NHS Devon

Devon Partnership NHS Trust

Action Plan for the NICHE independent investigation into the care and treatment of Patient A

Issue/ Recommendation / Area of Learning identified	Action to address recommendation	Person(s) Responsible for completion	Action Owner (Manager)	Start Date	Target date for completion (or date completed)	What will the evidence of completion be / how will this be demonstrated?
Recommendation 1 The Trust must provide assurance to the Board and its commissioners that **care plans** are updated in accordance with Trust policy. **Recommendation 2:** The Trust must provide assurance to the Board and its commissioners that **risk assessments and risk management** plans are updated in accordance with Trust policy, and that staff evidence a review of existing clinical risk documents when	Regular reporting on proportion of care plans for individuals in receipt of coordinated care in Adult Core Mental Health Teams updated, at least 6 monthly, via Directorate Governance Board and associated action plan for improvement agreed with directorate. Data Quality Improvement Programme: Supporting Safety, Quality and Performance. The work includes analysis and monitoring of safety and quality indicators, including care planning. The data quality improvement project commenced in February 2022 and reports for action are shared through Directorate Governance Boards with	Directorate Managers In addition Adults: Performance Manager – Adult Mental Health / Locality Managers	Chief Information Officer	Feb 2022	20 week programme	20220629 DQI Supporting SQP We Report in place (NOTE: monitor 12 month not 6 month completeness) The data quality reports are for care plans created or updated in the last 12 months for everyone (based on what should've been achievable in the 12 weeks of phase 1 & 2), the performance measures through Directorate Governance Board and Integrated Performance Report have a 6month period for reporting for those with greater needs.

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concerns are raised about a patient's presentation. **Both recommendations are covered by the same actions**	upwards reporting to Directorate Operations Boards.					**Already available:** Informatics Clinical Dashboard – care plan on system and 'My future support plan'
	An audit sample of quality-of-care plans to be produced with evidence of feedback to teams and clinicians, reflection and action to resolve issues via Quality Review of Clinical Records – in line with service changes implemented as part of Community Mental Health Framework, the quality standards have been updated.	Locality Practice Leads	Directorate Business Planning Meeting	In action	4 August 2022 (TBC)	 QRCR v3.docx Ratification = notes from Business Planning Meeting
	Audit findings are shared with the individual practitioner and used to shape supervisory conversations Thematic learning raised to Locality Learning from Experience to reflect on both positive in recording and areas of challenge. For areas of improvement consider if locality Quality Improvement required or learning based at individual level	Locality Practice Leads / Performance Manager / Governance Manager Team Managers / Team Practice Leads Team Managers / Team Practice Leads	Agree at F Community Services Manager / Locality Practice Leads Community Services Manager / Locality	In action	End August 2022 End of October 2022 End of October 2022	Evidence: blank report  Adult Directorate LFE Agenda- templa Evidence = Team level reports to Learning from Experience /Local Delivery Unit of how learning has been shared with team / individuals

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			Practice Leads			Evidence = Learning from Experience reports
Recommendation 2: The Trust must provide assurance to the Board and its commissioners that risk assessments and risk management plans are updated in accordance with Trust policy, and that staff evidence a review of existing clinical risk documents when concerns are raised about a patient's presentation.	The Trust Individual Safety and Harm Minimisation Policy Clinical Risk Assessment, Formulation and Management, Policy: R04 (formerly Clinical Risk Assessment Policy) which has been rewritten to emphasise the need for a personalised, evidence based and co-produced (with the person and their support network) approach to risk assessment must include a competency assessment is to be included in the associated mandatory Risk Assessment training and evidence of integration in audit programme to ensure embeddedness.	Clinical Lead, Safe from Suicide and Lead Psychologist, leading re-write of policy	Head of Psychology and Psychological Professions Deputy Director of Nursing and Allied Health Professions – Patient Safety	In action	Ratification of risk policy by end of November 2022 Plan agreed as part of ratification	Evidence: ratified policy Implementation Plan
	Clinical Risk Assessment Training emphasises importance of regular review and updates of Risk Assessments and highlights that the recommended review dates on the person's electronic patient record are a minimum requirement and that risk assessment and mitigation plan needs updating on any relevant change in risk.	Senior Risk Trainers			Complete	Clin Risk - L2 Clinical Risk - Level 2, Devon Partnership NHS Trust (developme.plus)

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Recommendation 3: The Trust must strengthen the discharge protocol to include a review of recent medication compliance (including liaison with the patient's GP) prior to discharging a patient from caseload. The Trust must also implement a system to monitor compliance with the whole protocol on a frequent and regular basis.	**POLICY** **CPA and Standard Care Policy (CO5)** is due for a review as a consequence of a national plan to move away from CPA as a model of care. Interim re-wording / changes have been drafted – ratification	Clinical Director and Locality Practice Lead	Deputy Director of Nursing and Allied Health Professions – Patient Safety		Ratification Process	Ratified Policy  CMHT prioritisation tool1 (002).docx  Appenndix to CPA_Standard care p  C05_Care_Programme_Approach_Stanc
	The Trust in its review of policy to support the move from Care Programme Approach (CPA) needs to be cognisant of learning points from this review include as short term amendments to CO5 and should include reflection on establishing engagement with care plan through review – where engagement with medication is a key determinate of wellness - access to GP connect to establish as part of planning for step down of care if the person is collecting repeat medication	Clinical Director Core Services		In progress	Dec 2022	Recommendations will also be embedded within the new Personalised care and treatment policy which we are working toward sign off by December 2022 – which will replace the Care Programme Approach (CPA) and Standard Care policy.

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	Audit: The Adult Directorate has designed a quality audit to monitor on a regular basis "step down" from coordinated care. The audit is being considered by the Directorate	Ratification via Adult Business Planning Team Managers & Practice Leads	Community Services Manager & Locality Practice Lead	October 2022	August 2022	 Quality Audit - discharge.docx Quarterly audit data considered at Learning from Experience
Recommendation 4: The Trust must ensure that when national guidance relating to Duty of Candour (regarding an incident that is also the subject of a serious criminal investigation) is published, local policies and procedures are updated. The Trust must also ensure that staff understand and implement the new policies and procedures.	The Trust has an ongoing Quality Improvement (QI) programme linked to the Patient Safety Incident Response Framework (PSIRF) implementation project, this will review any new guidance to ensure that our current practices and supporting arrangements comply with the guidance. The NICHE report states 'We have previously made a recommendation to NHS England to produce clear guidance for organisations regarding Duty of Candour when there is an incident that is also the subject of a serious criminal investigation.24 Therefore, we have not made the same recommendation here. Once that guidance has been published the Trust must	Head of Experience, Safety and Risk	Director of Nursing and Professions	Dependant on national guidance timescales, but will action within 6 months of publication	Dependant on national guidance timescales, but will action within 6 months of publication	The Trust duty of candour (DoC) policy, guidance and training materials including e-learning will be update to reflect the national guidance. DoC Quality Improvement programme of work includes the development of: Learning & safety bulletin (copy attached) Drop in sessions developed to support managers with DoC queries Manager's review training available on request which convers DoC DoC eLearning module

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	ensure that it is reflected in relevant local policies and procedures.'					
Recommendation 5: The Trust must ensure that the policy on engaging with families of victims of homicide committed by patients known to mental health services reflects best practice set out in the NHS England (London) Investigation guidance issued in April 2019 on engaging with families after a mental health homicide; Mental Health-Related Homicide: Information for Mental Health Providers (April 2019) NHS England (London) Investigations.	The Trust will develop and implement a new policy that specifically deals with engaging with families of victims of homicide committed by patients of the Trust. This will also link where appropriate with existing policies and processes relating to serious incident investigation and support services.	Head of Experience, Safety and Risk	Director of Nursing and Professions	June 2022	October 2022	The policy will be ratified and published.

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Recommendation 6: The Trust must implement an audit programme to provide assurance that the changes in response to the internal recommendations 2, 3, 4 and 7, and additional action 1 have been embedded.	Local clinical audits across the Trust will become an integral part of an overarching Trustwide Clinical Audit Programme to align with the Trust statutory audit programme; this will ensure all information regarding Trust national and local operational clinical audits are held in one place	Compliance Manager	Director of Corporate Affairs		December 2022	Paper to Strategic Executive Committee re proposal for development of the trust wide audit programme.  Scoping for local directorate audits tc
	Specific policies will be reviewed and revised to support the audit requirement as detailed in the actions above.	See actions above	See actions above	See actions above	See actions above	See action plan items above re policy development / leads Policy supporting process as highlighted in actions above: CO5 CPA and standard care - revisions identified. New policy to be developed reflecting national move from Care Programme Approach (CPA) Individual Safety and Harm Minimisation Policy:

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						Clinical Risk Assessment and Management RO4 – is awaiting ratification
Internal Report recommendation 2 The Trust should strengthen practice in relation to discharge planning to ensure discharge meetings involving the team occur and develop a discharge protocol to help standardise decision-making	Audit plan devised by the Adult Directorate to be agreed at business planning process – auditing occurrence of discharge planning meetings with whole MDT and use of discharge planning tool	Team community practice leads / team manager	Locality Practice Lead / Governance manager	August 2022	December 2022	Production of audit showing adherence to: • Discharge from community mental health team (CMHT) meetings occur involving the whole multidisciplinary team (MDT) • Includes use of discharge checklist Quality Audit - discharge.docx
Internal Report recommendation 3 The Trust should establish standards and processes for the continuity of care for long-term clients including care co-ordinator allocation and handover arrangements	Audit to be developed with Adult Directorate to consider internal handover arrangements and prioritisation of re-allocation determined by agree tool. External step down of care is monitored via audit outlined in R2 above	Locality Practice Leads		August 2022 – development September 2022 – DIRECTORATE GOVERNANCE BOARD ratification	January 2023 Audit feedback	Audit Tool Action outlined above

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Internal Report recommendation 4 The Trust should identify how responsibility for monitoring concordance with medication is assured at either an individual patient level or at an organisational level with the development of clear guidance Note: Links to meds queries from line one recommendation Additional recommended actions Note: links with actions from external NICHE report.	The Medicines Policy (P01) has section 3.5 "All staff have a duty of care to ensure that medicines are used safely and effectively, promoting concordance with medication and preventing stock piling of medication in patients' homes	Deputy Chief Pharmacist - Medicines Safety and Governance	Deputy Chief Pharmacist - Medicines Safety and Governance	September 2022	December 2022	Additional evidence Safe from Suicide developing guidance for staff around medication whilst monitoring people on the community mental health waiting list. Currently going through Clinical Advisory Group. Anthony Reilly will have more details/evidence Policy and process in place but need to develop the testing/audit
	This policy is due for review and will be updated to reflect recommendation being explicit about means by which clinicians could monitor concordance and under what circumstances specific arrangements would be required and evidence the implementation	Deputy Chief Pharmacist - Medicines Safety and Governance	Deputy Chief Pharmacist - Medicines Safety and Governance	September 2022	March 2023	
Internal Report recommendation 7 The Trust should assure itself that it has systems in place which allow the concerns of relatives and carers to be recognised, considered and acted	System in place: a. Website references access to carer information / support b. Letters are embedded with feedback QR codes with separate feedback F&F+ survey's for users / family c. Learning from compliments / complaints embedded into Learning From Experience				No further action	Carers and families | DPT Copy of letters (example):  CMHT_Initial Appointment Letter Learning From Experience agenda

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upon and additional action 1 have been embedded.	Confidentiality and carer guidelines shared within the Adult Directorate as part of Quality Improvement work				No further action	Carers, Family & Friends QIP_Adult D Downloads and publications for Confidentiality and carers guidelines | DPT Suicide prevention: sharing information DAISY - Devon Partnership NHS Trust Intranet (dpt.nhs.uk) **Additional evidence:** Safe from Suicide piloting a series of 'Stronger Together' workshops. Session 1 is specifically for carers, to build skills and resilience in supporting someone who is suicidal. Session 2 aims to increase both Carer and Staff awareness of difficulties of working on either side of the consent barrier and the
	Quality Review of Clinical Records – in line with service changes implemented as part of the Community Mental Health Framework, the quality standards have been updated (ratification Directorate Governance Board / Business Planning) Audit findings are shared with the individual practitioner and used to shape supervisory conversations. Thematic learning raised to Locality Learning From Experience to reflect on both positive in recording and areas of challenge. For areas of improvement consider if locality QI required or learning based at individual level				No further action	

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						guidance and legislation that enables them to effectively navigate this. The focus includes the 'small things' that practitioners can do to value and collaborate with carers; this includes being able to listen even when there is no consent to share, consideration of mental capacity and best interests, the importance of documentation. Pilots to be rolled out in Q3 / 4 of 2022/2023. Piloting the use of my family views form for use prior to CPA. To ensure the voice of the family, in accordance with part c. Secure Services
The Trust must also provide assurance that actions are not signed off as complete when there remain documented concerns about the efficacy of the changes made.	All Serious Incident action plans will be subject to a final review and sign off of all completed actions and associated evidence used to support closure prior to the action plan being marked as complete.	Head of Experience, Safety and Risk	Director of Nursing and Professions		**Action completed**	The standard action plan template now includes the identification of the relevant senior service lead with responsibility for the action plan, each action plan now includes a standard

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	Each action plan will have a designated senior lead who will review and agree closure. The action plan template will be revised to reflect this requirement and an additional action will be added to every action plan to reflect the requirement for this final review and sign off.					action for the review and agreement of the closed actions and overall action plan, this action is added to the risk management system (RMS) and is monitored with other SI actions.
Recommendation 7: The NHS Devon CCG Serious Incident report quality review template should be revised to reflect detailed expectations with NHSE Serious Incident Framework guidance	Review the Serious Incident reviewer template and amend as required	Head of Patient Safety	Director of Nursing & Quality / Deputy Chief Nursing Officer NHS Devon ICB		**Action completed**	NHS Devon's Serious Incident report quality review template was updated in May 2022 and is in line with NHSE Serious Incident Framework guidance. A blank template provides evidence as to completion of this action. Completed reviews will be audited to provide assurance regarding the quality of the reviews.
Recommendation 8: NHS Devon CCG (and any future Integrated Care System) must implement a process to (a) identify high-profile, complex or high-risk serious	For the Patient Safety Specialist to confirm the processes for identifying high profile / complex / high risk incidents and management of their actions	Head of Patient Safety	Director of Nursing & Quality / Deputy Chief Nursing Officer NHS Devon ICB		**Action completed**	NHS Devon has developed a high profile / complex dashboard within it's Datix systems. Staff can refer cases to the dashboard for higher 'visibility'.

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incidents, (b) ensure that the provider action plan is followed up in detail, (c) seek assurance that all actions are implemented in a timely manner.						Evidence to support completion of this action is provided by a screen shot of the DATIX dashboard and emails to inform key staff of its implementation. NHS Devon follows up the actions from high profile / complex/ high risk incidents through the normal Patient Safety & Quality (PSQ) team process, through working collaboratively with the provider, undertaking audit on actions appropriately. Please note that NHS Devon's ongoing, evaluation and monitoring of high profile / complex / high risk incidents and management of their actions, will be aligned to the requirements of the recently published (18/08/2022) Patient Safety Incident Response Framework (PSIRF) on implementation of the

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						PSIRF to ensure NHS Devon's compliance with the PSIRF.
Mandatory Action for all action plans	Final review of all actions and supporting evidence to be completed by the identified service lead before agreement of the completion and closure of the action plan.	Directorate Manager Adult Directorate		April 2023	May 2023	The identified service lead will provide written confirmation to the Experience, Safety and Risk Team authorising the closure of the action plan on the risk management system.

Service Lead(s) for Action Plan (Overall responsibility for plan)

Name	Devon Partnership Trust	NHS Devon
Role	Directorate Manager	Director of Nursing & Quality / Deputy Chief Nursing Officer
Directorate	Adult Directorate	Nursing & Quality