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## Action Plan

The below action plan was developed by Oxford Health NHS Foundation Trust following our Serious Incident Investigation and was added to following the outcome of the external investigation commissioned by NHS England and NHS Improvement.

|  | **Recommendation** | **Action(s)** | **Person responsible for implementation** | **Date for Completion** |
| --- | --- | --- | --- | --- |
| 1 | Carry out a strategic review of the Think Family Approach to include how Think Family fits with safeguarding and carer involvement. | 1. A working group is planned across all directorates to take a strategic overview of all ‘Think family ‘work | Lead Nurse for Children’s’ Safeguarding  and  Deputy Director of Nursing, Mental Health Services | 31st December 2019  COMPLETED |
| 1. Additional prompts on Care notes to alert clinicians to the presence of children in a household where an adult has an enduring mental health illness. | Clinical Director, Oxfordshire and BSW Mental Health Directorate | 30th June 2020  COMPLETED |
| 1. Within the Trust a ‘Clinical Portal’ is to be developed which will allow clinicians to view patient records from Mental Health Carenotes, Community Health Carenotes and Adastra, using a solution called Graphnet which is due to go live mid-2020. All these will contain alerts where a vulnerable child or adult is recorded in Carenotes   The above action was strengthened following the outcome of the independent Serious Care Review in March 2020;  d) Develop a shared care record with partner agencies covering GPs, acute NHS Trusts, community services, mental health services and social care services. | Director of Strategy & Chief Information Officer | Combined c) and d).  30th September 2020  COMPLETED – however the Oxfordshire record was delayed in being implemented.  A shared care record was introduced across partners in Buckinghamshire in May 2020 and across Oxfordshire in June 2022. |
| 2 | Opportunities to obtain additional information from families, carers and others to inform assessment, particularly where a child is involved should be discussed in all multidisciplinary meetings.  Practice should shift to a standard that such information is part of all assessments unless there are clear reasons as to why it is not appropriate.  Mechanisms for associated documentation should be established. | 1. SBARD process to be developed for Multi-Disciplinary Team meetings including key questions:  * PRE-assessment: * Is there opportunity to gather additional information from families or carers? * Do we need to gather additional information? * Who is responsible? * POST assessment: * Was additional information gathered? * What did it add? | Adult Mental Health Assessment & Treatment Team Manager | 28th February 2020  COMPLETED |
| 1. Trust audits to include sharing of information and communications with families/ carers and bi-annual results shared through Quality Safety Sub-Committee to Trust Board | Deputy Director of Nursing, Mental Health Services  and  Service Directors/ Clinical Directors in both Mental Health Directorates. | 31st December 2020  COMPLETED |
| 3 | Training and reflection | 1. Facilitate a reflective session with the team and staff involved focusing on the learning points and recommendations | Adult Mental Health Assessment & Treatment Team Manager  and  Investigation authors. | 28th February 2020  COMPLETED |
| 1. Training session regarding parental mental health and risk to be arranged | Adult Mental Health Assessment & Treatment Team Manager | COMPLETED |
| 1. Clinical risk assessment and management training to be reviewed to ensure adequate focus on obtaining additional information from families and carers, Think Family and information sharing | Suicide Prevention Nurse Consultant | 31st October 2020  COMPLETED |
| 1. To explore any missed opportunities in communication between the two services (Adult Mental Health Team and Children’s social care) and implement relevant actions to address this and strengthen communication processes between services. | Head of Service, Buckinghamshire Mental Health Directorate | 31st October 2020  Partially completed. A multi-agency joint working protocol has been developed however this has not been tested yet. The testing workshops have not been held yet. |
| 4 | The Trust will develop a more systematic approach to offering and providing support to families and carers in the aftermath of traumatic incidents involving their loved ones who are/were under its care. | a) Establish a system whereby support can be offered to relatives when it is required. | Deputy Director of Nursing, Mental Health Services  and  Suicide Prevention Nurse Consultant | 30th November 2020  COMPLETED |