Independent Investigation Action Plan for Mr B (WEB7835)

South London and Maudsley NHS Foundation Trust Statement
We offer our sincere condolences to the family of Mrs B. The Trust is addressing the recommendations made in the independent investigation by ensuring actions are implemented to improve practice and to embed the lessons learnt. The actions will be reviewed by lead clinicians in the Quality Committee, directly monitored by the Trust Board of Directors and the Croydon Commissioning Group. We hope this offers some assurance that the lessons identified in the independent investigation have been learnt from this very tragic incident.

Croydon Health Services NHS Trust
Croydon Health Services would like to offer our condolences to the family of Mrs B. Croydon Health Services will continue to work with South London and the Maudsley NHS Foundation Trust to ensure that the dual note entry process is completed as standard. This will be monitored through South London and the Maudsley NHS Foundation Trust's monthly reference group and exceptions reported to the CAG governance executive meeting.

NHS Croydon CCG
Croydon CCG work with South London and the Maudsley NHS Foundation Trust to seek assurance that the services they provide are safe; effective; caring and responsive. Croydon CCG will continue to monitor the implementation of this action plan through a number of monitoring processes including: bi monthly local Clinical Quality Review Meeting (CQRM) - The CQRM provides commissioners with assurance by reviewing a range of evidence, provided by the Trust, to ensure they are providing services in line with the requirements stipulated within the contract held between the CCG and the Trust, the NHS Constitution, and Fundamental Standards of Care regulations. In this context, the meeting monitors and receives assurance on the Trust's implementation of specific actions resulting from Serious Incident investigations, Domestic Homicide Reviews, and Mental Health Homicide Reviews such as this case

Recommendations	Update since 2012	Leads	On-going Actions	Implementation by when	Evidence	Monitoring & Evaluation
Priority One Recommendations						
Recommendation 1 The Trust must ensure that up to date, comprehensive care plans are in place for all patients under the care of liaison psychiatry, home treatment team and Croydon Triage, particularly those who have been detained under the Mental Health Act and who are subject to Care Programme Approach. The Trust must also review and monitor an ongoing audit programme to provide assurance about organisational compliance with this requirement.	Since 2012 the Trust has made progress to ensure effective systems are in place for care planning across all services. From 2016 home treatment and acute inpatient services are operationally delivered as one service line. This has ensured that home treatment and the inpatient wards work closely together to plan care and manage risk. The Trust's operational protocols clearly set out the importance of establishing as early on as possible the reason for referral to home treatment or the purpose of admission to inpatient services. This has been critical in supporting care planning for patients during the respective treatment episode. The Trust has a well-established programme of audit to check the completion and quality of risk assessments against trust guidelines. This has been informed by on-going feedback from the Care Quality Commission (CQC) and the Trust's commissioners. The governance processes within the Trust have undergone a thorough review to ensure assurance is provided on quality and compliance. The Trust has reviewed the documentation	**<u>Psychological Medicine & Integrated Care CAG</u>** Clinical Director & Deputy Director **<u>Acute Care CAG</u>** Clinical Director, Deputy Director – Crisis Care & Deputy Director – adult inpatient	• The Digital Audit Tool for quality will be expanded to evaluate treatment plans formulated by liaison practitioners that are included in GP letters. • Continue to ensure that crisis plans of known services user are kept up to date by the relevant community teams. • The findings from digital audits of care plans will continue to be a standing agenda item to discuss and act upon by the CAG governance executive meetings. •	Implementation of amended digital tool by 31/03/2018 Further actions relate to the monitoring of the existing SLaM processes. Review and monitoring of the efficacy of actions due: 31/10/2018	Care plans are being completed in line with Trust standards. There is work being undertaken to improve quality of care plans and ensure that they are linked to the risk assessment. Evidence includes • CAG governance committee minutes • Quality Sub Committee minutes • Audits – Trust wide and local • Performance and Contracts Committee minutes	Each CAG has a monthly governance meeting chaired by their Clinical Director this forum is used to review the audit programme and its findings. Locally, randomised audits are completed by team managers on a monthly basis. If care planning falls short the completing practitioner will be expected to rectify the issue with in two working days. Assurance about audit process and associated action is reviewed at the Trust's Quality Sub Committee, which is chaired by Board Members. In October 2017, the Executive Director of Nursing chairs the Trust's Quality Governance Compliance meeting, held monthly to monitor the Trust's quality priorities and actions arising from CQC action plans. The Chief Operating Officer chairs the Performance and Contracts Committee reviewing the Performance Management Framework. This monitors compliance with key areas including clinical risk for patients on CPA, mandatory training and care plans

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	used for care plans and risk assessments. From January 2017 a single risk assessment is used in adult mental health, this tool links to the inpatient and home treatment team care planning tool. The care planning tool allows the creation of care plans based on identified risks and needs which ensure care plans are comprehensive and appropriate. In community services a Recovery and Support Plan has been developed to support clinicians to develop a comprehensive care plan considering a patient's needs and risks. This includes sharing information with others. The Trust has worked to ensure systems are digitalised and taken directly from the clinical notes. This includes compliance/completion information is available to teams via the My Dashboard function in the clinical notes system. This allows real time monitoring of compliance with care planning. A digital audit process ensures that care planning in both home treatment and inpatient services is not only completed but to a high quality. This digital process provides an audit framework and centralises the results. The digital audit of the quality of care plans commenced in October 2017, these require each CAG to review care plans completed within their services with the findings being reviewed in CAG governance meetings. The findings of the audits are reviewed at Acute Care Clinical Academic Group (CAG) governance executive meetings to monitor progress and implement actions where practice falls short. As psychiatric liaison services are based in Accident and Emergency Departments, a separate formal care plan is not devised because episodes are usually one off. The treatment plans for patients assessed in this setting are communicated in writing to the GP with a copy to the patients. There are specific documentation standards that are monitored by the clinical service lead and the findings are shared in the Psychological Medicine and Integrated Care CAG governance executive meeting.					being offered to patients. The Trust's Quality Committee, chaired by a Non-Executive Director provides oversight to the individual CAG governance meetings.

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	Patients who are receiving care from other part of the service must have a crisis plan that liaison practitioners in A&E can use to inform next steps in crisis management. The next step for the psychiatric liaison service is to expand the digital audit tool to reviewing GP letters. These approaches apply to all patients accessing crisis care, regardless of Mental Health Act Status or whether they are subject to the Care Programme Approach (CPA) or not. Any future developments in care planning processes will be auditable using the Trust's digital audit tool.					
Recommendation 2a The Trust must ensure that risk assessments and risk management plans are in place for all patients under the care of liaison psychiatry, home treatment team and Croydon Triage, particularly those who have been detained under the Mental Health Act and who are subject to Care Programme Approach. They must also be reviewed when new information comes to light. The Trust must also review and monitor an ongoing audit programme to provide assurance about organisational compliance with this requirement.	Since 2012, the Trust has undertaken a number of quality improvements in regards to risk assessment and risk management plans. This has included recovery orientated crisis planning for known patients, development of a new electronic risk assessment tool and ensuring risk assessment is the foundation of care planning in the inpatients and home treatment services. Crisis planning, particularly for people with a personality disorder, is informed by NICE guidance. With development of psychological treatments for people with personality disorder working collaboratively with service user to manage their risk is a central feature of this therapeutic work. This collaborative approach is embedded across all our treatment services and these plans follow service user when they are accessing crisis services (liaison psychiatry, home treatment and inpatient services) As a result of our journey over the last 5 years, which has been informed by feedback from the Care Quality Commission (CQC)the Trust have developed a single electronic comprehensive risk assessment tool that was implemented in January 2017 that is used by all of our services. The tool includes assessment fields for the common clinical risk domains. This information is then used to develop a risk formulation that informs clinical management. The management plan is incorporated into the assessment tool and articulates what the action is and by whom.	**<u>Psychological Medicine & Integrated Care CAG</u>** Clinical Director & Deputy Director **<u>Acute Care CAG</u>** Clinical Director, Deputy Director – Crisis Care & Deputy Director – adult inpatient	• Continue to ensure that a schedule of monthly randomised auditing of risk assessments is carried out by each team • Continue to ensure that crisis plans of known patients are kept up to date by the relevant community teams. • Continue to ensure that findings from digital audits of risk assessments are a standing agenda item to discuss and act upon by the CAG governance executive meetings.	Further actions relate to the monitoring of the existing SLaM processes. Review and monitoring of the efficacy of actions due: 31/10/2018	The audits to date demonstrate good compliance with the risk tool. A programme is in place to support staff in improving risk formulation, which has been identified as an area of development. Evidence includes • CAG governance committee minutes • Quality Sub Committee minutes • Audits – Trust wide and local	Audit programmes are discussed in the each CAG's monthly governance executive meetings. This meeting is chaired by a Clinical Director. Assurance about audit process and associated actions are reviewed at the Trust's Quality Sub Committee, which is chaired by Board Members. Locally, randomised audits are completed by team managers on a monthly basis. If care planning falls short the completing practitioner will be expected to rectify the issue within with one working day. The initial phase of local audits has indicated that there has been an improvement in compliance with risk assessment standards in the PMIC CAG. Governance meetings are monthly with the next meeting scheduled for 7 February. The Acute CAG have doubled the number of records audited for quality between November and December 2017. The initial results are being reviewed within the CAG governance executive and will result in an action plan to improve quality. Governance meetings are monthly with the next meeting scheduled for 1 February.

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	The assessment tool also includes an evidence based clinician rated outcome assessment for people who are actively suicidal. Once the risk management plan is completed, the risk domains identified for a service user are automatically populated in their care plan. Compliance/completion information is available to teams via the My Dashboard function in the clinical notes system. This allows real time monitoring of compliance with risk assessment standards. As with care planning the Trust's digital audit includes a review process for risk assessments, which is subject to the same scrutiny as care plans. As part of the risk assessment audit the Trust looks for evidence of regular review. Where there has been no change in risk the assessment should be reviewed six monthly. Where there has been a risk episode or change in risk, this should be updated on the day of the issue coming to the attention of the service. As with care planning these approaches apply to all patients accessing crisis care, regardless of Mental Health Act Status or whether they are subject to the Care Programme Approach (CPA) or not.					
Recommendation 2b The Trust must ensure when assessments of clients who are in police custody are undertaken, that clinicians obtain a clear history from police staff about the client's forensic history.	The Trust has criminal justice in mental health teams who provide assessments in police custody. The teams signed an information sharing agreement with the Metropolitan Police in 2015. Within this there is specific reference to a client's offending history. The Trust's staffs are encouraged to routinely enquire about Police warning markers and a summary of offending history, particularly in regards to violent offences as this informs our own risk assessment. However it is at the discretion of the Custody Sargent if they share information about offending history as this is on a case by case basis.	**Behavioural and Developmental Psychiatry CAG** Clinical Director Patient Safety Lead for Mental Health, NHS England (London Region)	• No on-going actions identified for SLaM • NHS England London Region will share the independent investigation with the Metropolitan Police via the Independent Incident Review Group (IIRG) to allow the Metropolitan Police to consider any additional actions	Agreement signed in 2015 February 2018	• Minutes of the Police Liaison Committee • Information sharing agreement • E-mail advising of the outcome of the discussion at IIRG	The Trust's Behavioural and Developmental Psychiatry Clinical Academic Group have oversight of the Criminal Justice in Mental Health Services. The Police Liaison Committee provides an interface between the Trust and Police services. Case specific issues can be brought to this forum. The chair is the Service Director of the Behavioural and Developmental Psychiatry CAG. NHS England Independent Incident Review Group

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Recommendation 3 The Trust must ensure that all staff consider the role of carers and that carers assessments and appropriate support are offered and documented, this includes drawing up an accurate family diagram. The Trust must also review and monitor an ongoing audit programme to provide assurance about organisational compliance with this requirement.	The Trust has taken a number of steps since 2012 to consider the needs of carers and their role in care. The Trust is committed to implementing the national standards from the Triangle of care. In 2015 the Trust produced guidance on How to find the right balance – Carers and Confidentiality to provide clear guidance on how Trust staff should engage with carers and inform carers of what to expect from SLaM services. The Trust has a Family and Carer's handbook with the second edition published in 2017. Both documents are available on the Trust external website which allows carers to access these at a convenient time. These are designed to empower carers to raise concerns and to ensure that staffs are confident in responding appropriately and sensitively. The Trust has reviewed the documentation of carer's assessments to ensure these provide the best support to carers and family in August 2017 the Trust introduced the updated Carers Support and Engagement Plan which is designed to ensure that staff identify and engage with carers and then offer appropriate information and support. The plan pulls through all relevant carers from the patient's clinical notes. The plan is printed and given to the carer as a summary document. The plan has a dedicated section about a service user's background, which includes prompts about significant relationships. In addition, the Trust's child risk screen requires data about a service user's contact with children and other people who have regular contact with the identified children. When the patient is able, we will gain a more in-depth understanding of significant relationships. We will also work with people close to the service user to gather this information, especially in the inpatient setting. Relationships with family and carers are considered as part of the assessment completed by an Approved Mental Health Practitioner for services users detained under the Mental Health Act, this social information to inform the Trust's own assessment.	Director of Social Care & Prof Head of OT/Lead Social Inclusion and Recovery	• Compliance to be added to individual team dashboards • The Trust will continue to monitor completion through the monthly Quality Compliance Meeting	March 2018 Further actions relate to the monitoring of the existing SLaM processes. Review and monitoring of the efficacy of actions due: June 2018	• Minutes of Quality Compliance Meetings • Carer support lead meetings • My Team Dashboards	The Quality Compliance Meeting monitors completion on a monthly basis. The Director of Social Care chairs a carers support lead meeting on a monthly basis which provides oversight of the plans. The Family and Carers Committee meet bimonthly, this meeting involves members of the local community and Trust staff.

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Recommendation 5 The Trust must ensure that when a diagnosis is recorded appropriate plans are put into place for ongoing treatment and support and this is reviewed and amended, if appropriate, when any changes to the diagnosis are made. The Trust must ensure that when changes are made to a patient's diagnosis, the management plan must be revised accordingly and must be consistent with the revised diagnosis and the patients' needs.	Specialist community teams provide interventions based on diagnosis. Since 2012 The Trust has implemented a personality disorder clinical pathway, which supports correct and timely diagnosis. People with personality disorder are supported by treatment community teams who review care and treatment at a minimum of six months. It is at this review that either confirmation or change of diagnosis is made. Appropriate care planning and risk management will be put in place. The diagnosis will be changed on the clinical record and communicated to the GP. The Trust developed a personality disorder c with implementation from July 2015 onwards. With the development of improved access to services for people with personality disorder, there has been an overall improvement in timely diagnosis. However, for people who are not known to service the diagnosis of personality disorders is informed by an on-going assessment. This is because certain personality disorder can be missed diagnosed, especially when a person is misusing substances. The Trust must be certain before we give this diagnosis to a service user because of the impact this can have on their life. This is particularly challenging when there is limited contact with mental health services in the past. Education and support is critical before feeding back this diagnosis and as already mentioned this will take time.	**Psychological Medicine & Integrated Care CAG** Clinical Director& Service Director	• Continue to ensure that as part of the CPA review process that diagnosis is reviewed, documented and communicated to the service user and other relevant parties. • Continue to ensure that at the point of changes to diagnosis care plans and crisis plans are reviewed where appropriate. • CPAs are reviewed monthly by the CAG	Further actions relate to the monitoring of the existing SLaM processes. Review and monitoring of the efficacy of actions due: October 2018	• Examples of CPA meetings • Minutes of CAG operational executive meeting	Compliance of the Care Programme Approach review meetings will continue to be monitored at the CAG operational executive meeting. The CAG hold a monthly care pathway executive, which reviews clinical pathways (to include personality disorder). The review explores progress against key performance indicators. Progress with care pathways is regularly discussed at the Trust's Quality Sub Committee, which is chaired by Board Members. The CAG reviews this in the CAG operational executive
Recommendation 8 The Trust and Croydon Health Services Trust must ensure when a patient attends A&E for treatment and is seen by the liaison psychiatry service that appropriate records of that attendance and any interventions are recorded in line with both organisational record keeping policies.	The Trust have continued to ensure that all Psychiatric Liaison Team staff located in Croydon University Hospital have access to A&E records. Access to CHS A&E records by liaison staff, continues to be available-currently on electronic systems and previously on paper systems - for the outcome of their assessment to be recorded in these records. Clinical practice continues to require dual note entry which has been emphasised and highlighted. From December 2017 the Trust has received confirmation that an electronic solution has been successfully implemented to more easily facilitate dual record entry by the Trust team on both CHS and SLAM records through a single computer terminal - completed action	**Psychological Medicine & Integrated Care CAG** Clinical Director & Deputy Director	• Audit of documentation by the Psychiatric Liaison Team to take place to provide additional assurance • Continue to work with Croydon Health Services NHS Trust to ensure good standards of documentation in both systems. • On-going monitoring of established actions as per monitoring and evaluation column	May 2018 Further actions relate to the monitoring of the updated SLaM processes. Review and monitoring of the efficacy of actions due: June 2018	• Minutes of the reference group	Monitor at the monthly reference group and escalate issues to the CAG governance executive meeting for review and action.

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	December 2017. Electronic flags have now been placed on electronic patient record systems for both CHS (CERNER) and SLAM (EPJS) for highlighting risks, actions and completion of care plans.					
Recommendation 13 The Trust must ensure that prior to discharging a client there should be an appropriate discharge plan and risk assessment in place that are shared with appropriate community staff and other agencies. Where possible this plan should be agreed and supported by the client and (subject to client consent) their carer.	There is a clear interface between community teams and inpatient services. Prior to admission the Trust's Acute Referral Centre identifies any potential barriers to discharge which is shared with the inpatient and community team. Within the Acute Referral Centre there is a Clinical Lead who focuses on the interface between the inpatient and community team. Each inpatient ward holds ward rounds which invite community staff and key agencies to be part of their care plans. The Acute Clinical Academic Group, who are responsible for adult inpatient beds, in 2017 the CAG developed and implemented the admission and discharge checklist which supports the implementation of the Trust Discharge and Transfer Policy. This also contains a discharge plan which can be hand written or typed and given to the client and relevant professionals. The CAG are undertaking a Quality Improvement in this area to monitor its efficacy and ensure implementation.	**Acute CAG** **Head of Nursing** **Clinical Director** **Service Director**	• A Quality Improvement piece of work is underway to improve the communication between inpatient and community teams in Lambeth. The learning from this will be shared across the Trust • The Acute CAG will continue to monitor and embed the Admission and Discharge Checklist using quality improvement methodology. • The Acute CAG will review the efficacy and provide an update on learning will be shared through the Serious Incident Review Group.	March 2018 Further actions relate to the monitoring of the updated SLaM processes. Review and monitoring of the efficacy of actions due: October 2018	• Admission and Discharge checklist • Audit of use of checklist • Summary of Quality Improvement Project findings	The Acute CAG Governance Executive provides oversight of the improvements made. Serious Incident Review Group and Quality Sub Committee.
Priority Two Recommendations						
Recommendation 4 The Trust must review the impact of the changes to policy and processes for child safeguarding, including obtaining feedback from staff about how effective the new processes are.	The Trust has reviewed the Safeguarding Children Policy, Principles and Procedures v5 (2015) since 2012 and currently provides training at differing levels with a plan for refreshers. This forms part of the Trust's mandatory training and is monitored in clinical teams and centrally through the	**Safeguarding Team** Director of Social Care & Trust named nurse for Safeguarding Children and Domestic abuse lead	• The Trust will discuss this recommendation in the Safeguarding Committee to gauge the efficacy of the new processes and identify any further actions.	Action to be raised under any other business at next Trust Safeguarding Committee on 18 January 2018	• Training compliance figures for mandatory training • Compliance meeting minutes • Safeguarding committee minutes	Compliance with the policy and feedback from each of the Clinical Academic Groups is through the Trust Safeguarding Committee. The Trust's Quality Sub Committee, which is chaired by the Executive

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	education and development department. Levels include • Safeguarding Children Level 1 • Safeguarding Children Level 1 and 2 • Safeguarding Children Level 3 The Trust revised the Safeguarding children documentation on the clinical records system and implemented revised documentation which allows improved monitoring of safeguarding by flagging to users entering a patient's clinical notes.		• A policy review is scheduled for July 2018. This report and recommendation will be considered as part of the policy review.	July 2018		Director of Nursing and provides oversight of the Safeguarding Committee and Policy. The Trust's Safeguarding Committee reviews and ensures that the Trust's safeguarding policies are embedded and appropriate. The Chief Operating Officer chairs the Performance and Contracts Committee reviewing the Performance Management Framework. The Committee monitors each CAG's compliance with mandatory training.
Recommendation 6 The Trust must clarify the care pathway for patients with personality disorder and ensure that staff are aware of the referral criteria for access to psychological services.	Since 2012, the Trust have developed and implemented a Personality Disorder Clinical Pathway in July 2015. The pathway has four tiers based on a patient's needs: 1. Peer support for people with personality disorders 2. Access to personality disorder specific therapies within the community team that the person accesses. Long term therapy for people whose risk is managed is available in our secondary psychological therapy services. 3. 18 month structured day programme for people with complex needs 4. Access to personality disorder inpatient programmes for people who cannot be discharged from hospital until they receive this treatment (this is external provision to the trust and funded by NHS England) The Trust believes that this pathway has improved the experience and treatment outcomes of people with a personality disorder. Critical to ensuring that the person is accessing the right part of the pathway is engagement and on-going assessment.	**Psychological Medicine & Integrated Care CAG Clinical Director& Service Director**	• Continue to monitor the efficacy of the Trust's Personality Disorder Clinical Pathway. • Identify resources to implement new evidence based treatments.	On-going with monitoring through the Psychological Medicine and Integrated Care Pathway Meeting monthly.	• Trust pathway is available and due for review in 2019 • Minutes of the Trust's Quality Sub Committee • Minutes of the Psychological Medicine and Integrated Care Pathway Meeting minutes	The CAG monthly care pathway executive reviews progress against key performance indicators. Progress with care pathways is regularly discussed at the Trust's Quality Sub Committee, which is chaired by Board Members.
Recommendation 7 The Trust must ensure that processes are in place to trace the correct GP for clients when a client record indicates that a client is not registered with a GP; and that this must be undertaken within seven calendar days.	The Local Care Record launched in February 2016, the system allows GP and local hospital records to be viewed from within the Trust's clinical notes for Southwark and Lambeth patients. GP registration can be identified and confirmed by all clinical staff. The Trust is currently working with other boroughs to replicate this system.	**Medical Director**	• The Trust will review the current system of providing access to the NHS Spine to ensure that all clinical services have access • The Trust will continue to work with other Boroughs are part of the integration of	April 2018 Review of current stage due April 2018	• Team dashboards to indicate where incomplete • The Trust's national publications show that we are achieving 99.4%, which is higher than both London and National average. • Report of the number of active users across the	Director of Performance to continue to provide data as part of our business intelligence reporting. All CAG executive teams review compliance on a regular basis. Chief Operating Officer to review data as part of the trust's

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	For all boroughs, clinical teams have access to the NHS Spine which provides current details of GP. This forms part of the admin roles within teams and is monitored through Business Intelligence Dashboards. The Trust's Acute Referral Centre ,triage all potential admissions to hospital) has access to the NHS Spine which provides details of patient's GP. This will be flagged before admission to inpatient services. There is an admission and discharge checklist in place which contains a prompt to clinical and administration staff to confirm a patient's GP status.		records		Trust	performance review framework.
Recommendation 14 The Trust must identify all stakeholders required to be present on the Board Level Inquiry panel at the point that investigations are commissioned, in order to reduce delays in implementing lessons learned. **And** **Recommendation 15** The Trust must manage clinical and organisational commitments appropriately to ensure that they do not cause delays in investigation of serious incidents and implementation of learning.	Since 2012 the Trust has amended the process for sign off for comprehensive serious incident investigations. The commencement and sign off of incident investigations are through strategy meetings to ensure all stakeholders are present to review and agree the specific actions before the sign off of the report. Where the allocated lead is not available they will be consulted with to ensure the action is appropriate and can be implemented. The Trust holds Lessons Learned events on the themes from serious incidents and complaints. Lessons are taken into the Team Leaders events, safeguarding events and shared with the education and training team to ensure that training is designed with an awareness of real life situations and learning from serious incidents. The Board has a quarterly report on the lessons learned from serious incidents. This is reviewed and any actions identified for further learning. The report is published on the Trust's intranet and shared with staff via CAG governance committees and team leader meetings. Blue Light Bulletins are produced where specific learning and/or actions are identified. These are circulated widely throughout the Trust and reviewed in teams across the Trust. Locally, each Clinical Academic Group holds a serious incident panel which reviews serious incident investigations and monitors learning from action plans. The panels review and	**Executive Director of Nursing**	• The Trust's audit department are currently completing an audit on the Lessons Learned from incidents including compliance with timescales for completion. Actions will be identified from the audit with oversight from the Quality Committee. • The Trust is commissioning an independent human factors consultant to review the themes and lessons from serious incidents to identify further recommendations.	March 2018 April 2018	• Completed audit • Minutes from Trust Serious Incident Review Group • Summaries of lessons learned events	Clinical Quality Compliance Meetings, Serious Incident Review Group, Clinical Academic Group Governance Meetings and the Trust Board have oversight of these processes. The Learning lessons report will be taken to the Trust Board on a quarterly basis. The Quality committee and Serious Incident Review Group will receive the Learning Lessons audit. The independent review will be taken to the quality committee for review and identification of any further actions.

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	identify if there is learning to be shared across the Trust. The Trust has moved away from paper based action plans moving to an electronic system. The system allows actions to be themed, evidence to be uploaded to support the implementation and progress of actions. Actions are allocated to a lead which results in a notification email to be sent to them. Clinical Academic Groups monitor actions as they are nearing their due dates and provide reminders to leads. Real time dashboards can be produced to allow oversight of outstanding and overdue actions. Local Serious Incident Panels were established with each of the SLaM commissioners to ensure there was adequate monitoring and oversight of learning. From December 2017 onwards, the Executive Director of Nursing commenced a single monthly Serious Incident Review Group which has oversight of all serious incidents within the Trust. The Group joins commissioners and clinicians from the Trust to review investigations and agree actions plans. The Executive Director of Nursing chairs monthly Clinical Quality Compliance meetings, these monitor the implementation of actions from serious incidents.					
Recommendation 16 The Trust must review the detail of the actions taken in response to the complaint made by Miss N to assure them that the failures in investigating and communicating in a timely fashion cannot be repeated.	The Trust provides weekly monitoring updates to each of the clinical academic groups, Chief Executive and Executive Director of Nursing. These monitor compliance with the timescale for complaints. The Quality Compliance Meetings chaired by the Executive Director of Nursing provides individual CAG monitoring. Any delays to complaints being completed are reviewed in details to ensure that complaints are signed off.	Deputy Director of Nursing	To strengthen the Trust's complaint policies several actions have been identified. • The Trust will amend the part 1 strategy meeting standard agenda for any concurrent processes to be referenced to ensure agreement on the investigation process • The Trust investigations policy will be reviewed and amended to outline how complex investigations can be investigated through the complaints and incidents processes • The Trust Complaints policy will be updated to provide clarity on the investigation	Completed in December 2017 April 2018 June 2018	Trust Serious Incident Review Group will ensure the actions are monitored and implemented. Quality Sub Committee will provide oversight and sign off of any policy amendments. The Policy Working Group will oversee the policy updates with policy bulletins being completed to notify staff of the changes within these. • Revised complaints policy	Trust Serious Incident Review Group will ensure the actions are monitored and implemented. Quality Sub Committee will provide oversight and sign off of any policy amendments.

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			processes			
Priority Three Recommendations						
Recommendation 9 The Trust must ensure that community staff understand and comply with the lone working policy and that staff read the records and undertake an appropriate risk assessment about the home visit prior to leaving Trust premises.	Since 2012, the Trust's lone working policy requires each community service to have a local lone working protocol. This requires practitioners to communicate home visits to the duty worker for that day. It is the duty workers responsibility to liaise with the practitioner to ensure they are safe. A discreet password unique to the team would indicate if a practitioner was in trouble. The protocol is also clear that when a service user has a history of violence, visits should be in pairs. This approach was validated by the Care Quality Commission in 2016.	**Risk and Health and Safety Team** Head of Risk and Assurance	• The Health and Safety Fire Committee will review the lone working policy in 2018. • Continue to annually review local lone working protocols compliance against the trust's Lone Working Policy.	March 2018 Further actions relate to the monitoring of the updated SLaM processes. Review and monitoring of the efficacy of actions due: September 2018	• Minutes of CAG performance executive meetings • Minutes of The Health and Safety Fire Committee	Local Lone Working protocols will be reviewed annually as part of the Trust's health safety assurance framework. Lone working protocol reviewed in the CAG performance executive meetings as a standing agenda item. Action is taken where teams do not provide assurance. The Health and Safety Fire Committee will provide oversight of the policy and will review in 2018.
Recommendation 10 The Trust must make the following amendments to the domestic violence policy so that it is in line with best practice: • clarify the Trust responsibility and commitment in providing the working environment and comprehensive training required in order that practitioners are able to meet their obligations safely and effectively; • clarify the Trust response when it is identified that an employee is a perpetrator of domestic violence; • Include more detailed responsibilities for responding when victims or perpetrators of domestic violence are identified within the workplace, including a protocol for reporting concerns about a colleague. • *N.B. This recommendation is based upon our review against best practice and has no direct link with this incident.*	The Trust has addressed the actions in relation to this recommendation through several policies and their implementation. • Domestic Abuse Policy v2.3 (2017) • Managing Safeguarding Allegations Against Employees v1 (2016) • Safeguarding Adults Policy v2.3 (2016) • Safeguarding Children Policy, Principles and Procedures v5 (2015) During 2016 the Trust reviewed the Domestic Abuse Policy and made updates that ensure that this recommendation is addressed. All clinical staff are given a brief introduction to domestic violence and abuse as part of both safeguarding children and safeguarding adults mandatory training. In addition to this, staff can also access e-learning around domestic violence and abuse via the trust's domestic violence and abuse intranet site and should be encouraged to attend face to face training. All domestic violence and abuse champions must attend specific training to undertake that role. This training will be provided by either the local safeguarding children's boards or the domestic violence and abus abuse voluntary sector. Locally the Trust have developed effective working relationships with Croydon Family Justice Centre. The Trust attends the Croydon Borough Domestic Abuse system wide network meeting and has provided education about mental health at these events.	**Safeguarding Team** Director of Social Care & Trust named nurse for Safeguarding Children and Domestic abuse lead	Actions to be raised in the Trust Safeguarding Committee for oversight. • Continue to monitor and embed the domestic abuse policy • Review of compliance in line with Domestic Abuse Policy, Safeguarding Adults Policy and Safeguarding children Policy	Action to be raised under any other business at next Trust Safeguarding Committee on 18 January 2018 Review and monitoring of the efficacy of actions due by: September 2018	• Minutes of Trust Safeguarding Committee • Minutes of The Domestic Abuse Steering Group • Minutes of Quality Sub-Committee	Trust Safeguarding Committee The Domestic Abuse Steering Group provides strategic oversight with feedback to the Trust's Safeguarding Committee. Quality Sub-Committee

Recommendations	Update since 2012	Leads	On-going Actions	Implementation by when	Evidence	Monitoring & Evaluation
	The Trust has a nominated Borough lead who attends the Croydon MARAC, providing information about known service user as per our information sharing agreement.					
Recommendation 11 The Trust must provide a separate handbook on the process for responding to clients or carers affected by domestic violence, to give greater detail to staff outside of the Trust policy.	The Trust has developed electronic resource pages on the Trust intranet to provide current information on Domestic Abuse, contacts of external agencies and where to access support. Locally in Croydon, Domestic Abuse information is displayed in community teams and bathrooms.	**Safeguarding Team** Director of Social Care & Trust named nurse for Safeguarding Children and Domestic abuse lead	• Actions to be raised in the Trust Safeguarding Committee for oversight. • The Trust will audit the knowledge of how to access Domestic Abuse advice from 2 team leaders in each Borough to ascertain if improvements need to be made in this area. • A Trust wide event will be held in 2018 focussing on the learning from domestic violence and abuse	January 2018 March 2018 September 2018	• Training compliance information • Summary of event	The Trust Safeguarding Committee provides oversight of safeguarding and domestic violence and abuse. The Chief Operating Officer chairs the Performance and Contracts Committee reviewing the Performance Management Framework. The Committee monitors each CAG's compliance with mandatory training.
Recommendation 12 The Trust must review the Adult Safeguarding Policy to ensure that it provides staff with clear direction as to what steps to take to raise concerns about a vulnerable adult, particularly when that person is also a carer.	The Trust Safeguarding Adults policy was revised in 2016, in light of both the Care Act 2014 and the new London Multi-Agency Safeguarding Adults Policy & Procedures (2016). The Trust policy reflects the statutory requirements and London procedures. The statutory framework introduced under Section 42 of the Care Act applies specific safeguarding duties to any person aged 18 or above whom: • Has need for care and support (whether or not the Local Authority is meeting any of those needs) and; • Is experiencing, or is at risk of, abuse or neglect, and • As a result of those care and support needs, is unable to protect themselves from either the risk of, or the experience of abuse or neglect. The revised Trust Safeguarding Adults policy (2016) gives advice on what other processes may be applicable to support a person in relation to a concern that falls outside the above Care Act S.42 remit, including signposting to local Domestic Abuse services, involvement of Police or referral to MARAC. The revised Trust policy also includes an Appendix, with supplementary information regarding Domestic Violence, adapted from 'Pan London' 2016	**Safeguarding Team** Director of Social Care & Trust Safeguarding Adults Lead	Safeguarding adults is part of the mandatory training provided by the Trust. Compliance is monitored by each of the clinical areas.	Policy update completed in 2016 Action to be raised under any other business at next Trust Safeguarding Committee on 18 January 2018 Review and monitoring of the efficacy of actions due by: September 2018	• Minutes of the Trust's Safeguarding Committee • Minutes of the Trust's Performance and Contracts Committee	Trust Safeguarding Committee provides oversight of safeguarding. The Chief Operating Officer chairs the Performance and Contracts Committee reviewing the Performance Management Framework. The Committee monitors each CAG's compliance with mandatory training.