Improvement plan in response to recommendations outlined in the independent investigation into the care and treatment of Ms Z 24 July 2017

In 2013 a very serious incident occurred in Derbyshire, which involved an individual in receipt of mental health services (Ms Z). Immediately following these tragic events, Derbyshire Healthcare NHS Foundation Trust undertook an internal investigation, in order to explore the care and treatment provided to Ms Z and identify any learning to ensure a similar incident was prevented from occurring again. 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 external review of the care and treatment provided to Ms Z. This report is being published today (24 July 2017), and the Trust's action plan in response to the recommendations outlined, follows below. 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 organisation.

The draft report was shared with the Trust in February 2017. The report and its recommendations have been accepted in full by the Trust. The action plan which follows has been in place since February 2017 and has been updated to reflect progress against each of the recommendations at 24 July 2017. The action plan will continue to be updated and the Trust is committed to implementing all recommendations in full. A number of the recommendations were identified in the Trust's own internal investigation report and are therefore complete, whereas some recommendations were slightly different or had a different perspective and therefore the Trust seeks to do further work to ensure all changes are introduced and embedded into current working practice across all of its services.

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

Ifti Majid
Acting Chief Executive
Derbyshire Healthcare NHS Foundation Trust

Improvement plan in response to recommendations outlined in the independent investigation into the care and treatment of Ms Z 24 July 2017

Key:

Complete	In progress	Attention required	Outstanding

	RECOMMENDATION	ACTIONS IDENTIFIED TO ENABLE IMPLEMENTATION	TIMESCALES	PROGRESS TO DATE				
1	Consolidating/fully reviewing all medical records		Complete	The Trust has now embedded an electronic patient record, which is accessed by all mental health clinicians. Inter-connectivity has been achieved with wider clinical systems in order to extend the record to wider services (including drug and alcohol services). This access to shared electronic patient records enables teams to work collaboratively and communicate with all involved in an individual's care and manage risk. This supports effective use of CPA. Additional training has been provided to Trust staff in this respect. This action was identified by the Trust's internal report in 2014 and was a known risk, with mitigation plans in place as we progressed to a full electronic patient record.				
		Promote access to GPs	December	Developments with the electronic patient record				

			2017	have enabled local GPs with access to all records and prescribing information. The Trust is currently promoting this access and associated benefits for GPs. Substantial improvement in GP's sharing records on System One and additional Q1 work on maintaining this (Safeguarding data). This is increasing clinical information, sharing. Access for clinicians to this record within IG sharing records-sharing with consent is expanding This is now embedded and rolled out , and available to services, to all areas with this EPR system. Information is also supplemented in 24 hr access in A&E, and extended hours in, in the Multi-agency communication hub in Derbyshire Police Head quarters.				

	a)The Trust takes steps to unify paper and digital patient records		All patient records are currently inter-connected. The Trust will continue to progress this action.	Unifying our clinical records to a single electronic patient record has been in progress since 2011. At the time of this incident, paper records were in place and the electronic patient record was in developmental stages. Whilst our electronic patient record is now in place, the need to have one single set of historical patient information remains important. To achieve this, clinicians working across our services have access to inter-connected electronic systems to ensure they have access to the most up to date information about the individuals in their care. Continual reviews of an individual's history take place during CPA reviews and during the patient safety planning process. Both of these processes create an electronic summary of an individual's clinical history. New functionality to link and connect all records live in Sep and Oct 2017 went live. In addition continued review of clinical risk history in risk history and profiles continue. In addition the new Criminal Justice team has gone live in (January 2018) with extended model and service with full access to all service records. This team has access to all records. There is a multi –agency communication hub in police head quarter which reviews and shares information. Derbyshire CCG has commissioned a community forensic service which will be reviewed and liaising in complex cases, with the need for case formulation and review. The length of time of community EPR is increasing and long term risks are gradually reducing. Full unification of all records will occur over 12 months period				

	b) Following this unification, patients' historical records must be reviewed and summarised at key stages in their care	Update to staff training required	Training is now being delivered. We aim for this approach to	New guidance being delivered to staff during training highlights potential risks that arise upon discharge or transition and the requirement to review notes at these stages. In CPA and in Patient Safety planning- a new summary of care needs is implemented. This will continue to be developed and refined. Automated compliance checks are in pilot stage for the in-patient areas and are rolling out trust wide. This is monitoring a review of patient safety plan at key stages of care e.g. such as admission.				

			be fully embedded into our services by June 2018.	Existing training has included the importance of historical records and the need for these to be reviewed. We have introduced a new safety planning process which includes a historical risk perspective and we are training staff in this new model.				
			Review to be complete by March 2018.	We are also seeking to lead a review of patients with key characteristics in their risk profiles. A nationally recommended model has been identified for this purpose and the Trust is currently in conversation with Commissioners to support the use of this model. A pilot of high intensity management has been confirmed for a pilot in (March 2018). Commencement date to be confirmed. Funding has been agreed and appointments to Police and nurse post has commenced. Service to be operational in May 2018.				

	c) Progress against these recommendations to be monitored and audited		March 2018- completed in February 2018 Next committee May 2018	The Trust has established plans to audit the impact of all changes made in response to the learning from this case. Additional audits are planned to review aspects of safeguarding adults, pertinent to this case. Scrutiny of these audits will take place at the Trust's Board Level Safeguarding Committee. This has occurred again in May 2018 and will continue. Safeguarding committee has received regular up-dates on progress and each board level committee receives a copy of this action plan.				
	d) The findings of these audits are to form part of discussions at regular Quality Assurance Meetings		March 2018 completed in February 2018 Review quarterly until completed	The outcomes of the audit identified above have been scheduled for regular discussion at the Trust's Board level committees for quality and safeguarding. The March QAG meeting will reviewed the implementation of these action plans – scheduled. The February and May Safeguarding committee reviewed progress against the action plan. These action plans are reviewed at each QAG review with commissioners. Last review May 2018 In addition NHS England have commissioned an additional 6 month review, e, interviews took place in May 2018.				

2	Responding to the service user's needs a)The ethos of CPA should be reflected and strengthened in training programmes	Ensure importance of family collateral patient safety review and a historical review of risk is reflected in updated training.	New training programme is underway. Revised CPA policy to be published by September 2017.	The Trust's CPA policy is undergoing significant review and a task group has been established, led by named safeguarding adults and clinical leads. The revised policy will reflect national best practice. Ongoing engagement will continue with staff to understand the ethos of CPA including promoting a continual review of longitudinal risk and using collateral information from families. Completed on a new additional model designed for roll out Jan 2018 Quality Committee. The Trust has developed a number of events to focus on learning from this case, including CPA. The use of CPA is monitored on our quality dashboard. CPA training is in place and staff are attending. This training will be further reviewed following the implementation of a new Trust-wise CPA policy. Learning from this incident is also featured in the Trust's safeguarding adults training, to ensure learning Further CPA reviews have been undertaken with Neighborhood CPA review last meeting held on the 7th March. CPA training continues, trust attendance at national conference on CPA includes, the Trust changes and developments.				
		Teams to evidence family inclusive practice in quality visits.	Complete	key recommendations are also considered from a safeguarding perspective. All clinical teams receive an annual quality visits and the programme for 2017 is underway. As part of this visit, teams are required to produce evidence of how they embed family inclusive practice or the Triangle of Care within their services. Triangle of Care Level 2 Trust wide was achieved in Nov 2017. (External audit and validation).				

		Update Carers policy to strengthen in respect to ethos of CPA.	Complete	Additionally, the Trust now has a ratified Carers Policy and is actively investing in the next stage of its Triangle of Care accreditation within the Carers Trust. Actioned Nov 2017.				
	b) Every six months all CPA records should be audited by managers to establish: • If CPA is being correctly applied and adhered to • If risk assessments are up to date • If staff are having regular supervision which includes providing care which recognises the ethos of CPA	Ensure supervision is taking place on a regular basis and is recorded.	June 2018	Supervision processes include caseload management supervision and the application of CPA. Steps have been taken to ensure all supervision is taking place on a regular basis and is recorded. We are able to see that this approach has resulted in an increase in the frequency of clinical supervision. This learning commenced initially with the teams directly involved in this case and has extended to the wider organisation. A continual review of supervision is in place. In addition, the use of CPA is included in the Trust's clinical records audit alongside caseload supervision standards, caseload review and clinical practice. A new clinical safety planning approach was introduced in April 2017, replacing the FACE risk assessment across adult services. This new approach will raise clinical standards as well as being more person-centred and longitudinal in its approach. The new approach means we are working side-by-side with service receivers being cared for				

				through under CPA so that they are encouraged to be the authors of their own 'safety plan'. This is something that is helping us to better understand our service receivers as individuals, and empowering them to think about how they can keep themselves, our staff and the public safe. CPA Audit – Jan 2018 (Quality Committee). Next CPA and care planning audit underway and completed in May and to be presented at next governance meeting 2018. EPR automated pilot model implemented in May 2018, roll out Trust wide.				
			Complete January 2018	Processes are in place to enable an escalation of issues from supervision to the clinical risk register or clinical operational (COAT) effectiveness audit has been completed. We are also making sure appropriate action is taken where clinical supervision has identified that staff are not meeting required standards. This includes capability procedures. We also have mechanisms in place to recognise good practice and to share this with wider staff. Improvement in supervision / continued improvement on quality of supervision. Next CPA and care planning audit underway, completed in May 2018 and presented at next committee.				

	c) Adherence to this recommendation to be audited on a six monthly basis		2018/19 Monthly reporting March 2018	Full roll out to be completed in 2017/2018 and full compliance with audit checks. A further audit will be undertaken as part of the introduction of a new CPA policy/ Phase 2 model. A patient safety planning audit has also been agreed for inclusion on the audit plan. This is included in the Monthly dashboard in addition there are additional checks on the quality of patient safety plans, that have been rolled out. An NHS England review of recommendations was undertaken in May 2018				

3	Improving long term care a) Regular audits to ensure managerial supervision policies and procedures to facilitate supervision are being used to promote the delivery of service user centred long terms care.		Complete January 2018	Management supervision performance has substantially improved. Additional audits of supervision and record keeping standards are to be maintained as per other actions. In addition audit will include qualitative and quantitative compliance audits. Evidence in Dec 2017/Jan 2018 Jan Quality Committee report. Supervision compliance continues to increase, regular audits and checks are completed. Next CPA and care planning audit underway in May 2018and presented at next committee				
	b) The audit process should include scrutiny of current samples of actual care delivery at every level to ensure clinical practice reflects the delivery of service user care viewed from a long term perspective.		Complete	Supervision compliance has significantly improved – both in respect of rates and depth. Clinical examples are scrutinised as per the revised supervision policy. In addition, compliance checks on risk assessments and personalised care plans have been undertaken and improvements have been endorsed by regulators. Processes are in place to enable an escalation of issues from supervision to the clinical risk register or clinical operational COAT A group effectiveness audit has been completed. We also have processes in place to ensure appropriate action is taken where clinical supervision has identified that staff are not meeting required standards. This includes capability procedures. We also have mechanisms in place to recognise good practice and to share this with wider staff. Nov 2017 continued with improvements in this area.				

4	Working with family members and carers a) Consent to share information should be updated regularly to promote effective communication between services, the service user and family members/carers. Protocols and policies should be introduced to secure this.		June 2018	The Trust is undertaking a project to ensure that we have up-to-date details of family and carers included on the electronic patient record. This will enable our teams to more effectively seek collateral histories and any wider relevant information from families. This project will be prioritised according to identified risks. This is supported by our SBARD communication tool and increased information being made available to families and carers. The process outlined above will be audited for completeness. The Trust's approach is secured in the new family and carers strategy. Evidence through achievement of ToR Nov 2017. Consent to share is revised with GDPR, and further new revised audits on family and carer information and consent to share will continue				

	b) Close family members should always be given a contact point to access the mental health system in a crisis	Further scrutiny of all offers of psychological support against up-take in 2017/2018.	Complete	The Trust introduced a new family liaison service in 2014. The service is now fully operational and has made early contact with families when significant incidents have occurred. Family Liaison can refer to access (internally) psychological support, CAMHS, family therapy and therapy support. This has been offered post 2014. External support can also be accessed where appropriate. The Trust has also funded psychological therapy external to the Trust/NHS resolution. This offer remains an open offer to families affected. This remains open indefinitely for the named family.				

				The Trust has developed a new, innovative communication tool (SBARD) which enables family members to share information with a clinician involved in the care of the individual concerned. This tool has proved successful to date and is being extended as best practice tool to wider mental health trusts. We have revised and reissued our family and carer support leaflets. Easily located information has been included on the Trust's website in order to provide access to support and information in a crisis. The rollout of the new mental health liaison service provides rapid access to support in a crisis.				
	c)The Trust reviews its family involvement strategy		Complete	The Trust's new family and carers strategy states that information should be shared wherever possible and that contact should be maintained with families and carers. The Trust has championed the 'Think Family' model and has 85% staff trained in 2017. We will continue to provide ongoing advice to clinical staff to enable them to share information and remain in contact with families and carers. These messages are also supported through additional safeguarding adults training to				

				maintain practice.				
	d)The Trust's Quality Assurance Programme be revised to ensure that teams are required to actively seeks family members' involvement and views		Complete	Teams are required to actively seek family members' involvement and views. The Trust's quality visits programme seeks evidence of family inclusive practice and ward visits include the active involvement of patients and carers.				
	e)Collateral histories should be taken to secure a greater insight into a service user's situation and those of the family members/carers themselves		September 2017	The Trust is developing a new family collateral information plan which includes a contact person for the family, in line with the wider review of CPA. Designed – roll out in Jan 2018, over a 12 month				
5	Learning from adverse events a) The Trust's framework for investigating serious incidents be reviewed		October 2017	A review of the Trust's serious incident process is underway. This was completed as per national timescale As part of this process we have been piloting the Human Factors approach (HFACS), which includes James Reason's wider work on systems learning. Learning from this pilot will be used to update the Trust's Serious Incident policy in addition to recommendations from the CQC National Quality Board requirements. A Trust-wide leadership event on learning from the experience of these families was held in 2014/2015 and again in 2016. A national event in 2017. A further event, learning from this case took place in July 2017, for all senior leaders where feedback was very positive on the dissemination of learning was completed.				

	b) The Trust to take active steps to ensure staff and clinicians are supported in relation to serious incidents		Complete July 2017	A support session has taken place to reflect on learning from this case, which had good attendance. Direct engagement has taken place with all staff directly affected by this case, in order to provide additional support and/or engagement. Staff working within our services have been involved in a learning review to embed changes into practice and cascade this learning throughout the organisation. Staff who did not attend the support session are being followed up for direct engagement/support. Further follow up in Jan 2018 – to follow up "Where are we now?" "Is there any more learning from the event?" The safeguarding lead will re contact remaining staff, to see if they would like a final session on any learning. 31st March 2018, further up-date required and no uptake- to date.				

			Complete	The Trust has apologised to all staff involved in this case, for their lack of support and put steps in place to ensure personalised support is available where required. A “buddy” system has been developed to ensure staff who experience such very serious incidents receive appropriate support, which has been activated. Wider team members have provided additional support to individuals throughout this process, including additional psychological support through peer support with follow up. Independently, NHS England has met with staff their experiences and reflections on the investigation process and impact. Staff have been notified prior to the-publication of this report, with additional support put in place at this time.				

			March 2018	Evidence of up-take is reviewed through health and safety and additional assurance checks undertaken. Staff support is included in Health and safety report 2018 The PIPS model of debrief is actively used The psychological support, has had mixed feedback been used. A further HR review of the Psychological support service has been requested to ensure this is an accessible service and does not result in referral to GP only				
	c) The Trust must implement processes to ensure learning from adverse incidents in order to embed learning in the day to day practices of those responsible for delivering care	A summary of the findings/recommendationsfor this case has been shared with the teams directly (not just those involved) to continually cascade the learning.	Complete	The Trust's Medical Director has recently led a fourth event for staff to learn from the recommendations of this case. This follows three previous events facilitated by the Director of Nursing and Patient Experience, who has sought to continually engage with all staff to ensure learning from this incident. This has included a focused reflection and learning event for mental health and drug and alcohol services. Learning from this incident is also included in a number of Trust training courses, including using collateral family information more extensively.				
			Complete	New processes are in place to ensure that the Lead Psychologist receives all notifications regarding incidents of this type. Requirements for staff support are also				

				Identified at an early stage through alerts generated by the Trust's electronic recording of all incidents.				
			March 2018- after year end in April for May	Uptake of psychological support offered is monitored at year end. Report requested from HR on actual uptake, for submission to May Safeguarding committee. Revised to People and culture committee and confirmation too Safeguarding committee at next meeting.				
			Complete	In the event of a serious incident, processes are now in place to hold immediate staff briefings. Members of the Trust's serious incident reporting group directly contact staff, depending on the nature of the incident and the actions required. Key lead roles have been identified to provide direct and rapid support to teams following an incident (through Heads of Nursing/Lead Psychologist).				

	d) The Trust must take steps to demonstrate greater awareness of the knowledge levels of family members of victims, their specific background and insights and their interactions.		Complete Ongoing	In 2014/2015, the Trust held leadership events on learning from the family of a young man with a learning disability who died in a Learning Disability service (incident from outside of Derbyshire). The family experience and NHS England videos on the family experience. In addition, an external independent investigation company provide a teaching event to all senior leaders on learning from very serious incidents and the experience of the family. The family's experiences in this case have also directly contributed to and featured within the training offered to our staff. The Family Liaison service is an important addition to support this work. Protected time to support families is critical to embedding practice in this area. The Trust's Executive and Board members have written to the families involved in this case to formally apologise and offer support. Facilitated through NHS England, the Trust and family members have agreed to meet to further discuss the independent investigation report once it has been published. This remains an open invitation to the named family. This remains open in March 2018, this offer remains open indefinitely.				