Serious Incident and Mortality Improvement Action Plan

Southern Health NHS Foundation Trust

Version No: 15.3 **Date:** 02/09/2016 **Produced by: (Name & Job Title)** Helen Ludford Associate Director of Quality Governance

Mazars Recommendation Theme	Mazars Recommendations	Related Actions	Responsible Lead Central Support Services	Responsible Lead Divisional	Executive Accountability	Input Action Timescale	Action Progress Blue - Complete Green - On Track / Begun	Expected Outcome / Benefit	Progress Update	How will you evidence that the completion of the actions has led to the intended outcome	Timescale for measuring success	Intended Outcome Achieved Blue - Complete Green - On Track / Begun
Board Leadership and Oversight	1. The Board needs to address the culture of lack of review and reporting of unexpected deaths, ensure staff at all levels recognise the need for timely, high quality investigation, how to include families and to ensure learning is demonstrated. a. The Board needs to ensure the processes of reporting and investigating unexpected deaths are consistent and robust throughout the organisation and to improve the quality of investigations and the involvement of families in those investigations. The Trust needs to prioritise the review of deaths as part of a wider mortality review process making better use of data available. b. The Board needs to understand and make full use of the data available and the underlying information required for assurance that unexpected deaths are being properly identified and investigated.	1.1a The Board will address the culture to stimulate improvement in the reporting of deaths and the recognition for high quality and timely investigations by launching the new procedure - Procedure for Reporting and Investigating Deaths - in all types of Trust-wide communications, discussing the process at all executive roadshows and cascade training through all the Trust managers. This is supported by the Trust-wide bulletin, an executive level video on the internet and executive level site visits. 1.1b Cultural change to continue to be addressed through the Trust-wide 'Viral' programme of events advertised by LEaD - this will make reference to the Mazars review and the behavioural requirement to learn from incidents which have been investigated in a timely manner with the production of a quality report. 1.1c Clinical leadership will adopt 'Back to the Floor' visits on Thursday mornings overseen by the Director of Nursing. This will provide the opportunity for face to face discussions with staff, patients and their relatives regarding improvement activities and actions.	Anna Williams, Company Secretary and Head of Corporate Governance (1a) Emma McKinney, Associate Director of Communications (1.1a & 1.1b)	N/A	Chris Gordon, COO and Director of Patient Safety (1.1a) Sandra Grant, Director of People and Communications (1.1b) Julie Dawes, Director of Nursing (1.1c)	30.06.16	Evidence obtained: Communication of new process cascading through the Trust, bulletin, video and executive site visits (1.1a) Viral programme of events (1.1b) Communication related to 'Back to the Floor events' (1.1c)	Engagement of all clinical staff at all levels in the mortality reporting procedure. Investigations and the involvement of families. Through the collection of positive evidence the outcome will be achieved.	Weekly Flash report in place 20% audit undertaken each month and reported to the Mortality Working Group and Quarterly to SOG (1.1a) External review of family involvement commissioned due to report end of September 2016 (1.1b & 1.1c) Focused question included in the AMH peer review tool (1.1a, 1.1b & 1.1c) Back to the Floor events occurring every Thursday morning (1.1c)	Compliance to the death reporting procedure numerically monitored by the Flash report. (1.1a) Compliance to the death reporting procedure Qualitatively monitored through the monthly 20% audit. (1.1a) Quality audit of the investigations to ascertain that families and loved ones were involved in investigations where is was appropriate and they wished to be.(1.1b & 1.1c) From the information ascertained via the peer review reports - focused question related to the death reporting procedure to which individuals positively describe the process. (1.1a, 1.1b & 1.1c)	30.10.16	Evidence required: Minutes of TEG to confirm that the Flash report and mortality is discussed (1.1a) Compliance to reporting. monitored by the Flash and Tableau reports and actively discussed with Divisions where action is required. (1.1a) Results of the monthly 20% IMA audit which review quality. (1.1a, 1.1b & 1.1c) Results of the external enquiry around family involvement. (1.1b & 1.1c) Results of the SI report audit to support whether families where involved in investigations where appropriate. (1.1b & 1.1c) Results of the peer review 1 to 1 staff questions related to the mortality process (1.1a, 1.1b & 1.1c)
		1.2a The Board will lead in forming a structure for mortality oversight within the Trust. A Serious Incident Oversight and Assurance Committee (SIOAC) will be formed (Board sub-committee) to monitor mortality and the implementation of the Serious Incident and Mortality Improvement Plan. 1.2b Formal reporting will be provided to the SIOAC - Serious Incident Trajectory Report, Mortality Flash Report and the Mortality Process Audit Report. The SIOAC will hear reports on a monthly basis, agenda coordinated by the Chair. The Chair will report to the Board on a monthly basis.	Anna Williams, Company Secretary and Head of Corporate Governance (1.2a & 1.2b)	N/A	Katrina Percy, Chief Executive Officer (1.2a & 1.2b)	29.02.16	Evidence obtained: Terms of Reference for SIOAC (1.2a & 1.2b) Meeting invitations (1.2a & 1.2b) Circulation / Meeting attendance request (1.2a & 1.2b)	Increased Board oversight by monitoring the implementation of the action plan and gaining assurance from the evidence of implementation and change. NED Chair to report to the Board.	Meeting in place with Executive membership, meets a minimum of monthly and scrutinises evidence submitted against the actions on the plan. SIOAC meeting weekly. 04.08.16 Outcome evidence obtained	Minutes of the meeting will provide assurance of the scrutiny applied to ensure that the changes within the action plan are implemented and embedding. (1.2a & 1.2b) Serious Incident and Mortality feature within the Board papers and minutes and is clearly an improvement priority for the Trust. (1.2a & 1.2b)	31.07.16	Evidence required: SIOAC agendas x 3 (1.2a & 1.2b) SIOAC minutes x 3 (1.2a & 1.2b) Chairs report to the Board - Board Papers x 3 (1.2a & 1.2b)
		1.3a A Trust-wide Mortality Working Group to be formed to report to the SIOAC which, under Executive Chair, monitors the performance of the Divisional Mortality Meetings and assures that the death reporting procedure supported by the Ulysses system is embedding. 1.3b The meeting is supported by Terms of Reference and: 1.3c There is Divisional attendance.	Helen Ludford, Associate Director of Quality Governance (1.3a and 1.3b)	Mary Kloer, Clinical Services Director (AMH) Mayura Deshpande, Clinical Services Director (Specialised Services) Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Peter Hockey, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Liz Taylor, Associate Director of Nursing (Childrens and Families) (1.3c - all leads are responsible for Divisional attendance)	Chris Gordon, COO and Director of Patient Safety (1.3a and 1.3b)	29.02.16	Evidence obtained: Terms of Reference (1.3b) Meeting invitations (1.3a) Circulation / Meeting attendance request (1.3a)	That there is Trust-wide forum to monitor and challenge the activities of the Divisional Mortality Meetings to provide assurance that all deaths are being investigated correctly.	Mortality Working Group in place and meets monthly. 04.08.16 Outcome evidence obtained	Minutes of the meeting will provide assurance of the scrutiny applied to ensuring that the changes within the action plan are implemented and embedding. (1.3a, 1.3b & 1.3c) Results of the qualitative monthly audit will feature as a standing agenda item and stimulate discussion which will promote improvement. (1.3a & 1.3c) Key performance indicator - that audit will show that in 95% of death reviews through IMA and the 48 hr panel process the decision to investigate and at what level is correct. (1.3a & 1.3c)	31.07.16	Evidence Required: Terms of Reference for the Mortality (1.3b) Working Group Agendas of the Mortality Working Group x 3 (1.3a) Minutes of the Mortality Working Group x 3 (1.3b) Attendance register for the Mortality Working Group (1.3c) Results of the Mortality IMA audit (1.3a)
		1.4a Weekly 'flash' report to be developed to describe the status and timelines for every SIRI investigation inclusive of deaths - this will be embedded into the Trust BI System. 1.4b The Flash report will be circulated to the Executive team and all Divisional leads accountable for ensuring that investigations are completed to timescales. The detail in the report will contain the stage the investigation is at and whether it has been rejected by the quality assurance panel at corporate level. 1.4c This will be discussed by the Executive team each week at the Wednesday meeting.	Helen Ludford, Associate Director of Quality Governance (1.4a & 1.4b) Anna Williams, Company Secretary and Head of Corporate Governance (1.4c)	N/A	Chris Gordon, COO and Director of Patient Safety (1.4a, 1.4b & 1.4c)	31.12.15	Evidence obtained: Flash report (1.4a) Flash report circulation list (1.4b) TEG minutes (1.4c)	That there is weekly executive oversight of the operational procedure compliance data for mortality, serious incident, complaints and risk data. This will enable a 'real time' executive overview of 'hot spot' areas of concern where compliance to process is not being maintained for further investigation and director level resolution.	The Flash report is provided to TEG each week and discussed by the executives. Chris Gordon draws executive attention to 'hot spot' areas with the relevant divisional director and requests further assurance of improvement at the following meeting or further insight into why improvement cannot be made or is slow. There is also an assurance of immediate patient safety given. 21.07.16 Flash report now fully embedded in Tableau - real-time daily reporting. 04.08.16 Outcome evidence obtained	This will be evidenced through position monitoring of the compliance to the process behind incident, serious incident, risk and complaints by the executive team. (1.4a, 1.4b & 1.4c) The TEG minutes will provide an indicator that a worsening position is developing and a related action to deal with this. (1.4c)	31.07.16	Evidence Required: Flash report (1.4a) TEG minutes (1.4c) Trust dashboard related to reduction in overdue serious investigation (1.4c)
		1.5a Lead Investigators to be appointed for each Division who will track compliance to timescales and support investigators to achieve this. 1.5b Job Description to be standardised with a 20% Corporate and 80% Divisional governance focus and: 1.5c An initial priority objective to deliver clearance of any SIRI backlogs which will be evidenced in the Flash report.	Helen Ludford, Associate Director of Quality Governance (1.5a, 1.5b & 1.5c)	Sara Courtney, Associate Director of Nursing East ISD Paula Hull, Associate Director of Nursing West ISD John Stagg, Associate Director of Nursing, LD TQ21 Carol Adcock, Associate Director of Nursing, AMH Nicky Bennet, Associate Director of Nursing, Specialised Services Liz Taylor, Associate Director of Nursing, Childrens and Families (1.5a -all leads are responsible for Divisional recruitment)	Chris Gordon, COO and Director of Patient Safety (1.5a, 1.5b & 1.5c)	30.11.15	Evidence obtained: Job Description for Lead Investigators (1.5b) Demonstration of individuals in post (1.5a)	That there is competent expertise at divisional level to monitor performance against the national framework criteria and through a process of support, education and feedback increase the quality of the investigation reports. Completion / submission of a quality investigation becomes standard Trust practice.	Key Performance Indicator monitored monthly and report to executive level within the trajectory and mortality and serious incident management papers supplied to Board sub-committees. As of 31st May the Trust reached a position of 87% compliance to the 60 days timeframe and 100% clearance of the historical SI backlog. Predicted 94% target achievement by 30th June 2016. 21.07.16 Compliant to 100% submitted within 60 days.	Dashboard results supporting the Key Performance Indicator of submission of a quality investigation report within 60 working days. Achievement will 90% and above sustained for a 6 month period. (1.5a & 1.5c)	30.11.16	Evidence Required: Dashboard of performance for a 6 month period demonstrating 90% compliance with submission of a quality investigation within 60 days (1.5a, 1.5b & 1.5c)
		1.6a Executive support to be sought and agreed to ensure that investigators are given sufficient time to investigate serious incidents as part of their job plans. 1.6b If improvement trajectories are not being met a divisional review of capacity will take place.	Helen Ludford, Associate Director of Quality Governance (1.6a)	Sara Courtney, Associate Director of Nursing East ISD Paula Hull, Associate Director of Nursing West ISD John Stagg, Associate Director of Nursing, LD TQ21 Carol Adcock, Associate Director of Nursing, AMH Nicky Bennet, Associate Director of Nursing, Specialised Services Liz Taylor, Associate Director of Nursing, Childrens and Families (1.6a & 31.6b - all leads are responsible for investigator capacity issues in their relevant Divisions and for escalation to their Director when issues arise)	Mark Morgan, Divisional Director AMH, LD & TQ21 Gethin Hughes, Divisional Director OMPH In Patients (East ISD) Chris Ash, Divisional Director, West ISD and Childrens and Families (1.6a & 1.6b - Divisional Director have ultimate responsibility and accountability for ensure that investigator capacity in their Division is 'fit for purpose')	30.11.15	Evidence obtained: WTE centralised lead investigators in post for each Division - mapping document (1.6a) Registers of trained investigators in each Division (1.6a) Flash report - weekly compliance review (1.6a & 1.6b) Serious Incident trajectory report provided to SIOAC and monthly dashboard of compliance to 60 days (1.6b)	That there is competent expertise at divisional level to monitor performance against the national framework criteria and through a process of support, education and feedback increase the quality of the investigation reports. Completion / submission of a quality investigation becomes standard Trust practice.	Key Performance Indicator monitored monthly and report to executive level within the trajectory and mortality and serious incident management papers supplied to Board sub-committees. Director escalation of failure to reduce the SI backlog in AMH resulted in increased investigator capacity and this is now being monitored monthly. 21.07.16 Trajectory monitored on a weekly basis, capacity in place to cover demand.	The trajectory report provided to SIOAC and the Flash report provided to the business and reviewed at TEG will assure that there are processes in place to monitor compliance to the 60 day submission of quality reports to reach a target of submission of 90% and above to this standard. (1.6a & 1.6b)	31.07.16	Evidence required: Flash report - weekly compliance review (1.6a & 1.6b) Serious Incident trajectory report provided to SIOAC and monthly dashboard of compliance to 60 days (1.6b) TEG minutes (1.6a)
		1.7a Serious Incident Investigation Training to include the National timescale requirement. Clarify and agree with Commissioners the reporting and achievement of the 60 day SIRI timescale includes/does not include Commissioner sign off. Obtain written agreement to enable benchmarking to other Trusts.	Helen Ludford, Associate Director of Quality Governance (1.7a)	N/A	Chris Gordon, COO and Director of Patient Safety (1.7a)	30.06.16	Evidence Required: Extract from the Serious Incident Framework 2015 plus training requirement from the Questions and Answer document 2016 (1.7a) Written agreement and clear definition of the 60 days pathway from the Commissioners - quality investigation to be undertaken, produced and submitted 60 days provider, 20 days for Commissioner sign off and closure (1.7a)	The Trust training is compliant to the national framework requirements and that there is a clear understanding between the Trust and the Commissioners regarding the monitoring of the compliance to this framework. Completion / submission of a quality investigation becomes standard Trust practice.	Discussions have taken place with the Commissioners to define the national framework guidance of 'submission of a quality report within 60 days'. 21.07.16 Raised as an outstanding issue at the Quality Oversight Committee. 04.08.16 Written agreement received from the Commissioners	Dashboard results supporting the Key Performance Indicator of submission of a quality investigation report within 60 working days. Trust to achieve 90% and over, sustained for a 6 month period. (1.7a) Framework checklist to be utilised at each SI panel - divisional, corporate and CCG closure panels: supplied as evidence of recognised good practice proven by recorded observation (1.7a)	30.11.16 (6 months following first achievement of above 90%)	Evidence Required: Minutes of the Strategic Oversight Group June 2016 (1.7a) Dashboard of performance for a 6 month period demonstrating 90% compliance with submission of a quality investigation within 60 days (1.7a) Evidence proved by recorded observation that the Framework checklist is used at all SI closure panels - internal and external (1.7a)

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		1.8a Provide Investigator Training to Divisional Lead Investigation Officers and those staff who undertake Investigating Officer roles. The course will be advertised and booked through the LEaD training system. The training will be a two day 'face to face' course and meet the requirements of the 2016 Serious Incidents Framework questions and answers publication, NHS England. This training will include: All related SHFT policies NPSA guidance tools on report writing in training Root cause analysis tools and how to use these to extract a root cause National Serious Incident Framework guidance inclusive of timescales Requirement for reporting deaths in detention Duty of Candour inclusive of involving families and other parties within investigations Human Factors Complaints management Ulysses system training Legal and inquest overview 1.8b A register of active trained Investigating Officers will be keep to ensure that supervision is provided and their is capacity within the Divisions to undertake all of the investigations required.	Kay Wilkinson, SI and Incident Manager Helen Ludford, Associate Director of Quality Governance (1.8a)	Sara Courtney, Associate Director of Nursing East ISD Paula Hull, Associate Director of Nursing West ISD John Stagg, Associate Director of Nursing, LD TQ21 Carol Adcock, Associate Director of Nursing, AMH Nicky Bennet, Associate Director of Nursing, Specialised Services Liz Taylor, Associate Director of Nursing, Childrens and Families (1.8b - all Divisional ADoNs are responsible and accountable for ensuring that registers are kept and capacity issues are escalated)	Chris Gordon, COO and Director of Patient Safety (1.8a)	31.04.16	Evidence obtained: Course programme and timetable (1.8a) Course attendance register (1.8a) Divisional investigating officers registers (1.8b)	Trained investigators within the Trust to meet the requirements of the 2016 update to the Serious Incident Framework NHS England incorporated in the questions and answers document. Outcome - increase the quality of the investigations and compliance to the 60 day submission of a quality report requirement.	Divisional registers created. 21.07.16 Course capacity increased by another 70 places per annum, 140 places offered in total.	Register of trained investigators for all Divisions who have attended the trained which is offered via LEaD every 6 months - 2 day course. (1.8a & 1.8b) Compliance to the 60 day target via monitoring of the Key Performance Indicator of submission of a quality investigation report within 60 working days. 90% achievement to be sustained over a 6 month period. (1.8a & 1.8b)	30.11.16	Evidence Required: Dashboard of performance for a 6 month period demonstrating 90% compliance with submission of a quality investigation within 60 days (1.8a & 1.8b) Divisional investigating officers registers (1.8b)
		1.9a Quality of the investigation reports will be monitored through the Divisional and Corporate Panels with executive Chair. Feedback will be provided at the panel on the standard of the report. The panels will utilise the 'checklist' from the National Framework document to aid the judgement on quality. 1.9b Corporate Panels booked weekly but can be increased as per demand. 1.9c Learning from serious incidents will take place in a timely manner as a result of improved lessons learnt, recommendations and actions.	Kay Wilkinson, SI and Incident Manager (1.9a, 1.9b & 1.9c)	N/A	Chris Gordon, COO and Director of Patient Safety (1.9a & 1.9b)	31.01.16	Evidence obtained: Quality checklist used at all Corporate panels including of the grading tool and the National Framework checklist document arranged with the CCGs. (1.9a) Corporate panel diary and schedule (1.9b)	The quality of the reports will improve through a process of the panels applying scrutiny and challenge to ensure that all elements of the national checklist are included. This will in turn ensure that the improvement lessons learnt from serious incidents will be shared in a timely way from which changes can be made in practice, for example policy changes to prevent recurrence.	Quality checklist utilised at all panel meetings used in coordination with National checklist and the grading tool. The quality checklist is loaded on to the Ulysses system as a record of the decision making at the Corporate panel.	Increase in quality with 85% of reports gaining Corporate Panel approval on 1st hearing. (1.9a) Managed Corporate Panel capacity which meets the demand. (1.9b) Policy and procedures changes resulting from serious incidents (1.9c) Please note timescale for outcome for action 1.9c, Policy and procedures changes resulting from serious incidents is 31.10.16	31.07.16 31.10.16	Evidence required: Dashboard indicator monitoring the investigation reports which gain Corporate Panel approval on the 1st hearing - target 85%. (1.9a) The trajectory report supplied to SIOAC provides assurance of activities to enable the Corporate Panel capacity to be increased during period of high demand. (1.9b) Policy and procedures changes resulting from serious incidents (1.9c)
		1.10a The involvement of families within investigations is of paramount importance. Early conversations with family members will ensure that the correct information is ascertained and that their questions are included as part of the investigation. The 48 hr mortality panel as part of the death process includes defining of family members, establishing their involvement in the process and participation in the investigation. 1.10b This will be assured through the audit of the process with the results being feedback to the Head of Patient Engagement and Experience.	Helen Ludford, Associate Director of Quality Governance (1.10a) Chris Woodfine, Head of Patient Engagement and Experience (1.10b)	Mary Kloer, Clinical Services Director AMH Mayura Deshpande, Clinical Services Director, Specialised Services Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Peter Hockey, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Liz Taylor, Associate Director of Nursing Childrens and Families Jennifer Dolman, Clinical Services Director, LD (1.10a - all Divisional leads are responsible for the 48 hr panels which will include addressing family involvement)	Lesley Stevens, Medical Director (1.10a & 1.10b)	31.01.16	Evidence obtained: Death reporting process includes guidance on defined family involvement which is discussed as the 48 hr panel (1.10a) Ulysses 48 hr panel questionnaire includes a check for family involvement (1.10a) The IMA / 48 hr panel audit has a specific question to test family communication (1.10b) Terms of reference for external review (1.10b)	Increased involvement of families in the investigation process will ensure that the investigation is holistic involving the opinions, views and questions of loved ones and where there has been an act or omission of care the Trust says it is sorry and learns from the events. The long term outcome is for SHFT to be evidenced as a Trust who is open and honest and keen to work in partnership with families for service improvement and redesign.	The death / mortality reporting process includes guidance on family involvement and there is a field on the 48 hr panel questionnaire related to this. The IMA / 48 hr panel audit is underway - 20% sample across all Divisions on a monthly basis. External review commissioned and commenced.	The external review into the quality of the experience of Duty of Candour / family involvement in SIRI investigations. To be completed and reported by 30.10.16. This will review the involvement of families and enable to the Trust to evidence improvement and plan further improvement actions. (1.10b) The Trust will self-monitor the inclusion of families where appropriate through monthly audit of 48hr panel this will provide internal evidence that the process is being correctly followed (1.10a & 1.10b) Please note timescales - Internal review through audit - 30.06.16 External review through commissioned enquiry 30.09.16 Internal thematic review due for completion 30.09.16	30.06.16 30.09.16	Evidence obtained: Monthly IMA / 48 hrs panel results produced and improvement activities to be discussed at MGW - audit results and MGW minutes this will provide evidence that discussions with families have occurred early on in the investigation process (1.10a &1.10b) Result of external review and related improvement plan (1.10b) Internal thematic review of Serious Incidents will prove that families have been included in 100% of investigations where appropriate and they wish to be involved (1.10b)
		1.11a Identify and deliver appropriate training for all non clinical Trust Board members to ensure they are able to interpret mortality data.	Anna Williams, Company Secretary and Head of Corporate Governance (1.11a)	N/A	Katrina Percy, Chief Executive Officer (1.11a)	30.06.16	Required Evidence: Schedule for Board training in relation to mortality data interpretation (1.11a)	To be able provide Board members with the additional skills to interpret and scrutinise mortality data which is presented to them. Scrutiny and challenge will lead to improvement.	Training has been delivered by Simon Beaumont.	Scrutiny and challenge regarding mortality to be evidenced in the Board minutes and resulting actions. (1.11a)	30.10.16	Required evidence: Board papers and minutes where mortality has been presented and discussed (1.11a)
Board Leadership and Oversight	2. The Board or its sub-committees should receive regular reports of all incidents of deaths. The report should: a. provide data on all deaths of people using a Mental Health or Learning Disability service including service users of the social care service - TQ21. b. outline how many unexpected deaths there have been and in which areas. c. outline how many IMAs have been written as a result and how many have progressed to CIR and then onto SIRI. d. include a summary of how many deaths are 'pending' for the purposes of investigation with a reason why. This would make the decision-making more transparent as regards to delays in reporting to SIEIS. e. provide information to enable trends to be identified and for Board members to become familiar with the information f. provide information which includes the categorisation of all deaths reported to Ulysses g. provide data at least twice a year on all deaths. Themes should be reported on which covers at least the previous 6 quarters (or a sufficient number to provide a reasonable sample from which to identify themes). This is particularly important for the Learning Disability arena where numbers of deaths in each quarter will be low and in areas that may not meet SIRI criteria e.g. non-suicide Mental Health deaths.	2.1a Weekly 'flash' report to be developed to describe the status and timelines for every SIRI investigation inclusive of deaths - this will be embedded into the Trust BI System. 2.1b The Flash report will be circulated to the Executive team and all Divisional leads accountable for ensuring that investigations are completed to timescales. The detail in the report will contain the stage the investigation is at and whether it has been rejected by the quality assurance panel at corporate level. 2.1c This will be discussed by the Executive team each week at the Wednesday meeting.	Helen Ludford, Associate Director of Quality Governance (2.1a & 2.1b) Anna Williams, Company Secretary and Head of Corporate Governance (2.1c)	N/A	Chris Gordon, COO and Director of Patient Safety (2.1a, 2.1b & 2.1c)	31.12.15	Evidence obtained: Flash report (2.1a) Flash report circulation list (2.1b) TEG minutes (2.1c)	That there is weekly executive oversight of the operational procedure compliance data for mortality, serious incident, complaints and risk data. This will enable a 'real time' executive overview of 'hot spot' areas of concern where compliance to process is not being maintained for further investigation and director level resolution.	The Flash report is provided to TEG each week and discussed by the executives. Chris Gordon draws executive attention to 'hot spot' areas with the relevant divisional director and requests further assurance of improvement at the following meeting or further insight into why improvement cannot be made or is slow. There is also an assurance of immediate patient safety given. 21.07.16 All Flash reports now embedded into Tableau. 04.08.16 Outcome evidence obtained	This will be evidenced through position monitoring of the compliance to the process behind incident, serious incident, risk and complaints by the executive team. (2.1a, 2.1b & 2.1c) The TEG minutes will provide an indicator that a worsening position is developing and a related action to deal with this. (2.1c)	31.07.16	Evidence Required: Flash report (2.1a) TEG minutes (2.1c) Trust dashboard related to reduction in overdue serious investigation (2.1c)
		2.2a The Board will lead in forming a structure for mortality oversight within the Trust. A Serious Incident Oversight and Assurance Committee (SIOAC) will be formed (Board sub-committee) to monitor mortality and the implementation of the Serious Incident and Mortality Improvement Plan. 2.2b Formal reporting will be provided to the SIOAC - Serious Incident Trajectory Report, Mortality Flash Report and the Mortality Process Audit Report. 2.2c Oversight of Serious Incidents is through the Quality and Safety Committee (QSC) (Board sub-committee) to which the Quarterly Serious Incident and Incident Report is provided. These reports will include the elements stated within the recommendation.	Anna Williams, Company Secretary and Head of Corporate Governance (2.2a & 2.2c) Helen Ludford, Associate Director of Quality Governance (2.2b)	N/A	Katrina Percy, Chief Executive Officer (2.2a, 2.2b & 2.2c)	29.02.16	Evidence obtained: Terms of Reference for SIOAC (2.2a) Meeting invitations (2.2a) Circulation / Meeting attendance request (2.2a & 2.2c) SIAOC agenda / papers (2.2b)	Increased Board oversight by monitoring the implementation of the action plan and gaining assurance from the evidence of implementation and change. NED Chair to report to the Board.	Meeting in place with Executive membership, meets a minimum of monthly and scrutinises evidence submitted against the actions on the plan. 04.08.16 Outcome evidence obtained	Minutes of the meeting will provide assurance of the scrutiny applied to ensure that the changes within the action plan are implemented and embedding. (2.2a) Serious Incident and Mortality feature within Board sub-committee papers (2.2b & 2.2c) Serious Incident and Mortality feature within the Board papers and minutes and is clearly an improvement priority for the Trust. (2.2a)	31.07.16	Evidence required: SIOAC & QSC agendas x 3 (2.2a, 2.2b & 2.2c) SIOAC & QSC minutes x 3 (2.2a, 2.2b & 2.2c) SIOAC Chairs report to the Board - Board Papers x 3 (2.2a, 2.2b & 2.2c))
		2.3a The Quality Governance team to provide a monthly report to the COO and Director of Patient Safety and the Director of Nursing on Mortality and Serious Incidents for inclusion in the Board report to provide oversight and assurance.	Helen Ludford, Associate Director of Quality Governance (2.3a)	N/A	Chris Gordon, COO and Director of Patient Safety (2.3a) Julie Dawes, Director of Nursing (2.3a)	30.01.16	Evidence obtained: Monthly COO and Director of Patient Safety and the Director of Nursing reports (2.3a)	Monthly oversight of mortality and serious incidents to be included in the Board report for assurance.	Monthly reports provided to the Director of Nursing and COO and Director of Patient Safety.	Detailed assurance narrative featuring within the Board report.(2.3a)	30.09.16	Evidence required: Board report x 3 (2.3a)
		2.4 a Each Division will provide mortality data inclusive of all elements of the recommendation in the report submitted to their monthly Divisional Performance Review (DPR).	Julie Giles, Performance Team (2.4a)	Sara Courtney, Associate Director of Nursing East ISD Paula Hull, Associate Director of Nursing West ISD John Stagg, Associate Director of Nursing, LD TQ21 Carol Adcock, Associate Director of Nursing, AMH Nicky Bennet, Associate Director of Nursing, Specialised Services Liz Taylor, Associate Director of Nursing, Childrens and Families (2.4a - Divisional Leads are responsible for the reporting which is associated with their DPR)	Mark Morgan, Divisional Director AMH, LD & TQ21 Gethin Hughes, Divisional Director OMPH In Patients (East ISD) Chris Ash, Divisional Director, West ISD and Childrens and Families (2.4a - Each Divisional Director is accountable for their own Division)	31.07.16	Evidence required: DPR papers from each Division (2.4a)	Divisions will own their mortality and serious incident data reporting these aspects for challenge and scrutiny as part of the Divisional Performance Review. Improvement activities will be captured within their improvement plans.	Mortality and serious incident management is discussed at DPR and is reported within the body of the reports. 04/08/16 Evidence has been provided by the performance team of inclusion at DPR. The system is changing to MOM's (monthly operational meetings) and the Governance Business Partner is included in the ToR's to ensure that the action is covered.	Divisional Performance Review reports and associated minutes will ensure that management of mortality is a key focus for improvement. (2.4a)	30.09.16	Evidence required: DPR minutes where mortality and serious incident improvement and assurance has been discussed (2.4a) Peer review reports where understanding of the mortality / death process is discussed with staff members (2.4a)
Board Leadership and Oversight	3. The 2015/16 Annual Report should provide a more transparent breakdown of deaths including a analysis of the themes that occur for people with Mental Health and Learning Disability challenges.	3.1a A review of the annual report should be undertaken to establish which inclusion around mortality can be made. Inclusions into the Quality Account will be the priority for improvement in year 2016/17 related to mortality and undertaking investigations.	Anna Williams, Company Secretary and Head of Corporate Governance Briony Cooper, Head of Quality Contracts and Quality Performance (3.1a - joint responsibility)	N/A	Julie Dawes, Director of Nursing (3.1a)	31.07.16	Evidence required: 2015/16 Annual Report which includes the Quality Account (3.1a) 2016/17 Quality Account priorities (3.1a)	Openness and transparency within the annual Quality Account as to the priority for improvement linked to mortality and serious incident management.	Analysis could not be provided for 2015/16 however this has been highlighted within the Quality Account as a priority for 2016/17. 2015/16 report on track to be published 30 June 2016. 04.08.16 Combined Annual Report and Quality Account published.	Quality Account publication will result in clear transparency of improvement indicators for 2016/17. (3.1a)	31.07.16	Evidence required: 2015/16 Annual Report which includes the Quality Account (3.1a) 2016/17 Quality Account priorities (3.1a) both to be published on NHS Choices as of 30.06.16 Schedule of monitoring QA priority related to Mortality /Serious Incident Improvement (3.1a)

Mazars Recommendation Theme	Mazars Recommendations	Related Actions	Responsible Lead Central Support Services	Responsible Lead Divisional	Executive Accountability	Input Action Timescale	Action Progress Blue - Complete Green - On Track / Begun	Expected Outcome / Benefit	Progress Update	How will you evidence that the completion of the actions has led to the intended outcome	Timescale for measuring success	Intended Outcome Achieved Blue - Complete Green - On Track / Begun
Board Leadership and Oversight	4. There is clear national and Trust policy guidance on reporting and investigating deaths. Trust policy includes a full set of templates and processes - the Board should ensure these policies are being followed and templates being used.	4.1a Serious Incident Management policies and procedures to be rewritten to reflect the National Framework inclusive of flowcharts to assist staff. The Trust will follow the guidance of the newly created Procedure for Reporting and Investigating Deaths which is inclusive of flowcharts to assist staff in their decision making. Staff will be able to refer to both of these documents: The Procedure for Reporting and Investigating Deaths is prescriptive of what deaths to report and how to do it. The Serious Incident policy and procedure describes what a serious incident is and provides guidance of how to report with the support of the centralised team. Decision making will be quality assured by the central governance team and audited through the IMA / mortality audit.	Thomas Williams, Ulysses Systems Developer Kay Wilkinson, SI and Incident Manager (4.1a - joint responsibility) David Batchelor (4.1a - review evidence)	Mandy Slaney, Lead IO AMH Eileen Morton, Lead IO AMH Georgie Townsend, Lead IO Childrens and Families Angela O Brien, Lead IO East ISD Jane Bray, Lead IO West ISD Nic Cicutti, Lead IO LD & TQ21 (4.1a - responsible for assuring the promotion and monitoring of the policy an procedure use in Divisions)	Chris Gordon, COO and Director of Patient Safety (4.1a)	31.01.16	Evidence obtained: Serious Incident Management Policies and Procedures rewritten(4.1a) Procedure for Reporting and Investigating Deaths created (4.1a)	Staff will be able to report deaths on the Ulysses system and there is a robust auditable decision making process as to whether an investigation is required and at what level and that this is correct. The outcome will be that all deaths will receive the correct level of investigation.	All rewritten and newly developed policies and procedures published. Monthly audit of 20% of mortality incident reports established and undertaken by clinical staff. 21.07.16 Q2 audit increased to 50% of mortality reviews due to continuing underperformance on the KPI / 95% target.	Audit of the decision making process as to the level of investigation required will prove in 95% of cases the decision was correct. Please note timescale for outcome for action Peer review reports to provide assurance that staff know about the death reporting and serious incident procedures and how to use them. (4.1a) is 31.10.16	31.08.16 31.10.16	Evidence required: Compliance to the procedure via the mortality Flash report (4.1a) Achievement of 95% correct clinical decision to investigate a death and at what level, assurance gained by audit (4.1b) Peer review reports to provide assurance that staff know about the death reporting and serious incident procedures and how to use them. (4.1a)
		4.2a Create an investigation template for the Ulysses Safeguard system to guide investigators with the process of report writing and ensure that additional tools / supplementary documents can be stored with the investigation. The use of prescribed electronic tools will ensure that all elements of the investigation are accurately recorded which ensure the richness in the quality of the investigation report. 4.2b Include scenario based system use within the Investigating Officers training to ensure that all investigators are trained to use the system embedded templates. Support to be provided by the Lead Investigating Officers.	Thomas Williams, Ulysses Systems Developer (4.2a) Kay Wilkinson, SI and Incident Manager (4.2b)	Mandy Slaney, Lead IO AMH Eileen Morton, Lead IO AMH Georgie Townsend, Lead IO Childrens and Families Angela O Brien, Lead IO East ISD Jane Bray, Lead IO West ISD Nic Cicutti, Lead IO LD & TQ21 (4.2a - all are responsible for assuring that Divisional Investigation Officers are trained to use the system correctly)	Chris Gordon, COO and Director of Patient Safety (4.2a & 4.2b)	31.01.16	Evidence obtained: Investigation Template (ERCA) within Ulysses Safeguard system developed (4.2a) All investigating officers receive systems training and further 1 to 1 support from their Central Lead Investigating Officer (4.2b)	Quality investigations are produced within the required national timescale which ensure that lesson are learnt and practice changes are made to prevent recurrence.	31.01.16 All new serious incident investigations completely systems based - ERCA on Ulysses Safeguard 30.03.16 System based tracking module implemented	Compliance to use of the standard system checked at each Corporate Panel. Bi-annual audit to be undertaken. (4.2a & 4.2b) Please note timescale for outcome for action Policy and procedures changes resulting from serious incidents is 31.10.16	31.08.16 31.10.16	Evidence required: Audit of the Serious Incident investigation reports to assure that the Ulysses template in being used and completed correctly, quality indicator (4.2a & 4.2b) Policy and procedures changes resulting from serious incidents (4.2a)
		4.3a The Board are to be assured of the use of the system and embedded templates through the reports which include the audit of the death reporting process and the Corporate SI Panel monitoring that all investigation reports post 01.01.16 are embedded into the Ulysses system.	Thomas Williams, Ulysses Systems Developer Kay Wilkinson, SI and Incident Manager (4.3a - joint responsibility)	Mandy Slaney, Lead IO AMH Eileen Morton, Lead IO AMH Georgie Townsend, Lead IO Childrens and Families Angela O Brien, Lead IO East ISD Jane Bray, Lead IO West ISD Nic Cicutti, Lead IO LD & TQ21 (4.3a - all are responsible for assuring that their respective Divisions use the Ulysses ERCA for all investigation report)	Chris Gordon, COO and Director of Patient Safety (4.3a)	31.01.16	Evidence obtained: Report style checked at every Corporate SI Panel for compliance with the Ulysses system. (4.3a)	Board assurance of the correct use of the Ulysses system with embedded investigation templates which support SI investigation processes. The outcome will lead to a quality investigation if all aspects of the template are completed.	31.01.16 All new serious incident investigations completely systems based - ERCA on Ulysses Safeguard 30.03.16 System based tracking module implemented 31.05.16 As the backlog in now cleared all reports are generated through the ERCA built into the Ulysses Safeguard system.	Audit of the compliance to the use of Ulysses and review of the quality to be included in Board reports. (4.2a & 4.2b)	31.08.16	Evidence Required: Audit of the Serious Incident investigation reports to assure that the Ulysses template in being used, completed correctly and the Board have been assured of this (4.2a & 4.2b)
Monitoring mortality and unexpected deaths / attrition	5. Unexpected deaths should be defined more clearly. We suggest the Trust uses, as a starting point, the classification outlined in this report to identify the potential need for review or investigation in each case. In particular, the definition of an 'unexpected death' needs to be refined to be more applicable to the circumstances of people with a Learning Disability regardless of setting.	5.1a Through consultation with the Clinical Leadership of each division create a Trust-wide Procedure for Reporting and Investigating Deaths which clearly defines the reporting criteria, review process as to what level of investigation should be undertaken and involves families. 5.1b Monitoring of this procedure will be through the Mortality Working Group under executive chair which reports to Serious Incident Oversight and Assurance Committee SIOAC (Board sub-committee). 5.1c Audit of the process is to be shared with the CCG commissioners on a quarterly as an assure of how the decision to investigate deaths and at what level is made. This information is reported internally on a monthly basis.	Helen Ludford, Associate Director of Quality Governance (5.1b & 5.1c) Thomas Williams, Ulysses System Developer (5.1a)	Mary Kloer, Clinical Services Director AMH Mayura Deshpande, Clinical Services Director, Specialised Services Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Peter Hockey, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Liz Taylor, Associate Director of Nursing (Childrens and Families) Jennifer Dolman, Clinical Director (LD) (5.1a & 5.1b - all are responsible for assuring that their respective Divisions use the procedure appropriately and have a member on the MWG)	Chris Gordon, COO and Director of Patient Safety (5.1a, 5.1b & 5.1c)	31.12.15	Evidence obtained: Procedure for Reporting and Investigating Deaths written and published (5.1a) MWG membership, Terms of Reference and agenda (5.1b) Audit tool created , audit completed on 20% of reported deaths per month (5.1c)	The procedure will enable all deaths to be reviewed, reporting and a decision made as to whether an investigation is required by senior clinicians. This will provide assurance that all deaths which require investigation will be recognised and families will be notified and included at the earliest opportunity.	01.06.16 Compliance to procedure 100% Audit result 83%	Compliance to the procedure will be monitored through the weekly Flash report. (5.1a) Detail of the decision making will be through monthly audit of 20% of the reports. (5.1c) SIOAC papers will demonstrate monitoring of compliance to the procedure (5.1b)	30.09.16	Evidence required: Mortality audit results above 90% correct decision making as to the level of investigation and compliance to the procedure at 100% (5.1a and 5.1c) Assurance evidence obtained demonstrated to the Board through SIOAC papers (5.1b)
Monitoring mortality and unexpected deaths / attrition	6. The Trust should develop a Mental Health and Learning Disability Mortality Review Group which includes reviewing unexpected deaths which do not constitute a serious incident. Clear terms of reference should be developed. This group should serve a number of purposes: a. to provide oversight of all deaths occurring amongst the Trusts Mental Health and Learning Disability service users b. develop a mortality dashboard which is provided to stakeholders and reported in the annual report that provides a full picture of all deaths, themes, CIRs and serious incidents c. monitor causes of deaths amongst its service users by using the 2013/14 MHMDS data release to see if the ICD 10 chapters show any trend d. provide an evidence base to share with Local Authority commissioners and other providers highlighting themes that are arising relating to social care and other agencies issues e. to ensure that liaison with acute provider colleagues can take place at a clinical and managerial level where the Trust has concerns raised with it about care in acute settings f. should include a GP as part of its membership g. the formation and progress of this new group should be monitored at Board level h. the group must aim to improve the transparency of reporting levels of unexpected deaths.	6.1a ALL Divisions inclusive of Mental Health and Learning Disability to introduce regular Mortality Review Meetings (minimum of once a quarter) to review and identify learning from ALL deaths (not just SIRIs)	Helen Ludford, Associate Director of Quality Governance (6.1a)	Mary Kloer, Clinical Services Director (AMH) Mayura Deshpande, Clinical Services Director (Specialised Services) Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Peter Hockey, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Liz Taylor, Associate Director of Nursing (Childrens and Families) Jennifer Dolman, Clinical Director (LD) (6.1a - each lead responsible for the meeting in their Division)	Lesley Stevens, Medical Director (6.1a - for ensuring Divisional clinical leadership) Chris Gordon, COO and Director of Patient Safety (6.1a - for devising process and supporting tools)	30.01.16	Evidence obtained: SharePoint site of planned Mortality Meetings (6.1a)	Increased oversight of deaths of service users and patients in receipt of care from SHFT will prove valuable data for scrutiny of the clinical model and care delivered.	All Divisions have Mortality Meetings in place. 21.07.16 Concerns have been raised regarding the attendance at the AMH Mortality Meeting this will be explored at the MWG.	Robust evidence of mortality review recorded through the minutes of the meetings which are shared through a central SharePoint site which are auditable. (6.1a) Audit of these minutes will prove that there is a richness of clinical discussion occurring about causes of deaths and improvements which could be made. (6.1a)	30.09.16	Evidence required: Audit of the contents of the SharePoint site record of Mortality Meetings (6.1a)
		6.2a Terms of Reference and standardised agenda inclusive of case study review to be drawn up by the Governance Workstream of the Quality Programme and implemented within each group.	Helen Ludford, Associate Director of Quality Governance (6.2a)	N/A	Chris Gordon, COO and Director of Patient Safety (6.2a)	30.01.16	Evidence obtained: Terms of Reference (6.2a) Standardised agenda (6.2a)	Consistent approach to the review of deaths through Mortality Meetings across the Trust.	Standardised Terms of Reference and Agendas in place.	Robust evidence of mortality review recorded through the minutes of the meetings which are shared through a central SharePoint site which are auditable. (6.2a) Audit of these minutes will prove that there is a richness of clinical discussion occurring about causes of deaths and improvements which could be made. (6.2a)	30.09.16	Evidence required: Audit of the contents of the SharePoint site record of Mortality Meetings (6.2a)
		6.3a Divisional Mortality Meetings to be chaired by the senior clinician in a senior leadership role. 6.3b The Senior Clinician Chair should attempt to recruit membership from primary care (GP), external stakeholders such as the Local Authority and a representative for patients this should be supported by the Head of Patient Engagement and Experience.	Chris Woodfine, Head of Patient Engagement and Experience (6.3b)	Mary Kloer, Clinical Services Director (AMH) Mayura Deshpande, Clinical Services Director (Specialised Services) Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Peter Hockey, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Jennifer Dolman, Clinical Services Director (LD & TQ21) Liz Taylor< Associate Director of Nursing (Childrens & Families) (6.3a & 6.3b - each lead responsible for the actions in their Division)	Lesley Stevens, Medical Director (6.3a & 6.3b - for ensuring Divisional clinical leadership)	30.01.16	Evidence obtained: Terms of Reference (6.3a) Standardised agenda (6.3b)	Consistent approach to the review of deaths through Mortality Meetings across the Trust managed by a Senior Clinician with the skills to applied scrutiny and challenge. Non SHFT attendees should bring a further aspect of check and challenge based on the external view point of the wider health economy.	All Chairs defined as Senior Clinicians.	Robust evidence of mortality review recorded through the minutes of the meetings which are shared through a central SharePoint site which are auditable. (6.3a) Non SHFT attendees should be clearly auditable within the minutes.(6.3b)	30.09.16	Evidence required: Audit of the contents of the SharePoint site record of Mortality Meetings (6.3a & 6.3b)

Mazars Recommendation Theme	Mazars Recommendations	Related Actions	Responsible Lead Central Support Services	Responsible Lead Divisional	Executive Accountability	Input Action Timescale	Action Progress Blue - Complete Green - On Track / Begun	Expected Outcome / Benefit	Progress Update	How will you evidence that the completion of the actions has led to the intended outcome	Timescale for measuring success	Intended Outcome Achieved Blue - Complete Green - On Track / Begun
		6.4a Divisional Mortality Meetings to report into the Mortality Working Group under Executive Chair which in turn reports through to the Serious Incident Oversight and Assurance Committee (Board sub-committee). 6.4b Themes and trends should be escalated and consideration for 'deep dive' thematic analysis to be undertaken. On completion findings should be shared with external stakeholders where appropriate.	Helen Ludford, Associate Director of Quality Governance (6.4a) Tracey McKenzie, Head of Quality, Compliance and Assurance (6.4b)	Mary Kloer, Clinical Services Director AMH Mayura Deshpande, Clinical Services Director, Specialised Services Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Peter Hockey, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Jennifer Dolman, Clinical Services Director (LD & TQ21) Liz Taylor, Associate Director of Nursing (Childrens and Families) (6.4a & 6.4b) - each lead responsible for the reporting and thematic analysis in their Division)	Lesley Stevens, Medical Director (6.4a & 6.4b)	31.10.16	Evidence obtained: Terms of Reference (6.4a) Standardised agenda (6.4a) Evidence required: Completed thematic analysis linked to mortality (6.4b)	Upward reporting of the mortality review process from Division to Board provides a richness of information to provide assurance or the requirement for further check and challenge.	SharePoint in place for the collection of the documentation related to all levels of mortality meeting. 23.08.16 Schedule for the presentation of thematic reviews in development by the MWG. 30.08.16 Recovery plan for action 6.4b submitted to SIOAC and action timescale approved for change - reset at 31.10.16	Robust evidence of mortality review recorded through the minutes of the meetings including the Mortality Working Group which are shared through a central SharePoint site.(6.4a) Bi-annual audit of the minutes to be reported to the SIOAC will provide assurance that mortality and serious incidents are being scrutinised and lesson learnt throughout the Trust.	30.09.16	Evidence required: Audit of the contents of the SharePoint site record of Mortality Meetings (6.4a) Audit of the minutes of the SIOAC (6.4a) Thematic review reports and documented changes to practice (6.4b)
		6.5a Data for Mortality Meetings to be produced by the Ulysses systems analyst (monthly). Data Quality Audit to be implemented for cross checking Ulysses data against Tableau live data to ensure all deaths are accurately recorded and included in Divisional Mortality Reviews	Simon Beaumont, Head of Informatics Thomas Williams, Ulysses Systems Developer (6.5a - joint responsibility)	N/A	Chris Gordon, COO and Director of Patient Safety Paula Anderson, Chief Finance Officer (6.5a - joint accountability)	30.01.16	Evidence obtained: Screen shot of mortality data reports on Tableau (6.5a)	Consistent data set to guide the discussion at the Mortality Meetings.	Data published to Tableau the trust BI system.	Robust evidence of mortality review recorded through the minutes of the meetings including the Mortality Working Group which are shared through a central SharePoint site which are auditable. (6.5a) Bi-annual of the minutes will ensure that this is being utilised appropriately at the meetings to highlight themes for further investigation. (6.5a)	30.09.16	Evidence required: Audit of the contents of the SharePoint site record of Mortality Meetings (6.5a) Audit of the minutes of the SIOAC (6.5a) Thematic review reports and documented changes to practice (6.5a)
		6.6a All Divisions to use "Hot Spots", "Learning Matters" and "Could it happen here?" templates to share thematic review findings and enhance organisational, divisional and team learning. This should include learning from family involvement.	Tracey McKenzie, Head of Quality, Compliance and Assurance (6.6a)	Mandy Slaney, Lead IO AMH Eileen Morton, Lead IO AMH Georgie Townsend, Lead IO Childrens and Families Angela O Brien, Lead IO East ISD Jane Bray, Lead IO West ISD Nic Cicutti, Lead IO LD & TQ21 (6.6a responsible for their allocated Division)	Lesley Stevens, Medical Director Chris Gordon, COO and Director of Patient Safety (6.6a - joint accountability)	31.03.16	Evidence required: Publications for the Divisions - Hotspots, Learning Matters and Could it Happen Here (6.6a)	Evidence of divisional learning which should reduce the risk of potential recurrence of the incident when the root cause describes a SHFT related failing.	Publications present in all division accept the East ISD. 21.07.16 Further check underway with the East ISD to assess compliance	Reduction in themed root causes which described a SHFT related failing over a 12 month period, data provided by audit. (6.6a)	31.12.16	Evidence required: Results of audit tracking the themes from root causes (6.6a)
Thematic reviews	7. A template for a thematic review should be produced. All thematic reviews should be undertaken in an agreed format which meets best practice standards and includes follow up, evaluation and demonstration of lessons learned and practice change.	7.1a Creation and publication of a template to support thematic review this will be implemented through the Mortality Working Group for mortality related reviews and will be implemented through the Clinical Audit Facilitator responsible for Trust-wide thematic reviews. 7.1b Pilot use in the divisions and promote via the Mortality Working Group.	Tracey McKenzie, Head of Compliance and Assurance (7.1a & 7.1b)	N/A	Chris Gordon, COO and Director of Patient Safety (7.1a & 7.1b)	31.03.16	Evidence obtained: Thematic review template (7.1a) Mortality Working Group minutes (7.1b)	Consistent documentation support thematic review to ensure that quality reports are received from which improvement actions can be easily extracted.	Template piloted and shared with the Commissioners for opinion. Piloted and launched in the Trust. 21.07.16 Evidence of discussing thematic reviews at the Mortality Meetings has not been obtained and this will be discussed at the MWG 04.08.16 Discussed at the MWG, thematic template to be recirculated, East ISD and West ISD have both commenced a thematic review 30.08.16 Recovery plan for action 7.1a & 7.1b submitted to SIOAC and action timescale approved for change - reset at 31.10.16	Quality thematic reports which can be shared as learning throughout the Trust. (7.1a) Reduction in incidents with identical root causes to be evidenced by audit. (7.1b) Please note detail behind timescale: 30.06.16 31.12.16 - for audit to prove reduction in incidents with identical root causes (7.1b)	31.10.16 31.12.16	Evidence required: Mortality Working Group minutes - presentation of a thematic review (7.1a & 7.1b) Audit of root causes to prove reduction (7.1a & 7.1b) (results not expected until 31.12.16)
Thematic reviews	8. There should be further work undertaken to establish whether all deaths of people over the age of 65 are being appropriately reported and investigated - in particular amongst inpatients.	8.1a The Procedure for Reporting and Investigation Deaths includes the reporting of all Older Persons Mental Health (OPMH) inpatient deaths. A 48 hour panel is to be established with Senior Clinical Chair at Divisional to decide the level of investigation which is require for each death on a case by case basis. Panel decision to reported within the Ulysses system as per process.	Thomas Williams, Ulysses System Developer (8.1a)	Sarah Constantine, Clinical Services Director, OPMH inpatients and East Division (8.1a)	Lesley Stevens, Medical Director (8.1a)	29.02.16	Evidence obtained: Procedure for Reporting and Investigating Deaths created and in use within OPMH (8.1a)	All OPMH inpatient deaths are reviewed inline with the SHFT procedures and reasons not to investigate are clearly defined by the 48 hour panel.	Senior clinical chair for each 48 hr mortality review panel. Monthly IMA / Mortality process is covering OPMH investigations. 21.07.16 Evidence of discussing thematic reviews at the Mortality Meetings has not been obtained and this will be discussed at the MWG 04.08.16 Discussed at the MWG, thematic template to be recirculated, East ISD and West ISD have both commenced a thematic review 30.08.16 Recovery plan for action 8.1a submitted to SIOAC and action timescale approved for change - reset at 31.10.16	Improved levels of investigation into OPMH inpatient deaths over a 12 month period evidence by audit and thematic review. (8.1a) Please note detail behind timescales: 30.06.16 - Externally commissioned thematic review 31.01.17 - Audit after 12 month working under the new process to assess the level of reporting	31.10.16 31.01.17	Evidence required: Thematic review results (8.1a) Audit of all reports deaths (8.1a) - evidence not due until 31.01.17 Monthly audit of 20% of the mortality / death reports / IMA which is inclusive of OPMH
Thematic reviews	9. The Trust, CCG and local authority should undertake a retrospective review of all Learning Disability unexpected deaths regardless of place of residence with particular reference to: a. the quality, timing and follow up of dysphagia assessments b. the level of support provided by hospital liaison services and the challenges faced in acute liaison c. the decision-making process for PEG insertion d. the hydration and nourishment of service users refusing to eat e. delays in decision-making for treatment - including primary care, decisions by care staff and responses in A&E and on wards f. the inclusion of carers and families in investigations g. waiting times for therapy services and community nursing h. identification of early warning signs of deterioration through behavioural change i. arrangements for attending appointments and seeing healthcare professionals j. reporting and acting on safeguarding concerns.	9.1a Engage all stakeholders in a workshop to discuss the appropriateness, the capacity for and ownership of the terms of reference for retrospective and forward planned thematic review. 9.1b SHFT to commission an external appreciative enquiry into the experience of families in the investigation process over the last 2 years.	Helen Ludford, Associate Director of Quality Governance (9.1a) Chris Woodfine, Head of Patient Experience and Engagement (9.1b)	Mary Kloer, Clinical Services Director AMH Mayura Deshpande, Clinical Services Director, Specialised Services Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Peter Hockey, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Jennifer Dolman, Clinical Services Director (LD & TQ21) Liz Taylor, Associate Director of Nursing (Childrens and Families) (9.1a & 9.1b - responsible for Divisional participation in thematic reviews)	Chris Gordon, COO and Director of Patient Safety (9.1a) Julie Dawes, Director of Nursing (9.1a) Lesley Stevens, Medical Director (9.1b)	29.02.16 (9.1a) 31.08.16 (9.1a) 01.06.16 (9.1b)	Evidence required: Workshops with CCG Commissioners to discuss multi-agency retrospective and forward planned thematic review (9.1a) Commissioning documents for external appreciative enquiry (9.1b)	That joint thematic reviews are commissioned correctly and involve all providers of care to the cohort of patients.	This is a joint action which SHFT are working with the commissioners to achieve. SHFT has commissioned an external appreciative enquiry into the experience of families in the investigation process over the last 2 years as this has been deemed as extremely important for guiding improvement activities.	Meetings to be held to discuss any joint thematic reviews that are to be jointly commissioned and Terms of reference shared. (9.1a) Results of the appreciative enquiry (9.1b)	30.09.16	Evidence required: Report from externally commissioned thematic review.(9.1a) Outcome of wider stakeholder discussion re thematic review. (9.2b)
Thematic reviews	10. The Trust and CCG should undertake thematic reviews in Mental Health on a number of the issues raised in this review, including: a. A joint review of the circumstances of death of people with serious mental illness on long term antipsychotic drugs encompassing a review of safeguarding alerts, self neglect and physical health management. b. A joint review of all deaths relating to people with a drug related death in conjunction with local providers encompassing a review of referral processes between agencies. c. A joint review with the CCG of recent cases of death relating to serious eating disorders to understand how services need to improve by bringing both physical and psychological management together. d. A joint review of alcohol related deaths in conjunction with local providers encompassing a review of self-referral processes.	10.1a Engage all stakeholders in a workshop to discuss the appropriateness, the capacity for and ownership of the terms of reference for retrospective and forward planned thematic review.	Helen Ludford, Associate Director of Quality Governance (10.1a)	Mary Kloer, Clinical Services Director AMH Mayura Deshpande, Clinical Services Director, Specialised Services Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Peter Hockey, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Jennifer Dolman, Clinical Services Director (LD & TQ21) (10.1a - responsible for Divisional participation in thematic reviews)	Chris Gordon, COO and Director of Patient Safety (10.1a) Julie Dawes, Director of Nursing (10.1a)	29.02.16 1st workshop 30.09.16 2nd workshop	Evidence required: Workshops with CCG Commissioners to discuss multi-agency retrospective and forward planned thematic review (10.1a)	That joint thematic reviews are commissioned correctly and involve all providers of care to the cohort of patients.	This is a joint action which SHFT are working with the commissioners to achieve.	Meetings to be held to discuss any joint thematic reviews that are to be jointly commissioned and Terms of reference shared. (10.1a)	30.09.16	Evidence required: Report from externally commissioned thematic review.(10.1a)
Thematic reviews	11. The Trust should provide staff with regular training and guidance to help them manage physical health conditions of long-term mental health service users. Diabetes management stands out as an area for greater awareness from a number of cases we reviewed.	11.1a Review the content of the five day physical health course which LEaD provide. Course content and learning outcomes which will be reviewed. 11.1b Ensure that there is the correct percentages of staff attending from each service. 11.1c Attendance data recorded per service. 11.1d Review published Physical Assessment and Monitoring Procedure for Mental Health and Learning Disability Services which includes a reference to diabetic monitoring.	Mayura Deshpande, Associate Medical Director, Patient Safety (11.1a) and all Clinical Service Directors Jane Hazelgrove, Director of Education (11.1a, 11.1c & 11.1d)	Carol Adcock, Associate Director of Nursing AMH (11.1a, 11.1b & 11.1c) Mary Kloer, Clinical Services Director AMH (11.1a, 11.1b & 11.1c) Kate Brooker, Associate Director AMH (11.1a, 11.1b, 11.1c, &11.1d)	Mark Morgan, Divisional Director AMH, LD & TQ21 Julie Dawes, Director of Nursing and Allied Health Professionals (11.1a, 11.1b & 11.1c - joint accountability)	31.07.16	Evidence required: Course content and learning outcomes (11.1a) Percentages of for the staff who have undertaken it by service (11.b) Attendance registers (11.1c)	All AMH services will have staff who are competent in managing physical health care needs of the individual service users. Reduction in the rate of physical health management featuring as a contributory factor in SI investigation reports.	11.1a Course content currently being reviewed by the ADoNs from AMH and a LEaD representative. Additional options being scoped alongside the 5 day course. Alternatives are physical health specialist subject sessions and e learning. Subject matter inclusive of diabetes and respiratory. 11.1b & 11.1c Training records being obtained by Louise Hartland LEaD. 04.08.16 Input evidence request made for information - meeting was held with ADoNs to discuss e learning and shorter course options	Divisional and service level training records to that staff have been trained. (11.1b & 11.1c) Achieve of 90% compliance to clinical audit of physical health needs. (11.1a) Physical health audit to be undertaken in Q3. Audit of SI contributory factors to be undertaken in Q2. (11.1a)	30.11.16	Evidence required: Course attendance records - site / service percentage (11.1b & 11.1c) Results of the physical health audit of AMH sites (11.1a) Audit of SI reports proving a reduction in physical health contributory factors (11.1a) Review published Physical Assessment and Monitoring Procedure for Mental Health and Learning Disability Services which includes a reference to diabetic monitoring (11.1d)

Mazars Recommendation Theme	Mazars Recommendations	Related Actions	Responsible Lead Central Support Services	Responsible Lead Divisional	Executive Accountability	Input Action Timescale	Action Progress Blue - Complete Green - On Track / Begun	Expected Outcome / Benefit	Progress Update	How will you evidence that the completion of the actions has led to the intended outcome	Timescale for measuring success	Intended Outcome Achieved Blue - Complete Green - On Track / Begun
Thematic reviews	12. The Trust should undertake thematic reviews of the issues raised in the review, including: a. Medical input and senior medical oversight b. The role of the care co-ordinator c. The need for pharmacy colleagues to be more explicitly involved in cases involving drug toxicity and polypharmacy.	12.1a Review the themes which the Mortality Report suggests require further investigation such as, the role of the care coordinator. Undertake review and report the findings and the actions taken to Quality and Safety Committee. The requirement for thematic reviews will be discussed at the Divisional and Corporate panels and will be specifically aimed at the themes resulting from the Serious Incidents. By undertaking thematic reviews quality improvement plans will be created that will lead to improvement.	Mayura Deshpande, Associate Medical Director, Patient Safety and all Clinical Service Directors (12.1a)	Mary Kloer, Clinical Services Director AMH (12.1a)	Lesley Stevens, Medical Director (12.1a)	31.10.16	Evidence required: Minutes of a meeting where these issues have been discussed (12.1a)	The quality of care will improve through the outcomes of thematic review and the development of quality improvement plans. Thematic review will include expert opinion such as, pharmacist where necessary.	04.08.16 Raised at the MWG 01.08.16 - schedule of thematic reviews to be created 30.08.16 Recovery plan for action 12.1a submitted to SIOAC and action timescale approved for change - reset at 31.10.16	Thematic review reports will provide the evidence base for quality improvement activities at service level which will be documented in improvement plans.(12.1a)	30.11.16	Evidence required: Thematic reviews which do include clinical expert opinion and role scrutiny (12.1a) Serious investigation reports which contain expert opinions (12.1a) Quality Improvement plans which have been developed from thematic reviews (12.1a) Policy and procedures changes resulting from thematic reviews (12.1a)
		12.2a Provide evidence of thematic review to the CCG commissioners through CQRM's and SOG.	Tracey McKenzie, Head of Quality, Compliance and Assurance (12.2a)	Mary Kloer, Clinical Services Director AMH Mayura Deshpande, Clinical Services Director, Specialised Services Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Peter Hockey, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Jennifer Dolman, Clinical Services Director (LD & TQ21) (12.2a - responsible for Divisional participation in thematic reviews)	Mark Morgan, Divisional Director AMH, LD & TQ21 Julie Dawes, Director of Nursing and Allied Health Professionals (12.2a - jointly accountable for ensuring thematic reviews take place and are shared)	31.10.16	Evidence required: Thematic review template (12.2a) Completed thematic review (12.2a)	The Trust will share the results of thematic review in an open and transparent style with Commissioners to stimulate discussion regarding changes in service provision for patient and service users where necessary. This will result in dynamic service transformation which will improve outcomes for patients.	Template for thematic review developed and circulated Trust-wide. 30.08.16 Recovery plan for action 12.2a, completed thematic review, submitted to SIOAC 31.08.16 - action timescale extended to 31.10.16	Thematic review reports will provide the evidence base for quality improvement potential for the wider health economy therefore evidence of sharing and the associated quality improvement activities discussed with be evidenced through minutes. (12.2a)	30.11.16	Evidence required: Thematic reviews which have been undertaken (12.2a) Minutes of meetings where thematic reviews have been discussed (12.2a)
Thematic reviews	13. A regular review of all sudden deaths of OPMH inpatients should be carried out. This should include a review of whether care treatment decisions are taken quickly enough, whether cooperation and liaison with acute medical staff is adequate and whether staff feel confident in managing and identifying sudden physical deterioration including CPR.	13.1a The Procedure for Reporting and Investigation Deaths includes the reporting of all OPMH inpatient deaths. 13.1b A 48 hour panel is to be established with Senior Clinical Chair at Divisional to decide the level of investigation which is require for each death on a case by case basis. Panel decision to reported within the Ulysses system as per process. 13.1c Within the Terms of Reference for investigations physical health deterioration with be explored.	Helen Ludford, Associate Director of Quality Governance (13.1a)	Sarah Constantine, Clinical Services Director, OPMH inpatients and East Division (13.1b & 13.1c)	Chris Gordon, COO and Director of Patient Safety (13.1a & 13.1b) Lesley Stevens, Medical Director (13.1c)	30.06.16	Evidence obtained: Procedure for Reporting and Investigating Deaths created (13.1a) Ulysses template for mortality 48 hour panel in OPMH (13.1b) Ulysses incident report for OPMH with physical health related Terms of Reference (13.1c)	All OPMH inpatient deaths are reviewed inline with the SHFT procedures and reasons not to investigate are clearly defined by the 48 hour panel. Physical health concerns will feature as part of the panel discussion.	Senior clinical chair for each 48 hr mortality review panel. Procedure for Reporting and Investigating Deaths published - includes the requirement for OPMH.	Improved levels of investigation into OPMH inpatient deaths over a 12 month period evidence by audit. (13.1a & 13.1b) Reduction in contributor factors associated with the management of physical health will be seen over a year an evidenced by audit. (13.1c)	31.12.16	Evidence required: Audit of 12 months of OPMH related serious incident investigation reports to prove a reduction in physical health related contributory factors. (13.1a, 13.1b & 13.1c)
Reporting and Identifying Deaths	14. The Trust should review the way that deaths are categorised under the incident reporting policy so that: a. All relevant deaths are re-graded accurately before and after investigations have taken place (14.1a, 14.2a, 14.2b) b. All relevant deaths are reported on regardless of impact grading to ensure that deaths have greater prominence in the Trust's reporting systems. (14.3a) c. Accurate information is provided for future Trust Mortality Reviews. (14.4a) d. That immediate work with the NRLS team is undertaken to ensure the changes to the local risk management system map as expected to NRLS and on to CQC. (14.5a)	14.1a Re-write SHFT incident policy to include enhanced information on impact grading as defined by the National Reporting and Learning Service (NRLS). This is a national requirement and processes need to be correct to gain accurate benchmarking data.	Kay Wilkinson, SI and Incident Manager (14.1a)	N/A	Chris Gordon, COO and Director of Patient Safety (14.1a)	30.03.16	Evidence obtained: Serious Incident Management Policies and Procedures rewritten (14.1a)	Monitoring our accurate reporting to the NRLS will enable SHFT to accurate benchmarking against other Trusts within the sector to ascertain that improvements made through learning from serious incidents has resulted in less harm being experienced by our patients.	Policy re-written and published.	Benchmarking NRLS data should evidence that SHFT is not a data outlier. Please note NRLS data is published 6 months in arrears therefore improvement cannot be measured until the April 2017 publication. (14.1a)	01.04.17	Evidence required: Screenshot evidence of uplift of to the NRLS (14.1a) Published NRLS data April 2017 (14.1a)
		14.2a Create a Corporate Panel tool that records the impact grading which is applied to the investigation at the point of final sign off by the panel under the executive director Chair. 14.2b Serious Incident support officers to update the impact grade in the Ulysses system following panel.	Kay Wilkinson, SI and Incident Manager (14.2a & 14.2b)	N/A	Chris Gordon, COO and Director of Patient Safety (14.2a & 14.2b)	30.03.16	Evidence obtained: Corporate tool which records impact grading (14.2a) Corporate panel SOP which required the officers to update the impact grade (14.2b)	Monitoring our accurate reporting to the NRLS will enable SHFT to accurate benchmarking against other Trusts within the sector to ascertain that improvements made through learning from serious incidents has resulted in less harm being experienced by our patients.	Tool created and is in use at each Corporate Panel.	Benchmarking NRLS data should evidence that SHFT is not a data outlier. . Please note NRLS data is published 6 months in arrears therefore improvement cannot be measured until the April 2017 publication. (14.2a & 14.2b)	01.04.17	Evidence required: Published NRLS data April 2017 (14.2a & 14.2b) Audit of corporate panel grading tool results with comparison to the uplifted reports to StEIS with provide assurance of accurate grading (14.2 & 14.b)
		14.3a Through consultation with the Clinical Leadership of each division create a Trust-wide Procedure for Reporting and Investigating Deaths which clearly defines the reporting criteria, review process as to what level of investigation should be undertaken and involves families. 14.3b Monitoring of this procedure will be through the Mortality Working Group under executive chair which reports to Serious Incident Oversight and Assurance Committee (Board sub-committee).	Helen Ludford, Associate Director of Quality Governance Thomas Williams, Ulysses System Developer (14.3a & 14.3b)	Mary Kloer, Clinical Services Director AMH Mayura Deshpande, Clinical Services Director, Specialised Services Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Peter Hockey, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Jennifer Dolman, Clinical Services Director (LD &TQ21) Liz Taylor, Associate Director of Nursing (Childrens and Families) (14.3a & 14.3b - responsible lead for their own Divisions)	Chris Gordon, COO and Director of Patient Safety (14.3a & 14.3b)	31.12.15	Evidence obtained: Procedure for Reporting and Investigating Deaths written and published (14.3a) MWG membership, Terms of Reference and agenda (14.3b) Audit tool created , audit completed on 20% of reported deaths per month (14.3b)	The outcome will be that all reportable deaths are reviewed by a consistent process defined by procedure and that families are included in investigations where appropriate and their questions answered in an open and transparent manner.	01.06.16 Compliance to procedure 100% Audit result 83%	Compliance to the procedure will be monitored through the weekly Flash report. (14.3a) Detail of the decision making will be through monthly audit of 20% of the reports. (14.3b) SIOAC papers will demonstrate monitoring of compliance to the procedure (14.3b)	30.09.16	Evidence required: Mortality audit results above 90% correct decision making as to the level of investigation and compliance to the procedure at 100% this audit will also demonstrate the involvement of families (14.3a & 14.3b) Assurance evidence obtained demonstrated to the Board through SIOAC papers (14.3a & 14.3b)
		14.4a The death reporting procedure is to be supported by the Safeguard Ulysses system enabling accurate and auditable extractions of mortality information. Supporting data input screens to be developed and users to be educated.	Lottie Turner, Risk Manager Thomas Williams, Ulysses System Developer (14.4a - joint responsibility)	N/A	Chris Gordon, COO and Director of Patient Safety (14.4a)	31.12.15	Evidence obtained: Screenshots of the Ulysses System for mortality reporting and 48 hour panels (14.4a)	SHFT will be compliant to providing easily extractable for any Mortality Review which includes auditable recording of reporting deaths and decision making as to whether an investigation is required. This will enable accurate benchmarking and provide public reassurance of improvement in process which is compliant to the national guidance .	01.06.16 Compliance to procedure 100% Audit result 83%	Compliance to the procedure will be monitored through the weekly Flash report. Detail of the decision making will be monitored through monthly audit of 20% of the reports. (14.4a)	31.04.16	Evidence obtained: Flash report compliance to the procedure (14.4a) Monthly audit of 20% of the mortality 48 hr panel information (14.4a)
		14.5a Governance team to meet with the NRLS centralised team to ensure that the SHFT impact grading and uplift processes are occurring within the required criteria. This upload is electronic supported through a system extraction of all patient safety incidents. The information is onwardly shared with the CQC.	Fiona Richey, Head of Business Continuity and Risk Thomas Williams, Ulysses System Developer (14.5a - joint responsibility)	N/A	Chris Gordon, COO and Director of Patient Safety (14.5a)	30.03.16	Evidence obtained: Minutes to support meeting with NRLS to verify Trust procedure for uplift (14.5a)	Monitoring our accurate reporting to the NRLS will enable SHFT to accurate benchmarking against other Trusts within the sector to ascertain that improvements made through learning from serious incidents has resulted in less harm being experienced by our patients.	01.06.16 NRLS uplift undertaken on the 18th of each calendar month. NRLS team have reviewed SHFT process and agreed it as accurate.	Assurance that SHFT is managing the national NRLS uplift process correctly demonstrated by uplift confirmation messages directly from the NRLS. (14.5a)	31.04.16	Evidence obtained: System confirmation messages of successful uplift to the NRLS (14.5a)
Quality of Investigation Reporting	15. The Serious Incident investigation process needs a major overhaul in the Trust. Improvements are needed in: a. Separation of people responsible for quality assurance and those undertaking investigations. This would enable training in review processes and quality assurance to be targeted at senior staff and in investigation techniques at a dedicated group of investigators. (15.5a, 15.5b, 15.5c, 15.5d) b. Quality assurance processes including independent review and sign off (15.5a, 15.5b, 15.5c, 15.5d, 15.6d) c. Achieving high professional standards in written presentation (15.1a, 15.2b, 15.3a, 15.3b, 15.3c, 15.4a)	15.1a Rewrite of SHFT Serious Incident Management policy and procedures to be more inclusive of flowchart to provided guidance to staff.	Kay Wilkinson, SI an incident Manager (15.1a)	N/A	Chris Gordon, COO and Director of Patient Safety (15.1a)	30.03.16	Evidence obtained: Serious Incident Management Policies and Procedures rewritten (15.1a)	Clear instruction about reporting and managing serious incidents will improve compliance to reporting and the quality of the investigation.	Updated policy and procedure published	Compliance to policy and procedure to checked by audits: mortality IMA monthly audit and the bi-annual SI report audit. From the information ascertained via the peer review reports - focused question related to the death reporting procedure and serious incident management.	30.09.16	Evidence required: Extract from peer review results - specific question about mortality reporting (15.1a) Monthly 20% audit of the mortality reports and 48 hr panel information (15.1a)
		15.2a Recruit centralised Serious Incident Investigator team to be known as the Divisional Lead Investigation Officers.	Helen Ludford, Associate Director of Quality Governance (15.2a)	Sara Courtney, Associate Director of Nursing East ISD Paula Hull, Associate Director of Nursing West ISD John Stagg, Associate Director of Nursing, LD TQ21 Carol Adcock, Associate Director of Nursing, AMH Nicky Bennet, Associate Director of Nursing, Specialised Services Liz Taylor, Associate Director of Nursing, Childrens and Families (15.2a - responsible for the Lead IO's for their Division)	Chris Gordon, COO and Director of Patient Safety (15.2a)	30.11.15	Evidence obtained: List of Lead IO's in post per Division (15.2a)	That there is competent expertise at divisional level to monitor performance against the national framework criteria and through a process of support, education and feedback increase the quality of the investigation reports. Completion / submission of a quality investigation becomes standard Trust practice.	Key Performance Indicator monitored monthly and report to executive level within the trajectory and mortality and serious incident management papers supplied to Board sub-committees.	Dashboard results supporting the Key Performance Indicator of submission of a quality investigation report within 60 working days. (15.2a)	30.06.16	Evidence obtained: Dashboard demonstrating to Trust's performance against submitting quality reports within 60 days (15.2a)

Mazars Recommendation Theme	Mazars Recommendations	Related Actions	Responsible Lead Central Support Services	Responsible Lead Divisional	Executive Accountability	Input Action Timescale	Action Progress Blue - Complete Green - On Track / Begun	Expected Outcome / Benefit	Progress Update	How will you evidence that the completion of the actions has led to the intended outcome	Timescale for measuring success	Intended Outcome Achieved Blue - Complete Green - On Track / Begun
		15.3a Create a register of Trust-wide Investigating Officers to ensure all have been trained and competency assessed by undertaking a minimum requirement of one investigation per annum. 15.3b Investigating Officer to receive post-panel feedback on the quality of their investigation report following Corporate Panel. 15.3c Investigation skills to be discussed within the appraisal with the line manager.	Helen Ludford, Associate Director of Quality Governance (15.3a & 15.3b)	Mandy Slaney, Lead IO AMH Eileen Morton, Lead IO AMH Georgie Townsend, Lead IO Childrens and Families Angela O Brien, Lead IO East ISD Jane Bray, Lead IO West ISD Nic Cicutti, Lead IO LD & TQ21 (15.3a and 15.3c - responsible for their own Division)	Julie Dawes, Head of Nursing (15.3a, 15.3b & 15.3c)	30.11.15	Evidence obtained: Trust-wide register of trained IO's which is maintained (15.3a) Corporate panel feedback sheet (15.3b) Appraisal paperwork (15.3c)	Trained and competent investigators will provide quality reports which will establish cause and themes for learning.	Feedback to be input into appraisals.	Quality investigations which stimulate learning to prevent reoccurrence. This will be evidenced in a reduction in the reoccurrence of themes over a 12 month period. (15.3a, 15.3b & 15.c)	31.12.16	Evidence required: Audit of serious incident investigations 12 months after IO's have been in post to ascertained that learning has taken place and themes have reduced (15.3a, 15.3b & 15.c)
		15.4a Develop a Divisional Lead Investigating Officers supervision session for case study learning from Panels and updates to National guidance.	Helen Ludford, Associate Director of Quality Governance (15.4a)	Mandy Slaney, Lead IO AMH Eileen Morton, Lead IO AMH Georgie Townsend, Lead IO Childrens and Families Angela O Brien, Lead IO East ISD Jane Bray, Lead IO West ISD Nic Cicutti, Lead IO LD & TQ21 (15.4a - responsible for their own Division)	Chris Gordon, COO and Director of Patient Safety (15.4a)	30.03.16	Evidence obtained: Schedule of IO supervision meetings (15.4a)	That lead investigators will be supported through clinical supervision sessions and changes to National guidance will cascade through the Trust this will ensure that a high level of quality is maintained and the Trust is recognised as a learning organisation.	Supervision meetings held every 2 weeks.	Continued increased quality of the investigation reports which adhere to national standards proven by audit. (15.4a)	31.12.16	Evidence required: Audit of serious incident investigations 12 months after IO's have been in post to ascertained that learning has taken place and themes have reduced (15.4a)
		15.5a Create a system of Divisional and Corporate Review Panels which assess each investigation report for quality and compliance to the Nationally set criteria. These panels will apply scrutiny and challenging to the findings of the investigation. 15.5b The Divisional Panel will be Chaired by a Senior Clinician. 15.5c The Corporate Panel will be chaired by an Executive Director. 15.5dThere will be fixed Terms of Reference in place for both levels of panel. These actions will facilitate a process of quality assurance which is separated from the investigating officer undertaking the investigation. The panels will be comprised of members who are not involved in the investigation. The panels will use the closure checklist extracted from the national framework document to judge quality compliance.	Helen Ludford, Associate Director of Quality Governance (15.5a, 15.5c & 15.5d)	Mary Kloer, Clinical Services Director AMH Mayura Deshpande, Clinical Services Director, Specialised Services Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Peter Hockey, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Jennifer Dolman, Clinical Services Director (LD & TQ21) Liz Taylor, Associate Director of Nursing (Childrens and Families) (15.5b - responsible for their own Division)	Chris Gordon, COO and Director of Patient Safety (15.5a, 15.5c & 15.5d) Mark Morgan, Divisional Director AMH, LD & TQ21 Gethin Hughes, (15.5b) Divisional Director OMPH In Patients (East ISD) (15.5b) Chris Ash, Divisional Director, West ISD and Childrens and Families (15.5b)	31.12.15	Evidence obtained: Serious Incident Management Policies and Procedures rewritten (15.5a) Death reporting Procedure (15.5a) Approved Chair list for all panels (15.5b) Corporate panel schedule with allocated Chairs (15.5c) Terms of Reference (15.5d)	That there is a consistent process independent to the investigation to review and sign off of quality reports which in turn facilitates learning and improvement by investigation reports having robust resulting actions. The complete process has executive oversight to assure that it is maintained.	Updated policies and procedures published. Panel schedules and Chair lists obtained.	Continued increased quality of the investigation reports which adhere to national standards proven by audit. (15.5a, 15.5b, 15.5c & 15.5d) Please note dates for measuring success are: 31.03.16 production of monthly dashboard monitoring tool 31.12.16 for 12 month audit	31.03.16 31.12.16	Evidence required: Dashboard of the percentage of reports approved by corporate panel on the first occasion, monthly collection of data. Audit of serious incident investigations 12 months after IO's have been in post to ascertain that quality has increased. (15.5a, 15.5b, 15.5c & 15.5d)
		15.6a All serious incident investigation reports to be subject to CCG lead closure panel scrutiny and challenge. This is an independent panel comprising of Quality Managers external to the Trust and representative of the commissioners. This is a framework stipulated independent quality assurance action. All Lead IO's to be present at the panel to assist with presenting cases.	Kay Wilkinson, SI an incident Manager (15.6a)	Mandy Slaney, Lead IO AMH Eileen Morton, Lead IO AMH Georgie Townsend, Lead IO Childrens and Families Angela O Brien, Lead IO East ISD Jane Bray, Lead IO West ISD Nic Cicutti, Lead IO LD & TQ21 (15.6a - responsible for their own Division)	Chris Gordon, COO and Director of Patient Safety (15.6a)	30.03.16	Evidence obtained: Minutes of CCG closure panels x 3 (15.6a)	That there is a consistent process independent to the investigation and SHFT to review and sign off of quality reports which in turn facilitates learning and improvement by investigation reports having robust resulting actions.	Closure panels scheduled for every two weeks. 21.07.16 Dashboard supporting the external closure panel not yet finalised. Further discussion with the CCG Quality Managers have taken place. 04.08.16 Outcome evidence overdue - have been unable to produce dashboard percentages of external closure due to the panels concentrating of the backlog clearance as of 1st August this data can be collected.	Continued increased quality of the investigation reports which adhere to national standards proven by audit. (15.6a) Please note timescale for measuring success is: 30.06.16 production of monthly dashboard monitoring tool 31.12.16 for 12 month audit	30.06.16 31.12.16	Evidence required: Dashboard of the percentage of reports approved by external closure panel on the first occasion, monthly collection of data. Audit of serious incident investigations 12 months after IO's have been in post to ascertain that quality has increased.(15.6a)
Timeliness of investigations	16. Reporting to StEIS should be undertaken within the 2 working days of notification as required by the national guidance.	16.1a Serious Incidents will be recorded on StEIS within 2 working days of the occurrence being reported on the Safeguard Ulysses system as specified by the National Framework by the SI and Incident Team. 16.1b The 48 hr panels at Divisional Level will decided on the level of investigation required to support the prompt reporting and this will be documented on the Safeguard Ulysses system.	Kay Wilkinson, SI and Incident Manager Mandy Rogers, SI Officer Lee Rockingham, SI Officer (16.1a - joint responsibility)	Mary Kloer, Clinical Services Director AMH Mayura Deshpande, Clinical Services Director, Specialised Services Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Peter Hockey, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Jennifer Dolman, Clinical Services Director (LD & TQ21) Liz Taylor, Associate Director of Nursing, Childrens and Families (16.1b - responsible for their Division)	Chris Gordon, COO and Director of Patient Safety (16.1a) Mark Morgan, Divisional Director AMH, LD & TQ21 Gethin Hughes, (16.1b) Divisional Director OMPH In Patients (East ISD) (16.1b) Chris Ash, Divisional Director, West ISD and Childrens and Families (16.1b)	30.06.16	Evidence obtained: Serious Incident Management Policies and Procedures rewritten (16.1a) Dashboard monitoring reporting to StEIS within 48 hrs (16.1a) 48 hour panel process (16.1b)	Prompt notification of SI's will aid the prompt commencement of an investigation . This will lead to timely information being gathered regarding causes and an opportunity for earlier patient safety recognition by discussing the immediate patient safety actions which require attention.	31.05.16 48% compliance to 48 hr reporting onto StEIS 21.07.16 47% compliance to 48 hr reporting onto StEIS (16.1a) 69% compliance to 48 hr panels being held within 48 hrs (16.1b) 04.08.16 31% (5/16) compliance to 48 hr reporting onto StEIS (16.1a) 04.08.16 84% compliant to the mortality panels being held in 48 hours, should by 95%	Timescale calculation - percentage of SI's reported on to StEIS within 48 hrs of reporting to be presented as a Key Performance Indicator on the dashboard. Please note that the timescale for measuring success is: (16.1a) 31.03.16 (16.1b) 30.06.16	31.03.16 30.06.16	Evidence required: 85% compliance to reporting to StEIS within 48 hrs - dashboard (16.1a) Compliance to 48 hr panels being held within 48 hrs (16.1b)
Timeliness of Investigations	17. There should be more explicit action to commence investigations promptly even when a coroner conclusion is not immediately available unless there is a specific reason to delay; any delay should have senior sign off.	17.1a The SHFT Procedure for Reporting and Investigating Deaths will stipulate that there is no delay in commencing an investigation whilst waiting for a Coroner decision on cause of death. Each death will reviewed as an individual case and the decision to investigate and at what level of investigation will be made on the clinical presentation. Each 48 hour panel Chair will be made aware of this requirement.	Kay Wilkinson, SI and Incident Manager (17.1a)	Mary Kloer, Clinical Services Director AMH Mayura Deshpande, Clinical Services Director, Specialised Services Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Peter Hockey, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Jennifer Dolman, Clinical Services Director (LD & TQ21) Liz Taylor, Associate Director of Nursing, Childrens and Families (17.1a - responsible for their own Division)	Chris Gordon, COO and Director of Patient Safety (17.1a)	31.01.16	Evidence obtained: Serious Incident Management Policies and Procedures rewritten (17.1a)	That the judgement of the 48 hr panel to investigate at death will not be dependent on the Coroners findings which may delay an investigation causing a potential loss of an opportunity for learning and improvement due to time delays.	21.07.16 Dashboard in place monitoring of monthly percentage of achievement against the 48 hour target. (17.1a)	6 monthly audit of reasons for delays in reporting to StEIS should show a reduction in cases where an investigation has only commenced after a Coroners ruling. (17.1a) Please note that the timescale for measuring success is: 30.03.16 for dashboard monitoring 31.08.16 for initial audit results	30.03.16 31.08.16	Evidence required: Dashboard monitoring of monthly percentage of achievement against the 48 hour target. (17.1a) Audit of delays in reporting to StEIS will show that no serious incident investigation has waited for a Coroners ruling, the decision has been made earlier. (17.1a)
Involvement of Families	18. The involvement of families in investigations requires improvement. In particular, improvements are needed in: a. developing clear guidelines for staff, including expected timescales and core standards, which recognise the need for iterative engagement when the family is ready (18.1a, 18.2a, 18.5a) b. ensuring that the investigation process is clearly defined and separate from the support and assistance offered by local treatment teams (18.3a, 18.4a, 18.5a) c. the Trust should ensure that investigators talk to families as early as possible in the process to identify any concerns and take these into account in the ensuing investigation (18.1a, 18.3a, 18.3b) d. provide reports to coroners in time for inquests (18.2a and also links to 17.1a) e. explicitly demonstrating why families are not involved (18.6a) f. identifying next of kin details for all service users as part of a core assessment including where consent to share has not been provided to enable investigators to find relatives more easily. (18.9a) g. working with primary care to identify family members (18.9b) h. where the Trust delays the commencement of an investigation due to inquests or other investigations this should be made explicit to families and the reasons explained. (18.2a) i. the performance of divisions in involving families and securing feedback (18.6a)	18.1a Process to be developed (and included in first revision of new Death reporting procedure) which formally invites any concerns from families to be raised following a death that meets the criteria set out in the new procedure and advises families as to whether an investigation will take place. (this will be over and above the actions already required by Trust policy when it is clear from the outset that the death constitutes a SIRI and Duty of Candour is engaged as well as the requirement to invite families to participate in the investigation) The Duty of Candour policy includes a flowchart for the involvement of families and points of communication. This is over and above the legal requirements of Duty of Candour and meets the requirements of the CQC regulation 20 dealing with the important factor of the involvement of families and lived ones. The Death Reporting procedure includes a guidance section specific to the involvement of families and the communication which should take place and differing points. 18.2a the Serious Incident policy and procedure specifies timescales for investigations and the sharing of reports with Coroners. There should no longer be any reason why an investigation should be delayed until an inquest is heard. It is now the approach of the trust that when required an investigation will run in tandem with police investigation unless otherwise instructed by the police and this will be explained to the family by the Investigating Officer / FLO.	Briony Cooper, Head of Quality Contracts and Quality Reporting Sarah Pearson, Head of Legal and insurance Services (18.1a - joint responsibility)	Mary Kloer, Clinical Services Director AMH Mayura Deshpande, Clinical Services Director, Specialised Services Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) Peter Hockey, Clinical Services Director (West ISD) Juanita Pascal, Clinical Services Director (North ISD) Jennifer Dolman, Clinical Services Director (LD & TQ21) (18.1a - responsible for their own Division)	Julie Dawes, Director of Nursing (18.1a)	31.07.16	Evidence required: Rewritten Duty of Candour policy inclusive of flowcharts (18.1a) Death reporting Procedure (18.1a)	That families will be involved, where appropriate and where they want to engage in the investigation process which will support an outcome that the investigations are conduct in an open and transparent way which leads to honesty as to any act or omission in treatment. The FLO will ensure that the families feel supported and that their voices are heard. Families will be encouraged to be a participant in service improvement to prevent recurrence of what act or omission in care their loved one may have experienced. The further information which families provide will assist the investigation and provide the trust with a greater understanding of what went wrong.	External review commissioned. SHFT has commissioned an external appreciative enquiry into the experience of families in the investigation process over the last 2 years as this has been deemed as extremely important for guiding improvement activities.	The external review into the quality of the experience of Duty of Candour and the involvement of families in SIRI investigations will provide information which will be reviewed by the Trust. There is an expectation that the Trust has improved in this area however the report will be analysed and improvement actions applied as required. (18.1a) To be completed and reported by 30.09.16	30.09.16	Evidence required: Report from externally commissioned thematic review.(18.1a) Internal thematic review of Serious Incidents will prove that families have been included in 100% of investigations where appropriate and they wish to be involved (18.1a) 3 x example of serious incident investigation reports where families have been involved in the investigation and received the report (18.1a, 18.2a) SIOAC minutes where case studies have been presented to show the involvement of families and the provide a richness of information to the investigation (18.1a, 18.1b)
		18.2a Duty of Candour policy to be reviewed and rewritten to be specific about the involvement of families in investigations in an open and transparent manner. Non-family members will also be considered within this policy as will the involvement of other important others such as care staff.	Briony Cooper, Head of Quality Contracts and Quality Reporting Sarah Pearson, Head of Legal and insurance Services (18.2a - joint responsibility)	N/A	Julie Dawes, Director of Nursing (18.2a)	31.07.16	Evidence required: Rewritten Duty of Candour policy inclusive of flowcharts (18.2a) Death reporting Procedure (18.2a)	That staff are confident about families participating in the investigation process through guidance and support provided by the procedure documents and the team who contactable through details supplied on the documents.	Policy refreshed and published 3 June 2016 External review commissioned. Monthly validation audit.	The external review into the quality of the experience of Duty of Candour and the involvement of families in SIRI investigations will provide information which will be reviewed by the Trust. There is an expectation that the Trust has improved in this area however the report will be analysed and improvement actions applied as required. (18.2a) To be completed and reported by 30.09.16 The monthly DoC audit will supply information as to the quality of the recording of DoC related activities on the Ulysses system. (18.2a)	30.09.16	Evidence required: Report from externally commissioned thematic review.(18.2a) Monthly report from the validation of the DoC information. (18.2a) Internal thematic review of Serious Incidents will prove that families have been included in 100% of investigations where appropriate and they wish to be involved (18.1a)

Mazars Recommendation Theme	Mazars Recommendations	Related Actions	Responsible Lead Central Support Services	Responsible Lead Divisional	Executive Accountability	Input Action Timescale	Action Progress Blue - Complete Green - On Track / Begun	Expected Outcome / Benefit	Progress Update	How will you evidence that the completion of the actions has led to the intended outcome	Timescale for measuring success	Intended Outcome Achieved Blue - Complete Green - On Track / Begun
		18.3a Role description for the Lead Investigator (centralised team) to include the specific role of oversight of communication and involvement of families. Investigation officers training involves a continuous golden thread through out the two day course about involving families: how to involve them, how to communication with them, how to record the communication and how to feedback to report to them. 18.3b There is a responsibility of the Divisional 48 hour panel to discuss Duty of Candour and involvement of families to ensure that there is a contact plan defined. 18.3c Scope the role, create a job description and recruit a Family Liaison Officer to directly liaise with families regarding their involvement in investigations, the questions which they would like addressing and to support the process through an agreed and structured communications plan. This role will predominantly support the families but will also support the 48 hour panels and the investigating officers. (action added 04.08.16 therefore input achievement timescale extended until 31.10.16)	Helen Ludford, Associate Director of Quality Governance (18.3a and 18.3b)	Mandy Slaney, Lead IO AMH Eileen Morton, Lead IO AMH Georgie Townsend, Lead IO Childrens and Families Angela O Brien, Lead IO East ISD Jane Bray, Lead IO West ISD Nic Ciuotti, Lead IO LD & TQ21 (18.3a and 18.3b)	Chris Gordon, COO and Director of Patient Safety (18.3a and 18.3b)	31.10.16	Evidence obtained: Lead Investigator Role Description (18.3a and 18.3b) Recruitment of FLO (18.3c)	That families will be involved, where appropriate and where they want to engage in the investigation process which will support an outcome that the investigations are conduct in an open and transparent way which leads to honesty as to any act or omission in treatment. The FLO will ensure that the families feel supported and that their voices are heard.	External review commissioned. Monitoring through Corporate panel that the DoC requirements have been completed and families where appropriate have been involved in the investigations.	The external review into the quality of the experience of Duty of Candour and the involvement of families in SIRI investigations will provide information which will be reviewed by the Trust. There is an expectation that the Trust has improved in this area however the report will be analysed and improvement actions applied as required. To be completed and reported by 30.09.16. (18.3b) The corporate panel process ensures that the DoC has been achieved where possible for each individual case and this is recorded on the panel checklist. (18.3b)	30.09.16	Evidence required: Report from externally commissioned thematic review.(18.3b) Corporate panel checklist, random selection of 10 records (18.3b) Internal thematic review of Serious Incidents will prove that families have been included in 100% of investigations where appropriate and they wish to be involved (18.3c)
		18.4a Leaflet to be created which explains the Duty of Candour requirements and how families are welcomed to be involved in investigations to service users / patients / staff / next of kin.	Briony Cooper, Head of Quality Contracts and Quality Reporting Sarah Pearson, Head of Legal and insurance Services (18.4a)	N/A	Chris Gordon, COO and Director of Patient Safety (18.4a)	31.03.16	Evidence obtained: Duty of Candour Leaflet (18.4a)	The families will be informed of the investigation process both verbally and in writing. A leaflet has been provided to this effect explain what the DoC is and introducing contacts for the investigation. This will assure that families and patients feel better informed and are involved where it is appropriate and they wish to be.	External review commissioned. Leaflet approved through committee for imminent launch in the Trust (at printers). 04.08.16 Leaflet now available to all services	The external review into the quality of the experience of Duty of Candour and the involvement of families in SIRI investigations will provide information which will be reviewed by the Trust. There is an expectation that the Trust has improved in this area however the report will be analysis and improvement actions applied as required. To be completed and reported by 30.09.16 (18.4a) The monthly DoC audit will supply information as to the quality of the recording of DoC related activities on the Ulysses system. (18.4a) Internal thematic review of Serious Incidents will prove that families have been included in 100% of investigations where appropriate and they wish to be involved (18.4a)	30.09.16	Evidence required: Report from externally commissioned thematic review.(18.4a) Monthly report from the validation of the DoC information. (18.4a) Internal thematic review of Serious Incidents will prove that families have been included in 100% of investigations where appropriate and they wish to be involved (18.4a)
		18.5a The Trust will seek to engage lay people, families and service users to oversee the development of documents in relation to Duty of Candour and the investigation processes. This will ensure that the documents - policies, procedures and leaflets are written to easily understood by all parties and process followed.	Emma McKinney, Associate Director of Communications Chris Woodfline, Head of Patient Engagement and Experience (18.5a - joint responsibility)	N/A	Lesley Stevens, Medical Director (18.5a)	31.03.16	Evidence obtained: Role descriptions for lay persons (18.5a)	True lay person involvement in the development of processes to ensure that they engage families in investigations and that contacts are specifically recorded. This support true partnership working.	Role description advertised for the MWG. 21.07.16 Lay person recruited to join the MWG. Healthwatch have agreed to have input into the SIOAC. Outcome will remain overdue until the evidence of this engagement is documented in the minutes. 04.08.16 - Evidence outcome remains red as lay person is yet to attend 3 x MWG but will join the meeting on 02.09.16 following DBS and reference checks 30.08.16 Recovery plan for action 18.5a submitted to SIOAC and action timescale approved for change - reset at 31.11.16 to allow for 3 sets of minutes following the meetings	Evidence of lay involvement in the ratification of policy and procedures through clear documentation of the ratification groups. To be overseen by the patient engagement and experience workstream. (18.5a)	30.11.16	Evidence required: Minutes of SIOAC x 3 (18.5a) Minutes of MWG x 3 (18.5a)
		18.6a Ulysses Safeguard screens to be further developed to map the Duty of Candour and family involvement and to record full compliance with each stage. This information will include why families are not involved. Audit of data capture will be used as an evidence base for assuring family involvement or reviewing cases where it has not been appropriate to facilitate involvement. This will be reported back to the different divisions as a performance check.	Thomas Williams, Ulysses Systems Developer (18.6a)	N/A	Chris Gordon, COO and Director of Patient Safety (18.6a)	30.06.16	Evidence obtained: Screenshot of DoC capture screens on Ulysses (18.6a) Guide to use (18.6a)	Assurance that families are involved where possible and correct in the investigations and to what level. There feel supported, able to ask questions and that they are receiving honest and open answers.	Monthly validation audit in place but requires review to add additional questions.	Monthly audit to ascertain that the Duty of Candour is being undertaken and there is documentation to support this. (18.6a) The Corporate Panel checklist will ensure that the correct level of engagement where appropriate has taken place and that this is documented on a case by case basis for serious incidents. There is an expectation that the Trust will achieve 100% compliance undertaking DoC requirements as per Regulation 20 CQC and that this is clearly documented. Internal thematic review of Serious Incidents will prove that families have been included in 100% of investigations where appropriate and they wish to be involved (18.6a)	30.09.16	Evidence required: Monthly report from the validation of the DoC information. (18.6a) Corporate panel checklist, random selection of 10 records (18.6a) Internal thematic review of Serious Incidents will prove that families have been included in 100% of investigations where appropriate and they wish to be involved (18.6a)
		18.7a Data from Ulysses Safeguard to be used to report the Duty of Candour and regulation 20 (CQC) compliance to Commissioners via CQRM process. This will include the involvement of families in investigations which is over and above what is required by the regulations.	Briony Cooper, Head of Quality Contracts and Quality Reporting (18.7a)	N/A	Chris Gordon, COO and Director of Patient Safety (18.7a)	31.03.16	Evidence obtained: Monthly report from the validation of the DoC information. (18.7a)	Assurance for CCGs that SHFT is fulfilling the Duty of Candour requirement correctly therefore has robust information to support that conversation and the appropriate level of correspondence has been sent to patient and families. The Trust has been open and honest and said sorry for and acts or omissions in its care which has led to patient harm.	Monthly validation audit in place but requires review to add additional questions.	Monthly audit to ascertain that the Duty of Candour is being undertaken and there is documentation to support this. The Corporate Panel checklist will ensure that the correct level of engagement where appropriate has taken place and that this is documented on a case by case basis for serious incidents. There is an expectation that the Trust will achieve 100% compliance undertaking DoC requirements as per Regulation 20 CQC and that this is clearly documented and reported externally to commissioners. (18.7a)	30.09.16	Evidence required: Achievement of 100% on the monthly report from the validation of the DoC information. (18.7a)
		18.8a Commission an external review of the current quality of the experience of the involvement of families in SIRI investigations over a 2 year period. The Review will use a mixture of Appreciative Inquiry and Experience Based Design methodology to understand the experience for staff, families, carers, patients and service users involved in SIRI investigations in the mental health and learning disability directorate. The review will provide recommendations to improve the experience of investigations for families and staff and to achieve an excellence standard of engagement.	Lesley Stevens, Medical Director (18.8a - commissioner) Helen Ludford, Associate Director of Quality Governance (18.8a - data contact)	N/A	Lesley Stevens, Medical Director (18.8a)	31.05.16	Evidence obtained: Commissioning agreement / scoping document. (18.8a)	Independent findings of an external review into family involvement will provide information which supports practice improvements actions that the trust can make going forwards. The enquiry is over a 2 year period and it is anticipated that improvement will be seen during the last 6 months of the investigations reviewed.	External review commissioned and underway	The external review into the quality of the experience of Duty of Candour and the involvement of families in SIRI investigations will provide information which will be reviewed by the Trust. There is an expectation that the Trust has improved in this area however the report will be analysed and improvement actions applied as required. To be completed and reported by 31.10.16 (18.8a)	30.09.16	Evidence required: Report from externally commissioned thematic review.(18.8a)
		18.9a The electronic patient records where possible and at the consent of the patient or service user will contain up to date next of kin contact details and there is an information sharing agreement in place. These should be checked at each appointment. This facilitates the correct contact in the case of an emergency. 18.9b In instances where there is no recorded next of kin detail the investigation should approach other agencies to assist such as the Coroners officer or GP however they have no obligation to share. Please note - in death, there is a legal challenge that patient / service user confidentiality no longer applies in the absence of a sharing agreement however the nature of the death and the information within the investigations should be reviewed for appropriate sharing and the approach should be discussed with the Coroner. Families my still participate in the investigation and be supported to pose their specific questions. New action as of 04.08.16	Paula Hull, Associate Director of Nursing responsible for record keeping (18.9a) Simon Beaumont, Head of Informatics (18.9a - compliance monitoring)	Sara Courtney, Associate Director of Nursing East ISD Paula Hull, Associate Director of Nursing West ISD John Stagg, Associate Director of Nursing, LD TQ21 Carol Adcock, Associate Director of Nursing, AMH Nicky Bennet, Associate Director of Nursing, Specialised Services Liz Taylor, Associate Director of Nursing, Childrens and Families	Julie Dawes, Director of Nursing (18.2a)	31.10.16	Evidence required: Record keeping procedure stipulating the responsibility (18.9a) Serious Incident procedure (18.b)	Where possible up to date next of kin details should be available and a sharing agreement in place. This enables early contact with family members to support involvement in any investigation. Families will feel involved and that they have a voice.	04.08.16 New action to address the lack of next of kin details for some patient / service users.	An informatics report will provide a base of line of recorded next of kin details which can be improved through a targeted unit based communications and monitoring supported by the record keeping group.	31.10.16	Evidence required: Informatics report showing that 80% of patient records have a next of kin listed (18.9a) Serious incident investigation report where next of kin details have been obtained through an alternative means (18.9b)
Multi-agency working	19. The Trust Board should seek co-operation with other providers and commissioners to agree a framework for investigations in preparation for future incidents regarding escalation. Divisions should then apply this framework where the incident report suggests another organisation should review or investigate the circumstances of a death.	19.1a As part of a wider stakeholder group comprising of CCGs, Acute Trust and the Local Authority create a process framework for undertaking multi-agency Serious Incident investigations. The issue regarding differences between the health and social care investigation frameworks should also be clearly defined. This group is being lead by the CCG. When this process is defined it will be adopted into the SHFT Serious Incident management policies. Whilst the process is being clearly defined by the CCG there is in place an interim process of communication with the CCG when another provider fails to engage with SHFT in a joint investigation.	Helen Ludford, Associate Director of Quality Governance (19.1a)	N/A	Chris Gordon, COO and Director of Patient Safety (19.1a)	30.06.16	Evidence obtained: Agenda and minutes related CCG lead meetings to define the process for multi-agency investigations (19.1a)	That the deaths of those individuals who cross services will be investigated only once by a multi provider team thus providing a comprehensive report for families and other parties such as the Coroner.	Engagement with WHCCG who are leading on the development of a protocol. Temporary agreement in place where SHFT can request assistance from the CCG if it is believed that a multi provider investigation is necessary but other parties will not engage. 04.08.16 (19.1a) Audit has not yet been completed and is featuring as part of the thematic review to be published 30.09.16 although the evidence outcome is red the thematic review is underway and will provide a more detail review than a pure audit. (19.1a) Example of a multi-agency investigation has been sourced. 30.08.16 Recovery plan for action 19.1a submitted to SIOAC and action timescale approved for change - reset at 30.09.16 as the audit will complete at this time	Quarterly report which stipulates which Serious Incident investigation have had multi provider which is shared with the CCGs. It is anticipated that SHFT will always respond to a request to be involved in a multi provider investigation and will be able to document this through audit. (19.1a)	31.09.16	Evidence required: Audit of Q1 SI's stipulating which have been multi agency focused (19.1a) Example of a multi-agency investigation in which SHFT have participated or led (19.1a)

Mazars Recommendation Theme	Mazars Recommendations	Related Actions	Responsible Lead Central Support Services	Responsible Lead Divisional	Executive Accountability	Input Action Timescale	Action Progress Blue - Complete Green - On Track / Begun	Expected Outcome / Benefit	Progress Update	How will you evidence that the completion of the actions has led to the intended outcome	Timescale for measuring success	Intended Outcome Achieved Blue - Complete Green - On Track / Begun
Deaths in detention and inpatient deaths	20. The Trust should retain a contemporaneous list of all inpatient deaths mapped to Mental Health Act status to enable Trust-wide oversight of all inpatient deaths and deaths in detention.	20.1a A Ulysses Safeguard / Tableau extraction report to be written to provide a quarterly report of all deaths in detention under the Mental Health Act. Report to be validated by the Senior Clinical Chairs of the 48 hr mortality review panels to ensure that the system information capture is correct and all deaths of this type have been reported as Serious Incidents. 20.1b SHFT will follow the Coroners documented and published guidance into investigating 'deaths in custody'.	Simon Beaumont, Head of Informatics Thomas Williams, Ulysses Systems Developer (20.1 a - joint responsibility) Kay Wilkinson, SI and Incident Manager (20.1b)	Mary Kloer, Clinical Services Director AMH Mayura Deshpande, Clinical Services Director, Specialised Services Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) (20.1a and 20.1b - each responsible for their own Divisions)	Mark Morgan, Divisional Director AMH, LD & TQ21 Gethin Hughes, Divisional Director OMPH In Patients (East ISD) (20.1a and 20.1b - each accountable for their own Divisions)	30.06.16	Evidence obtained: Serious Incident Management Policies and Procedures rewritten (20.1a and 20.1b)	That all deaths of those under detention will be investigated for learning and compliance to the National Framework.	Flag' for in detention present within the Ulysses Safeguard system. Tableau extraction report to be created.	Quarterly report which provides audit information stipulating that each death in detention has been reported as an Serious Incident and investigated. (20.1a and 20.1b)	31.08.16	Evidence required: Ulysses extraction report proving that all inpatient deaths of those under a section have been investigated as a Serious Incident. (20.1a and 20.1b)
Deaths in detention and inpatient deaths	21. All deaths of service users in detention should be investigated, whether expected or not. These investigations should occur regardless of inquest conclusions. This will give assurance that the 24/7 nature of the care required has been of the highest standard. Specific issues addressed in the Terms of Reference for these investigations should include: a. to ensure that physical health care symptoms are not dismissed where challenging behaviour presents; b. that delays in seeking physical health care are not apparent; c. that service users are fully aware of decisions regarding whether to treat or investigate chronic or acute symptoms and that these are made in an informed manner; d. that access to full care and treatment is not restricted in any way; e. that staff are adequately supported to provide physical health care and trained to do so.	21.1a The death of a service user under detention must be investigated as per the Serious Incident Framework 2015. A 'flag' will be apparent on the Ulysses Safeguard risk management system which will trigger a decision to investigate at the 48 hr panel by the panel Chair. This process will be supported by SHFT Death reporting process where it is specific that all deaths of detained patients are reported and investigated as a Serious Incident. Terms of Reference for the investigation will be constructed on a case by case basis but will include a review of both of the mental health and physical health care which has been provided to a service user or patients. In situations where SHFT may not be the main provider of physical health care the opinions of that provider will be sought, if engagement in the investigation cannot be gained this will be reported to the CCG commissioners. This may be the case is a patient is transferred from SHFT inpatient services to an acute trust for physical health care needs but remains under a section of the mental health act. Terms of reference will also be constructed to address the specifics of the recommendation listed in a, b, c, d and e.	Helen Ludford, Associate Director of Quality Governance Kay Wilkinson, SI and Incident Manager (21.1a)	Mary Kloer, Clinical Services Director AMH Mayura Deshpande, Clinical Services Director, Specialised Services Sarah Constantine, Clinical Service Director OMPH In Patients (East ISD) (21.1a - each responsible for their own Divisions)	Mark Morgan, Divisional Director AMH, LD & TQ21 Gethin Hughes, Divisional Director OMPH In Patients (East ISD) (21.1a - each accountable for their own Divisions)	30.03.16	Evidence obtained: Serious Incident Management Policies and Procedures rewritten (21.1a)	That all deaths of those under detention will be investigated for learning and compliance to the National Framework.	Flag' for in detention present within the Ulysses Safeguard system. Tableau extraction report to be created.	Quarterly report which provides audit information stipulating that each death in detention has been reported as an Serious Incident and investigated. (21.1a)	31.08.16	Evidence required: Ulysses extraction report proving that all inpatient deaths of those under a section have been investigated as a Serious Incident. (21.1a)
		21.2a Review the content of the five day physical health course which LEaD provide and ensure that there is the correct percentages of staff attending from each service. Course content and learning outcomes which will be reviewed. 21.2b Attendance data recorded per service.	Mayura Deshpande, Associate Medical Director, Patient Safety and all Clinical Service Directors Jane Hazelgrove, Director of Education (21.2a and 21.2b - joint responsibility)	Carol Adcock, Associate Director of Nursing AMH Mary Kloer, Clinical Services Director AMH Kate Brooker, Associate Director AMH Sarah Constantine (OPMH) (21.2a and 21.2b - responsible for own Divisions)	Mark Morgan, Divisional Director AMH, LD & TQ21 Julie Dawes, Director of Nursing and Allied Health Professionals (21.2a and 21.2b - joint accountability)	31.07.16	Evidence required: Review of course content and learning outcomes (21.2a) Attendance records by service by team (21.2b)	All AMH services will have staff who are competent in managing physical health care needs of the individual service users. Reduction in the rate of physical health management featuring as a contributory factor in SI investigation reports.	21.2a Course content currently being reviewed by the ADoNs from AMH and a LEaD representative. Additional options being scoped alongside the 5 day course. Alternatives are physical health specialist subject sessions and e learning. Subject matter inclusive of diabetes and respiratory. 21.2b Training records being obtained by Louise Hartland LEaD. 04.08.16 Input evidence request made for information - meeting was held with ADoNs to discuss e learning and shorter course options	Divisional and service level training records to that staff have been trained. (21.2b) Achieve of 90% compliance to clinical audit of physical health needs. (21.2a) Physical health audit to be undertaken in Q3. Audit of SI contributory factors to be undertaken in Q2. (21.2a) Please note the timescales for measuring success are: 31.12.16 for Q3 audit and training records 30.09.16 for SI Q2 audit	31.12.16 30.09.16	Evidence required: Results of Q3 physical health audit (21.2a) Attendance records by service by team (21.2b) SI contributory factors audit for Q2 (21.2a)
		21.3a As part of service redesign, ensure that integrated teams contain physical expertise as part of the staffing component.	Mayura Deshpande, Associate Medical Director, Patient Safety and all Clinical Service Directors Jane Hazelgrove, Director of Education (21.3a - joint responsibility)	Carol Adcock, Associate Director of Nursing AMH Mary Kloer, Clinical Services Director AMH Kate Brooker, Associate Director AMH Sarah Constantine (OPMH) (21.3a - responsible for own Divisions)	Mark Morgan, Divisional Director AMH, LD & TQ21 Julie Dawes, Director of Nursing and Allied Health Professionals (21.3a - joint accountability)	31.07.16	Evidence required: Service redesign plans to include physical health nursing staff in a mental health setting (21.3a)	All AMH services will have staff who are competent in managing physical health care needs of the individual service users. As a result of this action there will be a reduction in the rate of physical health management featuring as a contributory factor in SI investigation reports.	HR are involved in the recruitment of general registered nurses for all of the MH inpatient units. This activity is being supported by the ADoNs. 04.08.16 Input evidence request made - verbal update provided that all MH units are advertising RN positions as part of their staffing review.	Divisional and service level training records to that staff have been trained. Achieve of 90% compliance to clinical audit of physical health needs. Physical health audit to be undertaken in Q3. Audit of SI contributory factors to be undertaken in Q2. (21.3a) Please note the timescales for measuring success are: 31.12.16 for Q3 audit and training records 30.09.16 for SI Q2 audit	31.12.16 30.09.16	Evidence required: Results of Q3 physical health audit (21.3a) Attendance records by service by team (21.3a) SI contributory factors audit for Q2 (21.3a)
		21.4a A clinical audit to be undertaken within Q3 of 2016/17 to evidence that physical health needs of mental health and learning disability patients are being met.	Mayura Deshpande, Associate Medical Director, Patient Safety and all Clinical Service Directors Helen Algar, Clinical Audit Facilitator (21.4a - joint responsibility)	Carol Adcock, Associate Director of Nursing AMH Mary Kloer, Clinical Services Director AMH Kate Brooker, Associate Director AMH Jennifer Dolman, Clinical Services Director LD John Stagg, Associate Director of Nursing LD (21.4a - responsible for own Divisions)	Mark Morgan, Divisional Director AMH, LD & TQ21 Julie Dawes, Director of Nursing and Allied Health Professionals (21.4a - joint accountability)	31.11.16	Evidence required: Physical audit proforma (21.4a)	This action will create a focus on physical health care which will lead to better standards being delivered.	Audit scheduled for Q3	90% to be achieved through clinical audit of physical health needs to provide assurance that the Trust is providing the correct level of physical health care by skilled doctors and nurses. (21.4a)	31.12.16	Evidence required: Results of Q3 physical health audit (21.4a)
Information management	22. The Trust should develop an agreed RiO extract and Ulysses reporting protocol to capture all deaths of Adult Mental Health, Older People Mental Health and Learning Disability service users including community and inpatient locations to form the basis of future mortality review.	22.1a Tableau based reports to be devised by informatics team which extract data from the Ulysses system. The content of this reports will be incident / mortality data extracted from Ulysses triangulated with the mortality data which is extracted from the National Spine. This will ensure that the Mortality Meetings have knowledge of all service users and patients who are on an active caseload and have died.	Simon Beaumont, Head of Informatics Thomas Williams, Ulysses Systems Developer (22.1a - joint responsibility)	N/A	Chris Gordon, COO and Director of Patient Safety Paula Anderson, Chief Finance Officer (22.1a - joint accountability)	30.03.16	Evidence obtained: Tableau based mortality reports (22.1a)	The complete dataset of mortality information and incidents is easily accessible through the Tableau system for use within the Mortality Meetings.	Tableau reports available	High quality correct data which informs the Mortality Meeting evidenced through the minutes on SharePoint. This is to ensure that all deaths are know to the Trust and that the procedure is applied with the outcome being that all deaths which need to be investigated are investigated. This will be evidenced through the Mortality Meeting minutes. (22.1a)	30.09.16	Evidence required: Minutes of the mortality meetings x 3 ALL DIVISIONS (22.1a) Observed attendance at the mortality meetings (22.1a)
Information management	23. The spreadsheet arrangement currently in place in TQ21 is insufficient to monitor deaths at corporate level as part of the whole Learning Disability service provision. TQ21 service users should be incorporated into Trust administration systems in a way which ensures their deaths are captured for reporting and investigation purposes.	23.1a Devise and replace the current process in TQ21 with a more robust and complete process agreed by all parties. Report solution to the Mortality Working Group. TQ21 is a social care provider does not have a 'patient administration system' which can be triangulated against the National Spine data. Case load NHS numbers should be investigated as a solution.	Simon Beaumont, Head of Informatics (23.1a)	Carol Cleary, Head of Service TQ21 Jennifer Dolman, Clinical Service Director (LD & TQ21) Debbie Robinson, Associate Director TQ21 (23.1a - joint responsibility)	Mark Morgan, Divisional Director AMH, LD & TQ21 Paula Anderson, Chief Finance Officer (23.1a - joint accountability)	30.06.16	Evidence required: Process for TQ21 to be inserted into the Death reporting Procedure at the next review (23.1a)	The complete dataset of mortality information and incidents is easily accessible through the Tableau system and compared to the TQ21 caseload by matching against NHS numbers.	In discussion re process 21.07.16 Raised at the Quality Oversight Committee for discussion. Questions posed as to how mortality monitoring especially around the 12 months post discharge information is managed by other social care providers. 04.08.16 Discussed at MWG process now in place	High quality correct data which informs the Mortality Meeting evidenced through the minutes on SharePoint. This is to ensure that all deaths are know to the Trust and that the procedure is applied with the outcome being that all deaths which need to be investigated are investigated. This will be evidenced through the Mortality Meeting minutes. (23.1a)	30.09.16	Evidence required: Minutes of the mortality meetings x 3 TQ21 (23.1a) Observed attendance at the mortality meeting (23.1a)