

ACTION PLAN PRODUCED IN RESPONSE TO THE INDEPENDENT REVIEW INTO THE CARE AND TREATMENT OF MF
STEIS No: 2013/1805
Incident Date: 10 January 2013

RECOMMENDATION	Actions Required	Progress	Responsibility	Timescale	Outcomes
1. The Trust must ensure that a systematic process is implemented to allow management oversight of patients who have been out of contact with services, that regular audits of that process are undertaken and that an assertive approach is taken to tracking any patient who has been out of contact with services.	<ul style="list-style-type: none"> • Teams to ensure that contact is made with all Service users on Care Pathway Approach (CPA) within a 4 week period. • A quarterly audit to be undertaken to ensure that this is occurring. • A standard template to be used within Multi Disciplinary Team Meetings (MDT) which includes a section for discussion on service users who DNA/ Disengage. • Annual audit of teams MDT minutes and process. 	Current template for MDT meeting agenda in place and re-disseminated to Team Managers	Clinical Service Managers AMH/Sefton & Kirkby and Liverpool Team Managers/AMH Service Manager	Commenced December 2014 Quarterly Starting April 2015 Commenced October 2014	
2. The Trust must ensure that clinical risk assessment, risk management and supervision policies are consistently implemented	<ul style="list-style-type: none"> • Within supervision one case to be discussed in detail with the supervisee that will include the following as standard <ul style="list-style-type: none"> ○ Safeguarding ○ Formulation in respect 	A CPA Review is being undertaken and this is being piloted in 5 areas across the Trust.	Service Line Managers/ Team Managers	Commenced August 2014 due for completion March 2015	

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<p>and that a systematic process is in place to monitor compliance and regular audits are undertaken.</p>	<p>of care plan</p> <ul style="list-style-type: none"> ○ Risk assessment ○ Equality and Diversity ○ Contact with family/carers <p>To be reviewed in Annual Supervision full audit.</p> <ul style="list-style-type: none"> ● Undertake a CPA Review which includes clinical risk assessment and risk management ● An annual audit of supervision files, ten files per team to be reviewed against Supervision Policy standards. ● Monthly Team Manager self assessment will audit compliance with standards re supervision and deficits will be managed by the Service 		<p>CPA Review Project Lead / Education and CPD Lead Pharmacist</p> <p>Deputy Chief Operating Managers/Sefton & Kirkby and Liverpool Service Manager AMH</p> <p>Lead for Nursing and Quality</p>	<p>Commenced August 2014 due for completion March 2015</p> <p>April 2015</p> <p>Commenced December 2014</p>	
<p>3. The Trust must implement a programme of audits to provide assurance that the recorded Mental Health Act status is correct.</p>	<ul style="list-style-type: none"> ● To carry out audit programme a bi-annual audit of Mental Health Act status. 		<p>Audit Lead for Junior Doctors</p>	<p>July 2015 and January 2016</p>	

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<p>4. GPs must implement a process to notify the local Mental Health Trust when a patient who is on Care Programme Approach moves outside of the Trust area.</p>	<p>NHS England and Liverpool CCG will develop a learning lessons case study to share with GP practices to inform them of the issues identified within the report. .</p> <p>Local dissemination - NHS England Sub Regional Team will email the learning lessons case study to all practices within Cheshire and Merseyside. Information will also be sent out via The Liverpool CCG bulletin to their members.</p> <p>Regional dissemination will be via the North's Mental Health Homicide Review Group. Confirmation of how this has been disseminated at local level will be sought.</p> <p>National dissemination - The case study will be shared with the regional leads at the National Quality and Safety Leads (Homicide) Meeting.</p>		<p>Catherine Wardle Independent Investigation Lead NHS England / Christine Griffith-Evans Quality and Safety Manager, NHS England</p>	<p>March 2015</p> <p>May 2015</p> <p>May 2015</p> <p>June 2015</p>	<p>The key issues relevant to GP practice will be identified and enable best practice to be shared to prevent future reoccurrence.</p> <p>Dissemination of this action will be at Local, Regional and National level</p>
<p>5. The Trust must ensure that a systematic approach is taken when planning organization change, to ensure risks are identified, mitigated and managed for all groups of patients,</p>	<ul style="list-style-type: none"> • An evidence based approach to change such as PRINCE2 to be taken during all future organisation change processes. • All service users/carers that will be affected by 		<p>Change/Service Lead as and when identified</p>	<p>Commenced December 2014</p>	

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<p>particularly those who are already disengaging with services.</p>	<p>organisational change will receive the appropriate level of communication and engagement.</p> <ul style="list-style-type: none"> All changes made will consider how individual high risk service users will be affected and how their safety can be maintained. 	<p>Change pro-forma to be identified</p>	<p>Service Development Lead in each Division</p>	<p>Commenced January 2015</p>	
<p>6. It is recommended that a Memorandum of Understanding be developed between NHS England and partner NHS agencies in the UK to ensure that serious incident Investigations that cross NHS borders are commissioned jointly. This should allow all aspects of care and treatment to be explored and for system learning to be shared across public services regardless of where they are delivered.</p>	<p>NHS England will share the report and recommendation with the NHS England Patient Safety Domain Lead responsible for the SI Framework and Department of Health Mental Health Lead. A formal request will be made for them to discuss with other National Stakeholders if and how this recommendation could be enacted across the different Health Services within the UK.</p> <p>NHS England will share with the Scottish Mental Welfare Commission the report and recommendations.</p>		<p>Catherine Wardle Independent Investigation Lead NHS England</p> <p>Catherine Wardle Independent Investigation Lead NHS England</p>	<p>June 2015</p> <p>Completed February 2015</p>	<p>To ensure that this recommendation is raised formally for discussion at National level. Feedback on the feasibility of the recommendation from National stakeholders to be shared at the National Quality and Safety Leads (Homicide) Group and the outcome disseminated to all Regional Homicide Review Groups.</p> <p>To facilitate wider learning. Valuable links made with Commissioners of Mental Health Homicide Independent Investigations in Scotland.</p>

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7. The Trust must implement a quality control system in order to provide assurance that the National Patient Safety standards are being met when serious incident reports are produced.	<ul style="list-style-type: none"> All serious incident reports to be reviewed against Patient Safety standards 		Director of Patient Safety / Validation Process	April 2015	

Signed: _____

Date: _____