Sussex Partnership NHS
NHS Foundation Trust

ACTION PLAN PRODUCED IN RESPONSE TO THE THEMATIC REVIEW OF HOMICIDES BY SERVICE USERS AND A VICTIM OF PEOPLE USING SERVICES AT SUSSEX PARTNERSHIP NHS FOUNDATION TRUST – UPDATE AS OF 10TH JULY 2018

Recommendation 8
The Trust should continue to act on its commitment to implementing the 'Triangle of Care' approach to involving carers in the care and treatment of service users. The Trust should aim to achieve membership of the national programme within 12 months.

Action	Assurance	Lead	Time scale	Progress at 10th July 2018
(a) Recruit Carers Lead to support and drive through improvements for carers (including Triangle of Care)	Carers lead in post	Director of Patient Experience	November 2016	• Complete. Carers lead appointed.
(b) Review progress with Triangle of Care and other relevant programmes that promote effective carer involvement and improve experiences • Currently Adult Mental Health, Secure and Forensic services operate the Triangle of care • CAMHS and LD will review their work around carers engagement and involvement	Report presented to Service Delivery Board	Deputy Director of Patient Experience	March 2017	• Decision made to implement Triangle of Care in two phases • Stage 1 - at least 80% of all adult mental health inpatient and related services self-assessed by scheme by 1st August 2018 • Stage Two – remaining 20% of above services self-assessed, and all community teams or MH related services completed by 1st August 2020 • Paper went to Quality Committee and to Trust Board in May • Application completed and sent with sign up from the 3 primary carers' orgs in July • Carers Trust have approved application and as of 1st August 2017 we are a full member of the Triangle of Care • Full action plan created • Action plan being implemented through Positive Experience Committee (Chief Nurse is the Vice Chair) which reports into the Quality Committee therefore agreed action can be closed
(c) Work with families involved in past SI cases; carers, patients, staff and partners, to examine the improvement opportunities that can be delivered to meet the needs of carers in all services and create transformational change into the clinical practice of everyday care.	Formation of a service user and carer evaluation panel, to monitor the progress against this plan and to support the direction of further advancement.	Chief Nurse	April 2017	• SI policy reviewed by families involved in serious incidents. New policy created. Ratified and in place June 2017 – completed • Families and carers coproduced family information leaflet to be issued during SI process. Family involvement in writing the new 'Duty of Candour' leaflet. Leaflet has been completed and in the policy and printed - completed • Duty of Candour Policy now completed and is uploaded onto the intranet -completed • Healthwatch involved in Complaints Scrutiny Panel • Carers attend Safety Committee where SI's are reported. Service user to start attending in July 2018 • Director of Education and Training agreed 2/7/18 action could be closed
(d) In addition to the broad stakeholder involvement, the Trust will develop a specific work stream with its own set of KPIs (co-designed with patients and carers) around improving engagement and involvement of carers and service users.	A service user and carer work stream is agreed and in place with specific performance measures	Deputy Director of People Participation	April 2017	• The Hackathon event identified 10 must dos which exist as the initial KPIs • These will be embedded into the Triangle of Care implementation • These actions will be taken forward and integrated into the Triangle of Care self-assessment tool from there on in so action closed
(e) Develop ten "Must dos" that will occur in every service with regards exploring the carers input and engagement with the recovery of the patient."	Result achieved from Hackathon event	Deputy Director of People Participation	January 2017	• Paper went to Quality Committee and Trust Board in May • The Hackathon event identified 10 must dos which exist as the initial KPIs • These will be embedded into the Triangle of Care implementation. • These actions will be taken forward and integrated into the self-assessment tool from there on in so action closed
(f) identifying and assessing carers needs document from NHS England and scope out the feasibility of SPFT	Programme scoped out with NHS England colleagues and	Deputy Director of Patient Experience	April 2017	• Scoping engagement work with NHS England was completed and group recognised any further work would be carried out by CCGs. No further action.

leading the STP in this area to develop the memorandum of understanding about the very key issues which should always occur for carers and the transfer of information as patients transition services etc.	Commissioners			
(g) Carers rights day, a suite of activities planned for November 25th	Delivered with Triangle of Care leads, and support from East Sussex Care for the Carers and Carers Support	Director of Patient Experience	November 2016	• Complete
(h) The trust will introduce formal Family Liaison and Support for people affected by Level 2 serious incidents. This will focus on families/carers whose family member have died as a result of an unexpected death while receiving inpatient care or as a result of a homicide. (NB wording updated)	Individuals affected by Level 2 serious incidents will have an identified contact person who is independent from the incident. They will ensure regular (weekly) updates on progress with the investigation are provided; help with any questions raised and help people navigate their way through the process.	Chief Nurse	February 2017	• 13 family Liaison Leads have received training and are in place to fulfil the role • Recent Root Cause Analysis training has been reviewed to incorporate significantly more content on how to involve the family in the investigation. 20 staff have very recently completed the amended training. • In place – Chief Nurse advised that the Homicide Thematic Review Meeting agreed action can be closed
Recommendation 1 The Board of Directors should monitor the implementation of the CDS structure and the use of the Safeguard Serious Incident recording system (Ulysses) to assure itself that investigation management and implementation of action plans are consistent with Trust policies, processes and systems.				
Action	**Assurance**	**Lead**	**Time scale**	**Progress at 10th July 2018**
(a) Review each CDS against the 2016/2017 annual plan with specific attention to Governance • Fundamental Standards Self-Assessment • Management of the Risk Register • Complaints - themes and performance • Serious Incident reporting and learning (timeliness and completed actions)	Each CDS will demonstrate effective internal controls and delivery of the 2016/17 governance objectives. Patients and carers will be part of this oversight and scrutiny	Chief Operating Officer	April 2017	• Local teams, service users and carers have been involved in the development of the clinical strategy • CDSs have quarterly performance meetings to provide assurance on all key measures and agree actions to mitigate risk • Fundamental Standards governance is managed via Service Delivery Board and Quality Committee • Risk Register governance is managed via Service Delivery Board and Trust Board • Complaints system is in place which is based on the national model. Performance is monitored and a new dashboard is being developed to establish themes in regards to the upheld complaints • SI process is robust • Action plans relating to SI's are closely monitored by the Clinical Governance Team on a monthly basis, with actions also monitored by the CDS. The CDS's also receive monthly reports on outstanding actions for them to action. Open actions are also discussed at the Operational Management Board (OMB) which is chaired by Deputy Chief Operational Officer. Robust Processes are in place to monitor the completion of SI action plans. In addition the clinical governance team choose at random one closed SI/action plan per CDS every 6-8 weeks and request evidence to support closure • Internal Audit Report on Implementation of Serious Incident Action Plans final report completed April 2018 • Thematic Review of Homicides project group confirmed this action can be closed

Recommendation 2 The Board of Directors should build upon the work already in place to assure themselves, their stakeholders and the wider public that learning from all recommendations is being fully embedded across the organisation in a timely manner. Currently and in the future, where there is Level 1 evidence, the Board should be expecting the Trust to move towards Level 2 compliance with recommendations; and likewise, where there is Level 2 evidence the expectation of Level 3 evidence should be made clear. If these are not appropriate, then the Trust should be transparent as to the reasons.				
Action	**Assurance**	**Lead**	**Time scale**	**Progress at 10th July 2018**
(a) Undertake a full review of the Serious Incident policy ensuring we raise the profile and scrutiny of the learning and service/practice improvement as a direct result of the lessons learned.	Revised Serious Incident investigation and review reports evidence learning and service improvement, progress of which is monitored and reported through the Safeguard system A range of learning arrangements are in place which reach all parts of the Trust	Chief Nurse	April 2017	• SI policy reviewed by families involved in serious incidents. New policy created. To be ratified by mid May 2017 • Families and carers coproduced family information leaflet to be issued during SI process. Leaflet will be available May 2017 • 13 Family Liaison Leads have received training and are in place to fulfil the role • Chief Nurse advised that the Homicide Thematic Review Meeting agreed action can be closed
(b) Develop local and Trust wide learning lessons forums, focussed serious incident reflective groups, creating conditions that embed learning into practice.	Revised Serious Incident investigation and review reports evidence learning and service improvement, progress of which is monitored and reported through the Safeguard system A range of learning arrangements are in place which reach all parts of the Trust	Chief Nurse	April 2017	• New Patient Safety Briefings scheduled for all staff. First event took place at Langley Green Hospital on April 4. Future dates are: June 23, August 3, October 6, November 23, January 16 • Second Learning event occurred on 23rd June – theme medication safety 16 front line staff attended. Co-facilitated by pharmacist. Patient Safety Matters being produced monthly and sent out electronically, via Susi and in printed hard copy to the wards/teams. Feedback has been positive. August session will be co-facilitated with a carer with the theme carers and confidentiality. • August session facilitated with a carer- numbers are increasing and feedback very positive – request to repeat the learning event with the doctors in East Sussex which is in the process of being organised • System is place to ensure the learning events are occurring at regular intervals – Chief Nurse advised that the Homicide Thematic Review Meeting agreed action can be closed
(c)Introduce podcasts, easy to read bulletins to ensure learning occurs at every level across the Trust.	Revised Serious Incident investigation and review reports evidence learning and service improvement, progress of which is monitored and reported through the Safeguard system A range of learning arrangements are in place which reach all parts of the Trust	Chief Nurse	April 2017	• New Patient Safety Bulletin created to go out to all staff, clinical and non-clinical, monthly. First edition issued March 2017. • As above – 3 issues now produced. Second one with carer involvement and 3rd with Pharmacy involvement. • August – system now in place to regularly produce (every month to 6 weeks) a Patient Safety Matters bulletin – Chief Nurse advised that the Homicide Thematic Review Meeting agreed action can be closed
(d) The NHSE South Mental Health Homicides Team will work with Sussex Partnership NHS Foundation Trust colleagues to develop and deliver a one day training event for clinicians entitled “Learning from homicides and other serious incidents, making sustainable organisational and practice changes”. We will seek to engage our colleagues in NHS Improvement (NHSI) and the local Academic Health Sciences Network (AHSN) to maximise local expertise and contributions in line with	The learning events will be targeted on key staff with responsibilities for shaping policy, practice and culture and audited as set out in section 7	Chief Nurse and Director of Innovation and Improvement	May 2017	• Money secured from HEKSS for event £8.5k • Draft programme has been developed from a programme previously used by NHS England • A film/video has been made which captures a family’s experience of the incident review • Learning event 1/11/17 at Sussex University (attended by over 140 people) • Will use HEE money to provide face to face training across clinical services where SPFT trainers and SUs will facilitate team training events. A lead will work with teams, trainers and SUs to support the programme which should start in October • Agreed action can be closed

Institute for Healthcare Improvement (IHI) methodology and patient safety best practice				
(e) The NHSE South Mental Health Homicides Team will facilitate a further development session for Sussex Partnership NHS Foundation Trust delivered by the "Making Families Count" Collaborative. This session will build on the success of the summer workshop hosted by the Trust and will focus on the development of best practice initiatives and protocols in positively involving families in investigations when incidents occur.	Delivered and attendees asked to consider how this will change their practice and report back	Chief Nurse and Director of Innovation and Improvement	May 2017	• This included partner organisations, clinical staff and support services • Carers organisations, CCG Quality Leads, CQC invited • Targets set for each CDS for front line staff to attend • Arrangement in place to have programme printed • Director of Innovation and Improvement liaised with Making Families Count Collaborative re the event • Event was held on 13/6/17 (over 100 people attended) and policies now actively involve families in SI investigations • Evaluation completed • Action closed
Recommendation 3 The Board of Directors should assure themselves that there are robust systems in place to provide evidence that actions have been implemented in a timely manner and in line with the requirements of each action plan.				
Action	**Assurance**	**Lead**	**Time scale**	**Progress at 10th July 2018**
(a) Each CDS to provide confirmation on the completion of actions arising from SI by the prescribed date.	Report provided to the Strategic Director of Delivery and Performance	Chief Operating Officer	November 2016	• Service and clinical directors receive and review all SI for their areas and have processes in place to check that the actions are being completed and that the learning is shared • SI process is robust • Action plans relating to SI's are closely monitored by the Clinical Governance Team on a monthly basis, with actions also monitored by the CDS. The CDS's also receive monthly reports on outstanding actions for them to action. Open actions are also discussed at the Operational Management Board (OMB) which is chaired by Deputy Chief Operational Officer. Robust Processes are in place to monitor the completion of SI action plans. In addition the clinical governance team choose at random one closed SI/action plan per CDS every 6-8 weeks and request evidence to support closure • Audit Committee to undertake an audit on the implementation of the SI action plans • Thematic Review of Homicides project group confirmed this action can be closed
(b) Peer audit (to include Service users, carer representatives, Clinical staff and commissioners) to confirm that reported actions have been taken and that changes to practice is evidenced.	Report provided to the Strategic Director of Delivery and Performance	Chief Operating Officer	April 2017	• We have established Quality and Safety reviews involving staff, commissioners and service user governors • Service users carrying out independent reviews • The 5 key areas of learning are covered as part of the Quality & Safety toolkit • As of July 2018 looking to have service users and/or a carer taking part in Quality & Safety reviews and this will be governed by the Positive Participation Committee • Action closed at meeting 6/3/18

Recommendation 4 The Trust should ensure that clinical staff have dedicated time for recording notes and record keeping; that staff record the rationale for the clinical decisions they make and use risk assessment and formulation to inform relapse planning.				
Action	**Assurance**	**Lead**	**Time scale**	**Progress at 10th July 2018**
(a) Ensure current clinical risk training is supplemented with case discussions and reflection which supports service improvement, and promotes the use of relapse planning.	Revised clinical risk training is in place which emphasises proactive relapse prevention strategies. Risk assessment/care plan audit Publication of audit results and presentation to Service Delivery Board Clinical staff diarise admin time and effectiveness is included in supervision.	Director of Education	March 2017	• Clinical Risk Policy, containing a link to the Minimum Standards for the Recording of Risk, and associated Policy on a Page have now all been published on the intranet. • The revised clinical risk e-learning is completed and has been published on My Learning • Each CDS has developed a face to face training strategy to supplement eLearning and has started an ongoing roll out of this • Director of Education and Training and Lead Consultant Psychologist advised action to now show as complete
(b) Introduce Risk Assessment documentation which incorporates risk reduction strategies that can be incorporated into care plans	Revised clinical risk training is in place which emphasises proactive relapse prevention strategies.	Chief Medical Officer	March 2017	• Minimum standards published and have been widely communicated so action closed
(c) Review audit tools to ensure relapse planning is included in annual care plan audit.	Risk assessment/care plan audit Publication of audit results and presentation to Service Delivery Board Clinical staff diarise admin time and effectiveness is included in supervision.	Chief Medical Officer	March 2017	• Audit tool now includes relapse planning as part of annual risk and care plan audit • An integrated clinical risk and care plan audit has been completed for acute and community services. This includes a baseline audit of the quality of crisis and contingency plans • Results have been distributed to each team to inform specific improvement areas. The focus of ongoing quality improvement will be those teams achieving less than 90% compliance in qualitative and quantitative measures. • Final Trust report published in April 2018 and includes the results of the audit of quality standards, analysis of quantitative data – number of clinical risk and care plans completed and training records for 2017-18 • Re-audit taking place June 2018 • Following the re-audit, the QI group will host an event with all CDS leads for the audit. Using the data from 2017-18 bespoke quality improvement methods as applicable for each service will be designed to ensure a rolling programme of quality improvement in clinical risk monitoring and management, crisis and contingency planning and care planning. • Audit of GP letters for all consultants was completed Oct 2017. As a result of the audit, it has been agreed that a GP letter template (with diagnosis with ICD10 code, risk assessment narrative, care/safety plan, medication and contact details) will be rolled out to all Psychiatrists in community settings. A re-audit is taking place June 2018 • The risk assessment in Carenotes is being further developed to make it more useable and readable so that it pulls through historical risk as a summary • Action closed at meeting on 6/3/18
(d) Introduce job planning to community staff to provide diarised admin time	Community Job Planning protocol in place. Community Job Planning	Transformation Director – Operational Services	End of Q4 2017/18 (updated timeline	• Stocktake of all CDS plans for job planning – Complete • Build community job planning in to priority Clinical Strategy Team Development workstream – Complete • Synthesise outputs and outcomes of SDIP, Clinical Strategy workstreams and stocktake

	template in place for each professional group. Job Plan training developed and available Phased delivery plan in place for introduction of job planning across all teams. Focus on team development and job planning is integral to the Clinical Strategy as a separate workstream.		– previously August 2017)	and align with pilot evaluation in CDS - Complete • Job planning will be picked up through the Clinical Strategy workforce group and a template on the work plan is being completed • Governance and template to be held by the Clinical Transformation Board • Action closed at meeting on 6/3/18
Recommendation 5 The Trust should investigate the feasibility of technological solutions to make it easier to complete records and improve productivity. This might include the use of voice recognition technology when recording on the electronic record system.				
Action	**Assurance**	**Lead**	**Time scale**	**Progress at 10th July 2018**
(a) Complete a pilot with clinicians for the use of Dragon Dictate to aid automatic input into the electronic patient record (EPR) and other key applications.	Confirmation by Technology Board	Director of IT	Complete	• Complete
(b) Ensure Dragon Dictate is available on the 'IT catalogue' for all services to choose, along with training where required.	Technology Board confirm access to Dragon Dictation	Director of IT	Complete	• Complete
(c) Improve the uptake of digital dictation across the Trust, now that Carenotes (EPR) has been implemented.	Digital Board monitor license increase from current baseline of 50 to 200	Head of Digital Development	September 2017	• A number of demonstrations of Dragon have taken place • Messages have gone out through the Partnership Bulletin and Intranet promoting the availability of Dragon • Form available on Intranet for staff to register their interest • 380 people have registered their interest for the trial. Over 230 of these have been activated and live • Very positive feedback, staff are reporting varying degrees of time saved from between 2-6 hours per week • Agreed action can be closed and Digital Board to continue to oversee
(d) Explore other methods to aid with automated, or easier, input into the Trust's key applications e.g. use of Apple and Microsoft tools.	Digital Board report	Head of Digital Development	March 2018	• Teams being contacted to assess any gaps in IT kit. If identified then requests being made. Some IT kit has been made available through the decommissioning of services in Kent. • Current upgrade of Carenotes should enable better use of iPADs to access the system across the Community and Inpatient wards. Expecting to be able to push this from December. • This action closed and overseen by Digital Board going forward. • Additional work is being done to reduce the number and complexity of forms in Carenotes. This action closed and overseen by the Carenotes Editorial Board
e) Agree what needs to be recorded in relation to diagnosis (primary presenting mental health problems) then review and make any necessary changes to Carenotes to enable recording of a primary diagnosis for all patients. Ensure appropriate training in place to support the		Chief Medical Officer Head of Digital Development	March 2018	• Main Mental Health Problem descriptors agreed and will be recorded for all patients after assessment e.g. depression, anxiety, psychosis etc • This will be in addition to the ICD10 diagnosis which is recorded once it has been made by a professional qualified to make a diagnosis (psychiatrist or psychologist) • The Main Mental Health problem descriptors will be added (in the form of a drop-down menu) to the Careplan form at the next system upgrade in mid-May and should be live

recording of diagnosis. (action reworded)				on the system by 16th May 2018 • Support and guidance for staff will be developed and circulated prior to the new form going live • Chief Medical Officer advised action could be closed
Recommendation 6 The Trust should consider developing a checklist of key requirements, based on the themes identified in this report, to be used at all CPA reviews.				
Action	**Assurance**	**Lead**	**Time scale**	**Progress at 10th July 2018**
(a) Develop in partnership with patients and carers a simple quality checklist that can be used in every CPA *(Personal Support Plan)* review. That meets the needs of all involved and can be utilised to ensure quality not just completeness	CPA *(Personal Support)* steering group publish agreed checklist	Care Programme Approach lead	January 2017	• Quality improvement event with service users and carers completed. This concluded a preference for a service user completed checklist which is sent to the service user prior to the CPA review. • Checklist finalised (February 2017.) • Guidance on usage will be incorporated into the revised CPA Policy (end Nov 2017) • Checklist circulated to all CDS Service and Clinical Directors to operationalise locally • Director of Occupational Therapy and Recovery Practice confirmed completed and action can be closed
(b) Investigate/Request upgrade to Carenotes (EPR) to include a "completed checklist" tab to allow for monitoring and audit	Confirmation by Carenotes editorial board	Head of Digital Development and Carenotes Editorial Board	March/ April 2017	• The checklist will not be on Carenotes as it is for service user personal use, not part of the clinical record (requested by service users) - agreement made by Credit Planning QI group • Head of Digital Development/Director of Occupational Therapy and Recovery Practice agreed action could be closed

Recommendation 7

When the Trust evaluates training and education, they should evaluate not only the learner experience but also the impact of the training, using a model such as Kirkpatrick:

Level 1: Reaction (Staff enjoyed and engaged in the training)

Level 2: Learning (Staff acquired the intended knowledge, skills and commitment from the training)

Level 3: Behaviour (Staff apply what they learned back in the workplace)

Level 4: Results (Achievement of organisational targets or goals as a result of the training).

Action	Assurance	Lead	Time scale	Progress at 10th July 2018
(a) Review current training available using Kirkpatrick's model ensuring training, development and education provided is purposeful, meaningful and is used to improve patient care.	Training review report to be provided to both Quality Committee and Trust Board. Executive Director involvement in the review. Service user and carer to form part of the evaluation and review	Director of Education	January 2017 (deadline extended to April 2017)	• A report on the evaluation of the risk eLearning course has been completed. • Recommendations regarding including the perspective and involvement of service users and carers will be taken forward at the next review of the E-learning (February 2018) and will also be included in the review of our strategy for face to face training strategy (This will sit with the Effective Care and Treatment Committee following the Safety Committee meeting on 29th September 2017). • Recommendations regarding future evaluations will be taken forward by the Education & Training Department. • Director of Education and Training advised this action is closed
(b) Ensure learning is supported by good quality supervision, reflection, Action Learning sets and clinical forums enabling a culture of constant learning and evaluations.	Supervision audit completed 6 monthly	Director of Education	December 2016	• Supervision audit completed with the recommendations being addressed through the CDS Leadership Teams and Professional Leads. • Trust-wide team development days will be launched from April 2017 which will allow team reflection on training in key areas including risk, SI learning and suicide and homicide prevention. Evaluation is still being gathered to monitor feedback. • Supervision policy updated to include a need to review learning from audit and training in supervision. This policy is now ratified and will be disseminated through team supervision training from April 2017. My Learning will now record management/clinical and professional supervision data. • Further work is in place to make sure staff have more opportunities for mentoring, coaching and reflection. This includes the use of handovers, MDT reviews, reflective practice groups etc which complement face to face supervision. • % compliance with supervision standards is currently being surveyed across all teams and services through the CQC Project Team. • Director of Education and Training advised this action is closed
(c) Use service user and carer feedback to measure the impact of training on their experience of services supported by 360° feedback.	Introduction of 360° feedback with thematic feedback	Director of Education	March 2017	• We are implementing service user and carer feedback on impact of interventions delivered by staff after training in new interventions. • Service user involvement in training design and delivery has been written into out training strategy as a core standard • Director of Education and Training advised this action is closed
(d) Ensure regular reviews and monitoring of all training delivered and ensure changes are made as a result of the outcome.	Training review board includes Service Director as well as service user and carer input	Director of Education	January 2017	• Service user and carer reps and Director from each CDS or their nominee are now invited to attend the bi-monthly Effective Care and Treatment Committee. • Director of Education and Training advised this action is closed
(e) Introduce team based training to focus on findings and actions from Thematic Review (new action)	Include thematic review content/learning in team development days support materials	Director of Education	September 2017	• Team development days to be launched for July 2017, supported by materials including training/film content regarding thematic review, for local delivery by local experts. Launched at CEO briefing in July 2017, to be followed by Intranet content to support delivery by September 2017. • Film commissioned to detail learning from the thematic review for use in team development days, for launch 1 October 2018