Assurance Report: Southern Health NHS Foundation Trust

NHS England independent investigation Mr JK 2014.20490

September 2018

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First published: September 2018

Niche Health & Social Care Consulting is an independent management consultancy that specialises in supporting health care providers with all issues of safety, governance and quality, including undertaking independent investigations following very serious incidents.

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1 Introduction

1.1 This paper sets out the Niche assurance assessment of the Southern Health NHS Foundation Trust (the Trust) action plan following the independent investigation into the care and treatment of JK. The purpose of this is to test whether the Trust has completed every action, embedded the changes and can demonstrate each action's impact or effectiveness. The oversight of the process by NHS Southampton Clinical Commissioning Group (CCG) is also reviewed.

1.2 NHS England South commissioned Niche Health & Social Care Consulting Ltd (Niche) to conduct an independent investigation into the care and treatment of Mr JK by the Trust. The investigation was undertaken by Sue Simmons and the report was published in January 2017.

1.3 This evidence based review has been carried out by Sue Simmons and has been peer reviewed by Carol Rooney, Deputy Director at Niche. The draft report was sent for comment to the Trust and NHS Southampton CCG.

1.4 NHS England South have maintained broad oversight of the action plan implementation and review process.

Criteria for assessment

1.5 This review has looked at two aspects of the action plan:

- The quality of the plan including the appropriateness and robustness of action points;
- Whether the action plan has been completed and has had an impact in relation to the original recommendations.

1.6 For both criteria we have explored quantitative and qualitative evidence.

Methodology for the Assurance Audit

1.7 The review process comprised a review of Trust documents including action plans, policies, practice guidance and pathways, and interviews with a small number of staff.

1.8 The oversight by NHS Southampton CCG of the Trust's serious incident management process was also reviewed.

1.9 A full list of all documents reviewed is in Appendix A.

1.10 As part of the review we discussed the action plan with the following people:

- Chief Nurse / Director of Nursing and Allied Health Professionals
- Associate Director of Nursing – adult mental health

- Southampton area manager
- Southampton clinical services director
- Family liaison officer
- Associate Director of quality governance
- NHS Southampton CCG City Quality Manager

2 Summary of the incident

2.1 JK (not his real initials) was receiving mental health care from the Trust and had been known to the Southampton adult community mental health service since 2004 when he was referred at the age of 25. He had a diagnosis of schizophrenia and was being monitored in outpatients although he missed many appointments.

2.2 At the time of the incident, 24 June 2014, JK was living in the guest house that he had lived in for approximately three years. He was friendly with his landlady and had known Mr W, the victim, for around ten years. Mr W was also a friend of his landlady.

2.3 JK stabbed Mr W three times outside his landlady's house. Mr W died later in hospital.

2.4 JK was arrested later that evening and was subsequently found guilty of murder and sentenced to life imprisonment with a twenty year tariff.

3 Analysis of the Action Plan

3.1 Prior to the independent investigation the Trust had carried out an internal investigation with an external expert panel member. The internal investigation was detailed and thorough and made seven recommendations which were developed into a structured action plan. At a later date the Trust added in a further six action points which, it was hoped, would be wider ranging and would address the recommendations systemically. The majority of these action points were being implemented and followed through at the time of the publication of the independent report.

3.2 The Niche independent report endorsed the recommendations from the internal investigation, and set out a further six recommendations. The Trust then merged the two sets of recommendations into one large action plan. However, this evaluation will focus on the six recommendations from the independent report. These are discussed below.

3.3 The Trust's implementation of each of the six recommendations made by the independent investigation is discussed in turn as well as the evidence and assurance for its implementation.

Recommendation 1

> The Trust's care pathways should give due prominence to the importance of having one or two key members of staff who can provide continuity of care for a long-term service user.

Trust actions to address this recommendation

3.4 All service users who meet the criteria for the Care Programme Approach are now allocated a care co-ordinator who works in partnership with the service user and aims to build a therapeutic relationship. The care co-ordinator remains constant and provides continuity during the involvement of other professionals. Compliance with this standard is monitored by the 'Tableau' business intelligence tool.

3.5 Service users who do not meet the criteria for CPA will have a lead practitioner either through their consultant psychiatrist or through a practitioner led clinic. The Trust has developed guidance for these and other clinics. No service users who are being followed up only in outpatients would now be seen by a series of junior doctors. Instead at the end of a rotation their care will be passed back to the consultant and they will continue with that consultant. In the case of JK he would not now have a series of junior doctors providing his care.

3.6 The Trust currently reports on all CPA compliance activity to its commissioners through the regular joint Clinical Quality Review Meetings (CQRM). The Trust's CPA 12 month review up to November 2017 demonstrated compliance across all services of above 96%. This means that

all patients on CPA have had their care reviewed by a care co-ordinator at the appropriate time interval.

3.7 The CPA audit looks for evidence in the medical records of care planning collaboration and care planning details, as well as sharing of the completed care plan (CPA and non-CPA) with service users and other health professionals, and the involvement of carers. There are plans for a new section to be added which will seek the views of patients directly. A further CPA audit was undertaken in January 2018. Results, not yet fully analysed, indicate (amongst other indicators) significant improvements in the proportion of service users who were appropriately on CPA, documented evidence of the involvement of families and carers, service user involvement in risk assessment, and service user involvement in a CPA review (up from 78% to 94%). This comprehensive document is broken down by team, thus providing useful information for targeting further training and service development.

Comment

3.8 There was clear accountability for the achievement of these action points in the Trust's action plan. The actions were appropriate to address this recommendation and were robust and auditable. It appears that the actions have been completed. However such actions will need continuing monitoring particularly at times of pressure on the service.

3.9 At the time of the independent investigation the Trust acknowledged that the Southampton service was particularly stretched and under pressure. A Southampton improvement plan was developed. This addressed the recommendations 1 and 2 from the independent report, amongst other issues, and some of the earlier recommendations in the internal investigation.

3.10 There is evidence of progress in improving the services in Southampton, including more visible clinical leadership, fewer vacancies, and more staff in inpatient units. We have seen the Southampton AMH Quality Improvement spreadsheet and it is clear that there has been progress but there is still much to focus on, caseloads are still high in community teams and there are a number of nursing vacancies on inpatient wards. There are however plans to address these issues over coming months.

Recommendation 2

The Trust should adopt and more closely follow the NICE schizophrenia quality standards and the Royal College of Psychiatrists' report particularly in relation to risk assessment and risk management, family education and support, relapse indicators, social circumstances, engagement and psychological interventions.

Trust actions to address this recommendation

3.11 The Trust has developed the 'Triumph' Psychosis pathway with the Academic Health Science Network.[1] This provides guidance for staff, carers and service users on what NICE interventions should be offered. The first year evaluation indicated some relatively small but positive improvements in care provided for individuals and their families. The availability of cognitive behavioural therapy for psychosis has been increased and a set of 'Triumph' leaflets have been produced which explain the therapeutic options, including cognitive behaviour therapy, family work and family and friends support groups.

3.12 Outcome measures for the early intervention in psychosis service (EIP) include a focus on social circumstances, e.g. accommodation and employment, and will provide measures of improvement in these areas. A recent review demonstrated that the pathway was meeting its targets in 80% of cases.

3.13 NHS Southampton CCG has funded access to the Healios family work website[2] which aims to empower patients and families affected by mental and physical illnesses. Carers' workers are employed within teams and some staff across EIP and community mental health teams (CMHTs) are trained family workers.

3.14 In Southampton, employment workers have been attached to each CMHT by the Local Authority using NICE approved employment interventions. The employment workers help service users to find work and then support them and employers to maintain that employment. Reports in March and August 2017 from this Integrated Mental Health Employment Service indicate that this is a valuable and effective service. We heard from Trust staff that the service is highly valued.

3.15 Assessment of relapse indicators is included in Wellness Recovery Action Planning and MyCrisisPlan which are being used with service users.

3.16 The report to the Clinical Quality Review Meeting (CQRM) in December 2017 indicated that the pathway has had a significant impact on practice. The report audited in detail the care provided to three service users with early psychosis and identified where practice had followed the pathway and where there were gaps.

Comment

3.17 This recommendation has been incorporated into the development of the Triumph psychosis pathway. The pathway appears to be comprehensive, clinically appropriate and quite ambitious in its scope. Many elements of the pathway are auditable, particularly if qualitative evaluation techniques are used, to complement quantitative data.

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[1] Academic Health Science Networks (AHSNs) are new organisations developed to drive innovation in the NHS and create wealth for the UK health economy through collaboration between industry, education, health and social care.

[2] Healios is developing and providing family intervention and behavioural change techniques, by blending technology, specialised expertise and a personal human connection. In Southampton they provided two innovative services, online family intervention and a mobile app, the Healios Decision Tool, for people with psychosis and their families.

3.18 These actions were therefore appropriate to achieve this recommendation and are embedded in service-wide changes in service delivery and practice. Like other action points they will need continuing audit and evaluation.

3.19 However, there was a recommendation in the internal investigation that all risk information held in earlier paper records should be uploaded onto the electronic RiO system so that it would be available currently. We were told that this has not happened in all cases. There was lack of clarity about whether the paper records would be available in community teams and outpatients or whether they would require requests to take them out of archives. This needs further clarification.

Recommendation 3

> The Trust should develop a policy and practice guidance on family engagement during an episode of care (including possible family meetings).

Trust actions to address this recommendation

3.20 There have been several developments to address this issue.

3.21 In Southampton, the charity Carers in Southampton has delivered training for staff, and there is also training for carers through the Recovery College. The Adult Mental Health Division are also hosting 'Learning Networks' on working with families and carers, with families attending to talk to staff about their experiences.

3.22 The Trust commissioned a review of families' experiences of the investigation process following the death of a loved one. A consistent theme to emerge from the families who participated was that engagement with them was poor even before their loved one died, making engagement after their death a much more difficult process. The review recommended that the Trust should work with service users, patients, families and staff to identify, develop and implement best practice on engaging with families.

3.23 This resulted in the development of a separate Family Involvement Action Plan. The action plan is comprehensive and contains 31 action areas many of which focus on family involvement from the beginning of care, training of staff, and confidentiality. The majority of the action points were recently assessed as complete or on track.

3.24 We have been told of a significant culture change in relation to family engagement within the Trust. Some of this has come about through family involvement following an incident when they are keen to make sure that something similar does not happen to other families in future.

3.25 The Trust has a new small tri-fold leaflet, entitled 'Families, carers and friends - what to expect from us during a person's care and treatment'. This leaflet is

clear, well-written and jargon free. It sets out how the Trust will enable family members to be involved in the development of services and in the care of their family member by listening, responding to concerns, and valuing their expertise and knowledge

Comment

3.26 This recommendation has been addressed through a comprehensive plan to focus on what has been recognised as a Trust-wide issue which needed some fundamental rethinking. The actions are appropriate and relevant and the original recommendation has been fully addressed.

Recommendation 4

> The Trust should develop guidance on family support and access to information after a serious incident to include guidance on implementation of this and the Duty of Candour policy.

Trust action to address this recommendation

3.27 This has been addressed in a number of ways:

- New Being Open and Duty of Candour policy and procedure guidance
- A leaflet for patients and their families entitled 'Information on investigation into serious incidents' which describes what happens when things go wrong.
- In the event of a death a personalised letter is written to the family offering condolences and informing them of the investigation including how they can participate.
- Guidance on family involvement in the Procedure for Reporting and Investigating Deaths.
- There are three levels of Duty of Candour / Being Open training. The basic level is now electronic, leading to a significant increase in staff undertaking the training. Between April 2017 and February 2018, 4799 clinical staff successfully completed this training. The electronic training programme is incorporated into induction and will be repeated by existing staff every three years.
- Training on the Duty of Candour and the involvement of families within the two day Investigation Officers training
- Compliance with Duty of Candour is recorded within the risk management system and is monitored in two ways:

a) Through the serious incident process with the 48 hour panel asking the question as to whether the initial contact has been made and
b) ensuring someone is nominated to lead on determining what contact/support the patient or the family require.

- We have seen evidence of this in an extract from a regional Initial Management Assessment (IMA) panel where the duty of candour and a nominated person to link with the family of a deceased service user were discussed.

- The review of the serious incident investigation reports through both divisional and corporate panels.

- Recognition through the involvement of families in the investigation process that different people want a varying level of support that is completely individualised to their wishes.

- Recruitment of a Family Liaison Officer (FLO) whose role it is to offer that higher level of individual support and act as a contact point for advice and signposting to other services. There is evidence of the FLO reporting regularly to the Caring Group and other meetings.

- Trust-wide master class training provided by the FLO and chaplain on how to share difficult information with family members.

3.28 In addition the Trust's Family Involvement Action Plan includes details of a significant number of action points relating to serious incidents and family involvement, most of which are reported as being on track.

Comment

3.29 The Trust has developed a range of relevant and appropriate changes in policy and practice which address this recommendation. There is evidence that these are having a significant impact on the way in which families are kept informed and supported following a serious incident. Once again this is ongoing work.

Recommendation 5

The Trust should ensure that the lead for liaison with family members and carers after such a serious incident should be at executive director or equivalent level, in accordance with the NPSA good practice guidance. This director would not necessarily carry out all contacts but would make the initial contact and would guide the continuing support and information sharing.

Trust action to address this recommendation

3.30 Whilst the numbers are very low, for the most serious incidents (homicides and inpatient suicides) initial contact with families is now from an Executive Director.

3.31 For other serious incidents, the Executive Director for each division is notified through the Ulysses system via a serious incident alert. This is followed up by an internal notification form which alerts them to the external reporting of a serious incident on the STEIS system. The 48 hour panel, which is chaired in each division by either the Clinical Services Director, Head of Nursing or Head of allied health professionals (AHPs), oversees the process of determining who the most appropriate person would be to take forward contact with family members or the patient themselves. They will keep the executive director appraised of the situation and will facilitate their involvement in family liaison if this is requested.

Comment

3.32 This recommendation appears to have been fully addressed through these action points. We were told about two recent serious incidents following which Executive Directors have taken the lead in making contact with the families.

Recommendation 6

The Trust should ensure that future reports and recommendations following a particularly serious incident should be formally reviewed and discussed by the Trust's Executive and Non-Executive Directors.

Trust action to address this recommendation

3.33 There is now a clear process for incident reporting and investigating all of which is recorded on the electronic system, Ulysses. Each area within the Trust has a 48 hour panel which meets at 1 pm daily to review any incidents in the previous 48 hours. The panel membership may vary but generally includes the head of nursing, the clinical services director and the manager who has written the serious incident report. Action plans and recommendations are then scrutinised at the divisional panel and the corporate panel. All information on serious incidents is also uploaded onto STEIS and reported to the commissioners.

3.34 Reports on all incidents are taken to the Quality and Safety Committee (a committee of the board which has three non-executive director members). This committee may ask for more information. Reports on impact graded category 5 serious incidents go to the Board in full.

3.35 There are joint meetings with the CCG and the Trust which focus on the review of actions plans. The Clinical Quality Review Meeting (CQRM) receives the numbers of serious incidents, some information about new

incidents and those which have been closed and their learning points. However the details of incidents are not taken to this meeting. Instead there is a joint meeting twice a month between the CCGs and the Trust referred to as the Serious Incident Closure Panel or the Serious Incidents (SI) Commissioners Review Panel which scrutinises reports and action plans and considers closure of the investigation.

3.36 The ongoing work of implementation of action plans is followed up within the Assurance Panel which meets monthly and is convened by the Trust and attended by at least two of the CCGs. This meeting is also known as the Evidence of Improvement Panel, and receives details of recommendations and action plans when they are nearing completion. These are often attended by clinical staff who are able to tell the meeting about the actual implementation of recommendations in practice. The action plans are not automatically signed off at the meeting, rather the panel may ask for further evidence or more detail.

3.37 Processes have been put in place to ensure that in addition to the current information they receive, Trust Board members will receive the full details of investigation reports for particularly serious incidents. This will include reports into:

- homicides;
- inpatient suicides;
- where the incident has been reported to the National Reporting and Learning System (NRLS) as the most serious Grade 5 category and
- deaths where the inquest resulted in a Prevention of Future Deaths Report from the Coroner.

3.38 Each month, a Corporate Governance paper is presented at Public Board meetings. This includes an appendix which details items that have been reported to Board members in the previous month. This section will now include details of reporting to Board members on the above four groups of particularly serious incidents. Evidence will also be obtained through the QSC minutes.

Comment

3.39 This recommendation appears to have been fully addressed and the actions have been embedded into Board practice.

4 CCG oversight of the action plan

4.1 The Trust is commissioned by a number of CCGs. The lead CCG for mental health services is NHS West Hampshire CCG, while NHS Southampton City CCG leads for Southampton in a joint commissioning arrangement with Southampton City Council.

4.2 It would appear that the oversight of the original internal serious incident investigation/action plan was via the main Clinical Quality Review Meeting (CQRM), where the action plan was reviewed monthly between October 2015 and April 2016.

4.3 Since January 2017 and the publication of the Independent Review, no updates have been provided to the CQRM. Updates are usually provided once they have been through the Trust's internal governance processes. Changes in senior management within the Trust may have led to some delay in reporting to the CCGs. However, in the autumn of 2017 the CCGs received a copy of the amalgamated action plan, which included the original actions and the additional actions relating to the recommendations from the Independent Review. The new combined action plan was reviewed at the CCGs' Serious Incident Review Panel on 27 October 2017 where there was a robust and comprehensive discussion in which the Trust was asked to strengthen the action plan, identify accountable officers and dates and provide further evidence. The action plan was most recently reviewed at the meeting on 16 February 2018, with general approval for the progress which had been made.

4.4 It has been acknowledged by the CCGs that there has not been a clear process for the oversight of some serious incident reviews and this has led to some changes to monitoring processes, resulting in all homicide reviews now being monitored at the CCG Serious Incident Review Panel until such time as they are confident that all actions have been delivered and there is robust evidence to support this. The terms of reference for the Southern Health Commissioners Serious Incident Panel have been updated and these were approved at the October 2017 CQRM.

5 Findings of this Assurance report

5.1 We have found that the Trust has developed a detailed and comprehensive action plan to address the recommendations in the independent report. All of the action points were appropriate and robust, and the majority have been implemented successfully. In addition there is evidence of the action points having a positive impact on the services received by patients and their families.

5.2 Most of the recommendations and the actions points developed to address them are quite complex and not easily 'signed off' once and for all. The Trust has made significant progress but will need to be continually vigilant in relation to this action plan and other related service improvements, through audit, supervision, staff training and policy and practice development.

6 Areas for the Trust to focus on

6.1 In addition to a continuing focus on service and practice development there was a further issue which we believe the Trust should focus on as part of its implementation of the integrated action plan.

6.2 There is a lack of clarity as to whether previous clinical information, particularly in relation to risk, has now been uploaded onto RiO for all current service users. We were told that it had not happened for all, but we were also told that the paper, or secondary, files containing earlier information pre-RiO, should be completely available and accessible for those being seen in community teams, and that these would be reviewed for any new referral.

6.3 In our view there needs to be complete clarity about this situation so that clinical staff understand exactly how and where to access information from prior to 2010. The difficulties in implementing this recommendation arising from the initial internal review were discussed in the Commissioners' Serious Incident Review Panel in October 2017, but it is not clear whether a way forward has been identified.

Appendix A Documents reviewed

Southern Health documents:

- ACT (Acceptance and Commitment Therapy) Group - For family and friends of people who use Mental Health services. April 2016 (leaflet).
- Action plan for review of family involvement in investigations. December 2017.
- Adult Mental Health CPA Results Report. February 2018.
- The Being Open Procedure (incorporating the legal Duty of Candour) Version 4. October 2017.
- Care Planning Policy 2015.
- Clinical Disengagement/Did Not Attend Policy for Adult Mental Health Division. 2016.
- CPA 12 month review
- Divisional IMA panel minutes (extract) January 2018.
- Duty of Candour Compliance - tableau report - September 2017.
- Family Liaison Report to Caring Group. Sept 2017,
- Family Work for People with Psychosis. April 2016 (leaflet)
- Families, carers and friends – what to expect from us during a person's care and treatment. (leaflet)
- Guidance for Clinics held within Adult Mental Health Division. June 2017
- Information on investigation into serious incidents (leaflet for families).
- Integrated Mental Health Employment Service – snapshot, March 2017 and analysis of outcomes, August 2016.
- List of Southampton Area Team Carers Champions. Nov 2017.
- Minutes of the Quality & Strategy Meeting Thursday 19th October 2017
- Policy and Procedure for Reporting and Investigating Deaths
- Version 4. September 2014
- Presentation to the EIP oversight group of Treatment and Recovery in Psychosis (Triumph) Year One Results. August 2017.
- Psychological Interventions for People with Psychosis, April 2016 (leaflet).

- Questionnaire: 48 Hour Panel Death IMA Review Record
- Report to the Caring Group by Family Liaison Officer on results of the Family Engagement Questionnaire. March 2017.
- Sample letter from Family Liaison Officer to family member.
- Serious Incident, Incident and Mortality Report to the Patient Safety Group and Quality and Safety Committee. Sept 2017.
- Southampton AMH Quality Improvement Plan - 2017/2018

Other documents

- Hampshire CCGs and Southern Foundation Trust Serious Incidents (SI) Commissioners Review Panel: Terms of Reference.
- West Hampshire and Southern Health. Serious Incidents Requiring Investigation Panel. Agenda for October 2017.

  West Hampshire Clinical Commissioning Group
  North Hampshire Clinical Commissioning Group
  Southampton City Clinical Commissioning Group
  South Eastern Hampshire Clinical Commissioning Group
  Fareham & Gosport Clinical Commissioning Group
  Southern Health NHS Foundation Trust
- The Serious Incidents Commissioners Review Panel: Terms of Reference
- Commissioner Serious Incident Panel: Minutes of meetings on 27 October 2017, 22 December 2017 and 16 February 2018.

Appendix B Extract from the Trust's action plan

	Recommendation	Extracts from the Trust's merged action plan outlining actions taken to address recommendations	Clear responsibility and accountability?	Date for completion
1.	The Trust's care pathways should give due prominence to the importance of having one or two key members of staff who can provide continuity of care for a long-term service user.	All service users who meet the criteria for the Care Programme Approach are allocated a care co-ordinator who takes the lead in organising their care. The care co-ordinator model is used in standard Community Mental Health Teams (CMHTs) as well as specialist teams such as the Early Intervention in Psychosis (EIP) service. Service users who do not meet the criteria for the Care Programme Approach because their risks do not warrant it, will have a lead practitioner either through their Consultant Psychiatrist or through a Practitioner Led Clinic. Medical continuity of care has been addressed. Across all of the Trust's mental health services, patients are handed back to the substantive overarching consultant when a junior doctor rotates out of a post. This is now standard practice.	Yes	02/02/2018
2.	The Trust should adopt and more closely follow the NICE schizophrenia quality standards and the Royal College of Psychiatrists' report particularly in relation to risk assessment and risk management, family education and support, relapse indicators, social circumstances, engagement	The Trust has developed the 'Triumph' Psychosis pathway. This provides guidance for staff, carers and service users on what NICE intervention should be offered and when. The pathway is now being rolled out across the Trust, beginning with Early Intervention Teams and progressing to CMHTs. There is now access to the Healios family work website which aims to empower patients and families affected by mental and physical illnesses. It is NICE accredited for EIP and now CMHTs and is one option for family work alongside face-to-face work. The availability of Cognitive Behavioural Therapy for	Yes	Marked as complete

	and psychological interventions.	psychosis has been increased by provision of additional psychologist time and a set of Triumph leaflets have been produced which explain the therapeutic options. There is a focus on social circumstances in outcome measures. In Southampton, Employment workers have been attached to each CMHT using NICE approved employment interventions. Assessment of relapse indicators is included in Wellness Recovery Action Planning and MyCrisisPlan.		
3.	The Trust should develop a policy and practice guidance on family engagement during an episode of care (including possible family meetings).	In Southampton, training is now regularly delivered through the charity 'Carers in Southampton'. The Trust is also currently developing training for carers through its Recovery College. The Adult Mental Health Division are also hosting 'Learning Networks' on working with families and carers with families attending to talk to staff about their experiences. In spite of this work, the Trust recognises that this recommendation reflects an issue which has arisen as a theme for mental health services in particular but also other divisions over the years and for which additional effort is needed to bring about a tangible improvement. In the last 6 months, the Trust commissioned a review of families' experiences of the investigation process following the death of a loved one. A consistent theme to emerge from the families who participated was that engagement with them was poor even before their loved one died, making engagement after their death a much more difficult process. Recognising that family involvement begins with the very first patient contact, and that it is critical to delivering effective health care services the Trust should work with	Yes	01/05/2018

		service users, patients, families and staff to identify, develop and implement best practice on engaging with families who have relatives who are accessing services provided by the Trust.		
4.	The Trust should develop guidance on family support and access to information after a serious incident to include guidance on implementation of this and the Duty of Candour policy.	The Trust has rewritten the Duty of Candour policy and procedure guidance documents. This includes flowchart guidance for staff. The Trust has also published a leaflet entitled What happens when things go wrong which frontline staff are able to give to patients and their families and provides guidance about the investigation process when an incident has occurred which may have caused harm. This is for use in incidents which have not resulted in death. There is an expectation that in the event of a death a personalised letter will be written to the family offering condolences and informing them of the investigation including how they can participate. Information about compliance with Duty of Candour is actively recorded within the risk management system Safeguard Ulysses and is monitored in two ways: a) Through the serious incident process with the 48 hour panel asking the initial question as to whether the initial contact has been made and b) ensuring someone is nominated to lead on determining what contact/support the patient or the family require. The review of the serious incident investigation reports through both divisional and corporate panels provides another opportunity for the liaison and support provided the family to be verified and challenged ensuring that all the necessary support and engagement has been afforded to them. Within the new two day Investigation Officers training provided by the Trust to anyone who is involved in investigating serious incidents, there is a specific two hour	Yes	01/11/17

		session allocated to Duty of Candour requirements and involvement of families features as a golden thread throughout the entire course. The Trust has also introduced live Duty of Candour monitoring through the Tableau business information system. There has been recognition through the involvement of families in the investigation process that different people want a varying level of support that is completely individualised to their needs. Some families require more support than the investigating officer is able to provide and the Trust has therefore recently recruited a Family Liaison Officer (FLO) whose role it is to offer that higher level of individual support and act as a contact point for advice and signposting to other services such as those offering bereavement counselling and support. The FLO involvement in each case will be as per need and this will be monitored to ensure that the support model is correct. The FLO post-holder will also attend local specialist groups such as the Suicide Prevention Group, Southampton area, to gain best practice knowledge for sharing within the Trust. She will be a Trust-wide trainer in Duty of Candour and in how to share difficult information with family members.		

5.	The Trust should ensure that the lead for liaison with family members and carers after such a serious incident should be at executive director or equivalent level, in accordance with the NPSA good practice guidance. This director would not necessarily carry out all contacts but would make the initial contact and would guide the continuing support and information sharing.	January 2017 Update Whilst the numbers are very low, for the most serious incidents (homicides and inpatient suicides) initial contact with families will be from an executive director. For other serious incidents, the Executive Director for each division is notified through the Safeguard Ulysses system via a serious incident alert. This is followed up by an internal notification form which alerts them to the external reporting of a serious incident on the StEIS system. The 48 hour panel, which is chaired in each division by either the Clinical Services Director (medical consultant) or Head of Nursing or Head of AHP's oversees the process of determining who the most appropriate person would be to oversee contact with family members (or the patient themselves if not a mortality incident). They will keep the executive director appraised of the situation and will facilitate their involvement in family liaison if this is requested.	No, but appears to have been addressed.	Marked as completed
6.	The Trust should ensure that future reports and recommendations following a particularly serious incident should be formally reviewed and discussed by the Trust's executive and non-executive directors.	Processes have been put in place to ensure that in addition to the current information they receive, Trust Board members will receive the full detail of investigation reports for particularly serious incidents. This will include: Reports into homicides, Reports into inpatient suicides, Reports where the incident has been reported to the NRLS as the most serious Grade 5 category and Reports into deaths where the inquest resulted in a Prevention of Future Deaths report. In addition to Board members receiving the documents, these will also be discussed at the Trust's Quality & Safety Committee, the minutes of which are presented at Trust Board.	No, but appears to have been addressed	Marked as completed