**ACTION PLAN**

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| **Title** | Independent investigation into the care and treatment of a mental health service user, Mr P in Dorset.<br>Action plan to address recommendations for Dorset HealthCare NHS Foundation Trust made within report by NICHE, commissioned by NHS England and published 28th July 2020. |

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| **Date of event** | 16/08/2016<br>(NICHE Report Feb 2020 v3.17) | **Plan Owner** | Service Director Mental Health & Learning Disabilities |
| **Reference Number** | 2016/21910 | **Overseeing group/committee** | Serious Incident Review Group |
| **Date last updated (and version no)** | 28/02/2020 V1.1 | **Expected completion date** | 01/05/2020 |

| Ref no. | Recommendation | Action required<br>Clear & specific to meet recommendation | By whom | By when | Status | Update | Assurance mechanism<br>E.g. Audit |
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| P1<br>R1 | The Trust must ensure that all serious incident reports comply with all of the standards set out in the NHS England Serious Incident Framework so that:<br>• root causes to incidents are clear in cases where they are identified;<br>• appropriate learning can be identified and shared; | The serious incident investigation report template to be updated to ensure it demonstrates compliance to national standards | Serious Incident Manager | 15/12/2019 | | 2018 SI process amended<br>2019 Further improvements to report template to include the NHS E SI framework standards<br>2020 Quality assurance template in use | Quality assurance template report completed per each investigation. Monitored by Trust Clinical Governance Group with escalation to Quality Governance Committee as required. |

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| | • findings can be shared in an open and transparent way with affected parties. | The serious incident panel to ensure report template has been completed comprehensively when reviewing completed reports | Serious Incident Manager | 31/01/2020 | | Reports presented in January 2020 have commenced use of review form | Quality assurance template report completed per each investigation. Monitored by Trust Clinical Governance Group with escalation to Quality Governance Committee as required. |
| P1<br>R5 | The Trust must ensure that the forensic team is clear about all current and previous diagnostic formulations, particularly where there have been substantial periods of care in multiple settings, in order to ensure that assessment and treatment plans are relevant and appropriate. | A full clinical assessment and formulation including risk assessment to be conducted on all patients when accepted into the service | Clinical Forensic Psychology | 31/12/2019 | | The Dorset Forensic team Operational Policy IN-183 updated in December 2017, includes reference to MAPPA<br>A planned review will take place in August 2020<br>Additional consultant forensic psychiatrist appointed.<br>Consultant's job plans adhere to Royal College of Psychiatrists guidance.<br>Additional clinical sessions for new patient assessments and out of area liaison, has | Audit against standards of full clinical assessment and risk, planned for May 2020<br>Assurance visits to review compliance to policy and practice.<br>Reports to Directorate Management Group and Clinical Governance Group |

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| | | | | | | strengthened the assessment of patients entering the service negating the importance of existing case summaries and involves a full review of all historical records | |
| | | Assessment and formulation decisions to be communicated to the team within one month of assessment | Clinical Forensic Psychology | 31/12/2019 | | Post assessment feedback is an agenda item at the weekly bed management meeting and at the Dorset Forensic Team meeting | Audit referrals and admissions/treatment cases against standards |
| | | Implement a 'process tracker' for oversight of all patients on the pathway | Clinical Forensic Psychology | 31/12/2019 | | Database tracker in place for patients. | Review of cases against the process tracker as part of the audit process |
| | | The referral pathway to include a formal process for all patients who re-present to the Trust whilst in the community | Clinical Forensic Psychology | 31/12/2019 | | All re-referrals are reviewed at the weekly review with assessment feedback being provided within one month post assessment | Review of cases against the process tracker as part of the audit process |
| P1 R7 | Agencies involved in managing individuals through the MAPPA process must ensure that information about risks and management | The content of the current MAPPA policy to be reviewed and updated to include specific guidance on | Clinical Director for Mental Health | 31/04/2020 | | A MAPPA Task and Finish group established in 2018 and has worked through MAPPA | Audit of cases against policy standards in line with monitoring |

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| | of those risks is passed to other areas when an individual moves to the jurisdiction of another MAPPA group. The Trust should review it existing MAPPA policy with this recommendation and associated findings in mind.<br><br>MAPPA = Multi Agency Public Protection Assessment | the process to undertake and the responsibilities for an individual who moves to the jurisdiction of another MAPPA group. | | | | National Guidance Recommendations<br><br>MAPPA policy amended and updated. Ratified by Task and Finish Group in January 2020.<br><br>Bespoke MAPPA awareness training has been rolled out across the CMHT's and Specialist Services by the MAPPA Co-ordinators during the summer of 2019. MAPPA awareness training is scheduled for the Medical Advisory Committee for April 2020 | requirements |
| P1<br>R9 | The Trust must ensure that HCR-20's (risk assessments) are kept up to date with relevant information, particularly when responsibility for the patient's care and treatment is being transferred from another provider | Review of Trust policy/procedural document relevant to risk assessment | Clinical Forensic Psychology | 31/01/2020 | | The Clinical Risk Policy IN – 172a was reviewed February 2018.<br><br>A scheduled review is due in 2020<br><br>Training PowerPoint available for Forensic staff 'Assessing the Danger & Risk Management Planning' | Assurance visits as part of assurance schedule to review compliance to policy and practice, report to Directorate Management Group and Clinical Governance Group |

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| | | Completion of the risk assessment to be undertaken during the clinical assessment on all patients when accepted into the service | Clinical Forensic Psychology | 31/01/2020 | | RiO risk assessment and risk formulation completed on initial assessment. If patient is considered high risk of harm to others HCR-20 assessment. | Audit of HCR-20's risk assessments |
| | | HCR-20 assessment record to be completed on admission and at review | Clinical Forensic Psychology | 31/01/2020 | | All referrers are required to perform an HCR-20 when patients are referred for admission into service.<br>HCR-20 assessment will be completed by the first CPA at three months and reviewed by the full MDT.<br>Further review undertaken at every 6 month CPA subsequently | Audit of HCR-20's risk assessments |
| P1<br>R10 | The Trust must ensure that all communications executing their Duty of Candour responsibilities (including when acting in the spirit of Regulation 20) fulfils all of the requirements of the Regulation. | Duty of Candour (DoC) letters to be reviewed to ensure they meet standard required | Serious Incident Manager | 31/12/2019 | | 2017 Duty of Candour Policy IN – 143 updated. Scheduled review due in 2020<br>Initial Duty of candour letter has been reviewed to include an apology and ensure they | New Duty of Candour template letter used for each event |

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| | | | | | | meet requirements. | |
| | | Information on the full process for Duty of Candour to be made available to all staff | Serious Incident Manager | 31/12/2019 | | 2016 - Duty of Candour training and formal process in place.<br>Intranet video for staff available on process for duty of candour. | |
| | | Process standards for Duty of Candour to be monitored by Serious Incident Team | Serious Incident Manager | 31/02/2020 | | Investigation report template now includes Duty of Candour compliance<br>Serious Incident tracker to include Duty of Candour compliance | New report template used for each event<br>Compliance reported to Clinical Governance Group |
| P2<br>R4 | The Trust must ensure that patients are provided with appropriate information about medicines in order for them to be able to make an informed decision about consenting to accept the medicine.<br>This is even more important when a medicine is prescribed off licence. | Prescribing clinicians are to be advised that a record is to be made of discussions held with patients on the initiation or change of medication | Chief Pharmacist | 31/01/2020 | | A reminder has been sent to all non-medical and medical prescribers, including policy and forms to use.<br>This information is to be reinforced through prescribing learning groups and medical leadership | Audit of patient records as part of medication or record keeping reviews |
| | | Review Trust medicine policies to ensure requirement is clear | Chief Pharmacist | 31/12/2019 | | Non-medical prescribing policy IN-142<br>Prescribing Unlicensed and Off– | Available on Trust Intranet |

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| | | | | | | Label Medicines, IN-320<br>Medicines Management Policy Statement – IN-106 | |
| | | Where patients require time to consider medication written information is to be provided | Medical and Non-Medical prescribers | 31/12/2019 | | A Trust patient information leaflet is available to support decision making when using unlicensed medicines. | Audit of the record of information provided to patients<br>Report to Medicine Management Group |
| | | Prescribing staff are to be provided with guidance specific to what information on medicines used outside of license must be given to patients. | Chief Pharmacist | 31/12/2019 | | The Trust has a policy on Prescribing Unlicensed and Off–Label Medicines, IN-320, which contains the full process for prescribing and the considerations each prescriber must undertake. | Available on Trust Intranet |
| P2<br>R6 | The Trust must ensure that the relevance of previous post-traumatic stress disorder diagnoses and of potential current post-traumatic stress disorder symptoms should be routinely considered and appropriate guidance followed where relevant. | PTSD assessment tool to be used as part of initial assessment and admission process and will be completed by Clinical Psychologist | Clinical Forensic Psychology<br>Clinical Psychologists | 31/12/2019 | | Assessment of presence of trauma symptoms for all referrals to service.<br>Trauma Symptom Inventory tool used where trauma symptoms present | Audit of assessment process to evidence use of tool. |

Report recommendations key

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| **S** Specific | **M** Measurable | **A** Achievable | **R** Realistic | **T** Timebound | **E** Evaluated | **R** Reviewed |

Priority One P1: the recommendation is considered fundamental in that it addresses issues that are essential to achieve key systems or process objectives and without which, the delivery of safe and effective clinical care would, in our view, be compromised.

Priority Two P2: the recommendation is considered important in that it addresses issues that affect the ability to fully achieve all systems or process objectives. The area of concern does not compromise the safety of patients but identifies important improvement in the delivery of care required.

| Status tracking | |
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| **Complete** | **Green** |
| **On plan** | **Blue** |
| **Delay in progress** | **Amber** |
| **Not achieved** | **Red** |