Derbyshire Healthcare
NHS Foundation Trust

Improvement plan in response to recommendations outlined in the independent investigation into the care and treatment of Mr. S 22 September 2017

In 2010 a very serious incident occurred in Derbyshire, which involved an individual in receipt of mental health services (Mr. S). Immediately after this tragic event, Derbyshire Healthcare NHS Foundation Trust undertook an internal investigation, in order to explore the care and treatment provided to Mr. S and to identify any learning. An action plan was developed in response to this internal investigation, which has now been completed in full.

Separate to the Trust's internal investigation, NHS England commissioned an independent investigation into the care and treatment provided to Mr. S. This report is being published today (22 September 2017). It is usual procedure for NHS England to commission an external report following a serious incident of this type, which involved a patient in receipt of mental health services. The report and its associated recommendations come from a non-NHS organization.

A draft copy of the independent investigation report was shared with the Trust early in 2017. The report and its recommendations have been accepted in full by the Trust.

The Trust has developed an improvement plan in response to the recommendations outlined, which follows below. This improvement plan has been in place since April 2017 and builds on actions already undertaken as a result of our own initial internal investigation. The improvement plan will continue to be updated and the Trust is committed to implementing all the report's recommendations in full.

Derbyshire Healthcare NHS Foundation Trust deeply regrets the missed opportunities outlined in this report. We offer our sincere apologies to the families and friends of all those affected by these tragic circumstances.

Ifti Majid
Acting Chief Executive
Derbyshire Healthcare NHS Foundation Trust

Key:

Complete	In process	Attention required	Not started

	Recommendation	Comments from the Independent Investigation	Action and associated progress	Timescales
1.	**Ensuring formal adherence to the Care Programme Approach**	i) Whilst the investigation team acknowledges services were responsive (providing the person with both psychology and admission whenever required), they did not follow a formalized CPA process and were not able to obtain as full an understanding of Mr. S as they might have.	The Trust has committed to revise its CPA Policy in two phases. The first phase, to revise the policy in full, has now been undertaken and the new policy was ratified by the Trust's Quality Committee on 7 September 2017. The new policy includes clarification in respect of the role of a care coordinator and includes expectations in respect of family inclusive practice. The second phase will outline expected standards at each level of CPA, changes to electronic pathways and records to enact in practice, alongside further revisions in line with national recommendations and changes currently in development. Phase 2 is due to commence in November 2017 In addition the updating the CPA policy, the model of CPA in the Trust is in full redesign. Staff have been engaged through surveys and wider conversations regarding the changes have identified, which would support them in better implementing the CPA process. This engagement took place	Phase 1 has now been completed. A model of CPA is scheduled to be introduced new in **September 2018.** Phase 2 of further additional CPA service has now commenced and a new model has been designed and is in place Full development day has been undertaken at the end of 2017 12/12/2017. Consultation – Trust wide and communicating (Dec

			over the Spring/Summer of 2017.	A draft policy has been drafted, and has been out to consultation, and has now been supported by the COO and DON. This draft policy has been amended based upon National CPA conference with Dept of Health. Redesign and final revisions to draft policy, staff engagement in July and August 2018review.				
		ii) The ethos of the CPA should be reflected and strengthened in the training programmes staff are required to attend and the priorities identified in individual and group supervision.	The Trust has revised its CPA training programme to reflect the developments outlined in the new CPA policy. , Ongoing compliance checks will take place through supervision and audit processes.	A new training programme has been running since December 2017 and this model has been embedded into all training courses.				

		iii) Caseload management supervision should include routine review of all cases to ensure the appropriate applications of the principles and ethos of the CPA have been addressed, and to enable corrective action to be taken if required.	Following implementation of the new CPA policy, team managers will audit all current CPA records every six months.	Audits are now in place and will remain in practice as part of clinical governance procedures. CPA audits are active. Revised new model will occur on new levels of care and CPA. Care plan and practice audits have been redesigned and regular audits are occurring through a new automated process. (KW)- May audit completed. Scheduled for next governance				

		iv) The implementation of this recommendation should be monitored by periodic audit.	A summary report will be received by the Trust's Quality Committee for assurance every six months.	Reports are now submitted to the Quality Meetings in weekly meetings on the wards and in monthly to four weekly meetings in community settings. Caseload supervision audits are is being monitored via the monthly dashboard. This is presented monthly in assurance report CPA audits are carried out monthly and reported in the performance dashboard. Additional quality checks are undertaken on the quality of those plans by the Quality committee on six monthly basis.				

		v) The Trust's CPA policy and auditing of that policy should ensure that CPA Care Plans reflect the ethos of CPA in order that current psychiatric, social, family circumstances	A working group is reviewing ways to improve process and embed the ethos of CPA in clinical practice. A staff survey is underway to gather innovative ideas and suggestions.	The following have now been completed/in place: • Survey • Development documents • Working group – monthly • New model drafted Care plan and CPA audits have occurred, these reported to the Quality committee in a six monthly report to report on a monthly basis				

		and risk characteristics of service receivers are addressed and that individual service receiver centered care can be delivered.						

		vi) Management supervision of caseloads and co-ordination via the CPA must be enforced separately. These pre-existing processes must be used more effectively. The effective implementation of this recommendation should be monitored.	Team Managers will audit all current CPA records every six months. This process will commence in October 2017 and will include compliance checks on the quality of management supervision in place, to ensure that it is occurring and is effective. This will recommence once the phase 2 revision of the CPA policy is complete. Outside of the audit, additional random checks will also be undertaken by nursing and quality team, with direct feedback to the practitioner and manager concerned.	This is now part of on-going clinical records audit. Caseload – A CPA audit is now in place with reports to the Quality Committee on a 6 monthly basis EPR automated compliance checks on safety plans and Care plans are now in place on a daily basis, which has been rolled out Trust wide with weekly reports for community settings.				

2.	**Working with carers (and family members, where applicable)**	i) ”Consent to share” information should be updated regularly to promote effective communication between the practitioner, the service receiver and carers/family members. Protocols and policies should be introduced to secure this.	Consent to share policies are to be reviewed by the Trust’s information governance group in 2017. Standard operating procedures on updating family and key person/carer details will be audited as part of team manager audit of CPA every six months. Clinical teams and administrators are aware of this development and clinic based reviews have commenced, reconfirming details and contacts at clinics since June 2017.	. Consent to share policies are in place, up-date family and care details are in place. This will be included in the CPA audit Routine updating family and key person/carer details has commenced in out-patient clinics and will continue Trust wide in the next APRIS upgrade scheduled for Q3 2018 In progress.				

			The next phase will be to reconfirm consent to share information in new leaflets and structured programmes to check and ensure consent to share is refreshed as part of the reviewed CPA process at all clinical care levels.	Roll out is now completed and will be revisited in new policy implementation Consent to share is being audited in this cycle and will be revised further with changed in GDPR.				
		ii) Those closely involved in care should always be given a contact point to access the Mental Health system in a crisis. Communication should be established as early as possible.	Family/carer contact cards have been in place since 2012 and were revised in 2014. The cards were redesigned in 2017 and supplemented with the SBARD communication tool. The Trust's safeguarding lead has commenced an audit of the use and value of the contact cards. Discussions with family and carer groups have commenced, with a formal audit scheduled for November 2017. The cards will be revised following feedback received through this process.	Formal audit schedule Now in place 1. SBARD crisis numbers, Carers Handbook updated 2. Nov 2017 – Christmas card project with crisis for individuals and family disseminated- completed 3. Feedback from carers, 4E's used and valued 4. Survey January on use and improvement.				

		iii) The Trust reviews its policy for identifying carers and making it more flexible in its assessment and easier for individuals to be recognized and therein supported as "formal" carers.	A new Carers' Strategy has been developed and was launched throughout the organization in January 2017. The strategy will continue to be updated and audited. Triangle of care benchmarks will be continually revisited and reinforced.	Complete Leaflets have been reprinted Triangle of care level 2 was achieved Triangle of care level 2 achieved				
		iv) Collateral histories should be taken from carers/family	A new safety planning process was piloted in 2017 and introduced in April 2017 which	Complete.				

		members to secure a greater insight into a service receiver's situation and those of the carers/family members themselves.	includes an assessment of historical and current risks, informed by collateral histories. The new process for developing a patient safety plan includes family history and collateral information from a formal carer or family's perspective. We have trained over 90% of our staff to date. This process has been included in the Phase 1 Policy review. Think Family and family inclusive practice training has been completed since 2014 and at March 2017 was at over 85% of staff.	Complete.				
			The new safety planning process includes assessment of historical and current risks informed by collateral histories. Collateral history taking is included in safety planning training and suicide awareness training and process, which all clinical staff undertake.	This practice is in roll out and FACE risks screens are phasing out over an extended period. No new FACE assessments are completed since March 2017. The expected completion of roll out is 01/09/19. A further review of the completion in all cases will be reviewed in September 2018 (in line with new automated EPR process)				

		v) In order to obtain a comprehensive understanding of the service receiver's current psychiatric, social and family circumstances and risk characteristics, the Trust's Quality Assurance Programme should be revised to ensure	Collateral histories are collected to inform patient safety plans. A new process for developing effective patient safety plans was rolled out in April 2017. A review meeting was held with clinicians in July 2017. A second review meeting was held in October 2017 to continue this work and full Trust wide implementation.	In place This practice is in roll out and FACE risks screens are phasing out. A further review of the completion in all cases will be reviewed in September 2018				

		that teams are required to actively seek carers/family members' involvement and views.						
		vi) The standard practice of clinical teams in relation to this recommendation should be monitored by periodic audit.	The following periodic audits have been scheduled: Audit of carers' operational plan is scheduled for 2017's work plan ~ Audit of safety plan scheduled for the 2017 work plan	June 2018 The Trust wide dashboard with monthly audit, measures the up-take and roll out of safety planning March 2018 New compliance model of checks on safety plans completed and full Trust roll out is expected by September 2018		~		

3.	**Improving liaison with family after adverse events**	i) The Trust must take steps to demonstrate greater awareness of the knowledge levels of family members of victims, their specific backgrounds and insights and their interactions with the Trust post-incident.	Learning from these tragic circumstances is to be incorporated into the Family Liaison Service's operational practice. Operational processes have been improved and are described in the updated Learning from Serious Incidents and Deaths Policy, which was received by the Quality Committee in September 2017.	Completed Policy standards and practice up-dated Family liaison model visited by joint NHS E and NHS I and evidence provided of model and impact				
		ii) The trust implements and enforces policies to ensure that, in homicide/suicide cases such as this, the families of the victims are supported, continuously apprised of developments post incident and generally made to feel as though they are 'involved' in the process and not 'just forgotten about'.	A new family liaison service was established in Summer 2014, and the service became fully operational in 2015 to support families following serious incidents such as this. The service will continue to develop and learn from incidents to embed learning and make improvements to our operational practice. Operational processes have been improved and are described in the updated Learning from Serious Incidents and Deaths Policy, which was received by the Quality Committee in September 2017. This service will continually reflect upon Family and carer feedback to improve the service experience.	Complete. Audit / feedback on family liaison service – 2017/2018 (year end).				