Independent Investigation Action Plan for Mr E (WEB8285)

South London and Maudsley NHS Foundation Trust Statement

We offer our sincere condolences to those affected including the family of Miss A. The Trust is addressing the recommendations made in the independent investigation by ensuring actions are implemented to improve practice and to embed the lessons learnt. The actions will be reviewed by lead clinicians in the Quality Committee, directly monitored by the Trust Board of Directors and the Lambeth Clinical Commissioning Group. We hope this offers some assurance that the lessons identified in the independent investigation have been learnt from this very tragic incident.

NHS Lambeth CCG Statement

NHS Lambeth CCG offers sincerest condolences to all those family members and friends affected by this tragedy.
NHS Lambeth CCG work with South London & Maudsley NHS Foundation Trust to seek assurance that the services they provide are safe; effective; caring and responsive.

We will continue to monitor the implementation of this action plan through a number of monitoring processes including: monthly local Clinical Quality Review Groups Meetings (CQRG) - The CQRG provides commissioners with assurance by reviewing a range of evidence, provided by the Trust, to ensure they are providing services in line with the requirements stipulated within the contract held between the CCG and the Trust, the NHS Constitution, and Fundamental Standards of Care regulations. In this context, the meeting monitors and receives deep dive assurance on the Trust's implementation of specific actions resulting from Serious Incident investigations, Domestic Homicide Reviews, and Mental Health Homicide Reviews such as this case.

The CCG also monitors the quality and safety of service delivery by South London & Maudsley NHS Foundation Trust through the utilisation of monthly contracting meetings.
The CCG also attends monthly serious incident review meetings with the Trust where individual cases are discussed in depth.

Rec No.	Organisation	Recommendation	Changes to Trust since 2013	Actions to achieve recommendation	Implementation Lead	Implementation by when	Evidence of Completion	Monitoring & evaluation arrangements
Priority One: the recommendation is considered fundamental in that it addresses issues that are essential to achieve key systems or process objectives and without which, the delivery of safe and effective clinical care would, in our view, be compromised.								
1/2/3	SLaM	The Trust must undertake an audit of the effectiveness of the final protocols that have been developed: • management of patient care when patients are discharged from prison • working protocol for putting in place and managing Community Order "Mental Health Requirements"	The Trust is currently developing improved links with the Local Probation areas through interface meetings with the Director of Social Care. In 2018 the Trust redesigned the structure of services to a Borough based model from a clinical academic group structure.	As a result of the redesign the Trust will review to ensure these reflect the new structure and the communication between the Director of Social Care and Local Probation Services • management of patient care when patients are discharged from prison • working protocol for putting in place and managing Community Order "Mental Health Requirements" The Lambeth community team will review their response to any patient who has been released from prison over the past 6 months. The learning from this will be reported through the Lambeth Directorate Governance Executive and Trust Serious	Clinical Director Behavioural and Developmental Psychiatry Operations Directorate Lambeth Head of Nursing Lambeth Head of	31/07/2018 31/08/2018 30/09/2018	• Revised protocols • Completed audit for Lambeth • Learning identified in audit • Action plan from audit	Behavioural and Developmental Psychiatry Executive Governance Meeting Lambeth Executive Governance Meeting Trust Serious Incident Review Group Trust Board

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				Incident Review Group. Any amendments to the protocol will be made following this.	Nursing			
		The Trust must implement a process of monitoring the effectiveness of case note audits and individual supervision, implemented following the internal investigation, with regard to care plans and risk assessments. The Trust must undertake an audit to identify how effective the new systems are in providing assurance about the completion of documentation by team members	The Trust's internal action plan provided evidence of the completion of risk assessments and escalation of concerns for complex patients using a series of case note audits. The process was commenced with follow up through supervision, zoning and clinical formulation meetings. Formulation and zoning meetings are included in the team local operational protocols. During 2017 the Trust reviewed and further developed electronic audit and monitoring programme of the completion and quality of risk assessments and care plans. These are reviewed in individual Borough governance meetings with themes from these reviewed in monthly Quality Compliance meetings commenced in Autumn 2017 chaired by the Director of Nursing. The electronic quality audit looks at appropriateness of identified risk and plans to manage these. Audits are completed by team leaders and managers which ensures the learning and any patient specific feedback can be given to the team. Until 2018 the Trust held local records of supervision monitored by each of the Clinical Academic Group line management structures. The Trust is moving towards recording the dates of supervision on the LEAP system, which holds data on training and appraisals for staff across the Trust.	A 6 month review of the audit programme commenced in Autumn 2017 will be undertaken by the Lambeth community teams to identify learning and any areas of improvement. The Director of Nursing will receive this report as part of the Quality Compliance Meetings and as part of the Trust Serious Incident Review Group. An action plan will be compiled to address any areas of improvement. A 12 month review will be undertaken to review progress against the action plan and action plan from the 6 month review.	Lambeth Head of Nursing Lambeth Head of Nursing	31/08/2018 31/01/2019	Evidence will include • Monthly compliance audits • Monthly quality audits • Action plans from audits • Minutes of Quality Compliance Meetings • Minutes of Lambeth Directorate Governance Executive Meetings	Trust Quality Committee Trust Serious Incident Review Group Lambeth Directorate Governance Executive Meetings Quality Compliance Meetings

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4	SLaM	The Trust must ensure that all staff are clear about the process and timeframe to follow when there are concerns about the welfare of a service user who is not engaging with services. The Trust must also implement a system to monitor this and address any issues of non-compliance.	In 2015 Trust has developed a Did Not Attend (DNA) / Disengagement Policy which has been updated since the incident occurred. The most recent policy (2017) included the learning from this incident. The policy contains a 1 page flow chart outlining actions required should a patient disengage. Locally the timeframes for requesting a welfare check may differ. Patient's disengagement from services is looked at on an individual basis with the risk assessment tool, updated in January 2017 linking to the risk management plan and care plans. Each clinical contact should consider the risks presented by a patient, including if a patient is not engaging with a service. The Trust has increased the use of zoning across the Trust, to provide an at a glance status on risk. Consideration of a patient's zoning status incorporates the patient's risk of disengagement. Following changes within the local police, in 2018 the Trust circulated a briefing note on how to access welfare checks. This includes key standards for requesting welfare checks.	The Trust's systems currently in place have provide evidence to support the systems. The Lambeth community team will review a sample of patients from the full team caseload to ensure appropriate disengagement/DNA processes are in place/are being followed. An action plan will be developed to address learning from this as required.	Lambeth Head of Nursing	30/09/2018	• Trust Did Not Attend/Disengagement policy • Learning and action plan from audit	Trust Quality Committee Lambeth directorate governance executive
5	SLaM	The Trust must ensure that services are configured to allow for best practice in risk assessment to be implemented in all services.	Since 2013 the Trust has revised an updated the policies and procedures for the assessment of clinical risk and management of harm. In January 2017 the trust published an updated risk assessment incorporated a number of tools including risk events and risk management plans into a single format. The Trust developed an electronic audit tool to monitor completion of this document with an audit of quality to support. Risk assessments pull information from previous risk events and provide a framework for the formulation of risk. The Trust has invested in mobile devices	The Trust has completed work to ensure that services are configured to allow for best practice in risk assessment.	Director of Nursing	Completed January 2017	A comprehensive training was undertaken during the launch period for the new risk assessment tool. Systems for qualitative and quantitative monitoring have been embedded with team and Trust wide access. • Revised Policy for clinical risk assessment and management of harm	Trust Quality Committee Lambeth directorate governance executive

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			which allow clinicians to access and make entries electronic clinical records whilst out of the team base – these include tablet computers and mobile phones.					
6	SLaM	The Trust must ensure that care co-ordinators have the opportunity to review a service user's history and risk factors when a service user is first allocated to them. The Trust must also implement a system to monitor this and address any issues of service non-compliance through the appropriate routes.	The review of a service user's history is part of role transitions for any clinical staff. Clinical staff entering new teams are supported through inductions, handover, and clinical and managerial supervision. Strengthened supervision structures provide oversight and assurance for a robust handover of patients between clinicians. The Trust has invested in mobile working devices to allow clinicians to access clinical information as required this includes tablet computers and laptops with access to clinical notes.	To simplify the information held in patient note's, in 2017 updates were been made to the risk assessment and care plan documents. The revised documents pull through historic risks and lead to risk management plans. The single care plan in the community allows a formulation of the patient's presentation, history risks and needs.	Deputy and Associate Clinical Director, Clinical Service Lead and Team Leaders	Completed	• Trust Risk Assessment Tool • Risk Management Plans • Support and Recovery Plan • Supervision records of staff working in new teams	Directorate Governance Executives Trust Serious Incident Review Group
7	SLaM	The Trust must ensure that clinical staff are clear about the escalation processes when they are unable to secure a mental health act assessment in a timely fashion. The Trust must also monitor the use of those escalation processes in order to be assured of their effectiveness.	The Trust monitors delays in Mental Health Act Assessments using the incident reporting system. This allows monitoring and targeted actions for clinicians.	During January 2018, the Trust developed a clear escalation process to ensure any delays in mental health act assessments are addressed. The protocol was published in February 2018. Any delay is reported as an incident, with oversight by the Director of Nursing, Chief Operating Officer and Director of Social Care. Information is shared between the Trust and the Local Authority to ensure delays are addressed where possible. Each delay is documented as an incident on the Trust incident reporting system. In May 2018 a multi-agency stakeholder event took place attended by Trust Senior Managers, London Ambulance Service, Police and Approved Mental Health Professionals from the Local Authority. Discussions on blocks were held and actions agreed to address delays. Each Trust Borough will arrange a weekly multi-agency teleconference to ensure any issues in delays with Mental Health Act Assessments are addressed	Directorate Clinical Directors	Completed June 2018	• Escalation protocol in use across the Trust • Stakeholder event summary • Multi-agency phone calls taking place • Improvement noted at Trust Mental Health Law Committee	Trust Board Directorate Governance executives

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				by all stakeholders. The new processes are being embedded and will strengthen existing information sharing and partnership working between the Trust and other agencies involved in Mental Health Act assessments.				
8	SLaM	The Trust must ensure that section 117 aftercare needs are formally considered and liaise with the relevant organisation in order to ensure that identified needs are met.	The Trust has a section 117 aftercare policy in place. Guidance has recently been received from Association of Directors of Adult Social Care in relation to section 117 aftercare. The Trust's Director of Social Care has reviewed the Trust policy in conjunction with the local social services authorities to ensure the policy and procedure is understandable for staff. The revised policy is currently out for consultation with plans for an update to the clinical notes system using a discharge proforma and a flow chart for staff.	The revised section 117 policy will be ratified and circulated as part of the Trust policy bulletin. The policy flow chart and policy will be disseminated to all inpatient wards. The discharge proforma will be included as part of the Trust's clinical notes system. The Trust will confirm the timescale for completion of this.	Trust Director of Social Care	31/07/2018 Review of action due 31/12/2018	• Updated Section 117 policy • Email circulation of policy • Flow chart • Discharge proforma in clinical notes	Trust Board Trust Serious Incident Review Group
9	SLaM	The Trust must ensure that staff are clear about when information should be shared with other agencies (usually probation or the police) about a service user breaching bail conditions. The Trust must also ensure that staff comply with the guidance on when to share information.	Information Governance training is mandatory training for all staff with yearly refreshers. This training provides guidance on information sharing and where to seek advice if required. Information sharing is underpinned by the Trust's Information Sharing Policy which refers to information sharing with police and probation. The information governance team provide guidance on information sharing with other agencies. Training on information governance is mandatory, information requests are responded to within. The Trust's electronic clinical records, risk assessment and care plans, have specific section about communicating risk and plans as required. The Trust risk assessment tool links to the patient's risk management plan which can be used for local management of risk such as bail conditions. The Trust has a Police Liaison Committee chaired by a Service Director, attended by local Borough Police Officers. The committee can be	The Trust has clear policies and procedures on information sharing to ensure staff are aware including training, documentation and support from information governance.	Information Governance Team Director of Nursing Service Director leading on Police Liaison	Complete	• Risk assessment tool • Care plans • Training compliance • Trust Policies	Quality Committee Trust Board Police Liaison Committee

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			used to escalate any immediate communication issues as required.					
10	NHSE	Commissioners of prison health services must ensure that providers take appropriate and timely action to obtain relevant details about detained prisoners' care plans and risk assessments when they are made aware that the prisoner is known to a community mental health team.	NHS England took over responsibility for commissioning prison healthcare from the following PCTs: 1.HMP Pentonville – Islington 2.HMP Wormwood Scrubs - Hammersmith and Fulham 3.HMP Brixton – Lambeth 4.HMP Wandsworth – Wandsworth 5.HMP Belmarsh – Greenwich 6.HMP Isis – Belmarsh 7.HMP Thameside – Belmarsh 8.HMP Feltham - Hounslow	All prisoners who enter prison are screened by the healthcare team upon arrival. Mental health needs can be identified either through an existing record such as a Prisoner Escort Record, A GP SCR, a referral via a MH Liaison and Diversion team from police custody/court, or an initial screen at reception, a second screen following 72 hours of arrival, or via any other sources of referral during their stay in the establishment. If a prisoner is identified with having a mental health need then HC providers are required to make every effort to obtain details about the individuals care plan and risk assessment from community mental health teams. All providers have been communicated with regard to this requirement.	Jointly between the specific prison commissioning lead commissioner and colleagues from Nursing	Completed	Notes from Contract Review and Quality Review meetings. Action plans from Investigations and reviews.	This is measured through regular contract and quality monitoring, reviews of findings from investigations and recommendations following Death In Custody PPO reports, CQC inspections and SI reviews including RCAs.
Priority Two: the recommendation is considered important in that it addresses issues that affect the ability to fully achieve all systems or process objectives. The area of concern does not compromise the safety of patients, but identifies important improvement in the delivery of care required.								
11	SLaM	The Trust must ensure that when teams are disbanded and the functions absorbed into other teams (eg the assertive outreach function being absorbed into the community mental health team) the operating requirements of the new team function is clear to everyone.	In 2017 the Trust commenced a formal meeting led by the Medical Director and Director of Nursing to ensure any changes to teams have a Quality Impact Assessment completed. The Medical Director and Nursing Director, with the Service Directors, review proposed changes for Quality and Safety issues to mitigate against these as part of any changes. These include the new operating requirements of teams. Human Resources provide local support to Services to ensure changes are captured as part of the consultation process and changes are embedded in	The Trust has systems in place to ensure changes in team function are reviewed and considered for quality and safety issues and that functions of new teams are clearly communicated.	Medical Director Director of Nursing Chief Operating Officer	Completed in 2017	• Equality Impact Assessments • Plans to mitigate against risks • Revised operational protocols for new teams • Consultation documents	Trust Board Trust Quality Committee

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			line with Trust Policy.					
12	SLaM	The Trust must provide clearer guidance to staff on obtaining information form family members when there is no consent from the service user, but the service user is presenting with behaviour that is a risk to themselves or others. The Trust must also provide guidance to staff on obtaining collateral information from other individuals known to services users when the service user is presenting with behaviours that poses risk to the other individual.	In 2015 the Trust produced a Carer and Confidentiality booklet to support carers in sharing/receiving information. The guidance supports sharing risk information, receiving collateral information and provides carers with further support details. Carer and Confidentiality training is available for staff. Carer confidentially training for staff being piloted in the inpatient wards along with a video which deals with the difficulties of confidentiality. Each ward and HTT has a carers lead, with protected time for the role. There are bi-monthly carers leads forums. Aim of training: • To provide Carers and Confidentiality Training for all Acute Inpatient Wards. • To deliver the training in partnership with Carers Outcome of training: • For the participants to understand the complexity of ensuring confidentiality whilst supporting carers • For participants to feel more confident when dealing with issues of confidentiality with carers • For participants to understand the experience of carers with regard to confidentiality and the need to be sensitive and empathetic when listening to carers.	Actions completed in 2015	Trust Head of Information Governance and Trust Head of Inclusion, Recovery, Professional Head of Occupational Therapy and AHPs	Actions completed in 2015 Further review and revision completed in 2018	• Carer and confidentiality booklet – published December 2015 • Training video on working with carers • Minutes of Trust carer committee	Quality Committee Carer Committee

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13	SLaM	The Trust must undertake an audit of the timeliness of entries into clinical records following clinical team or zoning meetings. When the scale of the problem is understood, the Trust must put into place measures to rectify any problems identified and implement a system to monitor compliance on a longer term basis.	The Trust's policy supports the documentation of clinical meetings in patient's notes. Locally policy and protocols support this practice. Information is entered into systems as discussions takes place. Since 2013 the Trust has increased the mobile working devices such as laptops and tablets available to clinical staff. These devices allow staff to document and record clinical notes and meetings without access to a computer. The Trust has updated the clinical notes system to include a zoning tab. As a result, a patient's zoning status is displayed on the front page of the patient's clinical notes. The update further aids oversight of zoning status by team leaders and clinicians accessing notes and the associated risk management plans. Electronic dashboards are in place to provide an electronic oversight. Clinical teams have access to clinical notes in their clinical review meetings allowing them to input discussions directly onto the patient record at the time of the meeting.	The Lambeth Community Team will complete an audit of zoning meetings to review the timeliness of entries into clinical notes following zoning meetings to provide assurance that the current documentation systems are working. A summary of the finding and any additional actions from this audit will be presented at the Lambeth Governance meeting and the Trust Serious Incident Review Group. During these forums a decision will be made about any additional actions required across the Trust.	Clinical Service Lead and Team Leaders Lambeth Head of Nursing	01/12/2018 31/01/2019	• Outcome and learning from audit • Summary of changes in practice/protocols	Lambeth Directorate Governance Executive Meetings Serious Incident Review Group
14	SLaM	The trust must ensure communications with GPs are sent in a timely fashion and that when an action is requested of the GP, this is followed up by the relevant psychiatry medical team.	Since 2013 the Trust has developed and been part of the Local Care Record joining up patient records between GP practices in Lambeth and Southwark with Guy's & St Thomas', Kings College Hospital (KCH) and SLaM. The service allows GPs to access Trust records and vice versa. Discharge summaries are now sent electronically from the clinical record to the relevant GP practice. The Trust routinely sends electronic discharge notifications via email to primary care. These include a summary of the discharge plan, any outstanding tasks (e.g. around physical health) and	The Trust monitors use of these discharge emails including their completion within 24 hours of discharge.	Trust Deputy Medical Director	Completed	• Electronic discharge summary compliance	Quality Committee Serious Incident Review Group

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			current medication. This is a new initiative that was not in place in the community at the time of the incident					
15	SLaM	The trust must ensure that when a carer's assessment is recommended, appropriate actions are taken to ensure that this is offered to the carer in a timely fashion.	The Trust has taken a number of steps since 2012 to consider the needs of carers and their role in care. The Trust is committed to implementing the national standards from the Triangle of care. In 2015 the Trust produced guidance on How to find the right balance – Carers and Confidentiality to provide clear guidance on how Trust staff should engage with carers and inform carers of what to expect from SLaM services. The Trust has a Family and Carer's handbook with the second edition published in 2017. Both documents are available on the Trust external website which allows carers to access these at a convenient time. These are designed to empower carers to raise concerns and to ensure that staffs are confident in responding appropriately and sensitively. The Trust has this as a quality priority with 75% of all carers in Trust services to be offered the engagement and support plan. The carers support and engagement plan has also been introduced to provide key information to/for carers re: diagnosis/prognosis, their own support needs, any information they require and so forth as not every carer will be keen for an assessment under the Care Act. It has been informed by the NICE guidance for carers for those with schizophrenia.	The Trust has reviewed the documentation of carer's assessments to ensure these provide the best support to carers and family in August 2017 the Trust introduced the updated Carers Support and Engagement Plan which is designed to ensure that staff identify and engage with carers and then offer appropriate information and support. The plan pulls through all relevant carers from the patient's clinical notes. The plan is printed and given to the carer as a summary document. Monitoring of carer's assessments being offered is now part of the Quality Compliance Monitoring meetings chaired by the Director of Nursing. This will continue to form part of the meetings.	Director of Social Care	Completed February 2018	• Quality compliance meeting minutes • Carer support lead meetings	Quality Compliance Meetings Carers committee