be circulated for the meeting</td>
<td>Session with Blake Morgan held on 16.08.2016</td>
<td>Closed</td>
</tr>
<tr>
<td>152</td>
<td>07.07.2016</td>
<td>Arthur Monks</td>
<td>Patient Feedback by Survey Monkey</td>
<td>Requested further information be provided</td>
<td>07.07.2016 Email sent to Paula Hull/Chris Woodfine requesting response to further points raised</td>
<td>Open</td>
</tr>
<tr>
<td>153</td>
<td>05.08.2016</td>
<td>Peter Bell</td>
<td>Threatened claim against the Trust</td>
<td>Copy of email sent to Andrew Latham, Capsticks with notification of change of address</td>
<td>11.08.2016 email sent noting change of address</td>
<td>Closed</td>
</tr>
<tr>
<td>154</td>
<td>05.08.2016</td>
<td>Peter Bell</td>
<td>Investigation of a public governor - the story so far</td>
<td>Request for documents relating to investigation to be circulated to governors</td>
<td>PB circulated documents already</td>
<td>Closed</td>
</tr>
<tr>
<td>155</td>
<td>06.08.2016</td>
<td>Peter Bell</td>
<td>Annual declaration and revisions to code of conduct</td>
<td>Enquiry as to why issue previously raised was not on issue log and request for any other instances of issues on issue log</td>
<td>See 125</td>
<td>Closed</td>
</tr>
<tr>
<td>156</td>
<td>06.08.2016</td>
<td>Peter Bell</td>
<td>Amendment of Governors Code of Conduct</td>
<td>Request to circulate email exchange to governors about the role of Board in agreeing amendments to the Code of Conduct. This was not sent at the time due to the time between the email exchange and request. Email exchange now sent to support resolution submitted to CoG October 2016</td>
<td>Closed</td>
<td></td>
</tr>
<tr>
<td>157</td>
<td>06.08.2016</td>
<td>Peter Bell</td>
<td>NHS Providers</td>
<td>Request to circulate NHS Providers brochure to other governors</td>
<td>Link available on all Governor briefings as they are received</td>
<td>Closed</td>
</tr>
<tr>
<td>158</td>
<td>08.08.2016</td>
<td>Peter Bell</td>
<td>Annual Members' Meeting</td>
<td>Follow up to email sent on 27.07.2016</td>
<td>01.09.2016 response provided</td>
<td>Closed</td>
</tr>
<tr>
<td>159</td>
<td>08.08.2016</td>
<td>Peter Bell</td>
<td>An invitation from your DHCFT lead governor</td>
<td>Enquiry as to whether similar message sent to members from lead governor</td>
<td>23.08.2016 Response provided</td>
<td>Closed</td>
</tr>
<tr>
<td>160</td>
<td>08.08.2016</td>
<td>Peter Bell</td>
<td>Recent elections to the CoG</td>
<td>Request for the names of the candidates and when persons would officially commence their duties</td>
<td>10.08.2016 email sent advising an update on the elections would be included in the next Governor briefing</td>
<td>Closed</td>
</tr>
<tr>
<td>161</td>
<td>10.08.2016</td>
<td>Peter Bell</td>
<td>IR35 applicability</td>
<td>Request for confirmation that the Trust diligently carries out its responsibilities under HMRC rules</td>
<td>The Trust has a number of HR and Finance policies and procedures in place which are duly followed on all such appointments</td>
<td>Closed</td>
</tr>
<tr>
<td>162</td>
<td>10.08.2016</td>
<td>Peter Bell</td>
<td>Copy of ITV Meridian broadcast on 13.05.2016</td>
<td>Copy of email sent to Governors (see Issue 144)</td>
<td>n/a</td>
<td>Closed</td>
</tr>
<tr>
<td>163</td>
<td>10.08.2016</td>
<td>Peter Bell</td>
<td>Governor issue log</td>
<td>Request for issues not on issue log/not being actions to be agenda item on the next CoG</td>
<td>See 125</td>
<td></td>
</tr>
<tr>
<td>164</td>
<td>10.08.2016</td>
<td>Peter Bell</td>
<td>Date and time for legal advice</td>
<td>Request for confirmation of date and time of meeting with Blake Morgan</td>
<td>Session with Blake Morgan held on 16.08.2016</td>
<td>Closed</td>
</tr>
<tr>
<td>165</td>
<td>10.08.2016</td>
<td>Peter Bell</td>
<td>An example of another Trust's AMM invite</td>
<td>Request for invite from RD&amp;E to their AMM to be circulated to governors</td>
<td>Example filed for reference in 2017 when planning next AMM</td>
<td>Closed</td>
</tr>
<tr>
<td>166</td>
<td>11.08.2016</td>
<td>Peter Bell</td>
<td>RD&amp;E AMM event timetable</td>
<td>Request to circulate timetable to governors</td>
<td>Example filed for reference in 2017 when planning next AMM</td>
<td>Closed</td>
</tr>
<tr>
<td>167</td>
<td>13.08.2016</td>
<td>Peter Bell</td>
<td>Article in Daily Echo</td>
<td>Enquiry as to whether patient of Trust</td>
<td>22.08.2016 email sent advising not able to comment as this would breach DPA</td>
<td>Closed</td>
</tr>
<tr>
<td>ID</td>
<td>Date raised</td>
<td>Raised By</td>
<td>Subject</td>
<td>Question/Comment/Action requested</td>
<td>Response/Current Position</td>
<td>Closed</td>
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<tr>
<td>167</td>
<td>18.08.2016</td>
<td>Richard Mandunya</td>
<td>Committees for the CoG</td>
<td>Enquiry as to why no proposal for a Strategy and a Quality &amp; Safety Committee</td>
<td>22.08.2016 Response provided</td>
<td>Closed</td>
</tr>
<tr>
<td>168</td>
<td>23.08.2016</td>
<td>John Beaumont</td>
<td>SH Insider</td>
<td>Request for hard copy of latest membership magazine</td>
<td>SH Insider magazine posted to John Beaumont</td>
<td>Closed</td>
</tr>
<tr>
<td>169</td>
<td>23.08.2016</td>
<td>John Beaumont</td>
<td>SH Insider</td>
<td>Please advise when the next edition of the membership magazine is due to be published</td>
<td>24.08.2016 email sent advising next magazine due for publication October 2016</td>
<td>Closed</td>
</tr>
<tr>
<td>170</td>
<td>23.08.2016</td>
<td>John Beaumont</td>
<td>Membership</td>
<td>Please provide current membership numbers by constituency.</td>
<td>24.08.2016 email sent advising current membership numbers</td>
<td>Closed</td>
</tr>
<tr>
<td>171</td>
<td>22.08.2016</td>
<td>Sue Smith</td>
<td>Demfest - 25.09.2016</td>
<td>Poster advertising Demfest to be shared with Governors</td>
<td>Circulated to Governors via briefing 31.08.2016</td>
<td>Closed</td>
</tr>
<tr>
<td>172</td>
<td>02.09.2016</td>
<td>Arthur Monks</td>
<td>Sara Ryan Blog 160902</td>
<td>Request for email to be circulated to Governors</td>
<td>Circulated to Governors - 05.09.2016</td>
<td>Closed</td>
</tr>
<tr>
<td>173</td>
<td>12.09.2016</td>
<td>Peter Bell</td>
<td>Access to internet for patients</td>
<td>Request for an update of progress with the roll-out of patient and public WiFi access</td>
<td>Update to be provided when reported through Trust Committees</td>
<td>Closed</td>
</tr>
<tr>
<td>174</td>
<td>27.09.2016</td>
<td>John Beaumont</td>
<td>Trust Board P2 meetings</td>
<td>Request to observe Trust Board P2 meetings</td>
<td>Telephone call Anna Williams/John Beaumont held 03.10.2016. Interim Chair determined this is outside the requirements of the 2012 Act</td>
<td>Closed</td>
</tr>
<tr>
<td>176</td>
<td>06.10.2016</td>
<td>John Beaumont</td>
<td>Customer Experience Advisor - LNFH</td>
<td>It appears that the CEA is no longer at LNFH two days a week - is this permanent</td>
<td>Customer Experience Team advised the twice weekly service at LNFH would resume next week - information shared with John 07.10.2016</td>
<td>Closed</td>
</tr>
<tr>
<td>177</td>
<td>13.08.2016</td>
<td>Peter Bell</td>
<td>Newspaper article</td>
<td>Query whether a person is a SHFT patient and receiving appropriate care</td>
<td>Trust unable to comment due to Data Protection Act requirements</td>
<td>Closed</td>
</tr>
<tr>
<td>178</td>
<td>01.09.2016</td>
<td>Peter Bell</td>
<td>Appointment Committee</td>
<td>Request for minutes</td>
<td>Minutes can only be supplied for meetings convened since the governor became a governor. Details of specific issues considered prior to this date can be provided.</td>
<td>Closed</td>
</tr>
<tr>
<td>179</td>
<td>01.09.2016</td>
<td>Peter Bell</td>
<td>Appointment of Acting Chief Executive next meeting</td>
<td>Query as to when the Council of Governors will make this appointment.</td>
<td>Acting Chief Executive Officer appointed subject to confirmation by the Council of Governors. Confirmation to be sought at the next meeting (25/10/16)</td>
<td>Closed</td>
</tr>
<tr>
<td>180</td>
<td>03.09.2016</td>
<td>Peter Bell</td>
<td>Query re Annual Members Meeting</td>
<td>Query as to whether the Annual Meeting of Governors should also be part of the Annual Members Meeting.</td>
<td>Meetings convened in line with the Constitution</td>
<td>Closed</td>
</tr>
<tr>
<td>181</td>
<td>03.09.2016</td>
<td>Peter Bell</td>
<td>Tableau</td>
<td>Request for Governors to be briefed on this information system</td>
<td>Briefing occurred at the September Governor Development Day</td>
<td>Closed</td>
</tr>
<tr>
<td>182</td>
<td>05.09.2016</td>
<td>Peter Bell</td>
<td>Fact finding Investigation into a governor and others</td>
<td>Query when the report will be shared</td>
<td>Governor has been invited to discuss the draft report on a number of occasions and declined the meetings. Next steps, including formal action, being considered.</td>
<td>Open</td>
</tr>
<tr>
<td>183</td>
<td>05.09.2016</td>
<td>Peter Bell</td>
<td>Patient Experience Feedback</td>
<td>Example of another Trust’s engagement. Request whether SHFT has a similar feedback mechanism.</td>
<td>The Trust uses many means of communicating patient experience and new governor groups are a key way forward.</td>
<td>Closed</td>
</tr>
<tr>
<td>184</td>
<td>05.09.2016</td>
<td>Peter Bell</td>
<td>Legal advice for Council of Governors and others</td>
<td>Various requests as to when the advice would be received and circulated to Council of Governors.</td>
<td>Advice circulated 22.09.2016. Further comments and requests for follow up advice received and shared with the legal adviser.</td>
<td>Open</td>
</tr>
<tr>
<td>185</td>
<td>06.09.2016</td>
<td>Peter Bell</td>
<td>Appointment of Internal Auditors</td>
<td>Query on the process to appoint the internal auditor</td>
<td>Reminder and review of process supplied.</td>
<td>Closed</td>
</tr>
<tr>
<td>186</td>
<td>12.09.2016</td>
<td>Peter Bell</td>
<td>Access to internet for patients/public</td>
<td>Request that United Nations resolution is drawn to the attention of the Board. Update on roll out of wifi access to patients/public across the Trust.</td>
<td>Noted and update to be provided.</td>
<td>Closed</td>
</tr>
<tr>
<td>187</td>
<td>16.09.2016</td>
<td>Peter Bell</td>
<td>Guidance for trustees</td>
<td>Request to include protocols for behaviour as a trustee/governor at a future Governor Development Session</td>
<td>Noted and added to potential topics</td>
<td>Closed</td>
</tr>
<tr>
<td>188</td>
<td>23.09.2016</td>
<td>Peter Bell</td>
<td>Corporate Governance Team</td>
<td>Challenge/Concern on workload</td>
<td>Noted and issues being addressed within resource limits</td>
<td>Closed</td>
</tr>
<tr>
<td>ID</td>
<td>Date raised</td>
<td>Raised By</td>
<td>Subject</td>
<td>Question/Comment/Action requested</td>
<td>Response/Current Position</td>
<td>Closed</td>
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<tr>
<td>189</td>
<td>04.10.2016</td>
<td>Peter Bell</td>
<td>Deputy Chair appointment</td>
<td>Request for information around this appointment</td>
<td>Information supplied</td>
<td>Closed</td>
</tr>
<tr>
<td>190</td>
<td>04.10.2016</td>
<td>Peter Bell</td>
<td>Vacancies on Council of Governors</td>
<td>Information that there is at least one candidate for the staff vacancy. Followed up with request about when the election process for current vacancies will commence.</td>
<td></td>
<td>Open</td>
</tr>
<tr>
<td>191</td>
<td>06.10.2016</td>
<td>Peter Bell and others</td>
<td>Hampshire and IOW STP</td>
<td>Request for link to be shared with Governors and discussed at Council of Governors meeting.</td>
<td>Information to be shared with Governors when next version available. On agenda for 25.10.2016</td>
<td>Open</td>
</tr>
<tr>
<td>192</td>
<td>12.10.2016</td>
<td>Peter Bell</td>
<td>Volunteers Week 2016</td>
<td>Query as to why the information about Volunteers Week (held 1-12 June) was not shared with Governors</td>
<td>Information was shared in Governor Briefings</td>
<td>Closed</td>
</tr>
<tr>
<td>193</td>
<td>12.10.2016</td>
<td>Peter Bell</td>
<td>Alternative technologies for communicating within CoG</td>
<td>Closed LinkedIn or Facebook Group for governors to communicate with each other and Corporate Governance Team rather than email.</td>
<td>Trust will consider what options are available and can be supported on its platforms. Consult on alternative methodologies with CoG.</td>
<td>Open</td>
</tr>
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</table>
EXTRAORDINARY COUNCIL OF GOVERNORS MEETING, TUESDAY 17th MAY 2016
AGENDA ITEM:
VOTE OF NO CONFIDENCE IN THE SOUTHERN HEALTH (NHS) FOUNDATION TRUST BOARD

Observations by John L Green, Southern Health (NHS) Foundation Trust Public Governor

EXECUTIVE SUMMARY

• The response of Southern Health (NHS) Foundation Trust to the death, caused by negligence in its care, of Connor Sparrowhawk was wrong, inadequate and inappropriate. It brought into sharp focus that there were significant weaknesses within the Trust that needed to be dealt with.

• The findings of the Mazars report, published in December 2015, identified a “Lack of leadership, focus and sufficient time spent in the Trust on carefully reporting and investigating unexpected deaths of mental health (MH) and learning difficulty (LD) users”. It also identified quality and safety management failure: “The Trust could not demonstrate a comprehensive systematic approach to learning from deaths as evidenced by action plans, board review and follow up, high quality thematic reviews and resultant service change.”

• In January 2016 the BBC brought to light a previous report by Mike Holder, CMIO. Mike Holder, a self-employed chartered health and safety practitioner, was contracted by the Trust in late November 2011 as Interim Head of Health and Safety, Security. Within three months of his appointment he assessed that the Trust senior managers were neither willing nor able to implement a safety management system reflective of Health and Safety Executive ‘Managing for Health and Safety ‘(HSG 65) guidance notes; the consequences of which in his professional view, as a chartered safety practitioner, put the safety of patients at risk.

• In a Report submitted to the Trust upon leaving in February 2012 Mr Holder made very similar criticisms to those contained in the Mazars Report with regard to the Trust’s safety/quality management systems and lack of leadership.

• Investigations by Mazars, Mr M Holder and the Care Quality Commission (CQC) provides evidence that the Trust did not have and still does not have appropriate quality and safety management policies, structures, systems and processes in place. The CQC in a Warning Notice issued to the Trust in April 2016 stated that the “Trust did not effectively respond to concerns about safety raised by patients, their carers or staff, or respond to concerns raised by Trust staff about their ability to carry out their roles effectively”. It would appear that the present top down NHS/Trust quality management system of regulation and inspection is inadequate for the purpose of preventing unexpected deaths.

• The impact of the reduction in income from Clinical Commissioning Groups (CCG) of circa 20% in 5 years and pressure from the Government/NHS Improvement to hit financial budget targets is taking attention of all non front-line services managers away from providing a health service with its first priority of meeting the demands and individual needs of customers.

• The Trust Governance system is a deeply flawed democratic management process, which is seriously ineffective in representing the public, who are both owners and customers of the Trust.
On top of that, the Trust Board has not always been forthcoming with information or answers to questions raised by Governors or the Council of Governors (CoG). This has, to a great extent, frustrated the CoG’s ability to hold the Board to account and effectively rendered it powerless.

- This Paper seeks to address the alleged failure of leadership of the Trust. It concludes that the Trust Board is still failing and recommends that the management of the Board be changed and that quality and safety management systems be radically improved to standards adopted by other safety critical industries.

INTRODUCTION

Mazars Etc. Observations Paper Submitted to 26th January 2016 Council of Governors Meeting

1. At the 26th January 2016 Council of Governors (CoG) meeting I submitted a Paper ‘Causes of Serious Failures of the Southern Health Foundation Trust, which led to the Mazars Report and the Failures Identified in the Mazars Report 2015’ (Mazars Etc. Observations Paper). The Paper listed on the first two pages the two main criticisms of the Mazars Report, allegations against the Trust by the public attending Board and CoG meetings and criticisms of the Trust’s performance and management methods made by Governors at previous CoG meetings.

2. The main focus of the Paper was an examination as to the causes of the quality and safety and management failures to prevent unexpected deaths, which resulted in Recommendation 2. For reasons of lack of information at that time, alleged leadership failures were not addressed. However, I concluded that “there would appear to be sufficient evidence to require that an investigation be carried out into the alleged failure of the leadership of the Trust” and accordingly put forward, in Recommendation 1, that an investigation be carried out by a body external to the NHS to establish whether Trust senior managers should be censured for failings in leadership as alleged in the Mazars Report.

3. Recommendation 1. was not supported by the CoG. Instead the following Resolution was passed:

“At the first opportunity to convene an independently facilitated closed session where the governors can engage with the Trust senior team with the objective of gaining an understanding of and reviewing policy, practice and management of reporting and investigation of deaths and other significant events in order to determine necessary further actions.”

4. Recommendation 2. was substantially supported after an amendment to include Board Members and local Members of Parliament and the presumption that 2b could be covered within the single resolution. The following Resolution was passed:

“In conjunction with the senior management team, the Council of Governors explore with local Members of Parliament, with the aim of requesting the Secretary of State for Health, to further investigate the change in organisational paradigm of the NHS and the Trust necessary to enable the creation of a no-blame management culture and the achievement of a cost effective, high quality customer driven world class standard integrated healthcare service.”
5. In a letter to me from Alistair Burt MP, Minister of State for Community and Social Care, dated 22nd February 2016 thanking me for Mazars Etc. Observations Paper and my efforts Mr Burt stated:

“I would certainly endorse its (Paper) emphasis on the importance of quality improvement and of the scale of challenge we face in making a focus on quality improvement more widespread than at present”

Issues Relating to the Alleged Failings in the Leadership of the Trust

6. With a view to providing the five recently joined Governors with more information to assist them in their deliberations as to the leadership competence of the Trust Board, I enclose, in Appendix 1, a ‘Mazars Etc., JG Notes - Summary of Events and Observations’ document I drafted for my own purposes. I also enclose, in Appendix 2, a ‘SHFT Unanswered Questions’ document detailing the questions I asked of the Chair referred to in Appendix 1. To date, no answers have been received on questions 1 – 9 and question 10 has only been partly answered. My notes, observations and conclusions in this Paper represent my best efforts to understand what has taken place, given the information available to me. I apologise in advance for any errors of understanding or omissions.

THE HOLDER HEALTH AND SAFETY REPORT FEBRUARY 2012 AND SERVICE QUALITY AND SAFETY MANAGEMENT STANDARDS

Mike Holder Health and Safety Report, February 2012

7. After writing the Mazars Etc. Observations Paper I received an email from Michael Buchanan of the BBC, which enclosed a health and safety letter/report written by Mr Mike Holder CMIOSH, dated 21st February 2012. Mike Holder, a self-employed chartered health and safety practitioner, was contracted by the Trust in late November 2011 as Interim Head of Health, Safety and Security, upon the post becoming vacant. The reason for his appointment, as stated in a BBC report, was that the Trust had received an anonymous letter stating that “The Trust is extremely under-resourced to deal with health and safety issues considering the size and complexity of the Trust ”.

8. Julie Jones, Associate Director of Governance, who in a letter to the CEO dated 14th November 2012 expressed “concerns about the robustness of health and safety management arrangements”, appointed Mr Holder. The appointment was for a period of 4 – 6 months until a substantive appointment was made. Within three months of his appointment Mr Holder terminated his contract. He assessed that the Trust senior managers were neither willing nor able to implement a safety management system reflective of Health and Safety Executive ‘Managing for Health and Safety (HSG 65) ’ guidance notes; the consequences of which in his professional view, as a chartered safety practitioner, put the safety of patients at risk.

9. Upon leaving, he was asked by the Trust as to his reasons. In his thirteen page Report, plus appendices he criticised the standard of expertise and level of resources allocated to health and safety for an organisation of the Trust’s size, with specific regard to its ability properly to perform its legal responsibilities under the Health and Safety at Work Etc. Act 1974. He also appears to
have made very similar criticisms to those contained in the Mazars Report with regard to the Trust's patient safety/quality management systems and lack of leadership. It would therefore seem logical to conclude that there has been no serious/significant action taken by the Trust to address these issues in the four-year period since his Report. If this proves to be the case, accusations/concerns expressed by a number of complainants at recent Trust public meetings (including Sara Ryan and Richard West) that Trust failures since 2011 to put in systems properly to investigate deaths and take appropriate action to improve patient safety contributed to recent unexpected deaths, will almost certainly be justified.

10. Immediately after the January CoG meeting, at which I referred to the Holder Report, I formally requested of Mike Petter, Trust Chair, that it be circulated to Governors and that Mr Holder be invited to meet with the CoG to present his concerns. The Chair responded that the Holder Report could not be found and that anyway it was of no relevance to the Mazars Report findings; accordingly he refused my request. Later Katrina Percy, CEO at the 9th February 2016 Hampshire County Council HASC meeting made a similar comment in public:

"that the Trust was searching its archives to find the Report ...... and that anyway it had no relevance to the Mazars Report"

11. I attended this meeting, along with colleague Public Governor Arthur Monks, to present my Mazars Etc. Observations Paper. This statement caused both Arthur and myself reason for serious concern about the CEO and Board’s lack of knowledge and understanding as to how to achieve high standards of quality and safety management and the Board’s apparent indifferent attitude and inaction, both past and present. As a result, I decided on behalf of a number of Governors to investigate further past events and requested of the Chair, in an email dated 4th February 2016, answers to a number of important questions - see Appendix 2.

12. The other main criticisms raised by Mr Holder in his Report are as follows:

- That the Trust’s safety management systems and culture were inadequate and dysfunctional when compared to other industries with similar “safety critical environments”, which necessarily operated “Total Quality Management (TQM)/Safety Management Systems (SMS) standards” ... .......” and it is these sound principles and the resources necessary to support the latter that I reflect upon when reviewing the Trust’s approach to risk management/health and safety”.
- That health and safety was considered by Trust senior managers to be an adjunct to the Trust’s core business rather than an integral part of it (i.e. whereby procedures to ensure health and safety, developed by the staff teams doing the work and their managers are built into work procedures, methods and systems and the quality improvement/management process.)
- Numerous failures in safety management systems and that the performance measurement of safety was in breach of the Health and Safety at Work (H&SW) Etc. Act 1974. Specific areas of risk were also identified, which would appear to relate to later unexpected deaths.

He also referred to Appendices A and B of his Report, that he believed the Trust Board at the time felt it would be “beneficial to review the application of TQM systems similar to that used in the construction, car industry, etc.” inferring that his Report should be placed before the Board.
13. I enclose in Appendix 3, a copy of a letter recently emailed to me from Mr Holder at my request, which gives a summary list of the concerns in his Report. However, I recommend that every Governor prior to the Extraordinary CoG meeting obtains a copy of the Holder Report 13 page document and all other relevant letters, which after over 2 months of asking were recently sent to Arthur Monks, for their perusal. I also recommend all Governors obtain a copy of the ‘Trust Health and Safety Arrangements’ Paper submitted to the Audit, Assurance and Risk Committee dated 7th March 2016, the contents of which I challenged at the 26th April 2016 CoG meeting.

14. Governors will recall, at the CoG meeting, I referred to the Medical Officer’s letter to the CEO, dated 20th March 2012, which was one of the documents sent to Arthur Monks. It was written in response to a request from the CEO requesting Huw Stone, Medical Officer (MO) informally to investigate the statements made by Mr Holder in his letter/Report. The Medical Officer’s reply to the CEO in my view appears mostly to seek to discredit Mr Holder’s observations. As a result it equally appears not to seriously address the main criticisms in his Report with regard to the Trust meeting the H&SW Etc. Act 1974 standards. Based upon the response to my question at the last CoG meeting: “was Mr Holder’s Report ever placed before the Trust Board in 2012 for its consideration?” I believe we can assume it was not or, if it was, that no substantial review of his Report was carried out. I had previously asked this question of the Chair, along with other important yet unanswered questions arising from the findings of the Mazars Report - see Appendix 2, question 4.

15. As to the significance of the Holder Report, please see below the latest revelation from the BBC regarding the death of Connor Sparrowhawk. It suggests that the Trust knew of health and safety failings before his death but did not act upon them:

http://www.bbc.co.uk/news/uk-england-oxfordshire-36141808

16. See also below the recent tweet by Sara Ryan, mother of Connor Sparrowhawk, which refers to Appendices in the Holder Report relating to ligature management.


Sara draws upon documents in the Appendix of the Holder Report, of which she clearly has a copy. The tweet, albeit with strong language, which I can confirm refers to Appendix documents in the Report (of which I also have a copy), appears to have significant connection with the suicide by hanging of James Younghusband at Ravenswood in 2013 and it may well also have connections with other deaths.

17. In my past career I worked in the safety critical oil refining industry as a training officer and later in a personnel management role at board/director level in local government in the 1970s and 1980s, where I was responsible for ensuring the authority’s compliance with the H&SW Etc. Act 1974. I am amazed that both the above deaths have not previously been fully investigated already by the Health and Safety Executive with regard to compliance with this Act and other appropriate legislation.

Quality and Safety Management Standards

18. With regard to the ‘Trust Health and Safety Arrangements’ Paper submitted to the Audit,
Assurance and Risk Committee on 7th March 2016, Governors will also recall at the 26th April 2016 CoG meeting that I challenged the Board as to:

- The adequacy of its recent investigation into the significance of the Holder Report
- Whether the Trust Board had even now understood what was needed and whether the Trust had the appropriate level of expertise and manpower resource to ensure it satisfied current H&SW Etc. Act 1974 requirements.
- That the draft papers ‘Our Quality Improvement Strategy 2016 -2021 Report’ and ‘Quality Report and Quality Account 2015/16 ‘ submitted to the Quality and Safety Committee, 21st March 2016, did not appear to address the need for the Trust radically to improve its quality and safety management system standards to the Total Quality Management/Safety Systems Standards level specified by Mr Holder – a level he considered essential for safety critical industries.

19. In mid 2013 Julie Jones produced a quality and strategy report, which advocated the improvement of quality management to Total Quality Management (TQM) standards, as recommended by Mr Holder in his Report. Arthur Monks and myself also requested the implementation of TQM levels of quality management many times at CoG meetings. Both of us have substantial experience of its implementation and practice in both the public and private sector, although neither of us had any knowledge of the Holder Report until the BBC brought it to my attention in January of this year.

20. Later in 2013 Simon Waugh, the then Chair of the Trust, attempted to introduce Customer Experience Project Pilots with two front line teams. His intention was radically to improve customer feedback and quality management methods in the Trust to TQM/car industry standards. However, these projects were never commenced due to the negative/indifferent attitudes of the Chief Executive Officer (on returning from maternity leave) and the Director of Performance, Quality and Safety/Chief Operating Officer, whose support was absolutely essential for the projects to succeed. In mid 2014 the Chair advised me that Julie Jones had left the organisation.

21. The Mazars report was published in December 2015. Its main findings were:

- Top management failure: “Lack of leadership, focus and sufficient time spent in the Trust on carefully reporting and investigating unexpected deaths of Mental Health & Learning Difficulty Users.”
- Quality and Safety Management failure: “The Trust could not demonstrate a comprehensive systematic approach to learning from deaths as evidenced by action plans, board review and follow up, high quality thematic reviews and resultant service change.”

22. In April 2016 the Care Quality Commission served a formal Warning Notice to prompt the Trust to improve which stated:

- The Trust has “failed to mitigate against significant risks posed by some of the physical environments...”.
- The Trust “did not operate effective governance arrangements to ensure robust investigation of incidents, including deaths”.

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• The Trust “did not effectively respond to concerns about safety raised by patients, their carers or staff, or respond to concerns raised by Trust staff about their ability to carry out their roles effectively.”

23. It is accepted that the overall remedial work to improve, repair, replace physical buildings and structures is both time-intensive and costly. However, it is noted that CQC aren’t saying that the Trust has simply failed to fix the underlying issues. They are saying that the Trust hasn’t done anything to reduce the risk of harm in the meantime. The CoG has been told several times during the past year that investigations were improving, but the CQC indicate that this has not gone far enough or, more importantly, fast enough. Action to prevent further deaths should be enacted within days if not hours - not weeks or mostly many months, as is presently the case.

24. Other evidence of continued criticism in 2015 and 2016 by coroners and complainants with regard to lack of effective investigation of deaths and, more importantly, failure to take effective action to prevent further unexpected deaths would seem to confirm the findings of the Mike Holder, Mazars and CQC. Reports. It would also seem to confirm that the present command and control top down driven regulation and inspection quality management methods (even hyped up) adopted by the Trust and approved by Monitor over the past 12 – 18 months is totally inadequate. It should be remembered that neither Monitor nor the CQC (in its mass inspection of the Trust in the Autumn of 2014) picked up on the failures identified in the Mazars or Holder Reports. Also, to my knowledge neither have substantial expertise in health and safety or quality management methodology. However, I note that NHS Quality, along with Monitor and the Trust Development Agency is now under the auspices of the newly created NHS Improvement.

25. For more information and observations on issues since the publication of the Mazars Report please see Appendices 1 and 2.

26. In April 2016 NHS Improvement (NHSI) served an Improvement Notice and later issued a new condition on the Trust’s licence to the extent that they will be able to remove Directors, Non-Executive Directors and Governors in the event that the failures identified by CQC remain unresolved. At the same time NHSI appointed Alan Yates to advise the Board on a one day per week part-time basis and later appointed Tim Smart as the chair of the Trust upon the resignation of Mike Petter on 28th April 2016. Both are ex NHS chief executives with considerable experience.

27. Based upon the findings of the Holder, Mazars and CQC Reports, I have very serious doubts as to whether the Trust could satisfy standards required of the H&SW Etc. 1974 Act at the present time, let alone at the time of the deaths of James Younghusband and Connor Sparrowhawk. I also have no confidence in the Trust’s ability to do so in the future with the present Board in place. I understand that the Health and Safety Executive is now carrying out investigations into the above deaths and other appropriate unexpected deaths, which have occurred since February 2012. Much will likely be learned from those investigations. However, in the meantime it is clear that, separate from the involvement of NHS Improvement and the CQC, independent qualified H&S and quality management experts should be contracted as a matter of urgency. Their task being to examine whether the Trust has the resources and quality and safety management expertise required to ensure it implements the highest level of quality management and safety systems to enable it to meet the standards of the H&S Etc. Act 1974, but most importantly to prevent further unexpected deaths.
PRESSURE TO ACHIEVE REDUCING FINANCIAL BUDGET TARGETS AND ITS IMPACT UPON
QUALITY AND SAFETY STANDARDS

28. Radically improving inspection standards and developing effective action plans swiftly to implement improvements (arguably in a safety critical environment within hours and days rather than weeks/months and years, as at present) will almost certainly require additional investment in the training of managers and front line staff teams in high quality TQM level standards and safety management methodology. It will also likely require additional care support staff and capital investment in buildings and equipment. I assess, that over the past 5 years, funding to the Trust in real terms has decreased by 20% along with staff numbers. This combined with huge pressure on the Trust, imposed by NHS Improvement/Monitor, to achieve financial budget targets I believe has seriously militated against the Trust taking effective action to prevent unexpected deaths. By way of example:

To meet increased demand for acute mental health services to resolve the problem of mental health patients being retained in police cells (many after been turned way by A & E and the Trust), circa 60 acute bed placements were contracted outside the Trust area from 2013. However, over the past 18 months all these beds have been removed. At its peak in 2014/15 the cost to the Trust per annum was just over £5 million. The removal of beds has not resulted in a re-investment of some of the saved monies to provide essential extra care support to families to whom loved ones have returned or to help those patients without families to cope better on their own. It seems that the level of demand and needs of mental health patients are a real financial problem/burden in preventing the Trust from achieving it financial budget targets. - as reflected in the answer to the question from a Governor at the 26th January 2016 CoG meeting on the subject of the reinvestment of monies saved. The approved minute reads:

“the use of out of area beds had incurred a loss to the Trust and that a reduction in usage had therefore not generated any money for re-investment.”

29. It is clear from this minute statement that the Board appears to have focused so much on hitting budget targets that it has actually forgotten what the purpose of the Trust is i.e. to satisfy mental health patient needs and demand. This is particularly significant in respect of mental health, as it appears that the suicide rates in the cities of Portsmouth and Southampton, compared with other areas in the same deprivation decile, are higher than all the other 13 cities/boroughs in its category. However, I have observed that this attitude of needing to hit financial budget targets dominates most decisions made by the Chief Executive Officer and the Board. Customer demand and need has hardly ever been mentioned at any Board, or for that matter CoG meetings, I have attended in the past 4 years. For these reasons I consider that the Trust is not meeting the present needs and demands of many of its most vulnerable patients due to the reduction in revenue and the pressure from above to reduce costs to hit budget targets.

CONCLUSIONS

30. Drawing upon all the documents referred to in this Paper, it is concluded that:

- In the public interest and to regain public confidence in the Trust, three issues need to be
determined:
  o Are any Executive Directors or Non-Executive Directors culpable for unexpected deaths in the last 4 years since the Holder Report?
  o Is the Trust’s present quality and safety management system of the level appropriate for a safety critical organisation and thereby of a standard adequate to satisfy Health and Safety at Work Etc. Act 1974 and to prevent further unexpected deaths?
  o Is the existing leadership competent/capable of carrying out the improvements required - sufficient to regain public confidence?

• The response of Southern Health NHS Foundation Trust to the death, caused by negligence in its care, of Connor Sparrowhawk was wrong, inadequate and inappropriate. The death of Mr Sparrowhawk, and the Trust’s response, brought into sharp focus that there were significant issues and weaknesses within the Trust that needed to be dealt with.

• Investigations by Mazars, Mike Holder and the Care Quality Commission and statements from coroners and complainants provide evidence that the Trust did not have appropriate quality and safety management policies, structures, systems and processes in place to prevent such tragedies and still does not have. It is further reported that the Trust, contrary to the terms of the NHS Constitution, has not and still does not engage well with families, patients and staff when concerns have been raised. The Mazars Report detailed a set of failures and weaknesses that cannot be justified or discounted many of which were, at least in part, foreshadowed in the Report presented by Mike Holder in February 2012.

• It is clear that the present top down quality management system of regulation and inspection, approved by Monitor, is inadequate for the purpose of preventing further unexpected deaths. As stated in my Mazars Etc. Observations Paper, it creates an atmosphere of fear, which leads to cover up. Worse still, it does not engage fully with the front line staff teams, who are those people in the Trust most able to identify the causes of quality and safety failure. I challenge that any team of front line staff in the Trust, if asked, could quickly list what is wrong, what needs improving, how some of the faults in work methods and systems can be fixed and what, in terms of management culture, demotivates them. If well trained in quality management systems thinking, continuous quality improvement methods and problem solving tools and techniques, to improve work methods and systems to prevent re-occurrence, I further challenge that they could implement improvements with appropriate support from senior managers to a higher standard and much more quickly than at present.

• As stated in my Mazars Etc. Observations Paper, the Trust Governance system is a deeply flawed democratic management process, which is seriously ineffective in representing the public, who are both owners and customers of the Trust. On top of that the Trust Board has not always been forthcoming with information or answers to questions raised by Governors or the CoG. This has unquestionably frustrated the CoG’s ability to hold the Board to account and effectively rendered it powerless.

• That the current leadership of the Trust, in particular the CEO (who bears the ultimate responsibility for health and safety), is seen by the community as being responsible for and thereby inextricably linked to the failings of the Trust identified in the Reports, media, CQC and NHS Improvement warning notices. As reflected in a debate in the House of Commons on 4th May 2016, the leadership have lost the support and confidence of the public and community that it serves. It is also considered that the current leadership of the Trust are
neither the right people, nor capable of rescuing the organisation and its reputation from the mire of suspicion, mistrust and public opprobrium in which it, rightly, is engulfed. A number of MPs have already called for the resignation/dismissal of the CEO and Board Members. Arguably, the recent appointment by NHS Improvement of two ex NHS Chief Executive Officers is confirmation that the leadership lack competence. The Trust Executive Directors are very highly paid managers, who in any other industry I believe would have resigned or been dismissed by now - they are not apprentices.

- The impact of the reduction in income from Clinical Commissioning Groups (CCG) of circa 20% in 5 years and pressure from the Government/NHS Improvement to hit financial budget targets is taking attention of all non front-line services managers away from providing a health service with its first priority of meeting the demands and individual needs of customers. So much so that the Trust/NHS top management is in serious danger of forgetting the purpose of the organisation, if it has not done so already. In this context, the Trust and NHS leadership have failed to have regard to the NHS Constitution (also contrary to 4.5 of our Trust's own Constitution), inter alia: Principle 4; that the patient shall be at the heart of everything that the NHS does and Principle 7; that the NHS is accountable to the public and the communities and patients that it serves.

GOVERNANCE AND THE ROLE OF GOVERNORS AS REPRESENTATIVES OF THE PUBLIC, PATIENTS AND CARERS

31. To date, I believe that the CoG can be rightly accused of failing in its responsibility effectively to represent the public and to hold the Non-Executive Directors to account. The CoG’s only defence is that Governor efforts to do so have unquestionably been frustrated by the Board by not providing requested information to a number of Governors and not providing the opportunity for the CoG to meet with complainants to hear their views and meet with the Board to scrutinise the activities of senior managers properly to enable them to be held to account.

32. In considering the recommendation below, the CoG need to recognise fully that all the people who died unexpectedly under the Trust’s care did not die because the Trust failed to save their lives, either for reason that there was nothing more that could have been done to save them or an error was made – recognising that errors are not misconduct (Don Berwick KBE 2013). They died due to inadequate quality and safety management systems whilst in the care of the Trust. As stated by Katrina Percy, CEO “James Younghusband should not have died”.

33. The CoG should be minded of the fact that Governors are elected or appointed to represent Members of the Trust and the public (including patients, carers and complainants), all of whom are both customers and owners of the NHS. The CoG is not responsible for the management of the Trust. Thus, it is not the role of Governors to represent the Trust Board, NHS Improvement, the CQC, NHS England and CCGs or the Government - whatever it's political colour. All those bodies are more than capable of representing themselves. In this context, Governors should also be minded of the fact that the Trust/NHS is for most members of the public their sole provider of services for which most pay in advance by way of taxation, have no recourse to non-payment for poor service and have no access to a credible customer feedback/complaint system with which to influence change and quality improvement. Arguably, they are also entitled to receive a world-class quality service.
34. I submit, in the light of the continuing exposure in the media of Trust failures, that if the CoG does not now take appropriate action to deal with public concerns about the Trust Board's competence it will be seen by the public it represents to have failed them or, worse still, to be complicit with the Trust Board in its failures.

RECOMMENDATIONS

35. This Council of Governors Resolves (to be voted on separately) that:

1) It has no confidence in the Trust Board.

2) NHS Improvement be requested to take action along with the Council of Governors to change the Board management necessary to restore the confidence of the public, customers and Governors, with particular regard to the Executive Director positions of Chief Executive Officer, Medical Director and Director of Performance and Safety/Chief Operating Officer and longstanding Non-Executive Directors. Where possible, new appointments to have significant practical experience of world class quality and safety management methods.

3) A full investigation be carried out as to the findings in the Mike Holder Health and Safety Report, February 2012. The investigation, to be carried out by independent health and safety and quality management experts, to establish:
   a. What action has been taken by the Trust to implement improvements to quality and safety management since February 2012.
   b. What further improvement, appropriate to a safety critical organisation, is necessary to the management culture and quality and safety management methods to ensure compliance with the Health and Safety at Work Etc. Act 1974 and prevent further unexpected deaths.

4) Resolution 2 approved at the 26th January 2016 CoG meeting be implemented as soon as possible/prior to the recruitment and appointment of new Board Members:

   “In conjunction with the senior management team, the Council of Governors explore with local Members of Parliament, with the aim of requesting the Secretary of State for Health, to further investigate the change in organisational paradigm of the NHS and the Trust necessary to enable the creation of a no-blame management culture and the achievement of a cost effective, high quality customer driven world class standard integrated healthcare service.”

5) The Council of Governors of Southern Health (NHS) Foundation Trust sends a clear message to the patients, their families and the community that this Council, as their representative body, has both heard and understood them.

John L Green MSc.  8th May 2016  johnlewis.green@icloud.com
1. The Mazars report was published in December 2015. Its main findings were: Management failure – “Lack of leadership, focus and sufficient time spent in the Trust on carefully reporting and investigating unexpected deaths of MH & LD users.” Quality and Safety Management failure – “The Trust could not demonstrate a comprehensive systematic approach to learning from deaths as evidenced by action plans, board review and follow up, high quality thematic reviews and resultant service change.”

2. Prior to December 2015 Governors and the CoG were not provided with details of the Connor Sparrowhawk case (supposedly for legal reasons) or of the Mazars investigation, which they clearly should have been. At 5th January 2016 CoG meeting Governors were publicly criticised (and later in the press and media) for failing in their duty to hold the Non-Executive Directors/Board to account.

3. Complainant Richard West initiated a police investigation under s92 Care Act 2014 to establish whether details in respect of false or misleading information were contained in Trust reports. This investigation is ongoing. In July 2014 Mr West complained in writing to the Trust about the quality of the Trust’s investigation into deaths and to date has still received no reply.

4. 21st January 2016 the Mike Holder Health and Safety Report, February 2012 was revealed by the BBC (Report, press article and radio programme) and sent to JG by Michael Buchanan. Complainants, MPs, Ministers and NHS England also have copies - since early February 2016.

5. At the 26th January CoG meeting a Paper “Causes of Serious Failures of the SHFT which led to the Mazars Report and the Failures Identified in the Mazars Report December 2015” was presented to the CoG by JG. At the meeting JG also mentioned the Holder Health and Safety Report. Two recommendations were made to the CoG in the Paper presented by JG. During the meeting JG was asked by the Chair if he would, in view of some of the views expressed by Governors, delay voting on both recommendations for a later date to allow Governors to learn more at a proposed closed meeting between Governors and the Board. JG stated he wanted a vote taken on the day (to assess the overall view of colleague governors) even though a follow up meeting was to be arranged for Governors and the Board to enable, as he understood it (as implied by the Chair), Governors to investigate further and then if necessary return again to the recommendations. JG clearly stated his understanding at the meeting, which was not refuted. Recommendation 2 with amendments was substantially passed but Recommendation 1 was not supported at this time. Instead a resolution that the CoG should investigate further before deciding what action to take was passed.

6. 4th February 2016 JG, on behalf of a number of Governors, formally (by email) asked over 10 important questions of the Chair about a range of issues including the Mazars Report, Holder Report, numbers of deaths by suicide, details of people who had been dismissed or left the organisation and who had been paid off and a number of issues raised by complainants. Only one question has been partly answered by the Chair in over 2 months.

7. At the closed Governor and Board meeting on 24th February 2016, chaired by 2 independent
facilitators (neither of whose appointment had been agreed with the CoG/Governors), no opportunity was provided for Governors to ask questions of the Board in relation to the Mazars Report, Holder Report or issues raised by complainants. Since then the Board has still not provided an opportunity for Governors/CoG to ask questions of the Board to scrutinise what has gone on, as has been available to local councils one of which, Hampshire County Council (HCC), took a vote, which by no means showed a vote of confidence in the Trust.

8. 9th February 2016 it was publicly claimed by Katrina Percy, CEO, at the HCC HASC meeting that the Holder Report “could not be found in the archives … but anyway it was not relevant to the findings of the Mazars Report”. The Chair refused to circulate a copy of the Holder Report to all Governors and also refused to allow Mr Holder to meet the CoG to express his concerns – formally, by email, requested by JG in early February 2016. A copy of the Holder Report along with Trust letters and a 6th March 2016 Audit, Assurance and Risk Committee report was finally circulated to Public Governor AM in early April 2016. AM shared this information with JG. After reading the documents JG considered that the letter from the Medical Officer to the CEO, dated 26th March 2012, focused on discrediting Mike Holder and did not seriously address the key issues of health and safety deficiencies raised in his Report.

9. 28th February 2016, Mr Holder advised JG that he had requested the Health and Safety Executive (H&SE) to investigate certain deaths – James Youngusband and Connor Sparrowhawk in particular – the latter being on behalf of complainant Sara Ryan who is considering with other complainants both a class action and corporate manslaughter charges against the Trust. The H & SE is now investigating these deaths along with other deaths.

10. The ‘Trust Health and Safety Arrangements’ Paper submitted to the Audit, Assurance and Risk Committee on 7th March 2016 mentions health and safety resources, which is likely still inadequate for the size of the Trust organisation? The Report appears to indicate that the Committee carried no substantial review out of the Holder Report. It also makes no reference to the need radically to improve quality management/safety management systems, which is clearly a main factor in the cause of past failures identified in both the Mazars and Holder Reports. It appears that the CEO, Director of Performance and Quality etc. and the Board still does not, even now, understand what is required?

11. In early April Mr Holder advised JG that he met with the Care Quality Commission (CQC) at some length, prior to their Warning Notice being issued to the Trust resulting from recent investigations by them as to the performance of the Trust. Public Governor MA summarised well the CQC initial findings in their Report soon to be published. In a condemning email circulated to Governors he highlighted:
   a. The Trust has failed to mitigate against significant risks posed by some of the physical environments.
   b. Did not operate effective governance arrangements to ensure robust investigation of incidents, including deaths.
   c. Inspectors found that the Trust did not effectively respond to concerns about safety raised by patients, their carers or staff, or respond to concerns raised by Trust staff about their ability to carry out their role effectively.

12. 16th April 2016 the CQC issued a Warning Notice to the Trust. It appears to very much relate to ligature management failures and property safety deficiencies, which were highlighted in the
Holder Report. It is almost certain, from the Audit, Assurance and Risk Committee Chair reply at the 26th April CoG meeting, that the CEO never submitted the Holder Report to the Board in 2012. All the improvement identified by the CQC should have been done in 2012? Also, the Trust’s proposed improvements in the response to the CQC by the CEO are just more of the same regulation and inspection quality methods involving more committees and more consultants, all of which has proven to be ineffective quality management and safety improvement methodology. After CQC Warning Notice, NHS Improvement appointed Alan Yates, ex NHS CEO to advise Trust Board.

13. 26th April 2016 the result of the Ombudsman investigation into the suicide/unexpected death of Richard West’s son David in 2013 was published. Some of the findings are damning of the Trust.

14. The Trust Board still appears to remain indifferent to the feelings of complainants or incompetent in knowing how to deal with complainants’ letters received in early January 2016. Over 3 months had passed before the Chair got around to responding. Letters were sent on 26th April 2016 by the Chair without approval by the CoG. At the 26th April CoG meeting many Governors considered that a full response should have been made within days or weeks at the most. More to the point, considering the distressing nature of the complaints, Governors of the CoG who wished to do so should have met with complainants to at least hear their views.

15. In spite of the CoG being given many assurances, it is clear that the Trust managers/Board even working with NHS Improvement/Monitor, as it has been doing over the past year or so, is not sufficiently improving investigation methods, or more to the point taking appropriate action effectively to prevent further unexpected deaths. The Trust is still being criticised by coroners. It is also clear that even hyped up regulation and inspection methods of quality and safety management are not effective in preventing further unexpected deaths, which is the object of the exercise in investigating deaths.

16. Increasingly complainants are now going directly to their MPs to obtain satisfaction. MPs have met twice with Katrina Percy to gain assurances regarding improvement. After the last meeting on 19th April 2016, a request, as a result of “serious concerns”, was made by Rt Hon Suella Fernandes MP (chair of Hampshire MPs) for a debate on the Trust be held in the House of Commons after the publishing of the CQC Report.

17. The Trust appears to be continuing to lose the confidence of commissioners and as a result is losing contracts. The most recent was the £5.5 million LD contract with Oxfordshire County Council, which was terminated with the Trust from 31st December 2015 and moved to six new service providers on 1st April 2016.

18. At the CoG meeting 26th April 2016, MA (at the request of JG and AM) asked for an emergency item be put on the agenda to propose a vote of no confidence in the Trust Board. It was agreed to defer the debate to allow 5 brand new and recently appointed Governors to consider the proposal and to wait to hear the results of the CQC Report due to be published before the end of April. It was agreed that an Extraordinary CoG be arranged soon after the publication of the CQC Report. Mike Petter was criticised by JG and AM for not circulating the Holder Report to Governors, because it so obviously in their view related to the Mazars Report. The Trust Board was also criticised by JG for not investigating fully the significance of the Holder Report referred to at the 7th March 2016 Audit, Assurance and Risk Committee. JG also criticised the CEO,
Director of Performance and Quality and the Board for still relying upon regulation and inspection quality management methods, which had noticeably failed and further challenged the Board for appearing to still not to understand the need radically to improve its quality and safety management to standards – as was evident in recent draft reports on quality submitted to the 21st March 2016 Quality and Safety Committee.

19. 27th April 2016 Connor Sparrowhawk death - BBC claimed that that senior managers of the Trust knew about health and safety deficiencies, before Connor’s death but did not act upon them.

20. 28th April 2016 a number of Governors formally registered no confidence in the Chair regarding the handling of reply letters from the CoG to complainants. The Chair Mike Petter resigned.

21. 29th April 2016 CQC Report was published and was damning of the Trust leadership and stated that the Trust was still failing to implement effective quality and safety management systems. NHS Improvement appointed Tim Smart, another ex NHS CEO, to help and assess the leadership competence of the Trust. The appointment of two ex CEOs infers that it has no confidence in the competence of the present Board?

22. 3rd May 2016 a debate took place in the House of Commons on the management of the Trust. https://hansard.parliament.uk/commons/2016-05-03/debates/16050319000003/SouthernHealthNHSFoundationTrust

A number of MPs called for the resignation of the CEO and Board Members and serious challenges were put forward as to the level of funding for MH and LD services and the reduction of acute MH beds in the Trust. Alistair Burt MP, Minister of State for Community and Mental Health stated:

“We have to do both to effect change and to find out what has happened”

23. To date, no mention at any level of Government and the NHS has been made of the Holder Report and its findings, which are significant to the Mazars Report; yet it has been known to them for over 2 months and has led to an investigation being commenced by the Health & Safety Executive.

JG

John L Green 05.05.2016
Mazars Report, Holder Health and Safety Report and Governance

1. I understand that Mohammed Mohammed requested that 43 changes of wording be made to the Mazars Report. Were these changes accepted and what were they?

2. How much money has the Trust so far spent in defending itself against NHS England’s findings of the Mazars Report and is further spending of public money in this regard expected? It is incredible that we are in a situation where one part of the NHS contracts a consultant to carry out an investigation into another part of the NHS and that the latter part of the NHS contracts another in order to defend itself - both using public money. I cannot conceive of a situation where a two separate parts of a large industrial company separately employs consultants/ lawyers to investigate and defend each other in such a manner using company monies.

3. Various local government health scrutiny/select committees, e.g. Portsmouth City Council, Southampton City Council and the Hampshire County Council HASC met recently. Why were my papers (or at least my main Paper, Mazars Etc. Observations by JG) submitted to the CoG on 26th January 2016 not sent to these organisations?

4. Since the Mazars Report, the BBC brought up the issue of the Health and Safety Report written by M Holder, CM IOSH, (Chartered Health and Safety Practitioner), who was briefly contracted by the SHFT in 2011-12 (He was never an employee). http://www.bbc.co.uk/news/uk-england-35357247. Was this report ever placed before the Trust Board and if so what was minuted?

5. At a governor briefing meeting in January 2016 a number of governors were advised that disciplinary action was taken in respect of certain managers and staff involved with the death of Connor Sparrowhawk. What were the actions taken and to whom? In view of the above, did the Non-Executive Directors at the time consider that a similar scrutiny should be applied to senior Trust managers?

Letter and Request for a Meeting From Complainants

6. In Sara Ryan’s (Connor Sparrowhawk’s mother) letter to the CoG dated 02.01.16 she referred to Connor’s death being minuted as ‘death by natural causes’ and refers to minutes of the meeting 23.07.13 p83, which she says were signed off by the Board. Can we see these minutes?

7. Sara Ryan also raised in her email the issue about Dr Murphy banning the use of baths for safety reasons. The letter also requested details about the circumstances of Dr Murphy’s leaving the SHFT and whether whistleblowing (I assume) or other such like additional payments were made to Dr Murphy upon leaving etc. Detailed answers are requested on all these issues. Indeed I would like to know what whistleblowing/extra payments have been paid to individuals where people have voluntarily or otherwise left this organisation in the past 5 years. How much money was spent defending the Trust in legal proceedings in the Connor Sparrowhawk case?

8. I am extremely concerned that, in spite of two written email requests and a number of informal
requests to the Trust from me, that arrangements have not be made for distressed complainants to meet with the CoG or at least a representative/interested group of Governors. Nothing has happened over a period of one month (now three months) to arrange such meetings and I have heard nothing further about arrangements even being considered. Complainant Richard West formally requested such a meeting to myself, on behalf of a number of complainants at the SHFT Board meeting, on the 11th January 2016. To enable governors properly to assess what has happened in the Trust I consider it essential that Governors meet with those complainants that wish to meet us – ideally before the CoG closed 24th February 2016 meeting with the Board and certainly before the next extraordinary CoG meeting to be held in public on 8th March 2016.

**Improvement to Services/Reduction of Unexpected Deaths**

9. It seems that in the Trust's mental health services we are still mainly learning as a result of suicides. Since the death of Connor Sparrowhawk, coroners still appear to be criticizing the Trust. We seem to be giving the impression that we are learning as a result of each death rather than doing anything to prevent further deaths? Surely, based upon past investigations into suicides and attempted suicides over the years the Trust now should have quality management systems in place, which prevent further suicides or is it assumed that some suicides, whatever the resources and treatment provided, will never be prevented? I request that governors be given copies of coroners' statements of suicides, where adverse comments have been made since the death of Connor Sparrowhawk.

10. I would like to know the total number of suicides per annum that have occurred in various areas of our patch e.g. Southampton, Portsmouth, New Forest etc. over the past 10 years. Additionally, I would also like to know the reduction in the level of funding, acute beds and staff to mental health services over the past 10 years.

John L Green

04.02.2016
Dear John

Re: Southern Health NHS Foundation Trust – Management of Health & Safety

Further to your recent request, please find below a summary of my main concerns regarding the management of health and safety at Southern Health NHS Foundation Trust. I must make it clear these concerns were raised with Julie Jones, Sue Damarell-Kewell and Huw Stone verbally during November 2011 to March 2012 during brief one to one’s, emails and written reports.

I did so in the belief that given my experience and scope of engagement, my recommendations would be considered and acted upon. Regrettably this was not the case and I believe that a number of patients died between 2012 and 2016 as a direct consequence of the Trust’s inaction; a view I believe that is supported by the recently published Mazars report and will be by the forthcoming CQC report due at the end of this week.

- The management of health & safety was under resourced given the size of the Trust, the number of properties it was responsible for, the number of patients it cared for and its geographical spread. As a direct consequence the Trust could not meet the general requirements of sections 3 or 4 of the Health & Safety at Work etc Act 1974, Regulation 5 of the Management of Health and Safety Regulations 1999, guidance HSG 65 or other relevant statutory provisions;

- There was no risk register or documentation that demonstrated the Trust had undertaken risk assessments in accordance with Regulation 3 of the Management of Health & Safety at Work Regulations 1999. Although it was understood that this element of software was to be purchased in 2011 year no progress was made regarding its procurement, nor was I involved in the installation or development of any such system;

- The Trust did not have a comprehensive or contemporaneous risk register that helped identify areas of risk either proactively through assessment, inspection or audit or reactively through incident recording or the measuring of performance using key performance indicators insofar as they relate to health and safety. Where registers did exist they did not contain details that enable compliance with the requirements of Regulation 3 of the Management of Health & Safety at Work Regulations 1999;

- The Trust owned in the region of 557 properties. Validation of compliance of the implementation of policies and procedures (which was not undertaken at the time of writing) at a rate of 30% would have taken a minimum of two to three years, during which time patients would be exposed to a risk to their health and safety;

- The Trust did not have trained employees with the experience, competence or capacity to proactively review the environment, work activities within these properties insofar as they related to the safety of patients;

- Ligature assessments were not undertaken in accordance with Trust policy and would not be construed as ‘suitable and sufficient’ with regards to Regulations 3 of the Management of Health and Safety at Work Regulations 1999. Many of the risks identified have not been adequately managed in accordance with the principals of prevention detailed within Regulation 4 and Schedule 1 to these Regulations of the Management of Health and Safety at Work Regulations 1999;

- The Trust considered the risk associated with ligatures was being managed effectively, despite:
– a trend analysis showing a consecutive and significant increase in events over the last five years;
– the existence of ligature points within patients rooms at Ravenswood.

• The geographic and organisational details contained within the incident reporting system did not reflect the organisational structure or geographical spread. The latter affected the ability to accurately input or extract meaningful information, the details of which would be used to identify areas of concern and measure performance insofar as it related to the safety of patients;

• The information provided by the incident reporting systems could not be relied upon to provide accurate statistical analysis of events, assist in the investigation of incidents, or support the implementation of respective policies or procedures;

• Incidents reported on Safeguard were often incorrectly graded, downgraded by administrators or closed without completion of action plans. Any risks identified were not placed onto the risk register;

• The non reporting of a number of events represented a breach of The Reporting of Injuries, Disease and Dangerous Occurrences Regulations 1995, a criminal offence which the Trust was obliged to address;

• Events such as RIDDOR reports, complaints, civil claims, work related absence, etc, were not seen as key performance indicators that fell within the remit of health and safety, although all relate to respective policies, procedures, statutory, CQC and NHSLA standards;

• There was a lack of evidence to demonstrate proactive monitoring or validation of the systems which monitor the design, development, installation and operation of safety management arrangements, risk control systems or workplace precautions;

• There was no other evidence that demonstrated effective reactive systems which monitor accidents and incidents, or management or monitoring of deficient health and safety performance. As a consequence trends could not be established or risk identified such as localities with high incident rates, or whether mortality rate were higher when being seen by a particular clinical team or a member of the medical staff;

• There was no evidence to support the systematic review of performance based on data from monitoring or audits for the whole of the health and safety management system. Having spoken to employees I understand that the previous risk manager was not a qualified safety practitioner, that the previous LSMS only held part one of his NEBOSH Diploma and that prior to his departure, he was instructed not to get involved with any aspect of health and safety.

Given the omissions identified above it was and remains my professional opinion that the general requirements of sections 3 and 4 of the Health & Safety at Work etc Act 1974, Regulation 5 of the Management of Health and Safety Regulations 1999 and the requirements of relevant statutory provisions were not supported by the Trust and as a direct consequence, the safety of patients was and until these issues are addressed, remains at risk.

Should you require any further advice or information regarding the above, do please contact me.

Yours sincerely

Mike

M Holder CMIOSH
Chartered Safety Practitioner
Connor Sparrowhawk death: NHS Trust 'knew of failings'

An NHS trust knew of failings at a care unit 10 months before a teenager drowned in a bath there, the BBC has learned.

A leaked 2012 review found staff did not feel Slade House, Oxford, was safe and that it was dirty and difficult to track the care of patients at the unit. Connor Sparrowhawk, 18, died at the site in July 2013.

Southern Health NHS Foundation Trust said a post-review plan had not been completed before his death.

Updates on this story and more from Oxfordshire

An inquest jury found in October that neglect contributed to Mr Sparrowhawk's death.

Dr Sara Ryan, his mother, said she would be asking police to open an investigation. She said the leaked documents were the "missing piece" for a corporate manslaughter charge, and described seeing the 2012 report as "devastating".

"Numerous things were wrong that were clearly important failings. To think that was known about... is awful, shocking, and harrowing," she said.

"There's so many failings within the failings."
The internal review involved staff carrying out a mock Care Quality Commission (CQC) inspection.

Staff described safety as either "medium" or "low", while others were "very clear" that it was not safe.

There was also a "lack of clarity" around care plans, risk assessments and risk management, and a "gap" between information stored on its electronic system and on paper.

In addition, the review found evidence of "difficulty in maintaining an acceptable level of cleanliness".

The report was undertaken while the trust - which covers Hampshire, Dorset, Wiltshire, Oxfordshire and Buckinghamshire - was in the process of taking over the unit from the Ridgeway Partnership.

Visits by the CQC in 2013 said it needed "urgent" action to make it safer. It has since been closed.

Gail Hanrahan, from Oxford Family Support Network, said the details that had emerged were "heartbreaking" and "incredibly sad".
She added: "The fact that they were flagged up almost a year before Connor died... words fail really, it's just devastating."

The trust said the findings in the review were "circulated to an internal meeting and discussed as part of our governance process".

It said they also contributed to a larger report in October 2012 and that an action plan was put in place.

"However, the trust fully accepts that these had not all been completed at the time of Connor's death," it added.
Sloven and the ligature risks

Posted on April 25, 2016

A few weeks ago, we found out someone sent an anonymous letter to the Sloven CEO in 2011 flagging up health and safety concerns. Katrina Percy was, of course, totally oblivious. An independent Health and Safety consultant, Mike Holder, was appointed to troubleshoot. Two months later, he handed in his notice. Sloven were not prepared to listen or act.

Holder has shared the relevant documents and his leaving report with the Care Quality Commission (CQC), the Health and Safety Executive and Hampshire MPs, Suella Fernandes and Kit Malthouse. I caught up with some of this paperwork this evening. A couple of things leap out (outside of Holder’s meticulous detailing of the myriad ways Sloven were breaking Health and Safety legislation). These relate to ligature risks.

Holder shared this diagram showing the increase in ligature incidents over four years with the Interim Director of Nursing and AHP (dunno what AHP stands for) in Feb 2012.

Her reply is enough to make hair follicles seal up:

Mike

As promised I talked to the Div Directors for MH/LD this afternoon – and it seems this is something of a hot topic – that it would appear needs more debate.

The thoughts from them were that there is evidence of adhering to the policy – the challenge is at what point do the trust board say this is the point at which we will have to tolerate a certain degree of risk – and that may not be the same in very service.

I think perhaps there needs to be a wider debate at either assurance or governance and safety committee as to how we move forward as there is certainly a feeling that we are carrying a degree of risk much of which is mitigated but some which the organisation will struggle to ever mitigate.

Example – ‘Bluebird’ is a ligature tree service – however – one could argue that the young people have access to video games with cables – TV have leads – bedclothes – or any other clothes can be used – so the point being you cannot eliminate the ligature tree – you can optimise the environment – is no exposed pipe work etc but short of having no clothes or bedclothes! There will always be a degree of risk and perhaps that is the focus for policy work…

Perhaps Governance as a start point – what are your thoughts?
Holder’s reply. Challenging the nonsensical with sense and clarity:

An interesting response, given the number of recent near misses/statistics and one that indicates a misunderstanding of the requirements of the Health & Safety at Work Act and associated Regulations. At no point within in any statutory provision is reference made to tolerance to risk, although this can form part of an organisation’s risk management strategy.

From a statutory perspective the Trust has an absolute duty to ensure the safety of its patients, particularly those that are vulnerable. This means that no reference could be made to baseline statistics as a defence in proceedings, i.e. the death of a patient could not be defended on the grounds that deaths of patients occur in greater number elsewhere. To compound the latter, the greater the vulnerability of the individual, the more the law requires the organisation to consider the risk and put in place measures that are proportionate to the degree of risk.

Rich and I chatted about this earlier. He was reminded of this quote from Clifford Geertz, a classic anthropologist:

I have never been impressed by the argument that as complete objectivity is impossible... one might as well let one’s sentiments run loose. As Robert Solow has remarked, that is like saying as a perfectly aseptic environment is impossible, one might as well conduct surgery in a sewer. Sloven clearly and consistently embrace the sewer approach with an abandon and a carelessness that is sickening. [There was another report today about the death of another patient/Sloven failings. Lesley Stevens, who seems to have a full time job attending inquests, was again bleating about ‘changes’.

Changes my arse.

Dipping back to Feb 2012, the second, related point, is around action plans and (non) actions. Someone working with Holder emailed him with serious concerns around ligature risks. The assessor was concerned that either the risk scoring was inaccurate or signalled a general lack of understanding about how to complete ligature risk assessments. Both were deeply worrying. He concludes:

Finally there are action plans in each of the assessments which list all the points where actions are required; there appears to be no record of any actions being completed. This raises the question as to whether the actions have been completed at all, and the assessments not updated to reflect that, or whether the actions are still outstanding.

The same old, same old shite. Across four years now. Documented and shared with the senior management team. Who ignore it.

Given that Holder’s appointment came about because of an anonymous letter raising safety issues, you’d think his resignation and the various health and safety breaches he identified in a couple of months, would be taken seriously. But no. It was business as usual. Six months later, in August 2012, a quality review, detailing shocking failings at the unit where LB died, was similarly ignored. [Howl]

Fast forward to April 2016, whipping past numerous failed CQC inspections, numerous deaths, inquests and Prevention of Future Deaths reports. Past the publication of the Mazars review… to which Sloven, four years after the above discussion about ligature risk, applied the same baseline stats (non) defence. The latest CQC inspection report
will be published later this week. The Sloven senior team are, by all accounts, mounting their schmooze counter-attack. There isn’t a reflexive bone in their collective body that allows them to think, hang on a minute… We’ve really ballsed up here. Repeatedly. Patients have died. Repeatedly. And we clearly can’t do what is needed to improve the services we provide…

Nah. Nothing like it.

This CQC inspection was part of Jezza Hunt’s response to the Mazars review. It was the necessary first step before the CQC and NHS Improvement decide on any regulatory action. [I know]. Given the inspection identified failures generating warning notices a week or so ago. Given everything that has gone before. Given everything. There cannot be any more propping up of this toxic senior management shower. Surely.
Luciana Berger (Liverpool, Wavertree) (Lab/Co-op)
Urgent Question: To ask the Secretary of State to make a statement on the safety of care and services provided by Southern Health NHS Foundation Trust.

The Minister for Community and Social Care (Alistair Burt)
I thank the hon. Member for Liverpool, Wavertree (Luciana Berger) for her question. At the outset of my response, I want to express my deep concern and apologies to the patients and family members who will again have felt let down by the contents of last week’s report from the Care Quality Commission. Our first duty to patients and their loved ones is to keep them safe. This applies to all of us with a role to play in the NHS, from the frontline to this House, and the Government are therefore clear that it is imperative to be open and transparent about what has gone wrong in order to minimise the risk of similar failings occurring throughout the NHS as a whole. We must ensure that the trust itself continues to be scrutinised and supported to make rapid improvements in care. If that means intervention from the regulators, they will not hesitate to take the necessary action, and we will not hesitate to back them.

Last week’s CQC report followed a focused inspection announced and requested by my right hon. Friend the Secretary of State in December 2015. The report from the CQC set out a number of concerns, including: a lack of robust governance arrangements to investigate incidents; a lack of effective arrangements to identify, record or respond to concerns about patient safety; and a need for immediate action to address safety issues in the trust environment. The report also found that the senior management and board agendas were not driven by the need to address these issues. None of those matters is acceptable.

NHS Improvement has taken action in recent months to address the issues at the trust. It has been working closely with the CQC and the trust, and on 24 March, NHS Improvement appointed an improvement director to the trust. On 14 April, following a CQC warning notice on 6 April, NHS Improvement placed an additional condition on the trust’s licence, asking it to make urgent patient safety improvements to address the issues found by the CQC. That condition gave NHS Improvement the power to make management changes at the trust if it did not make progress on fixing the concerns raised.

On 29 April, following the resignation of the trust chair Mike Petter, NHS Improvement announced its intention to appoint Tim Smart as the chair of the trust. As chair, Mr Smart will have responsibility for looking at the adequacy of the trust’s leadership. Given the centrality of issues of governance to the CQC’s report, I welcome the action taken by NHS Improvement. The direct appointment of a new chair by a regulator is a relatively rare step, and it reflects the seriousness of the issues at the trust. NHS Improvement will continue to monitor the situation closely in the coming weeks and months.

I understand that the CQC is considering the trust’s response to its warning notice, and the risks it highlighted, before deciding whether to take any further enforcement action, and none of its options
is closed. The notice required significant improvements to be made by 27 April. Dr Paul Lelliott, the deputy chief inspector at the CQC, was directly responsible for the report, and I spoke to him this afternoon. He informs me that the delivery plan required by 27 April has been received and is in the process of being evaluated. NHS Improvement is working closely with the CQC and the trust, and the improvement director appointed by NHS Improvement is on site regularly, so there is constant independent oversight of the progress being made as well as the formal monthly progress meetings between NHS Improvement and the trust.

In addition to the action we are taking on Southern Health, it is vital that we learn the wider lessons for the NHS as a whole. First, I hope the whole House can agree that it is right that we have robust, expert-led inspection from an independent CQC that provides an objective view about issues of safety and leadership, and that this is backed with action from NHS Improvement where that is required. Secondly, it is vital that we take the issue of avoidable mortality as seriously for people with learning disabilities and mental health problems as we do for other members of our society. To that end, the learning disability mortality review programme has been put in place by NHS England to ensure that the causes of this inequality are understood, and with the aim of eliminating them. In addition, the CQC will be leading a review of how all deaths are investigated, including those of people with learning disabilities or mental health needs. There can be no question but that the CQC report makes for disturbing reading, and that it demands action at local and national levels. We owe our most vulnerable people care that is safe and secure, and I am determined that we will do all we can to ensure patient safety.

Luciana Berger
I thank the Minister for very brief advance sight of his response. Patients and parents have a right to be angry at the failure of Southern Health NHS Foundation Trust, and we in this House have a duty to be angry on their behalf. To read the litany of failure, missed warnings, reports and recommendations ignored, and secrecy over the last four years would make any reasonable person angry, too. Friday’s CQC report shows that very little has been done since the House last discussed the matter in December.

The scandal at Southern Health has happened on this Government’s watch, and Ministers must take responsibility for what has happened to some of the most vulnerable people in our country. We should be angry that Connor Sparrowhawk was left to drown in a bath. We should be angry that Angela Smith took her own life. We should be angry that David West died in the care of this NHS trust—his father was repeatedly ignored when he raised his concerns. All of them were denied the care that they so desperately needed. Last week, the BBC reported that over the past five years, 12 patients who had been detained for the safety of themselves or others have jumped off the roof of a hospital run by this trust. Access to a roof was still permitted to people at risk of suicide. If all those tragic incidents were the only signs of systemic failure, we should be angry, but there is a much bigger story of neglect and malpractice, which aggregates into a major scandal.

When the Secretary of State responded to the urgent question on Southern Health in December, he rightly said:

“More than anything”
people will

“want to know that the NHS learns from”

such
The CQC report published on Friday shows that that clearly has not happened. So I ask the Minister: first, what guarantees can the Minister give to the 45,000 patients currently in the care of Southern Health, and their families, that they are safe? Secondly, where is the accountability, the culpability and the responsibility? There seems to be very little. I heard what he said about the chair, but does he agree that the chief executive’s position is now untenable, and that she should be sacked? Thirdly, will he listen to the heartfelt pleas of the victims’ families, the campaigners, and all of us who are demanding a full public inquiry into Southern Health and broader issues, such as the abject failure adequately to investigate preventable deaths?

As the Secretary of State said in December, such issues are not confined to one trust. The Ofsted-style ratings that he previously mentioned will make a difference only if there is proper accountability and the ability to take action to make real improvements to patient care and patient safety. The families have behaved with such dignity and tenacity, and we owe them a debt of gratitude, but it should not be left to them alone to push for accountability.

I listened carefully to what the Minister told the House, but I remain unconvinced that enough has changed. Four months ago, we heard similar reassurances. Today, we are debating the Government’s failure to act. The time for yet more warm words and hollow reassurances is over. We need action, and we need it now.

Alistair Burt
I thank the hon. Lady for her response. We are not actually debating the Government’s failure to respond at all. The Secretary of State did exactly what he said he was going to do, and the CQC’s inquiry and work that followed can be seen in the report that was produced last week. The report contains a number of further concerns — there is no doubt about that — and people are right to be angry, but there is a process to find out what is going on and to do something about it and that process is in place. That is what NHS Improvement is doing and it is important that that is done.

There is an issue of urgency, which is really important. There are things that are discovered and things take time to get done. I am not content with that in any way, but the process is in place to do something about that. The CQC has been engaged and has ruled out no option for further action. Its options are quite extensive, including prosecution for things that it has found. The process started by the Secretary of State is not yet finished. That my right hon. Friend has demonstrated his commitment to patient safety from the moment he walked into that office cannot be denied by anyone, and this is a further part of that.

I asked the same question that the hon. Lady asked about safety directly to the CQC this afternoon, and I spoke to Dr Paul Lelliott who compiled the report. I asked whether people are safe at the foundation trust today. People are safe because, as we know, the CQC has powers to shut down places immediately if there is a risk to patients. It has not done so, but I am persuaded that if it had found such a risk it would have closed things down. There is therefore no risk to safety in the terms that the hon. Lady suggests.

On the chief executive’s position, the power to deal with management change is held by NHS Improvement. I also offer a brief word of caution. There is a track record of Ministers speaking out, at great cost, about the removal of people in positions over which they have no authority. That is understandable in situations of great concern when an angry response seems right, but it is not an appropriate response. The chair has gone, and processes are available should any more management changes be necessary, which is important. Colleagues in the House can say whatever
they like, but a Minister cannot and must say that appropriate processes can be followed, because that is right and proper.

I do not yet know about an inquiry, and I want to wait and see what comes out of the further work being done in the trust. I do not rule out some form of further inquiry, but an inquiry is physically being carried out now by the actions taking place on the ground. What needs to follow is urgent action to respond to what the CQC has said, and a long drawn-out public inquiry is not necessarily the right answer. More work might be necessary, but I need to consider that in relation to further work being done at the trust.

On preventable deaths, as I made clear in my statement, I am sure that not enough attention has been given to those cases that require further investigation across the system, often dating back many years and preceding this Government. We have turned our attention to that issue, and we will make changes because such inequality must end.

Dr Sarah Wollaston (Totnes) (Con)
The report into Southern Health makes disturbing reading, but we will never tackle unacceptable levels of health inequality and early deaths among those who live with learning disability and mental health issues unless we address safety and risk. Will the Minister go further on the mortality review and set out how we can see where differences exist around the country? Will he reassure the House that duty of candour will in future be more than a tick in the box?

Alistair Burt
A tick in the box for duty of candour, which the report mentioned, was unacceptable—it must mean much more than that. The learning disability mortality review programme is important and will support local areas to review the deaths of people with learning disabilities, and use that information to help improve services. In time, it will also show at a national level whether things are improving for people with learning disabilities, and whether fewer people are dying from preventable causes. That review is already under way in a pilot in the north-east in Cumbria, which will help to inform us how the programme operates as it is rolled out. Plans are in place to roll out that review across all regions of England between now and 2018, with pilots commencing in other parts of the country between 2016 and 2017. That work has never been done before, and it is right that we are doing it now.

Dr Alan Whitehead (Southampton, Test) (Lab)
As the Minister and other hon. Members have said, Friday’s report makes grim reading for the many families and patients in the care of Southern Health NHS Foundation Trust. The Minister said that those failings are not isolated to that trust, but are on a much wider scale. In light of that, is he seriously considering a public inquiry that will get to the heart of the underlying factors in those matters? Patients and families who use this trust—some of whom are my constituents—must be reassured that those underlying issues are being properly considered and not brushed under the carpet.

Alistair Burt
It is vital that they are not brushed under the carpet, and I will come to that in a second. It is important to put it on the record that there are some positive aspects of this report, some of which relate to Southampton. I am sure the hon. Gentleman will already have seen those, with the trust being commended for its work on the community pathway. On the substance of his question, I spoke honestly a moment ago when I said that I really do not know at this stage whether an inquiry is the right thing to do. I am well aware of the seriousness of this matter, of the questions the families have raised, and of the fact that this has been going on for some time. The important thing
is both to effect change and to find out what has happened. The CQC report—the extensive work that has already been done—is in depth, public and transparent. That may well have the answers that are required, but if not, something further may be needed, which is why I have an open mind on this. The most important thing is to give the reassurance that certain things have happened, which the CQC report cannot yet do because that is where the work is needed and where the work is going on now.

Mrs Maria Miller (Basingstoke) (Con)
Our constituents, particularly those with learning disabilities, need to have confidence in the complex set of services provided by Southern Health. The failings that have been identified are completely unacceptable and disturbing, and I welcome the Minister’s statement and the CQC’s action with the warning notice it has issued. Will he join me in paying tribute to the dedicated staff at Southern Health facilities that are not implicated in these serious problems, including Parklands hospital in my constituency, which provides acute wards for adults needing intensive psychiatric care, in a much-needed facility that has very dedicated staff running it?

Alistair Burt
Absolutely. When I got the report over the weekend and turned to the summary of findings, I saw that the first positive summary finding was:

“Staff were kind, caring, and supportive and treated patients with respect and dignity. Patients reported that some staff went the ‘extra mile’.”

It is important to put that on the record; it does not minimise the things that are wrong, but in a trust that is so large, covering such a wide area and so many people, it is important that that good work is recognised, and that errors and faults of management and governance should not be laid at their door. I pay tribute to those staff, who work in incredibly difficult circumstances.

Several hon. Members rose—

Mr Speaker
I just note in passing that four Members on the Opposition Benches are standing and none of them hails from the area covered by the trust. That does not preclude a question, but I should just make the point that the question must be about this trust and this set of circumstances, rather than, as is commonly deployed in this House, “and elsewhere”. It is just about this matter, in this situation, covered by this trust—a matter that will be approached with great dexterity, I am sure, by Ann Clwyd.

Ann Clwyd (Cynon Valley) (Lab)
I will attempt that, Mr Speaker. I just want to ask the following: how long does it take to effect change? Some 45 years ago, the Ely hospital inquiry took place, under the chairmanship of Geoffrey Howe, and recommendations were made. I took part, writing a report on the condition of mental health facilities throughout Wales. We are talking about some 45 years here, and it seems to me that things are going at such a slow pace that we will be asking the same question again in 45 years’ time.

Alistair Burt
The frustration in the NHS is that although what the right hon. Lady says is not true in some places, it is in others; the special measures process in effect at the moment has effected change and has done so more quickly. There are other places where that does not happen. I am concerned that for too long in mental health the sense of defensiveness which we know has characterised parts of the NHS for too long has probably had too great a grip, and we have not always got things done more quickly
or demanded that things are done with the degree of urgency that we would expect, on behalf of constituents. I am very determined that any difficulties in getting things done locally in trusts when they need to be done will not be aided or abetted by any lack of urgency in the Department or the upper reaches of the NHS with which we have contact. The concern to make sure that urgency is there is rightfully expressed by the House, and we have to see that that is delivered.

Dr Julian Lewis (New Forest East) (Con)
In 2011 and 2012, I was locked in a bitter confrontation with Southern Health Foundation Trust over the determination of its top management to close no fewer than 58 out of its 165 acute in-patient beds for people suffering from mental health illnesses and breakdowns. It is the only constituency issue over which I have ever suffered sleepless nights, and I failed to stop the trust closing the Windsor ward in the relatively new Woodhaven hospital in my constituency. Today, apart from this terrible issue about the deaths, the system remains overfull, the beds remain too few and I understand that at least 80% of the in-patients are people who have been sectioned, leaving people a very low chance of getting an elective bed from Southern Health unless they are prepared to wait a long time. Can the CQC look into this wider issue, given that it has so many other serious concerns about the trust?

Alistair Burt
The CQC’s powers are extensive and I know that it will absolutely know what my hon. Friend says. The debate comparing the provision of beds for treatment with community treatment has been going on for some time in mental health, and different pathways are taken by different trusts. Some trusts put more people into beds, while others are doing more in the community. The general sense is that more should be available in the community, but that must not preclude the availability of emergency beds when they are needed. I will ensure that the CQC is aware of my hon. Friend’s concerns about that particular trust.

Paula Sherriff (Dewsbury) (Lab)
Are the failures at Southern Health a symptom of the growing and unsustainable pressure being placed on the mental health and learning disability services? In the context of increased demand, significant pressure on beds, higher thresholds for care, staffing cuts and shortages, how can the Minister guarantee that mental health and learning disability trusts are able to do their jobs?

Alistair Burt
Let me point out that we have announced an increased resource for mental health of £11.7 billion. The extra £1 billion that the Mental Health Taskforce recommended being spent by 2020 will be spent, and it will be spent right across the board from perinatal mental health to crisis care. It will also improve baselines to ensure that the governance and quality of foundation trusts are good enough, and we are watching what CQCs are spending. Yes, we recognise that there has been historic underfunding from Governments of all characters, but we are determined to improve it and the money is there.

Caroline Nokes (Romsey and Southampton North) (Con)
All too often it is our constituents with mental health problems and learning difficulties who find it hardest to get their voices heard. Those who are patients of Southern Health are not in a position to call for urgent change. I note that the Minister has said that the delivery plan is being evaluated, but can he reassure us that that is being done with the utmost speed so that we see improvements on the ground and not just more reports gathering dust?

Alistair Burt
Today, I met departmental officials and spoke to the regional director responsible for NHS improvement and, as I mentioned earlier, the deputy chief inspector of the CQC who is responsible for this report. I can assure my hon. Friend that, in so far as it is up to me or the Department, that change will be adequately delivered with a sense of urgency, because, as she rightly says, patients and families have, in some cases, waited much too long for this. If warm words are to mean anything, we must show that delivery follows.

Greg Mulholland (Leeds North West) (LD)
The failure of care for people with mental health issues, learning disabilities and autism has been shocking and the board should go. Equally shocking is that, 11 months before Connor Sparrowhawk’s tragic and unnecessary death, failures had been identified but not acted on. What can the Minister do to ensure that, as part of a robust inspection regime, when failures are identified they are acted on and done so very quickly to prevent such failures again?

Alistair Burt
Over the past 12 months I have met a number of families who have been victims in similar circumstances—some had children who had been placed badly in an inappropriate place, and, in one or two cases, death had been the result. My colleagues and I are determined to do whatever we can to break down those situations where people feel that they have to fight for everything, and where they find closed doors against them when they want to challenge something. All too often in mental health, when people are challenged, they respond defensively. The whole transforming care process stems from Winterbourne View and the determination of the NHS and the board that monitors and oversees that process, including those who have mental health issues themselves and their advocates. The concerns that have been expressed in the past will not go completely, but I am sure the system is better placed now to deal with them and to listen to people more seriously than was the case, tragically, in the past.

Suella Fernandes (Fareham) (Con)
Does the Minister agree that the resignation of the chairman is a measure of the seriousness of the issue, and that after two damming reports, serious changes in the leadership are needed? What reassurance can he provide to my constituents in Fareham, such as the family of David West, that the regulatory bodies have the powers necessary if intervention is required?

Alistair Burt
I know that my hon. Friend has followed these matters closely for her constituents. Since last year there have been nine changes to the board, and the chair of the board left last weekend. NHS Improvement has the powers to alter governance, and I know from speaking to NHS Improvement that it takes that power and responsibility extremely seriously. The balance is between ensuring continuity and stability so that what the trust has promised is delivered, and wholesale change, which would provide an opportunity for further delay and prevent the work going on, but I know that NHS Improvement is very aware of its responsibilities in relation to governance, as I hope is the trust itself.

Debbie Abrahams (Oldham East and Saddleworth) (Lab)
It is right that this House legislated for parity of esteem for mental health care; I am proud that we did that. I recognise the Minister’s commitment to quick resolution so that we can implement recommendations to address the failings of the trust. Will he consider an independent inquiry similar to the first independent inquiry into Mid Staffs that my right hon. Friend the Member for Leigh (Andy Burnham) initiated in 2010?

Alistair Burt
I can do nothing more than repeat what I said earlier. I am aware that there might be circumstances in which an inquiry would bring out more and would demonstrate the degree of concern that colleagues in the House might find appropriate and that the families and others would understand. My first duty is to make sure that everyone is safe in the trust and to ensure the completion of the work that needs to be done to deliver what the CQC has found. Even after this very thorough work by CQC, which is transparent—that is why we are talking about it today—if anything further is needed, I will give it genuine and serious consideration.

Kit Malthouse (North West Hampshire) (Con)
The Minister is right to call the report disturbing. It has caused alarm and uncertainty across my constituency, and it is with the uncertainty that I hope he can help. In common with other Members, I am keen to know whether he has a hard date by which the trust is to be reviewed again. If it were to fail that hurdle, what would the next action be—revocation of the licence or further improvements? He will understand that most of my constituents want to see a deadline for compliance and after that, significant change that might mean a new era at Southern Health.

Alistair Burt
The best way that I can convey it is to say that constant monitoring is being done. First, the improvement director, who was appointed not by the trust, but by NHS Improvement, is there. In due course he will have a constant presence, but the monitoring needs to be done on a very regular basis. Also, the CQC has made it clear that should there be any need for further unannounced inspections, it will carry them out, so the trust is under constant notice that there can be a further inspection at any time. Further powers of the CQC include issuing another warning notice, varying and removing conditions of registration, monetary penalty notice for prescribed offences, suspending registration, cancelling registration, and prosecution. I understand from speaking to Mr Paul Lelliott that none of these measures has been ruled out.

Marie Rimmer (St Helens South and Whiston) (Lab)
It is that very point I wish to talk about. The duty of candour was going to give us so much more strength, but it is not being applied as yet. It is a statutory duty, placed on people carrying out regulated activities. It can lead to prosecution by the CQC, including without a warning notice. Will the Minister assure me that he will watch carefully to make sure that the CQC uses those powers appropriately? If it does not, we are once again failing these very vulnerable people.

Alistair Burt
Absolutely. If we now have a system where there is, quite rightly, a degree of autonomy, and Ministers’ responsibility is to make sure that the process and the system work well, Ministers cannot make all the decisions personally, but we do have to make sure that decisions that need to be taken are taken and, if not, that there is a good explanation why.

The CQC’s powers have been strengthened. Just a few months ago, we had the first case of a care home owner being jailed because of the care given to people in their home. While I recognise that the work done in caring for vulnerable people is complex and difficult, and that prosecution will not be the right answer in every case, knowing that powers are there is really important. The hon. Lady’s anger is appropriate, and I know the CQC takes these powers very seriously.

Bob Stewart (Beckenham) (Con)
Does the NHS improvement director now have the power to go into any Southern Health NHS Foundation Trust facility to assess and neutralise threats we have learned about that have resulted in people dying?
Alistair Burt
I hope my hon. Friend will forgive me, but I will not say things from the Dispatch Box that I do not know, and I do not know the precise powers of the improvement director, although I know the CQC has exactly the powers my hon. Friend suggests. However, the purpose of appointing the improvement director, and indeed of NHS Improvement’s appointment of the new chair, Tim Smart—the former chief executive of King’s College Hospital NHS Foundation Trust—is to put in place people who know what they are doing, know what they are looking for and can authorise others to make sure that nothing is being covered up and that everything is transparent.

Chris Heaton-Harris (Daventry) (Con)
In this sorry saga, what assurances can the Minister give about current levels of care and safety to the families of patients with learning disabilities who are in the care of Southern Health?

Alistair Burt
I think the best thing, genuinely, is to refer to the CQC report. It highlights good practice and good work in relation to staff in a variety of places and community pathways and in relation to work being done for those with learning disabilities. This is a large trust, covering many areas and many different facilities, and it would be quite wrong to assume that the standard of care is uniform across the board in terms of the criticisms that have been made. The criticisms are very real and very strong, but the work done by individual members of staff caring for people is reported by the CQC to be good. Again, in terms of safety, I am reassured that the CQC has powers and that it has assured me that, if it needed to use those powers in relation to safety and risk to patients, it would do so.

Mr Speaker
I thank the Minister and other colleagues who have taken part in these exchanges. I content myself simply with the observation that they have been a very important treatment of a very important subject. Perhaps, on behalf of the House, I can express the hope that the Hansard text of these exchanges will be supplied to Southern Health NHS Foundation Trust. It needs to know that we have treated of it and what has been said—politely and with notable restraint, but with very real anxiety—in all parts of the House about the situation within its aegis. [Hon. Members: “Hear, hear!”]
An under-fire NHS trust that failed to investigate hundreds of deaths knew about health and safety failings four years ago, the BBC can reveal.

Mike Holder, who was employed by Southern Health NHS Foundation Trust, said record keeping was "haphazard".

He said senior staff at the mental health trust were told safety failings could be breaking the law.

Trust chief executive Katrina Percy said: "We are constantly striving to find ways to do things better."

'Missed opportunities'
Mr Holder, a chartered health and safety practitioner, was employed as the interim head of health and safety at the trust in November 2011.

He said: "They didn't see how health and safety would apply to caring for the people in their care.

"I think their record keeping in general was very, very haphazard. "I think there are missed opportunities and as a result of those missed opportunities, someone has lost their life."

In his resignation letter, seen by the BBC, Mr Holder wrote "existing safety management systems are dysfunctional" when he left in February 2012.

He was asked to set out his findings in more detail and sent a 13-page report. He claimed some incidents were not reported, which was "a criminal offence which you are obliged to address" and safeguarding incidents that were reported were "often incorrectly graded, downgraded by administrators or closed down without the completion of action plans".

Mr Holder said: "When I looked at some incidents I found they hadn't been reported. "Within a couple of months it was quite apparent they didn't have robust systems."

An independent report in December found the trust had failed to properly investigate hundreds of deaths of patients with mental health problems and learning disabilities over a four-year period.

Connor Sparrowhawk, an 18-year-old with learning difficulties, drowned in a bath at a Southern Health building in Oxford in 2013 and the inquest into his death prompted NHS England to commission the report.

His mother Sara Ryan has described the trust's leadership as "rotten" and called for resignations.
Earlier in 2011 Ms Percy received an anonymous letter which said: "The trust is extremely under-resourced to deal with health and safety issues considering the size and complexity of the trust."

In a response to the BBC Ms Percy said: "We are constantly striving to find ways to do things better and challenging ourselves to improve services across the whole organisation, as in any NHS Trust.

"All of the issues raised in the memorandum sent more than four years ago were looked into and addressed.

"Those issues in no way relate to the independent review of deaths of people with learning disabilities and mental health needs in contact with Southern Health at least once in the previous year."
Southern Health is one of the country's largest mental health trusts, covering Hampshire, Dorset, Oxfordshire and Buckinghamshire and providing services to about 45,000 people.
Southern Health NHS Foundation Trust (the “Trust”)

PROPOSED RESOLUTIONS

The following resolutions of the Council of Governors are proposed for consideration at the special meeting of the Council of Governors convened for 17 May 2016:

RESOLUTION 1.

The Council of Governors of Southern Health NHS Foundation Trust sends a clear message to our patients, their families and the community that this Council, as their representative body, has both heard and understood them.

RESOLUTION 2.

The Council of Governors of Southern Health NHS Foundation Trust declares that it has no confidence in the current leadership of our Trust.

RESOLUTION 3.

The Council of Governors of Southern Health NHS Foundation Trust withdraws its approval that Katrina Percy be appointed as the Chief Executive of the Trust and calls on the non-executive directors of the Trust to remove Katrina Percy from the position of Chief Executive forthwith.

RESOLUTION 4.

The Council of Governors of Southern Health NHS Foundation Trust calls on the Chairman, the Chief Executive and the non-executive directors of the Trust to remove Dr Chris Gordon from the position of Chief Operating Officer and Director of Performance, Quality and Safety forthwith.

RESOLUTION 5.

The Council of Governors of Southern Health NHS Foundation Trust calls on the Chairman, the Chief Executive and the non-executive directors of the Trust to remove Dr Lesley Stevens from the position of Medical Director forthwith.

RESOLUTION 6. (This resolution requires a 75% majority)

The Council of Governors of Southern Health NHS Foundation Trust hereby removes Trevor Spiers from the position of non-executive director of the Trust with immediate effect.

RESOLUTION 7. (This resolution requires a 75% majority)

The Council of Governors of Southern Health NHS Foundation Trust hereby removes Malcolm Berryman from the position of non-executive director of the Trust with immediate effect.

Proposer:  
Peter C. Bell  
Public Governor  
Southern Health NHS Foundation Trust  
Date: 7 May 2016
Southern Health NHS Foundation Trust (the “Trust)

PROPOSED RESOLUTIONS

The following resolution of the Council of Governors is proposed for consideration at the special meeting of the Council of Governors convened for 17 May 2016:

RESOLUTION 1.

The Council of Governors of Southern Health NHS Foundation Trust hereby resolves to establish a committee of the Council of Governors to be known as the Governors Public Consultation and Communication Strategy committee. The terms of reference, purpose, membership, attendance, frequency of meeting, authority, duties, reporting obligations and review of the committee to be as set out in Appendix 1. The committee is tasked to present its first report and recommendations for further action to the Council of Governors meeting in July 2016 or as soon thereafter as the next Council of Governors meeting is convened.

Proposer:
Peter C. Bell
Public Governor
Southern Health NHS Foundation Trust
Date: 10 May 2016
Appendix 1.

Governors Public Consultation and Communication Strategy committee

Terms of reference

1.1 Constitution

The Committee is a committee of the Council of Governors of the Trust to be known as the Governors Public Consultation and Communication Strategy committee. The Committee may exercise such powers of the Council which have been expressly delegated to the Committee in these terms of reference and which are not reserved to the a meeting of the full Council of Governors.

1.2 Purpose

1.2.1 This Committee is responsible for creating, updating and reviewing a strategy for the Council of Governors which promotes and supports the duty of Governors either as a body or individually to consult with the members of the Trust and with the Public and for the Council of Governors either as a body or individually to communicate to the member of the Trust and to the Public such information as properly ought to be communicated to them.

1.2.2 The Committee will have the delegated power to produce one or more documents or reports setting out a proposed strategy for approval by the Council of Governors.

1.2.3 The Committee will at all times act in accordance with the Constitution of the Trust and the Standing Orders adopted under the Constitution.

1.3 Membership (including quorum)

1.3.1 The Membership of the Committee shall comprise of not less than three of the Public Governors of the Council of Governors and all members of the Committee shall be either Public Governors or Staff Governors of the Council of Governors. One of the members of the Committee shall be appointed Chair of the Committee by the first meeting of the Committee. In the absence of the Committee Chair and/or an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

1.3.2 The Council of Governors shall appoint and remove members of the Committee.
1.3.3 A quorum shall be three members or 50% of the members of the Committee whichever shall be the greater.

1.4 Attendance

1.4.1 Any member of the Council of Governors shall be entitled to attend and be heard at any meeting of the Committee. However only members appointed to the Committee may vote on matters before the Committee.

1.4.2 The Committee may invite the Chief Executive or the Director of People and Communications to attend committee meetings.

1.4.3 The Committee may require the attendance of any non-executive director or any executive director of the Trust at any of its meetings.

1.4.4 The Committee shall meet in public and may invite any member of the public to address the Committee.

1.5 Frequency of meetings

1.5.1 The Committee shall decide at its first meeting the frequency of meetings and the format of those meetings.

1.6 Authority

1.6.1 The Committee is authorised by the Council of Governors to take action in respect of any activity within its terms of reference.

1.6.2 The Committee is authorised by the Council of Governors to obtain external legal or other independent professional advice after having consulted with the Chair of the Council of Governors.

1.7 Duties

1.7.1 The Committee is responsible for producing a draft strategy together with supporting proposals including draft budgets and draft policies and procedures for consideration by the full Council of Governors and for keeping the strategy (once approved by the Council of Governors) under review and proposing additions to or amendments to the strategy.

1.8 Reporting

1.8.1 The Committee shall cause formal minutes of its meetings to be produced and a summary of the proceedings of the Committee shall be submitted to the Council of Governors at the succeeding meeting of the Council of Governors.
1.8.2 The Committee will report annually to the Council of Governors in respect of its fulfilment of its duties as set out in these terms of reference and shall prepare a report to be submitted to the annual meeting of members.

1.9 Review

1.9.1 The terms of reference of the Committee shall be reviewed annually by the Council of Governors.

1.9.2 During the review, the Committee will be assessed to ensure that it has performed in accordance with these terms of reference, specifically that:

- the Committee has carried out the duties required;
- the Committee has reported to the Council of Governors as required;
- Membership, frequency of meetings and attendance has been as stated;
- the Committee has been quorate each time it has met.

END OF TERMS OF REFERENCE