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**AN INDEPENDENT REVIEW OF THE  
DELIVERY BY DERBYSHIRE NHS  
FOUNDATION TRUST OF ACTION  
PLANS FOLLOWING TWO  
HISTORICAL SUIs**

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**September 2018**

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## **1. INTRODUCTION**

- 1.1 NHS England commissioned an independent review of Derbyshire Healthcare NHS Foundation Trust's delivery against the action plans which were developed following two historical Serious Untoward Incidents (SUIs).
- 1.2 On the 2<sup>nd</sup> June 2010, Mr S who at the time was under the care of Derbyshire Mental Health Services NHS Trust, attacked his ex-partner and their 2-year-old son. He had been estranged from his ex-partner for a considerable period, although she had continued to offer him support. He used a knife, inflicting multiple stab wounds to both victims who died from their injuries, before then using the knife to take his own life. It should also be noted that his ex-partner was pregnant at the time of the incident and the foetal child did not survive.
- 1.3 The second case - On 9<sup>th</sup> December 2013, Ms Z who had a long history of care from Derbyshire Healthcare NHS Foundation Trust (formally - Derbyshire Mental Health Services NHS Trust) attacked her victim who was previously not known to her. At the time of the incident, Ms Z was squatting in the victim's house whilst she was on holiday. When the victim return home, she was immediately attacked with several weapons, and multiple stab wounds were inflicted. The following day, a second victim was attacked when he came to investigate why his friend (the original victim) was not answering his calls. Fortunately, despite a further assault he was able to make his escape and raise the alarm
- 1.4 The clinical background and organisational details of both cases have been explored in depth by the two independent investigations and are available, should person reading this review require them.
- 1.5 The conclusions and recommendations drawn from these investigations, in addition to those previously noted by the Trusts internal review, provide for the base of the examination for this review.

## **2. PURPOSE OF REPORT**

- 2.1 Following the publication of the two independent investigations which were published in July and September 2017 respectively. A meeting was held by North Midlands Director of Commissioning Operations (DCO) to consider the progress that had been made by the Trust in completing the agreed actions.
- 2.2 The Trust reported that good progress had been made in many areas and they anticipated completing all actions by May/June 2018.
- 2.3 The Head of Independent investigations - NHSE, Midlands & East commissioned *this* report to provide assurance following the reviews and to assess the implementation of the report's recommendations.

2.4 This report is provided in the understanding that it will be available to Commissioners, the Trust, the Victims' families and the wider public, as a document to demonstrate the progress which has been made and/or areas requiring continued attention to the lessons learnt from these two tragic events.

### 3. METHODOLOGY

3.1 Previous reports, action plans and related correspondence was provided giving the author back ground details of both cases

3.2 Derbyshire Healthcare NHS Foundation Trust was visited on the 16<sup>th</sup> & 17<sup>th</sup> May 2018 and interviews conducted with staff.

3.3 The Author had the opportunity to meet with the three Daughters of the victim of Ms Z, to discuss their experiences, clarify the expectations of this report and to offer the opportunity to facilitate any contact with the Trust. He has also spoken with the sister in-law of the victim of Mr S and has facilitated a point of contact with the "Family Liaison Officer" now employed by the Trust.

3.4 Following the above, a list of information requirements to demonstrate assurance of actions being taken was requested from the Trust. *Unfortunately, there was a delay in this being provided due to a full CQC visit taking place which stretched local resources.*

3.5 Once information was provided, a table (appendix 1) was developed. The aim of this, was to create a single document which provided a tabulated evidence base demonstrating the stated progress by the Trust, against the actions required by the independent investigations and supporting verification. This used information which was provided either by interview, supplementary documentation or observation.

3.6 As per Psychological Approaches CIC internal protocols, a peer review of the report also took place.

### 4. SUMMARY OF FINDINGS

**This summary is supported by evidence as detailed in Appendix 1.**

4.1 This section provides an overview of the key findings of the review. The details supporting these findings is contained in Appendix (1) *table of evidence*.

4.2 Within the two independent investigations, 5 principal areas of concern were identified these were;

- Consolidating/fully reviewing all medical records (Historically paper records)
- Responding to the service user's needs
- Improving long term care
- Working with family members and carers'

- Learning from adverse incidents

4.3 Each of the principal areas of concern was further broken down in the reports to include more specific and detailed points. The findings of the five areas are highlighted below.

4.4 The Trust has successfully managed to transition from paper to electronic patient records. Information was shared which demonstrated judicious management of this activity, along with a commissioned process for the rapid retrieval of paper records which have been achieved under contract with TNT.

4.5 The investments in electronic patient information systems, "Paris" and "SystemOne", includes an Online Information System which flags for example, the current team, referral information and clinical alerts. This investment has further supported the interconnectivity with some service areas that historically have used SystemOne i.e. CAMHS and drug and alcohol services.

4.6 An additional benefit of the electronic patient record is; for many GPs, who use System One, now have direct access to their patient's full mental health records, this greatly reduces the likelihood of prescribing errors and enhances clinical information sharing. *N.b – In the City of Derby, the majority of GPs are on SystemOne, in the wider County this number drops with more using Emishealth as their patient records system.*

4.7 Staff with access to the Paris system, have fed back in a positive manner and endorsed the specific function which affords for the function of "consent to share".

4.8 The Trust issued a revised CPA policy and procedure in October 2017. To accompany this, they provided a series of training sessions for staff covering its core aspects and key standards.

4.9 It is now expected that individuals clinical and risk histories are reviewed as part of the revised CPA and safety planning process. An audit was conducted which showed good progress in this area.

4.10 Via the monthly "Integrated Public Board Report" the Board see several compliance indices, including those for patients who are on CPA for >12 months. It is noted that the Trust performs well in this area in comparison to other Trusts Nationally.

4.11 Recognising some of the difficulties caused by teams being placed on multiple sites, the Trust commissioned in 2016, St Andrews House. This building with its large office space, has brought a number of teams together in a single location; including LD services, Social workers, including AMHPs and the Criminal justice liaison team thus aiding with communication.

4.12 A multi-agency safeguarding hub (MASH) has been established with the principal aim of improving communication between all agencies. The Criminal liaison team commissioned in January 2018, with a further planned and funded expansion due for 2019/20 feeds into MASH which importantly has via its membership full access to all the electronic Patient Information systems.

- 4.13 The Trusts action plans for the continual monitoring of progress against the recommendations of the independent reviews of these SUI's are taken to the Quality Assurance Group, which has in its membership members of the Board.
- 4.14 The author was encouraged to note work the Trust has done in recognition of Carers. This includes a dedicated Carers strategy, 2016 to 2019 entitled "Recognition, Respect and Respite". Furthermore, it has joined the "Triangle of Care Scheme" which following has an external validation process awarded the Trust two stars in recognition of its progress with Carers. A training package entitled "Better together" is now available to support staff training further in this area.
- 4.15 Although the Trust report favourable progress in both Clinical and Managerial supervision in comparison to other organisations, most teams continue to fall considerably short on a consistent basis of the Trusts own targets. However, despite this, progress seems slow
- 4.16 In response to the recommendations, the Trust audits CPA records every 6 months. It has therefore established a process where managers should pick this up in Clinical supervision. Given the time constraints of the reviewer, it was difficult to confirm that this is consistently happening but feedback from some staff indicated it was sporadic, due to other demands on their time.
- 4.17 It is positive to see that for those patients who require a risk plan as part of the Safety Planning Approach the position has improved. Staff's accordance in delivering this has increased following the replacement of the previous system FACE in April 2017. A recent audit demonstrated a 71% compliance.
- 4.18 The author has seen and read the bi-monthly e-newsletter, *Practice Matters*. This was a good initiative which was supportive and carried information in an easily digestible form for staff.
- 4.19 The Trust have for a considerable time run Quality Visits to teams. These are multi-functional in nature, giving staff the chance to showcase good practice and managers an opportunity to look a little deeper into a specific area of practice or service delivery. Service user and Carers are invited to be part of the process although there was no feedback on how much this is taken up. Feedback from some staff who have experienced the visits was mixed.
- 4.20 The introduction of the Family liaison service in 2014 has been extremely positive. This puts in place a strong response to the duty of candour requirement as the team facilitator reviews every datix report that is submitted, this now exceeds 400. The team also have a supportive role in embedding learning using real case material and provide the link on behalf of the Trust in the event of an SUI to friends and family. Numerous letters and cards of gratitude have been seen following such events and supportive contact.

- 4.21 The Trust revised its web-site which is viewed as well structured, easy to navigate and available in multiple languages. It also sign-posts service users or carers' to the Mental Health Liaison service in the event of a Psychiatric crisis.
- 4.22 Funded by the Academic Health Science Network, the Trust has developed a new and innovative communication tool which enables family members to share information with Clinicians. This is now being shared with neighbouring Trusts.
- 4.23 The Trust is proud of its "think family" model and reports that 85% of staff have undertaken training in this model since its inception in 2017.
- 4.24 In addition to the MASH, senior officers confirmed during interview that formal information sharing policies have been developed with others key stake holder agencies i.e. Police, Ambulance and the Local Authority, although this has not been seen by the author.
- 4.25 In response to the recommendation that collateral histories should be taken to secure a greater insight into service users situation and those of family and Carers. The Trust have built this into their CPA process a "collateral information plan". In support of this a document entitled, "Family liaison processes" was viewed which acted as a useful aid-memoir covering many key areas.
- 4.26 Following the criticism resulting from these SUIs, the Trust has put in place a number of actions and held a series of events in support of learning lessons. This has included piloting the Human Factors Approach in Complex Systems (*ref: James Reason*), which has been used in many industries and is commonly used in health as way to help staff to understand the theory of system failure.
- 4.27 Staff have been encouraged to attend Local and National events which have been repeated during the last 3 years with contributions from senior officers. This has included a presentation by the Trusts Medical Director, entitled "To unlock learning for the NHS" and cited these two specific SUIs. In addition to this, he also summarised in the Trusts e-newsletter his own reflections of the National Homicide Enquiry as an aid to staff learning from wider investigation.
- 4.28 The introduction of the post of Family Liaison and investigations Facilitator and the associated processes as already mentioned is particularly noteworthy. This investment has enabled the development of a process which reviews datix incidents, supports the duty of Candour as introduced following *The Francis Inquiry of Mid-staffs* and introduction of standardised letters which go out in a timely manner as demonstrated by the feedback in cards and letters. This concept has been replicated in other Trusts and was recently cited at a National conference as a best practice initiative.
- 4.29 The Trust has acknowledged and apologised to the staff who were involved in the two cases, acknowledging the lack of support provided at the time. The letter from the present Director of Nursing, referred to learning points and the introduction of a "buddying" system, which would be available to staff, in the event of a similar such event in the future.

- 4.30 The Trusts Lead Psychologist is also now made aware in the event of SUIs and direct psychological support to staff is available should the individual want this.
- 4.31 On behalf of the Trust Board and the Executive team, letters have been written to the families of the victims involved in these incidents, formally apologising and offer the opportunity to meet and provide any support.

## **5 CONCLUSIONS AND RECOMMENDATIONS**

- 5.1 It is evident from the information that has been seen in the process of this review that the Trust has made considerable progress in delivering against the actions and recommendations of these two tragic events.
- 5.2 The Trust acknowledge that in the immediate aftermath of the incident, it could have acted differently and faster to support the families of the victims and staff who had been directly affected.
- 5.3 Since these two Serious Untoward Incidents considerable investments have been made in support of infra-structure (such as information technologies), improved estate to aid better communication and personnel.
- 5.4 A number of major policy reviews have taken place with supportive training to aid “roll out” and implementation.
- 5.5 The Board have put in place information/communication structures to continue to analyse learning from these events and dash boards to pick up compliance in areas such as compliance with CPA and adherence to Management and Clinical supervision and Appraisal systems.
- 5.6 Positively the Trust have utilized these events as learning opportunities in training events for learning lessons.
- 5.7 Whilst the above is extremely positive, staff report that the expectation of the Trust that 3 clinical cases are routinely reviewed at each clinical supervision session is variable. The Trust should undertake an audit of compliance and work with staff to deliver an achievable process and target.
- 5.8 The Trust continue to use Quality Visits to teams. The author heard from senior staff that viewed this as an important process by which to hear about local best practice and to meet with staff. However, some staff “on the ground” did not see these visits as supportive but an added task which took them away from patient care. A review of the Quality Visits by senior management and team leaders would be beneficial.

## **6) GLOSSARY OF TERMS**

- SUI – Serious Untoward Incident
- CPA – Care Programme Approach
- DCO – Director of Commissioning Operations
- CQC – Care Quality Commission
- CIC – Community Interest Company
- PARIS – Electronic Patient Record system run by Civica
- SystemOne - Electronic Patient Record system run by TPP
- CAMHS – Children and Adolescent Mental Health Services
- MASH – Multi Agency Safeguarding Hub
- AMHP - Approved Mental Health Practitioner.
- LD – Learning Disability
- CMHT – Community Mental Health Team.
- FACE – “Functional Analysis of Care Environments” risk assessment is a checklist style risk assessment used by services when calculating risk.
- MDT – Multidisciplinary Team.

## Evidence of Adherence to Actions Required

	Recommendation	Trust stated Position	Evidence	Additional Supplementary Assurance	Questions
1	<p><b>Consolidating/fully reviewing all medical records.</b></p> <p><b><i>Note: In 2010 &amp; 2013 when these two SUIs took place, the Trust was either wholly, or partly reliant on a paper based record system.</i></b></p>	<p>Continual reviews of an individual's history take place during CPA reviews and during the patient safety planning process. Both processes create an electronic summary of an individual's clinical history.</p> <p>The Trust has now embedded an electronic patient record (Paris –which began to be rolled out from 2011/12 and is now fully operational. This is accessed by all mental health clinicians.</p> <p>Inter-connectivity has been achieved with wider clinical systems (SystemOne) to extend the record to wider services (including drug and alcohol and CAMHS services).</p> <p>This access to shared electronic patient records better enables teams to work collaboratively and communicate with all</p>	<p>The Trust successfully managed the migration and put in place mitigation plans as they progressed to a full electronic patient record</p> <p>Additional training has been provided to Trust staff.</p> <p>Previous medical records have been archived under a contract with TNT and can be accessed within 72 hours. A premium rapid retrieval service is also available if required.</p>	<p>Staff from the Trust can use an Online Information System (OIS) to see where electronic records are held, including contact details for the current team, referral information and alerts.</p> <p>Currently &lt;20,000 boxes of files are held in secure storage. Evidence provided suggests on average between 200 – 300 files are retrieved each month.</p> <p>The Trust commissioned St Andrews House in 2016 which has brought together, the City teams covering LD services, SW (including the AMHPs) and the Criminal Justice liaison team. This has created opportunities to informal and formal meeting easier. <i>(Staff from these teams</i></p>	

		involved in an individual's care and improves the ability to manage risk. This supports effective use of CPA.		<i>gave the example of how much easier it is now to arrange joint meetings or visits).</i>	
		<p>Developments with the electronic patient record has enabled many local GPs access to all records and prescribing information.</p> <p>The Trust continues to promote this access and associated benefits for all GPs and has seen improvements in take up</p>	<p>For those GPs using TPPs SystemOne (In the City most GPs have access to system1. In the County, the picture is more mixed).</p> <p>An information sharing protocol. Additional protective protocols are in place to ensure positive communication to reduce risks of supplementary prescribing.</p>	This is increasing clinical information sharing. Access for clinicians to this record within IG sharing records- sharing continues to expand.	
1(a)	The Trust takes steps to unify paper and digital patient records	<p>The use of paper records has now been completely replaced by the electronic patient record.</p> <p>The need to have one single set of historical patient information is recognised as significant. To achieve this, clinicians working across services have access to inter-connected electronic systems ensuring they have access to the most up to date information about the individuals in their care.</p>	<p>Functionality to link and connect all records went live in Sep/Oct 2017.</p> <p>In addition, the review of clinical risk history and risk profiles continues.</p>	<p>In addition, a new Criminal Justice team was commissioned in January 2018. This team has full access to all patient records and works in close liaison with the Police.</p> <p>As an example – where a patient is new to the Trust and only has a recent referral, then there will only be an electronic patient record. Clinicians would be able to access this directly from the PARIS system but also able to use the Online Information System (OLS) to see if a patient</p>	

				is known to other services.	
1(b)	<p>Following this unification, patients' historical records must be reviewed and summarised at key stages in their care</p>	<p>The Trust now state that at each CPA and in Patient Safety planning meetings, a summary of care needs is implemented.</p> <p>In October 2017, the Trust has issued a revised CPA Policy and procedure document. This is now a comprehensive document which leads with the following statement;</p> <p><i>"A coordinated plan of care should accompany each patient throughout their contact with Health and Social Care. Individuals and their families are central to their care plans in the spirit of "nothing about me without me".</i></p> <p>New guidance is being delivered in staff training which highlights the potential risks that arise upon discharge or transition and the requirement to review notes at these stages.</p> <p>The Trust plans to continue to be developed and refine;</p> <p>-&gt;Existing training to include the</p>	<p>The Integrated Public Board Report reports on a series of indices; compliance for those patients on CPA for &gt;12 months is reported monthly a generally vacillates between 95 -97%, this is a favourable comparator with other Trusts Nationally.</p> <p>A pilot for high intensity management has been confirmed.</p> <p>Funding has been agreed and appointments to Police and nurse post has commenced. The service became operational in May and is expected to be extended in 2019</p>	<p>A training programme is being delivered to staff which picks up on the key themes. An example of feedback from staff that have attended the training is positive.</p> <p>The Trust seek to lead a review of patients with key characteristics in their risk profiles. A nationally recommended model "the JET model" has been identified for this purpose and the Trust is currently in conversation with Commissioners to support the use of this model. This is currently in the early stages with staff still being recruited.</p> <p>The number of staff in receipt of Clinical Supervision in March 2018 was reported to be 61.15% against a target of 100%.</p> <p>Management Supervision was reported as 72.0% against a target of 100%.</p> <p>The Trust did provide an itinerary for the CPA training</p>	

		<p>importance of historical records and the need for these to be reviewed.</p> <p>-&gt; A new safety planning process was introduced which includes a historical risk perspective. Staff are being trained in this new model.</p> <p>The Trust monitors whether all patients on a CPA have had a 12 month review this is reported live. Compliance in July 2018 stood at 94.86%</p>		programme	
1(c)	Progress against recommendations to be monitored and audited	<p>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.</p> <p>Scrutiny of these audits will take place at the Trust's Board Level Safeguarding Committee. The Safeguarding committee has received regular up-dates on progress.</p>	<p>A detailed audit of Care plan compliance including quality indicators was provided. This shows progress in several areas for example evidence safety planning was 75% but the quality of this was mixed, although &gt;86% were deemed as 3 or above (score 0-5). Those with identified risk factors were clearly shown in 77% of records audited. Generally, service users themselves were involved in the process and in 57% of those audited family or cares were also shown to be involved. Of concern was the evidence</p>	<p>Compliance against Clinical Safety planning on e-learning in July 2018 was 91.8%</p> <p>80.7% of staff who are required, have taken level 3 Safeguarding children training</p> <p>A copy of the Safeguarding Committee (Feb 2018) and its accompanying Position statement which was presented to the February meeting has been viewed. This acknowledges the legal framework and governance obligations of the committee.</p> <p>The reports also show positive</p>	

			that where safe guarding concerns were raised only 35% could show evidence of being acted upon.	progress towards targets and reports back to update the Board on actions from lessons learned from SUIs	
1(d)	The findings of these audits are to form part of discussions at regular Quality Assurance Meetings	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 review the implementation of these action plans – scheduled.	A copy of the minutes of the March QAG have been seen. This reported extensively on the action plans resulting from the 2 independent investigations.	A multi-agency safeguarding hub has been established with the principle aim of improving communications between agencies.  A new forensic team (DICE) is to be established this year with additional investment and enhancements in 2019/20	
2	<b>Responding to the service user's needs</b>				
2(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.	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 aims to reflect national best practice.  Ongoing engagement will continue with staff to understand the ethos of CPA including promoting a continual review of longitudinal risk, using collateral	In October 2017, the Trust has issued a revised CPA Policy and procedure document.  A detailed slide presentation entitled; "Core Care Standards and the CPA" (30 slides) has been seen this includes;	A "Practice Matters briefing" has been produced to act as an aide-mémoire for staff to use; to help improve the experience of care for people using adult NHS mental health services. This document is intended to aid both discussions with service users and to gather background information from Carers or friends.  Locally the Trusts Medical	

		<p>information from families.</p> <p>The Trust has developed several events to focus on learning from this case, including CPA.</p> <p>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.</p> <p>Learning from this incident also features in the Trust's safeguarding adults training, to ensure learning</p> <p>Further CPA reviews have been undertaken with Neighbourhood CPA review last meeting held on the 7<sup>th</sup> March</p> <p>Key recommendations are also considered from a safeguarding perspective. All clinical teams receive an annual Quality Visit and the programme for 2017 is underway</p> <p>Teams to evidence family inclusive practice in quality visits.</p> <p>Update Carers policy to strengthen in respect to ethos of</p>	<ul style="list-style-type: none"> <li>• Mental Health Act 1983</li> <li>• HC90(23) CPA Circular 1990</li> <li>• Valuing People</li> <li>• Refocusing the CPA 2008</li> </ul> <p>And CPA standards of:</p> <ul style="list-style-type: none"> <li>• Assessment</li> <li>• Care Planning</li> <li>• Review</li> <li>• Care Co-ordination</li> <li>• Discharge/transfer</li> <li>• Service User and Carer Involvement</li> </ul> <p>The Trust positively has also become a member of the Triangle of Care scheme, and currently has been awarded two stars for working in conjunction with the Mental Health Carers Forum (Positive external audit and validation). A training package 'Better together' supporting this is available for staff.</p>	<p>Director along with other senior staff have facilitated a training session on the new CPA policy, also some staff attended the National conference.</p> <p>In addition to the training sessions some quizzes have been developed to support staff's training and knowledge, which have been shared with the reviewer.</p> <p>The Trust have shared their guidance for teams and panel members for Quality Visits which are conducted with all teams and evaluated on an accompanying feedback document.</p> <p>The Carers strategy 2016 – 2019, 'Recognition, Respect &amp; Respite' has been seen, this is a comprehensive document, detailing policies and legislation, definitions and the Trusts Commitment.</p> <p>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</p>	
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		CPA.		Nov 2017.	
2 (b)	<p>Every six months all CPA records should be audited by managers to establish:</p> <ul style="list-style-type: none"> <li>-&gt; If CPA is being correctly applied and adhered to</li> <li>-&gt; If risk assessments are up to date</li> <li>-&gt; If staff are having regular supervision which includes providing care which recognised the ethos of CPA</li> </ul>	<p>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.</p> <p>We can see that this approach has resulted in an increase in the frequency of clinical supervision.</p> <p>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.</p> <p>A new clinical safety planning approach introduced in April 2017, replaced the FACE risk assessment across adult services. The aim of this approach is to 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 under</p>	<p>The number of staff in receipt of Clinical Supervision in March 2018 was reported to be 61.15% against a target of 100%.</p> <p>Management Supervision was reported as 72.0% against a target of 100%.</p> <p>The Trust report a favourable position against other Trusts for CPA reviews in the last 12 months for those on CPA for &gt;12 months at over 95% against a stated median rate of 89% nationally.</p> <p>Staff appraisals are currently just above 82% and compulsory training is 88% both set against a target of 90%. Both are also showing an improving position (March 2018).</p> <p>Audit shows that compliance for those patients requiring clinical risk plan is currently 71%. This position has gradually improved as the Trust has transitioned from FACE to the new safety</p>	<p>In discussion with staff there appeared to be a variable uptake of clinicians bringing along 3 individual cases to discuss as requested by the Trust.</p> <p>The Board via the Quality Committee, continue to monitor the organisation's progress of improving and implementing their revised CPA – See report of 11/1/18.</p> <p>A "draft" audit report of safety planning in Neighbourhood Services, was seen (July 18). This showed a variance across teams in aspects of safety planning, although 76% were deemed to have reached a standard of "good enough" when measured against a standard set of criteria.</p> <p>An example of the Trust Safety Assessment form which is used for training was shared. This is a helpful template for staff to follow to aid formulation of risk profile.</p>	

		<p>CPA so that they are encouraged to be the authors of their own 'safety plan'</p> <p>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.</p> <p>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.</p> <p>The Trust has developed a process to recognise good practice and to share this with wider staff.</p> <p>Improvement in supervision / continued improvement on quality of supervision.</p>	<p>planning approach.</p> <p>The Derbyshire Healthcare Model – identifies patient need between 1 – 5 (Level 1 being highest need) (Level 5 – Supported by primary care). Case load ratios are also described as being linked to the above.</p> <p>The Trust aims to work within National policy implementation guidelines of holding caseloads at no more than 35, the CQC reviewed this in 2016 and raised no concerns.</p>	<p>An Audit of care plans and safety plans for inpatient units demonstrates excellent progress;</p> <ul style="list-style-type: none"> <li>• 239 patients show that care plans and safety plans are in place</li> <li>• 3 show no evidence of a care plan or safety plan in place</li> <li>• 2 have no care plan in place</li> <li>• 6 have no safety plan in place</li> </ul>	
2 ©	Adherence to this recommendation to be audited on a six-monthly basis	<p>Full roll out to be completed in 2017/2018 and full compliance with audit checks.</p> <p>A further audit will be undertaken as part of the introduction of a new CPA</p>	<p>The March 2018 Board report has been reviewed. Under the safety section 18 indicators are monitored, examples incl;</p> <ul style="list-style-type: none"> <li>• No of incidents of moderate/catastrophic</li> </ul>	<p>Compliance for those patients on CPA for &gt;12 months at the time of the review was 94.86%, this information whilst reported monthly at the Board, is refreshed at midnight each day therefore providing live data</p>	

		<p>policy/ Phase 2 model.</p> <p>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</p>	<p>actual harm.</p> <ul style="list-style-type: none"> <li>• No of patients held in seclusion</li> <li>• No of physical assaults on staff</li> <li>• % of staff compliant with Clinical Safety Planning</li> </ul>	<p>Of the 18 indicators, the Trust is outside its intended target position against plan in 15 of them.</p>	
<b>3</b>	<b>Improving long term care</b>				
3(a)	<p>Regular audits to ensure managerial supervision and policies and procedures to facilitate supervision are being used to promote the delivery of service user centred long term care.</p>	<p>The Trust reports audits of supervision and record keeping standards are to be maintained as per other actions. In addition, an audit will include qualitative and quantitative compliance audits.</p> <p>Management supervision performance has substantially improved.</p> <p>The Trust had begun a CPA and care planning audit which was due to complete in May 2018</p>	<p>The Trusts Quality Dashboard report presents a rolling 12-month longitudinal view of Clinical and Managerial supervision broken down by Campus.</p> <p>Clinical supervision showed;</p> <ul style="list-style-type: none"> <li>• 5 teams Green &gt;80%</li> <li>• 11 teams Amber between 60- 80%</li> <li>• 3 teams red &lt; 60%</li> </ul> <p>Managerial supervision showed;</p> <ul style="list-style-type: none"> <li>• 7 teams Green &gt;80%</li> <li>• 10 teams Amber between 60- 80%</li> <li>• 2 teams red &lt; 60%</li> </ul>	<p>It was clear from the rolling audit that some campus areas are consistently performing well below target. No information was available to demonstrate how this is being addressed.</p>	
3(b)	The audit process	Supervision compliance has	In some services areas, the	Issue 002 of the "Practice	

	<p>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.</p>	<p>significantly improved – both in respect of rates and depth. Clinical examples are scrutinised as per the revised supervision policy.</p> <p>In addition, compliance checks on risk assessments and personalised care plans have been undertaken and improvements have been endorsed by regulators.</p> <p>Processes are in place to enable an escalation of issues from supervision to the clinical risk register or clinical operational COAT Auxillary. A group effectiveness audit has been completed.</p> <p>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.</p> <p>We also have mechanisms in place to recognise good practice and to share this with wider staff.</p>	<p>Trust can demonstrate improvements in supervision, both clinical and managerial. However, this is not across all areas and the trajectory of improvements has been slow</p> <p>Issues were previously raised by the CQC during their inspection in 2016. The Trust is currently awaiting their report from the recent visit May 2018.</p> <p>The Trust have in place a Quality visits programme, this in part gives the teams opportunities to show case their good practice but also allows for areas of challenge</p>	<p>Matters” document was shared. This is a bi-monthly e-newsletter circulated by the Trust. This is a very informative document, giving useful feedback and information to staff. It covered areas such as;</p> <ul style="list-style-type: none"> <li>• Sign up to safety</li> <li>• The safety plan – the move from FACE to safety planning</li> <li>• Learning from Inquests</li> <li>• Team contributions</li> <li>• Learning from complaints</li> <li>• Recommendations &amp; learning from serious incident investigations</li> </ul> <p>Whilst the structure of these visits looks positive, feedback was that they were not always “valued” on the ground. Sometimes seen as a distraction rather than offering added value</p>	

4	<b>Working with family members and carers</b>				
4 (a)	<p>Consent to share information should be updated regularly to promote effective communication between services, the service user and family members/carers.</p> <p>Protocols and policies should be introduced to secure this.</p>	<p>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 (Paris). This will enable our teams to more effectively seek collateral histories and any wider relevant information from families.</p> <p>This is supported by our Situation, Background, Assessment, Recommendation (SBAR) communication tool and increased information being made available to families and carers. This process is planned to be audited.</p> <p>The Trust's approach is secured in the new family and carers strategy.</p>	<p>The Carers strategy 2016 – 2019, 'Recognition, Respect &amp; Respite' has been seen, this is a comprehensive document, detailing policies and legislation, definitions and the Trusts' Commitment.</p> <p>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</p>	<p>Staff feedback that with the implementation of the electronic patient record Paris, which was rolled out from 2011 onwards and is now fully operational and includes a "consent to share" section. Accessing information on families and friends is considerably easier.</p>	
4(b)	<p>Close family members should always be given a contact point to access the mental health system in a crisis</p>	<p>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.</p> <p>Family Liaison can refer to</p>	<p>Since the implementation of a Duty of Candour one role of the family liaison service is to review all datix report's. Since 2014 this is now considerably &gt;300 reports</p>	<p>Whilst visiting the Trust many information pamphlets were freely available to patients or visitors. Some were produced by the Trust, others were generic, i.e DHCFT</p> <ul style="list-style-type: none"> <li>• Advocacy – "who can help make sure your voice is</li> </ul>	

		<p>access (internally) psychological support, CAMHS, family therapy and therapy support. This has been offered post 2014. External support can also be accessed where appropriate.</p> <p>We have revised and reissued our family and carer support leaflets. Easily located information has been included on the Trust's website to provide access to support and information in a crisis.</p> <p>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.</p> <p>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</p> <p>The rollout of the new mental</p>	<p>Thus far there has been no reported uptake of this service externally although it currently remains available</p> <p>SBARD was funded by the Academic Health Science Network and was shared with all East Mids partners, anecdotal evidence suggests that staff wish to use this but currently there is no evidence base to support this.</p> <p>The crisis service is available to both service users and their families/cares</p>	<p>heard</p> <ul style="list-style-type: none"> <li>• How to get help – for families and carers</li> <li>• Your feedback card</li> </ul> <p>The Trusts website is well structured, easy to navigate available in multiple languages, sign posts people in a crisis and seeks feedback on experience.</p> <p><i>Note: There is no out of hours Trust response telephone line</i></p> <p>Generic pamphlets incl;</p> <ul style="list-style-type: none"> <li>• Samaritans – For once I felt someone got me</li> <li>• Mind (Derbyshire) – Independent health complaints advocacy services</li> <li>• Way – Widowed &amp; young, we are here to support you.</li> </ul>	
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		health liaison service provides rapid access to support in a crisis.			
4(c)	The Trust reviews its family involvement strategy	<p>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.</p> <p>We will continue to provide ongoing advice to clinical staff to enable them to share information and remain in contact with families and carers.</p>	<p>The Trust has championed the 'Think Family' model and reports 85% staff were trained in 2017.</p> <p>This message is supported Carers strategy and reinforced in the safeguarding adults training.</p>	<p>The Trust reports having an information sharing policy with other agencies i.e Police, LAs, Ambulance etc although this has not currently been viewed by the author.</p> <p>As part of the Trusts commitment to the triangle of care process they now describe having "Carers Champions" in most of their services (Sept 2017)</p>	
4(d)	The Trust's Quality Assurance Programme be revised to ensure that teams are required to actively seeks family members' involvement and views	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.	Guidelines to the Trusts Quality Visits includes the request that teams are encouraged to have "a strong voice from people who use services". In addition, the guidance for the visit seeks involvement from Service users, carers customers and all staff	No information was seen that indicated the uptake of other parties which were not employees	
4(e)	Collateral histories should be taken to secure a greater insight into a service user's situation and those of the family	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.	The family collateral information pack as described was not provided. However, a document entitled Family Liaison Processes was viewed. This	The Family Liaison Process includes headings covering; <ul style="list-style-type: none"> <li>• Incident reporting</li> <li>• Complaint received</li> <li>• Initial contact with Patient</li> </ul>	

	members/carers themselves	Designed – for roll out in Jan 2018, over a 12 month	is a useful aid-memoir	<p>or family</p> <ul style="list-style-type: none"> <li>• Further contact with the family</li> <li>• Investigations updates</li> <li>• Next steps</li> <li>• Case note (mortality) review highlights requirement for further review by serious incident group</li> </ul> <p>Additional consideration included amongst its issues;</p> <ul style="list-style-type: none"> <li>• <i>Duty of Candour: Responsibility in first instance to patient</i></li> <li>• <i>Referrals for Specialist Support</i></li> <li>• <i>Family Members under Care of DHCFT</i></li> </ul>	
<b>5</b>	<b>Learning from adverse events</b>				
5(a)	The Trust's framework for investigating serious incidents be reviewed	<p>A review of the Trust's serious incident process is underway. This was completed as per national timescale</p> <p>As part of this process we have been piloting the Human Factors</p>	The Family Liaison Process as described above provides the Trust with a process to follow in the event of an SUI. The document is a helpful planner for staff to follow locally	An event learning from SUIs case took place in July 2017, senior leader's feedback was very positive on the dissemination of learning was completed.	

		<p>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.</p> <p>A Trust-wide leadership event on learning from the experience of these families was held in 2014/15 and 2016. Staff also attended a national event in 2017.</p>	<p>The Family Liaison and Investigations Facilitator (FLIF) was interviewed as part of the process. She could share information which she routinely shares with families in the aftermath of an SUI. This included a standardised letter, offering condolences following the loss of a relative which offered support directly from the Family Liaison and signposted people to other services that may be able to help.</p> <p>There were also copies of letters explaining to families the process of investigation with points of contact.</p> <p>In addition, several letters from families were shared, who were clearly grateful for her support in the days, weeks and months following an incident.</p>	<p>Issue 002 of the “Practice Matters” as previously described has a section written by the Medical Director; “Mental Health Homicides, Medical Director’s reflective piece” his final paragraph includes his own personal reflection of the National homicide enquiry; <i>“Do not rely exclusively on what a patient is telling you at any one moment in time: remember to see the individual in their historical context and as part of their social and family network. Where possible allowing for confidentiality obtain information and share key information with the family and significant others, as well as relevant partnership agencies. Do not take false assurances from an apparently stable patient if there is a very significant past risk history and remember that relapse following discontinuation with medication is probably the single biggest precipitating factor for serious incident that we have in this context”</i></p>	
5(b)	The Trust to take active steps to ensure staff and clinicians are supported in relation to serious	A support session has taken place to reflect on learning from this case, which had good attendance.	The presentation slides of Dr John Sykes, Medical Director were shared, titled; Independent Homicide Investigations, commissioned		

	incidents	<p>Direct engagement has taken place with all staff directly affected by this case, to provide additional support and/or engagement.</p> <p>Staff working within our services have been involved in a learning review to embed changes into practice and cascade this learning throughout the organisation.</p> <p>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?”</p> <p>The safeguarding lead will re contact remaining staff, to see if they would like a final session on any learning. 31st March 2018</p> <p>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.</p> <p>A “buddy” system has been</p>	<p>by NHS England – To unlock learning for the NHS. AC Male - 2010 AC Female – 2013</p> <p>A letter from the Director of Nursing to staff directly affected by these SUIs has been seen. This cited several points of learning. It also introduced the concept of buddying, by staff who may have experienced an SUI, supporting staff who may be part of an active investigative process following an SUI.</p> <p>The Triangle of Care scheme for which the Trust has now been awarded two stars for working in conjunction with the Mental Health Carers Forum. Also, supports the training package ‘Better together’ which is aimed at all staff.</p>		
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		<p>developed to ensure staff who experience such very serious incidents receive appropriate support, which has been activated.</p> <p>Independently, NHS England has met with staff to hear their experiences and reflections on the investigation process and impact.</p> <p>Staff have been notified prior to the-publication of this report, with additional support put in place at this time.</p> <p>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</p> <p>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</p>	<p>Wider team members have provided additional support to individuals throughout this process, including additional psychological support through peer support with follow up.</p>		
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5(c)	<p>The Trust must implement processes to ensure learning from adverse incidents to embed learning in the day to day practices of those responsible for delivering care</p>	<p>Learning from this incident is also included in many Trust training courses, including using collateral family information more extensively.</p> <p>New processes are in place to ensure that the Lead Psychologist receives all notifications regarding incidents of this type.</p> <p>Requirements for staff support are also identified at an early stage through alerts generated by the Trust's electronic recording of all incidents.</p> <p>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.</p> <p>Key lead roles have been identified to provide direct and rapid support to teams following an incident (through Heads of Nursing/Lead Psychologist).</p>	<p>The Trust's Medical Director led one of a series of events for staff to learn from the recommendations of these two cases.</p> <p>Previous events were facilitated by the Director of Nursing and the Patient Experience lead, who as part of her role, has sought to continually engage staff to support learning from these incidents. This has included a focused reflection and learning event for mental health and drug and alcohol services.</p> <p>The uptake of psychological support offered is now monitored at year end.</p> <p>At the May Safeguarding committee the HR team reported a zero uptake in year one.</p>	<p>A summary of the findings/recommendations for this case has been shared with the teams directly (not just those involved) to continually cascade the learning.</p>	
5(d)	<p>The Trust must take steps to demonstrate</p>	<p>The Trust's Executive and Board members have written to the</p>	<p>In 2014/2015, the Trust held leadership events on learning</p>	<p>The Family liaison and investigations facilitator has</p>	

	<p>greater awareness of the knowledge levels of family members of victims, their specific background and insights and their interactions.</p>	<p>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.</p> <p>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.</p>	<p>from the family of a young man with a learning disability who died in a Learning Disability service (incident from outside of Derbyshire).</p> <p>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.</p> <p>The family's experiences in this case have also directly contributed to and featured within the training offered to our staff.</p>	<p>provided several standardised letters which she uses to engage families.</p> <p>In addition, written material is available at service sites signposting service users and their carers to places offering specific support in a crisis.</p> <p>Finally, many cards and letters from Families who have used the service and found it helpful and supportive have been shared as part of the investigation.</p>	
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## **Psychological Approaches CIC**

Psychological Approaches is a community interest company delivering a range of consultancy in collaboration with mental health and criminal justice agencies; our focus is on the public and voluntary sector, enabling services to develop a workforce that is confident and competent in supporting individuals with complex mental health and behaviour (often offending) that challenges services. We have a stable team of six serious incident investigators, and offer a whole team approach to each investigation, regardless of the specific individual or panel chosen to lead on the investigation. Our ethos is one of collaborative solution-seeking, with a focus on achieving recommendations that are demonstrably lean – that is, achieving the maximum impact by means of the efficient deployment of limited resources.

## **Mr John Enser – (RMN/RGN – DiP in Management / MSc in Health Services Management)**

John is a registered mental health and general nurse. He has 40 years' experience, initially in clinical practice before moving into middle and senior management roles. For 10 years, he was an Executive member of the Forensic Psychiatric Nurses Association (FPNA). John has designed and developed many new services including; In-patient services, Prison mental health and primary care, Police and Court Liaison services and community. Inevitably, this has involved working with multiple agencies and reviewing incidents when things have gone wrong as part of the governance and assurance framework. Independently and as a Director for Psychological Approaches, he has carried out on reviews of other services which were experiencing difficulties and led on "deaths in custody" reviews. He is an Honorary Lecturer at Canterbury Christchurch University and has an MSc in Health Services Management.