Donna and Zaki Oettinger

Independent Investigation Action Plan: StEIS: (2013/12847)

South London and Maudsley NHS Foundation Trust Statement

We at South London and Maudsley NHS Foundation Trust extend our deepest condolences to the family and friends of Donna and Zaki at the heart of this tragic incident. We also extend our sympathies to all those who were and continue to be affected by these sad events.

Our thanks go to IODEM who undertook a detailed examination of the service provision in place at the time and has helped the Trust focus on important areas for improvement. We have already made significant progress in addressing the recommendations made by the independent review. We look forward to working with our commissioners at Croydon CCG and other partners to ensure that the lessons from this tragedy lead to improved support for our service users in the future.

NHS Croydon CCG Statement

NHS Croydon CCG would like to offer our condolences to all those who were affected by this tragedy. Croydon CCG will continue to monitor the implementation of the action plan through a number of monitoring processes including: monthly Serious Incident Review meetings and Clinical Quality Review Groups (CQRG).

For information: The CQRG 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.

Rec No.	Organisation	Recommendation	Update since 2012	Actions to achieve recommendation	Implementation Lead	Implementation by when	Evidence of Completion	Monitoring & evaluation arrangements
1	SLaM	**Recommendation One – Managing a failing Team:** The Independent Investigation Team recommends that in teams which are identified as 'failing' or of being at 'risk', an immediate management plan should be initiated by an individual who is not connected in the line management of the failing team which seeks to: 1. Identify risk to new and existing patients of the current administrative processes and protocols; and, 2. Establish whether any immediate practical steps can be taken to reduce risk to patients notwithstanding action taken with regard to long term solutions such as seeking increased funding.	In 2011, following the formation of clinical academic groups (CAG's), an assessment and treatment team was established in Croydon for people with mood, anxiety and personality disorders. The service had two distinct functions: to act as a GP front facing assessment service and; provide medium to long term case management for people moderate to severe need. By 2013 it became apparent that these two functions needed splitting to demand and capacity. Two assessment and two treatment service were created to cover east and west Croydon within existing funding. In April 2013 a small assessment team was established and the former assessment and treatment primary focused on providing medium to long term treatment to people	The Trust routinely undertakes Best Practice visits which look at leadership engagement and quality indicators. A Best Practice visit can be triggered if there are concerns about a team e.g. through patient feedback, complaints or incidents. The Trust has a Complaints, Patient Advice and Liaison Service, Quality Alert process and Patient Experience surveys (PEDIC) which allow direct feedback on the quality of services. The Trust has a Freedom to Speak Up Guardian in post with champions across the Trust and sites. This promotes openness and allows notification to the Board of any safety concerns. The Trust's Whistleblowing policy also allows staff to raise concerns and identify concerns. The Commissioners have oversight of these areas through the Core Contract	Director of Nursing Chief Operating Officer	Complete	• Minutes of meetings with COO and DoN • Core contract	Core contract meeting (quarterly) Clinical Quality Review Group (bimonthly)

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			experiencing non-psychotic disorders. The assessment team and treatment services were subject to review in 2014 and Trust secured c. £2m investment from Croydon CCG for these two services. The services were redesigned 2015 to create one Borough wide assessment and liaison services and two treatment services. The assessment and liaison service were designed with the recognition that it required two full time consultant psychiatrist's and a greater number of senior practitioners to ensure that people referred received a high-quality assessment and a rapid formulation of peoples' needs. After assessment the service offers 12 week stabilisation by providing an array of biological, psychological and social treatments. The majority of people are discharged back to primary care at the end of the 12 weeks and some people will go on to have longer support in either the treatment, psychosis service and/or crisis services. The two treatment teams consist of a fulltime consultant and a multidisciplinary team consisting of nurses, occupational therapist, psychological therapists and social workers. In the majority of cases, the team provides 6 to 18 months treatment, which includes psychological therapies that are provided from within the team. A small number will receive indefinite care and treatment. Whilst developing the assessment and liaison team model, the Trust, in partnership with Croydon Council, developed a reablement service, which supports people to engage in meaningful occupation. The team	Meeting and Clinical Quality Review Group. Since August 2015 the Trust's Chief Operating Officer has run monthly performance and contracts monitoring meetings. The meetings review data from all teams within the Trust ensure performance standards are met. Where a team is not meeting the performance standards they are put into 'recovery', resulting in an increase in support, oversight and plan to address areas of concern. The Trust works with SLaM Partners who support the Trust with Quality Improvement and Team Development. For teams put into recovery SLaM Partners can work with teams to support improvement and sustain change. From Autumn 2017 the Director of Nursing has run Quality Compliance meetings which ensure quality standards are met in Trust services. The Chief Operating Officer and Director of Nursing triangulate data on services to identify if there are any areas presenting a risk to the organisation. The Trust runs Quality Walkarounds involving members of the Executive team visiting clinical teams. Teams are able to escalate any quality and safety issues impacting on the delivery of care and services, directly to a Board member. The Board member will then ensure any changes required take place. In 2018 the Trust underwent a reorganisation to a Borough model, which has removed layers of management between the Board and Ward improving oversight and escalation. The Chief Operating Officer, Service Directors and Contracts and Performance Management Team negotiate all contracts to provide teams with the adequate finances to ensure that teams can provide			meeting and CQRG meeting minutes	Quality Compliance Meetings (monthly)

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			consists of occupation therapists and support workers. The person using the service are often transitioned from the assessment service to receive support before being fully discharge back to the care of their GP. Finally, in 2015 other investment was provided to the home treatment service to have the capacity to provide robust crisis interventions to avoid admission to hospital or step-down people from hospital sooner.	care to the required evidence based standard. The Quality Improvemetn Team have recently launched the Community I Care initiative. The aim is for people who access SLaM community services to receive the highest quality care in the right place at the right time from a service that is sustainably run. Work has begun to define the scope of the work which will incorporate patient safety and quality standards for community teams. The Trust is currently developing the community Quality, Effectiveness & Safety trigger Tool (QuESTT). The tool provides an early warning indicator to detect potential deterioration in the quality of care which will enable proactive action prior to any deterioration occurring. The pilot of Community QuESTT started earlier in 2018 with older adults. Following this there was a redesign of the system and the testing is planned for October to December 2018 with the final roll out across all community teams from January 2019.	Director of Nursing Chief Operating Officer	January 2019	• QUESTT scores • Action plans and monitoring	Quality Compliance Meetings (monthly)
2	SLaM	**Recommendation Two – Improving reflective practice:** The Independent Investigation Team would make the following recommendation: • The Trust must conduct regular audits to ensure that its managerial supervision policies and procedures to facilitate supervision are being used to promote the delivery of service user centred long-term care. • 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.	The Trust has an established Supervision Policy which has been revised twice since this incident. The first revision was in 2014, where all existing policies were brought together into one document and a requirement was made for all clinical staff to receive supervision at least once a month for an hour. This was audited in a Supervision Audit to check that supervision was happening by CAG and discipline. In 2018 the second revision was completed with a plan for dissemination and implementation. The Trust monitors compliance with supervision through the appraisal system stored in the Education and	The Trust is currently working to move to electronic recording of supervision using the Education and Development LEAP system. This will include a template to record supervision and the option of uploading supervision records. The Trust is undertaking an audit to assess compliance with the Trust's Supervision Policy and the quality of the supervision staff experience. This will consist of direct contact with all staff via a survey and further review through the LEAP data.	Head of Psychology and Psychotherapy Head of Learning and Knowledge Systems Trust Audit team and Head of Psychology and Psychotherapy	December 2018 December 2018 (staff survey) March 2019 (compliance audit)	• Electronic records system on LEAP • Completed audits for staff survey and compliance with action plans	Quality committee (bimonthly)

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			Development LEAP system. It is a core requirement for 10-12 supervision sessions to take place over each year. The Trust's appraisal system requires both appraiser and appraisee to confirm that supervision has taken place. Individual staff supervision records are kept locally and "ensure clinical practice reflects the delivery of service user care".					
3	SLaM	**Recommendation Three – Responding to service users' needs** 3.1. The ethos of the CPA should be reflected and strengthened in the training programmes which Trust staff are required to attend.	The Trust has run a one-day CPA training in the past, as non-mandatory the course was stopped due to low numbers attending. The Trust has reviewed the need for training and does not believe that a one-day course is required. The revised CPA policy was ratified in May 2017, with publicity through the June policy bulletin. The policy is available on the Trust intranet. The policy can be accessed by any staff member on the policies page of the intranet and a quick guide for its use is the "Policy on a Page" document. Education and Training department were notified of the policy update so it could be in corporate in any training that referred ton CPA. Nursing forms a major part of the Trust's workforce. In May 2018 the Trust finalised core competencies and job descriptions for Band 2-6 nursing staff. Competencies for Band 5-6 nurses which includes specific assessment of a nurse's understanding and competence in relation to CPA which are aligned to job descriptions.	CPA training – The Trust will review the current requirement for training that directly supports the ethos of the CPA at the next meeting of the Trustwide Education and Development Committee in October 2018.	Head of Inclusion, Recovery, Professional Head of Occupational Therapy and AHPs. Deputy Director of Education and Development	Complete May 2018 October 2018	• Yearly reviews of CPA • Evaluation of new CPA documentation when completed • Minutes and outcome of Education and Development Committee	Quality committee (bimonthly) Quality committee (bimonthly)
		3.2. Every 6 months, a random audit of 10% of current individual service users' records are audited by the Managers in each service involved in the individual's care with a view to establishing:	3.2a) Each clinical team holds regular multi-disciplinary team meetings where patient's care is reviewed. Individual supervision is used to review caseloads of workers and care	The Trust will review a 10% of records for compliance.	General Manager – Croydon Community Head of Inclusion,	December 2018	• Audit and action plan	Croydon Quality and Performance Meeting (monthly)

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		a) Whether CPA is being correctly applied and adhered to; b) Whether all service users' risk assessments are up to date; c) Whether staff are having regular supervision which includes reference to providing care which recognises the ethos of CPA;	plans. The Trust's Chief Operating Officer reviews data on compliance with CPA reviews through the monthly performance and contracts meetings. In November 2017: 93.2% of people on CPA had a formal 12-month review, November 17: 91% of people on CPA had a formal risk assessment, Health intelligence indicates a total of 21% of our patients on CPA, a 6% increase from 15% when the implementation assurance for the policy was done in 2015. The Trust is currently working on the development of the new community care plan and risk assessment audit tool using Quality Improvement methodology. Functionality will include "pull through" of risk assessment information to develop the care plan in collaboration with the service user. The next phase is to streamline the suite of CPA yearly review documentation, to ensure that it is service user friendly and to incorporate a comprehensive review process.	Review of Trust CPA documentation An audit will be undertaken in the Croydon Assessment and Liaison Team to review a sample of records against the standards for CPA to ensure these have been correctly applied and adhered to. Learning from this audit will be shared through the Serious Incident Review Group and Croydon Performance, Operations and Quality meeting.	Recovery, Professional Head of Occupational Therapy and AHPs General Manager – Croydon Community	February 2019 December 2018	• Reviewed CPA documentation • Audit and action plan	Quality committee (bimonthly) Croydon Quality and Performance Meeting (monthly) Serious Incident Review Group (monthly
			3.2b) The Trust reviewed the risk assessment tools available to staff in January 2017 with the creation of a single risk assessment tool for adult mental health. Aligned to this improvement were made to the electronic system of monitoring compliance with risk assessment standards. Dashboards for completion are available to all teams and managers. An electronic audit tool to look at the quality of the completed documentation has been developed. Prior to this information was locally held and completed. This allows the Trust to ensure that risk assessments are completed and appropriately	Actions completed to address recommendation	Director of Nursing	Completed in 2017	• Risk assessment documentation • Completed audits and action plans • Minutes from Quality committee / Quality compliance meetings	Croydon Quality and Performance Meeting (monthly) Serious Incident Review Group (monthly

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			address the identified risks. The Director of Nursing reviews the audit results as part of the monthly quality compliance meetings with monthly reviews in each Directorate Governance Executives meeting.					Quality Committee (bimonthly)
			3.2c) The Trust has an established Supervision Policy which requires all clinical staff to receive supervision at least once a month for an hour. Clinical supervisors have access to a two-day training course is available to all clinical staff who are band 5 and above. This supports quality supervision to be provided to staff. The Trust audit of supervision (outlined in recommendation 2 above) will seek staff opinion on whether supervision has led to them being able to do their job more effectively. This provides some evaluation of the quality of care being delivered.	The Trust is due to undertake an audit as outlined in recommendation 2 which will incorporate action 3.2c).	Trust Audit team and Head of Psychology and Psychotherapy	December 2018 (staff survey) March 2019 (compliance audit)		
		3.3. Adherence to this recommendation is audited by the Trust on a 6-monthly basis.		The Trust will review adherence to this recommendation by July 2019 which will allow 2 audits to have taken place.	Deputy Director Croydon	July 2019	• Audit and action plan	Croydon Quality and Performance Meeting (monthly) Serious Incident Review Group (monthly
4	Commissioners	**Recommendation Four – Impact assessment**: Commissioners should consider conducting an impact assessment prior to the commissioning of 'new' services in order to establish the potential impact upon existing services in terms of staffing and recruitment in existing services.	Since 2012, Croydon CCG have introduced the Joint Impact Assessment Panel (JIAP), whose overarching remit is to provide a reliable and consistent approach for assessing the current and future impact across quality, equality and Privacy, prior to procurement or re-procurement of any new service; in addition to ensuring Patient and Public engagement.	No additional actions identified to meet recommendation.	Croydon CCG	Not applicable		Monitored at regular Joint Impact Assessment Panel (JIAP) meetings
5	SLaM	**Recommendation Five – Management of waiting lists:** 5.1. It is recommended that the Trust considers whether an IT solution could be adopted which manages patients' need for information about their inclusion on waiting	The recommendation has been discussed with the Chief Clinical Information Officer/Clinical Systems Transformations lead and with wider Executive Senior Management Team. Clinical teams are unable to provide	No additional actions identified to meet recommendation	Chief Clinical Information Officer & Clinical Systems Transformations lead Chief Operating Office	Not applicable	• Clinical records system	Individual team meetings (weekly/monthly) Quality and performance

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		lists.	information that can be accessed by patients through IT systems as urgent referrals to a service may affect the prioritisation of the waiting list. It would be unfair to provide information to patients that may change based on clinical need. Clinical teams have the functionality to show the full waiting list within a single view to ensure that referrals are appropriately triaged and receive treatment. During March 2018 the Trust's Quality Committee reviewed waiting list times for community services with a focus on areas of improvement. Waiting list times form part of the information reviewed by the Chief Operating Officer in monthly performance meetings. Any team in breach of waiting time targets are put into 'recovery' with additional support given until these improve. A further paper reviewing waiting times in key services will be scheduled for a future committee. The commissioners have oversight through a weekly phone call to provide an update on waiting times for patients. Croydon IAPT team provide a weekly and monthly report to commissioners. The process for booking appointments is outlined in the team's operational policy					meetings in each Directorate (monthly) Performance meetings (monthly)
		5.2. The Trust should review the manner in which it communicates with the patients of its psychological therapy services who are awaiting access to the service in order to ensure that the use of reverse opt-in processes is avoided. and 5.4. The Trust is to undertake an audit of correspondence produced in relation to	In tandem with the development of the assessment and liaison service, detailed above, the Croydon IAPT has undergone significant development through incremental investment since 2014. In 2012 the service was not funded to meet national policy aspirations. Due to IAPT service now being nationally mandated to meet these expectations, the investment has meant that the service is	While the IAPT service continues to engage with service users to co-produce effective communications methods General Managers across all services in conjunction with the Trust Patient and Public Involvement Leads will coordinate a review of letters and leaflets referring to waiting lists promote positive engagement and encourage a sense of hope.	General Managers with oversight from Directorate Service Directors	March 2019	• Paper summarising review findings • Recommendations / action plan from review	Quality meetings in Directorates (monhtly)

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		waiting list management in order to determine whether all written communications reflect aims and ethos of the service and seeks to promote a positive engagement with potential service users which encourages a sense of hope.	responsive to local need and the previous waiting times have significantly reduced. The service can assess people within a few weeks of referral and offer first steps to treatment rapidly, providing further support if the first intervention was not effective. The system of opting in was stopped on 2014. The service also works to protocols that ensure close liaison and joint working with the assessment and liaison service and the Boroughs secondary psychological therapy service. The service has also engaged with service users to co-produce the way in which we can communicate with patients and this is happened across all IAPT services.					
		5.3. Staff are appropriately trained to provide accurate information in response to queries about Trust services, likely waiting times and other sources of assistance.	In 2018 the Trust reconfigured services to Borough based models of care. The reconfiguration has led to a single general manager across the community services. The general manager has oversight of the waiting lists in each service and provides a single point of escalation for all community team leaders. All IAPT services have developed borough specific sources of assistance while on waiting lists and staff are made aware of current waiting times in weekly team meetings. Clinical team meetings also review the priority of patients awaiting a service. Staff can refer patients to the Patient Advice and Liaison Service (PALS) to support the provision of information in relation to waiting times. This is contained in complaints leaflets in each area. If an enquiry is received from a	No additional actions identified to meet recommendation	Chief Operating Officer Director of Nursing	Complete 2018	• Complaints report • Minutes and highlight reports	Trust Board (monthly) Quality Committee (bimonthly) Performance meetings (monthly) Quality Compliance meetings (monthly)

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			person on a waiting list for another service then they will be directed to the correct service. Monitoring of concerns in this area is through feedback from PALS and complaints. Where there is an increase in the amount of feedback for a service, they will review and actions will be put into place. This may also trigger a Best Practice visit.					
		5.5. The Trust should develop a protocol to provide guidance about information sharing in relation to the situation where a patient is receiving care from the private sector.	SLaM has an information sharing policy which outlines how and what information should be shared with any other care providers either private or NHS. The Data Protection Law and Data sharing principles apply to both private and public providers in the same way. Each policy has a clear implementation plan to ensure the principles are embedded throughout the Trust. Information Governance training is mandatory training for all staff to be updated on an annual basis. This includes sharing of information with other or private providers. Where there are concerns about the Trust providing information a Quality Alerts system is in place for other organisations to raise concerns. These are responded to with oversight from the CCG. The CCG monitor's the Trust's responses to Quality Alerts	As part of the next Information Sharing policy review a section will be added to explicitly state that the law applies the same way.	Head of Information Governance	October 2018	• Updated policy	Caldicott committee (quarterly)
6	SLaM	**Recommendation Six – Accommodating the needs of all service users:** Accordingly, it is recommended that the Trust review the Operational Policy: PMIC Assessment & Liaison Service (November 2016: Version 5) in order to ensure that all process noted within the policy are clear and accommodate the needs of all groups of	The Operational Policy for the Croydon Assessment and Liaison Team was updated in 2018 to ensure this met the needs of all service users. The assurance processes for individual operational protocols sit	Actions completed to address recommendation	General Manager/ Deputy Director of Service	Complete - May 2018	• Updated operational policy	Croydon Performance and Quality Meeting (monthly)

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		service users.	with the management structures of each Directorate. The Croydon Directorate Performance and Quality Meeting has oversight of these policies.					
7 & 11	SLaM	**Recommendation Seven – Audit of complaints against trainees** 7.1. An audit of the complaints made against trainees to establish any trends, in order to support the needs of trainees involved and the training provided by the Trust in general.	Each core trainee (junior doctor) has a requirement to report any complaints made against them to their supervisor as part of the training requirements. The Trust records the roles of professionals involved in any complaint using the complaints system.	An audit to be carried out for all complaints that have involved a trainee psychiatrist over the past year, identify the main themes and issues and develop guidance to clinical supervisors about how to respond to formal and informal complaints regarding trainees.	Director of Medical Education	October 2018	• Audit • Report and action plan	Quality committee (monthly) Postgraduate medical education committee
		7.2. The Independent Investigation Team recommends the introduction of a protocol for supervisors as to how to respond to a complaint about a trainee, whether made through the formal complaints process or otherwise. The Trust should audit the implementation and use of the protocol 6 months after its introduction.	All SLaM core trainees have an educational contract which includes the importance of supervision. Supervisors of core trainees are required to have a training portfolio including the use of supervision. Any complaints should be discussed with the supervisor in their clinical supervision. Core trainees receive an induction presentation on complaints and incident handling and the reporting systems. To support core trainees in appropriately signposting complainants – leaflets and posters are a core requirement of each clinical area. Information is also publicly available on the Trust external website. A protocol regarding supervising the trainee through the complaints process in parallel with the Trusts' complaints investigation policy is being developed. This will involve the trainee meeting with the clinical supervisor in the first instance and	Development of a protocol to support supervisors of junior doctors through the complaints process. The protocol will be completed with an implementation plan.	Director of Medical Education	December 2018	• Training contract and core trainee handbook • Medical supervisor training presentation • Protocol for complaints about junior doctors • Audit and action plan as required	Quality committee (bimonthly) Postgraduate medical education committee
		Recommendation Eleven - Response to complaints about the care of patients treated by junior doctors: It is recommended that the Trust introduce a protocol regarding the response by the supervisor to a complaint involving the care of the patient being treated by a junior doctor. This protocol should include the following elements: a) Highlight early warning signs that a trainee maybe struggling; b) Early meeting with the patient or their carer and the supervisor; c) The option to transfer care to another clinician.		An audit will be completed 6 months post implementation of the protocol to assess if the standards have been met with an action plan put in place to address this if not.		June 2019		Quality committee (bimonthly) Postgraduate medical education committee

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			being supported by their educational supervisor and training programme director with the involvement of the director of postgraduate medical education where necessary. The protocol will cover the need to consider the complaint as an opportunity for the supervisor to review the trainee's work load and performance, organise joint meetings with patient and/or carers if that is considered useful and transfer of patient care from the named junior doctor to a different clinician where necessary.					
8	SLaM	**Recommendation Eight – Audits of Efficiency:** The Independent Investigation Team recognises the considerable amount of work completed by the Trust including the re configuration of services and the introduction of the single point of access. However, in order to ensure that the learning from the care and treatment of DO has become embedded in the Trust's current practice, the Independent Investigation Team recommends that the Trust conduct an audit of the efficacy of the receipt of information from outside of the Trust in order to determine the action taken by the Trust in response to such a referral.	The Trust's Home Treatment Teams now accepts referrals from out of area mental health services e.g. CMHTs or psychiatric liaison teams. The Acute Referral Centre (ARC) receives referrals and triages them. If a community team received a discharge notification from an out of area A&E with a recommendation for referral to a Home Treatment Team this would be passed to the ARC.	A survey including 2 team leaders from each Directorate will be undertaken to ensure that they appropriately direct HTT referrals to the correct area.	General Managers for each Directorate	December 2018	• Survey results and outcome	Serious Incident Review Group (monthly)

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9	SLaM	**Recommendation Nine - Communication with patients following uncompleted suicide:** 9.1 The Trust is required to implement a suicide awareness training programme for its staff which addresses the following elements of care: a) the need to create and preserve hope; b) assist people to work through suicide towards achievable recovery and growth goals; c) integrate suicide care into recovery care. It is recommended that implementation of this recommendation is audited by the Trust 6 months after inception of the training programme in order to assess its effectiveness.	The Trust allocated a suicide prevention lead to who oversees the current training programme and links with local authority public health suicide reduction leads. The Trust has an established a one-day face to face training programme for suicide and self-harm awareness which ran until November 2017. This was a non-mandatory training accessible for all staff. The course is currently under review to ensure it meets the requirements of the recommendation. The programme has been co-designed and delivered by an experienced nurse and a service user. The Trust redesigned the Risk Assessment Tool in January 2017 which ensures that Trust patients in adult mental health services receive a single comprehensive risk assessment. The risk assessment contains prompts for the assessor to identify risk factors in self-harm and suicide including engagement and hopelessness. The assessment flags the SHIELD risk assessment which provides a score that can be used to explore the nature of thoughts and feelings experienced which can inform care planning including risk management plans. The risk assessment tool automatically pulls together individual risk events The Recovery and Support plan is used in community teams, the plan is focussed on the individual recovery, support and crisis care for the patient for their symptoms, including suicide and self-harm.	The suicide prevention lead will review the current provision of suicide and self-harm awareness training in conjunction with the Education and training department tutors to ensure the training recommences and is publicised to relevant clinicians. An analysis of training needs for suicide and self-harm will be carried out through the Trust-wide Education and Development Committee in October 2018. In June 2018 the Trust will review audit the efficacy of the training programme.	Suicide Prevention Lead (Deputy Medical Director) Suicide Prevention Lead (Deputy Medical Director)	December 2018	• Revised lesson plans for training • Updated training materials • Summary paper reviewing the course and audits undertaken • Action plan arising from audit	Mortality Review Group (quarterly) Education and Training Committee (quarterly) Serious Incident Review Group (monthly)
10	SLaM	**Recommendation Ten – Complaints Policy** 1) The Trust reviews its training requirements for individuals who are tasked	The Trust provides training on investigations through the Practical Guide to Structured Investigations	The MP members enquiry template response will be amended to ensure MPs are asked to share the response with their	Head of Complaints	Complete 2018	• Trust policy • MP members enquiry template	Quality committee (bimonthly)

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		with responding to complaints to ensure that the duty of openness is applied to all complaints, in order to ensure that all elements of complaints are addressed accurately.	training. This is a full day's training which provides investigators with the techniques and skills to investigate a complaint or serious incident. The training covers the importance of openness, family and carer involvement and the formal obligations of proactive communication arising from the Duty of Candour / national complaints legislation. Complaint investigators are provided with additional support through local governance complaints and serious incident leads, line management and the central complaints team. Each complaint investigation is reviewed and signed off by senior staff before it leaves the organisation to ensure that it is Open and Transparent; and that that the concerns outlined are addressed in full of actions to address these in place. This is also underpinned by Trust polices -The Complaints policy and Investigations policy both refer to the Trust's Duty of Candour / Being Open policy.	constituent and to signpost back to SLaM if there are any outstanding issues of concern.				Trust Board (monthly)
		2) The Trust reviews its complaints policy to ensure that complaints are used as a vehicle to drive improvements in care.	The Trust's Complaints policy was updated and ratified in 2015 has a clear statement that complaints are used to drive quality of care within the Trust. The Trust's Director of Nursing holds Quality Compliance meetings with each directorate to ensure that complaints are investigated and responded to appropriately.	Learning and development from complaints are underpinned by the Complaints Policy, Learning Lessons policy and Investigations policy. Further assurance that complaints drive improvements are through the quarterly Lessons Learned report and complaints report which share learning throughout the Trust and individual learning lessons events. Services complete in depth reviews on the themes from complaints to identify further learning and improvements. E&D prompt Directorate Training leads to include training resulting from lessons learned in their annual training plan, some areas have included this as a standing item on their Workforce Development committees.	Head of Complaints	Complete 2018	• Learning Lessons events • Lessons learned reports • Directorate learning events • Actions from complaints • Quality compliance meetings	Quarterly updates to Quality Committee and Trust Board

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				Individual complaint investigations are reviewed and signed off by senior staff in the organisation to ensure learning has been identified and actions are outlined. Learning and actions from each complaint is recorded on the Trust's complaints system which allows thematic review and ensures that where a need for improvement is identified, these are made.				
12	SLaM	**Recommendation Twelve – 'Being Open':** The Trust must review its 'Being Open Policy' with a view to include guidance for internal investigation teams in relation to: 1. Demonstrate an understanding and sensitivity to the traumatic events family members with whom they will be have endured. 2. Arrangements surrounding meetings with families and carers following an incident are made with a view to minimising distress to all those involved. 3. Conflicts in evidence between must be explored in reports in order to demonstrate that the evidence given by family members has been taken into consideration.	The Trust completes regular audits on Duty of Candour to ensure compliance with the standards, learning identified from these audits is shared across the Trust. These are reported externally to commissioners, centrally to the Quality Committee and locally to Directorate Governance Executives. For all comprehensive incident investigations an executive chaired strategy meeting is held at the start to commission the investigation and at the end, to sign off the investigation. During these meetings contact with families and carers is discussed and with plans for contact agreed. Consideration is given to any support needs families and carers may need to enable them to participate in the investigation. A senior member of the Trust will be assigned to make the initial contact with the person affected with follow up contact from the investigation team. Contact with families and carers underpinned by the Policy for Being Open and Duty of Candour and the Policy for the Investigation of incidents, complaints and claims. These policies outline the requirements for contact with families including consideration of the needs of those affected e.g. assistance to participate in the investigation, ongoing support and follow up following the incident.	The Trust is rolling out a series of lessons learned events with Directorates and will include a vignette on interactions with family members. The first will take place during the October Leadership event.	Head of Patient Safety	December 2018	• Vignettes • Reflections from clinicians on investigations	Quality Committee (as required) Serious Incident Review Group (monthly)

Rec No.	Organisation	Recommendation	Update since 2012	Actions to achieve recommendation	Implementation Lead	Implementation by when	Evidence of Completion	Monitoring & evaluation arrangements
			Meetings with families and carers are held at a convenient location for those affected. Training is provided to investigators through the Practical Guide to Structured Investigation training which includes meetings with families. Appraisal and evaluation of investigations is undertaken internally and externally to the Trust. From Autumn 2017 the Trust Serious Incident Review Group, chaired by the executive Director of Nursing, has reviewed each serious incident investigation. The group scrutinises reports to ensure Duty of Candour has been met and that the views of family members have been considered. Reports are shared family members as part of the review process to ensure their feedback is included as part of the evaluation process. Families and carers and given the opportunity to meet with the Trust to review investigations and are able to provide feedback in a way that is convenient to them.					