Independent Investigation Action Plan for Mr L		STEIS Ref No: 2014/7319	

Statement from Oxleas NHS Foundation Trust
The Trust would like to offer sincere condolenses to the family and friends of Mr Parsons. The Trust immediately carried out a board level Inquiry. Actions from this Inquiry have all been implemented. The independent report recognises that all actions have been completed and the changes embedded in clinical practice. We have fully implemented the new recommendations of the Independent Investigation. This will enable us to continue to minimise the possibility of such tragic events occurring in the future. The action plan will be presented to the Trust Board and the Council of Governors. The action plan will be monitored internally within the Trust via the Trust Board. The action plan will be monitored externally by the Clinical Quality Review Group, chaired by Bromley, Bexley and Greenwich Clinical Commissioning Group Directors of Quality.

Statement from NHS Bromley Clinical Commissioning Group

NHS Bromley Clinical Commissioning Group (CCG) would like to offer their sincere condolences to Mr Parsons' family and friends.

The CCG welcomes the publication of the Independent Investigation Report into the care and treatment of Mr L, which was commissioned in line with NHS England's Serious Incident Framework. The report provides a detailed account of the treatment provided to Mr L, together with recommendations for improvement. The recommendations are fully recognised and accepted by Oxleas NHS Foundation Trust and a number of further improvements have already been made by the Trust following their own internal investigation, which took place immediately after Mr Parsons' death.

As the commissioner of health services in Bromley, the CCG is committed to ensuring safe, effective and high quality services are available to our residents. Our focus will be on continuing to work closely with Oxleas NHS Foundation Trust to ensure that the recommendations from the independent investigation are quickly and thoroughly actioned. A detailed action plan has been developed which will be monitored closely by the CCG and reported to our Governing Body. We will also ensure that the findings from the independent investigation are used to influence system wide learning and improvements through our Quality Assurance governance process.

Report published: NHE to complete

Rec No.	Organisation	Recommendation	Update since the incident (inlude year)	On-going Actions	Implementation Lead	Implementation by when	Evidence of Completion	Monitoring & evaluation arrangements
1	Oxleas NHS Foundation Trust	The Trust must ensure that where a violent patient has been admitted to its services following concerns by other agencies; or complaints by neighbours about anti-social behaviour and noise that they have been made aware of: • The risks are assessed appropriately • There are care plans developed to address anti-social behaviours towards members of the public (who may have been victims) (these may involve other agencies) • There is a robust discharge planning process that fully involves these agencies prior to discharge The Trust should also work in partnership with other key agencies involved (local authority, housing agency, police and CCG) to ensure that there are processes in place to support the routine sharing of information regarding any potential anti-social behaviour of suspected / known service users. .	Since the incident in 2014, the Tarn, psychiatric intensive care unit, updated operational policy has been implemented, this includes robust discharge planning and fully involving agencies. The updated Tarn Operation Policy has been in place since June 2015 (and review dates monitored to ensure it is up to date). It explicitly states that patients will never be discharged from the Tarn to the community. All patients will be transferred back to the referring ward or alternative in-patient placement. Patients have not been discharged on a Friday and are not discharged directly to the community. This is monitored by the Greenwich Directorate. The independent inquiry has confirmed that the internal actions have been completed and that the Tarn Operational Policy addressed the concerns: • Where a person has a recent history of substance misuse there should be a consideration of its impact with a documented assessment of risk (including risk of violence). • A clear plan addressing the risk and relapse should be agreed and in place prior to discharge. Outcomes of meetings with family and discussion about risk should be documented in RiO. • If a low secure bed is not available at the time of referral and assessment there should be a case conference to agree and document a plan of care. • All conclusions of clinical discussions are to be recorded within the primary clinical electronic RiO record. • If a patient is discharged from acute adult mental health inpatient services over the weekend the care plan must take into account the support required in the immediate period after discharge. • The policy addresses the Care pathways, Referrals, PICU pre admission screening and Criteria for admission including a definition of which behaviours result in admission and exclusion. • The new policy describes the admission process including what should happen within the first 72 hours.	1. An additional column will be added to the bed management weekly meeting template to specifically record that for patients where concerns have been raised by other agencies or complaints by neighbours about anti-social behaviour /noise that they have robust discharge plans that fully involve these agencies prior to discharge. 2. Guidance about what will be discussed and recorded on the template form will be devised. 3. Training will be provided to all inpatient teams, overseen by the clinical directors. 4. The action will be implemented and monitored by the trustwide monthly Acute Care Forum chaired by the medical director.	Medical Director	1. May 2018 2. June 2018 3. July 2018 4. August 2018	• Guidance for completion of the bed management weekly template. • Completed weekly bed management templates. • Minutes from monthly Acute Care Forum	The action will be monitored by the monthly Performance and Quality Committee reporting to the bimonthly Trust Board.

Rec No.	Organisation	Recommendation	Update since the incident (inlude year)	On-going Actions	Implementation Lead	Implementation by when	Evidence of Completion	Monitoring & evaluation arrangements
			• There is a definitive statement about discharge planning. Patients will never be discharged from the Tarn to the community unless there are exceptional circumstances such as discharge by tribunal or nearest relative. If this is the case a comprehensive discharge plan will be implemented which will include information on how to access support. • All information and plans will be shared with the patient's carers. • The operational policy now includes a statement that no discharges will happen on a Friday even in the above exceptional circumstances. • In reference to the transfer process, the Tarn will now include planning as part of the process and sets out a number of criteria for transfer as well as an acknowledgement that there are two groups of patients who may potentially 'block ' a PICU bed. These are described as those requiring increased security and those who require a longer period of low security. • There is a section of the new policy which addresses the forensic (to and from) referral pathway. This also includes the criteria for referral and assessment and the multidisciplinary review of referrals, record management and time limits for action and outcome. • The policy includes a section on risk assessment and management and includes consideration of safeguarding adults, child protection, victim considerations, substance misuse and other vulnerabilities.					
			Risk assessments are a key part of person centred care planning. We have a clinical risk assessment and management policy updated in 2016. It outlines individual responsibilities in respect of assessment and management of risk and the incorporation of this into clinical practice rather than a parallel or standalone task. This includes principles of risk manager and discharge planning. It is audited monthly as part of the care planning audit. Our clinical information system Rio contains a risk assessment document which is the primary risk assessment tool. In addition inpatient units hold daily huddles and multidisciplinary team meetings which include community teams and key agency staff involved in patients' care plans. The multidisciplinary team meeting is facilitated by a multidisciplinary tool on the Rio including risk assessment information an updates.					
			Person centred care planning is a Trust key priority. We have a care plan policy updated in March 2018 to enable high standards of person centred care. It incorporates 13 principles including effective risk management and discharge planning. Care plans must outline clear risk management plans for all identified risks and discharge plans must be discussed with patients, their family and support networks. Training has been provided to all staff and facilitated by a dedicated care planning lead. All wards conduct a monthly audit of 5 care plans against the principles. This is reported to the bimonthly clinical effectiveness group chaired by the medical director. Care plans are reviewed in supervision.					
			Every month all teams complete a care planning audit including risk and service user involvement. The audit includes care level, location of care plan in the electronic information system RiO, the use of the risk assessment, completion of the risk assessment during episode of care, review of the risk assessment following significant risk incidents, changes in presentation or within the last 6 months, inclusion of specific factors identified in the risk assessment associated with increasing risk in the care plan , evidence of patient involvement in developing their care plan , patient provided with a copy of their care plan and service user support network tool and trends in audit results. The results are presented to the bi-monthly patient experience group chaired by the director of therapies and reporting to the monthly Performance and Quality assurance Committee.					
			Each directorate has an established relationship with local borough police teams and regular meetings to discuss individuals and promote joint working. We are part of a health innovation network Serenity Integrated Monitoring (SIM) pathfinder working with the police, launched in April 2018. SIM London is a new way of working with mental health service users who experience a high number of mental health crisis events. SIM brings mental health professionals and police officers together into joint mentoring teams. The police officer and the mental health professional work together to provide intensive support service users to reduce high frequency and high-risk crisis behaviours. Central to SIM is the care and response plan completed by patients, SIM police officers and SIM mental health professionals.					

Rec No.	Organisation	Recommendation	Update since the incident (inlude year)	On-going Actions	Implementation Lead	Implementation by when	Evidence of Completion	Monitoring & evaluation arrangements
			Since the incident in March 2014, multidisciplinary teams involve the antisocial behaviour teams or equivalent teams in professionals meetings, where there are issues needing resolution. All staff have been provided with information about local anti-social behaviour teams or equivalents teams. The teams are contacted to discuss any concerns with the Local Authority, who then send the referral to the Tenancy Team or the Community Services Team, depending on whether the referral is about a council tenant or other. We continue to work in partnership with the police, Clinical Commissioning Groups and Local Authorities via the High Risk Panels. The Community Safety Teams attend the High Risk Panels and we continue to receive information from them, shared by victims, if there is a suspicion that a service user is involved in anti-social behaviour.					
2	Oxleas NHS Foundation Trust	This recommendation is made to include practice in general and is not specifically related to care and treatment itself because Mr L did not meet Multi-Agency Public Protection Arrangements (MAPPA) requirments at the time of the incident. The Trust should ensure that consideration about referral to MAPPA takes place for patients with violent histories and convictions for serious violent offences. Such referrals should consider safeguarding issues and risks of domestic violence for wider family members.	**We have adhered to the pan-London** MAPPA guidance which includes that within 3 days of admission all MAPPA eligible patients are notified home and host borough with an additional notification sent when the patient starts escorted / unescorted leave and / or is discharged. We are members of high risk panels in the boroughs of Bexley, Bromley and Greenwich which operates at a sub-MAPPA and receives referrals for patients with violent histories who do not meet MAPPA thresholds. We have a safeguarding children policy and procedure reviewed in March 2018. It includes a specific section on the role of adult focused mental health services and working in partnership and complies with the Children Act 1989. Training for all staff is mandatory and monitored monthly. There is a dedicated safeguarding children advisor for mental health teams. Compliance and practice are monitored by the quarterly safeguarding children committee chaired by the director of nursing reporting to the monthly Quality Assurance and Performance Committee. We have safeguarding adults guidance updated in April 2016 which outlines responsibilities in relation to the Care Act 2014, duties, training and governance. We follow the pan-London multiagency procedures for safeguarding adults updated 2015. Compliance and practice is monitored by the quarterly safeguarding adult committee chaired by the director of nursing reporting to the monthly Quality Assurance and Performance Committee. In April 2018 the Trust's internal auditors rated safeguarding children practice and governance as significant assurance and safeguarding adults as significant assurance with minor improvements regarding data quality checks.	1. We are members of the London MAPPA Advisory group who have been updating MAPPA guidance. The guidance is anticipated to require that MAPPA notifications contain more information about the victim and must be stored where it cannot be accessed by the patient, that mental health services to have a system through which they can flag MAPPA patients for data collection purposes and for MAPPA levels to be reviewed in Care Programme Approach. The pan-London MAPPA policy and procedure are due to be finalised 2018. They will be presented the Oxleas Safeguarding Adult Committee, chaired by the director of nursing and a dissemination plan agreed. 2. A Rio solution is being tested in June 2018 to capture the data requirements.	Director of Nursing, Medical Director and Director of Informatics.	1. June 2018 2. June 2018 3. July 2018	1. Rio solution established to capture data 2. Dissemination plan 3. Audit to test data is being correctly captured on RiO 4. Minutes of safeguarding adult committee	The action will be monitored by the monthly Performance and Quality Committee reporting to the bimonthly Trust Board.
			We have a domestic violence policy and process updated in March 2017 for staff working with patients where there are concerns about domestic abuse. It includes responsibilities in respect of the Domestic Violence, Crime and Victims Act 2004 and their duties to the victims of mentally disordered patients. We developed guidance in 2016 to support multiagency risk assessment panel conferences (MARAC) including a domestic violence handbook, referral guidance and operational protocols to assist staff working with patients with care and support needs and who may have experienced or be at risk of domestic violence. It adheres to national guidance and was devised in consultation with Safe Lives.	3. Training will be provided to teams by the Head of Safeguarding Adults and Prevent.				

Rec No.	Organisation	Recommendation	Update since the incident (inlude year)	On-going Actions	Implementation Lead	Implementation by when	Evidence of Completion	Monitoring & evaluation arrangements
			We have an information sharing policy updated in 2017 which sets out the legal and ethical framework for sharing information with other agencies e.g. public bodies and voluntary agencies. It also includes advice for staff providing safeguarding services for children and adults. In addition we follow local safeguarding children and adult information sharing agreements including the Bromley LSCB information sharing protocol 2017. We have established a specific information field on RIO to record information about children in the networks of adult patients to record any safeguarding concerns or relevant information which may be missed or delayed. Training has been provided to all teams by the safeguarding advisors.					
			We introduced a family support network tool in 2016 which forms part of ongoing care planning and risk assessments to enable patients' families and networks to be identified, engaged and included in care planning and discharge planning. Training has been provided to all teams by psychologists. The use of this is audited monthly on all wards as part of the care planning audit.					
3	Oxleas NHS Foundation Trust	This recomendation is made to improve practice in general and not specifically related to care and treatment. The Trust must assure itself that all practices of seclusion and 'de facto' seclusion on the Tarn, including where patients have been segregated from others after rapid tranquilisation, are fully compliant with the requirements of the Mental Health 1983 (amended 2007), the MHA Code of Practice and the MHA Reference Guide.	**The Tarn does** not allow de facto seclusion. Patients on the Tarn have care plans to manage acutely disturbed behaviour. Where patients are presenting a significant risk of violence to others a management plan agreed by the multidisciplinary team is instituted and reviewed every shift and this is supported by up to 3 staff to observe the disturbed patient. For the period of time that patients are in their rooms, the patients are not locked in as a member of staff is always present and engaging with them but allowing personal space so that the patient's dignity is not impacted on but safety is assured. The nature of the door closing arrangements prevents patients being locked in their rooms and 'time out' is never used. De-escalation is used when needed, in line with prescribing guidelines requirement prior to rapid tranquilisation. If the risk level necessitates, arrangements are made to transfer the patient to an independent sector facility or our Bracton forensic services, where seclusion is available. We have a forensic service seclusion and long term segregation policy updated April 2016 which sets out best practice for supporting patients who require supervised confinement for a period of time based on the Mental Health Act Code of Practice 2015, in relation to seclusion, segregation and the needs of patients' privacy, dignity, medication and nutrition. It includes a checklist for seclusion which is monitored through peer review and CQC visits.	1. The Tarn unit will pilot the Broset violence and aggression tool, which has been successfully implemented on our forensic inpatient units and monitored through the Acute Care Forum. 2. The new de-escalation room will be planned by estates in conjunction with the Head of Mental Health Legislation to ensure issues of dignity and safety are addressed. 3. A Trustwide quality improvement project for the reduction of violence and aggression will be commenced and monitored through the Quality Improvement Committee reporting to the Board.	Acting Deputy Chief Executive	1. June 2018 2. The date is subject to discussions with Private Finance Initiative Provider of the hospital site and will be monitored by the Trust executive team. 3. July 2018	• Broset tool pilot audit report of implementation in the Tarn • De-scalation room plan and progress monitoring • Protocol for use of the de-escalation room • Minutes of Quality Improvement Committee. • Minutes of Acute Care Forum.	The action will be monitored by the bimonthly Performance Improvement Committee reporting to the bimonthly Trust Board.
			We have a forensic long term segregation policy updated in April 2016 which sets out best practice for supporting patients who need supervised confinement for a period of time and is based on the Mental Health Act Code of Practice 2015. It has a checklist and is monitored by peer review and CQC visits. We have guidance of long term segregation for all mental health and adult learning disability units updated in 2015, to ensure a consistent approach to patients who may need to be looked after in longer term segregation it makes it clear that this is only to be used in a way the respects human rights and is compatible with the Mental Health Act Code of Practice 2015. It is closely monitored by the Head of Mental Health Legislation and the bimonthly Mental Health Legislation Oversight Group chaired by the director of nursing and reporting via the bimonthly clinical effectiveness group to the monthly Quality Performance and Assurance Committee					

Rec No.	Organisation	Recommendation	Update since the incident (inlude year)	On-going Actions	Implementation Lead	Implementation by when	Evidence of Completion	Monitoring & evaluation arrangements
			We have a prevention and management of violence and aggression policy updated in April 2018 to improve reporting, identification and management of violence and aggression. Training is mandatory for clinical staff in coping with potential and actual violence and aggression, using de-escalation interventions and reducing need for restrictive interventions. It includes an appended standard operating procedure of de-escalation. We are launching a Trustwide quality improvement project for reducing violence and aggression. The forensic team introduced the Broset Violence Risk assessment tool in 2016. It has reduced the incidence of violence and aggression on the units by enabling teams to assess early warning signs and proactively prevent escalation. A MHA CQC visit in 2016 suggested that there may be benefits to establishing a de-escalation room in the Tarn, which has been explored by the unit and the estates team. Plans are in progress to create this room. We have agreed a Trustwide priority quality improvement programme for reducing violence and aggression.					