NEWS RELEASE
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PUBLICATION OF THE INDEPENDENT REVIEW OF THE DELIVERY OF ACTION PLANS FOLLOWING TWO HISTORICAL SERIOUS UNTOWARD INCIDENTS

23 January 2019

NHS England has today published an independent review of the delivery by Derbyshire NHS Foundation Trust of action plans following investigations into the care and treatment of Mr S and Ms Z.

Patient Ms Z was convicted of manslaughter with diminished responsibility. She had previously been in contact with mental health services delivered by Derbyshire Healthcare NHS Foundation Trust.

Patient Mr S killed victim 1 and victim 2 and then took his own life. He had been in contact with mental health services delivered by Derbyshire Healthcare NHS Foundation Trust.

The independent quality assurance review published today considers progress against the recommendations and actions identified as part of the independent investigations.

Dr David Levy, Medical Director at NHS England – Midlands and East said: "NHS England commissioned an independent quality assurance review to review progress against the recommendations and actions identified as part of the independent investigations which were published in July 2017 and September 2017 respectively.

"We have commissioned this review so that the NHS is open and transparent about what it is doing to make necessary changes to improve the care delivered to patients.

"The review found that the Trust has made considerable progress in delivering against the actions and recommendations identified following these two tragic events. Derbyshire Healthcare NHS Foundation Trust took the findings of the independent investigation very seriously and have taken appropriate action to make the necessary changes.

"Implementing change and improvement can take time and it is not unreasonable for improvement to take many months or even years in some cases but the Trust remains committed to ensuring its response to the recommendations are embedded to affect sustainable change."

The quality assurance review highlights that the Trust has changed the way it records information about people who use its services, has changed its policy for people being

supported under CPA (Care Programme Approach) and has promoted the value and importance of information being shared by families and carers. It has also shared the learning from these incidents with clinical teams to ensure staff learn from and embed the recommendations across services.

To fully meet the requirements set out the action plan, the trust will now do more work to do to ensure three clinical cases are routinely reviewed at each clinical supervision session. They will undertake an audit of compliance and work with staff to deliver an achievable process and target. The review also suggests that a review of the quality visits by senior management and team leaders would be beneficial.

NHS England continues to monitor the trust's progress to ensure it fully address all recommendations.

Ends

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