Independent Investigation Action Plan for Mr A and Mr B

STEIS Ref No: 2017/2165

South West London and St George's Mental Health NHS Trust Statement

A spokesperson for South West London and St George's Mental Health NHS Trust said:

"Our thoughts are with the family and friends of those affected by these very sad events in 2017 and our deepest condolences are with the family of the victim.

"The Trust has already taken a number of actions following our initial internal review, and is now implementing all the recommendations made in the independent investigation.

"We continue to monitor all these actions to ensure they are embedded into the organisation, with the safety of our service users and the wider public as our absolute priority."

Wandsworth Clinical Commissioning Group (CCG) Statement

We would like to express our sincere condolences to the family of Mr B for their loss. Wandsworth CCG has worked with and continues to monitor South West London and St George's Mental Health NHS Trust to make sure the services they provide are safe; effective; caring and responsive. We continue to work with the trust and the lead commissioning CCG to seek quality assurance through the regular Clinical Quality Review Meeting (CQRG). At this meeting we review the evidence provided by the Trust to ensure the services they provide meet the requirements stipulated within the contract held between the CCG and the Trust, the NHS Constitution, and Fundamental Standards of Care regulations.

Report Published: January 2022

Rec No.	Organisation	Recommendation	Actions to achieve recommendation	Implementation Lead	Implementation by when	Evidence of Completion	Monitoring & evaluation arrangements
1	SWLStG	The trust should have a system in place to ensure that the care coordinators within the EIS hold caseloads within the current national recommended number (no more than 15) to promote effective support to service users.	1. Increase in whole time equivalent by 0.6 wte to increase staffing capacity and to reduce the team caseload in line with current working average across EIS. 2. Complete Quality Improvement Initiative (Qii) to promote discharges ensuring appropriate package of care has been delivered and discharge planning to CMHT when required. 3. Demand and capacity review of CPA/Care co-ordinator capacity. 4. Business case to be developed regarding additional resources as part of Community Transformation or cost pressures work with the CCG.	1. Clinical Manager 2. Team Manager 3. Clinical Manager 4. Head of Service Delivery/Clinical Director	1. Completed September 2019. 2. Completed July 2019. 3. Completed September 2019. 4. Completed April 2021	1. 0.6wte is included in budget. Caseload management remains a priority, current caseload average is 19 with London wide average at 21. 2. Achievement of Qii Action Plan and caseload maintenance. 3. Document that outlines the needs of the service in relation to Care Co-ordinator capacity . Capacity paper presented to Service Line Governance Group April 2019 4. Business Case and Demand Pressures requests to CCGs completed November 2019. The SWL – ICS/CCG has provided a significant amount of baseline investments into Community Services from 2021-22 and following the submission of a bid to NHSE the ICS/CCG has successfully secured a significant amount of monies to support the transformation of community services, including increased capacity in Psychology, nursing, community support roles, a newly developing community rehabilitation team for the Trust and an increase in therapies for people with Personality Disorders. Year 1 investment started April 21.	Finance meeting for EIS as part of Community Service Line - monthly. Quality Governance Group for Community Service Line - monthly. Senior Management Team Operational meeting Community Service Line - monthly.
2	SWLStG	The trust should ensure that the EIS uses a model of working to enable clinical staff to work outside office hours so that service users can be visited, assessed and monitored face to face if necessary.	The Early Interventions Team to develop a standard operating procedure to enable clinicians to work outside normal office hours as many clients are in full time work. In addition the Trust's Lone Working policy aim is to safely meets needs of Service Users and is cross referenced within the SOP.	1. Team Manager	1. Completed September 2018.	1. SOP currently in place that detail the working out of office hours for staff.	EIS performance meeting - monthly. EIS Quality and governance meeting - monthly.

3	SWLStG	The trust should carry out an audit to ensure that CPA reviews take place in line with trust policy.	1. Manager to regularly review Team Dashboard to ensure CPA's are booked and reviews are happening in a timely manner in line with the current audit tool. 2. Complete 6 monthly audit using developed audit tool.	1. Team Manager 2. Team Manager	1. Completed - Ongoing Core Business 2. Completed - Ongoing Core Business	1. Up to date Dashboards 2. Report of Audit outcomes into Service Line Governance Group. This is currently showing over 95% for the EIS team.	Service Line Governance Group - monthly.
4	SWLStG	EIS should carry out regular audits to ensure that service users are placed within the correct zone in line with the risks that they present and that they are reviewed, and targeted mental health interventions are delivered in line with the standards within the zoning system.	1. Develop Audit tool in line with Zoning Guidance 2. Complete audit monthly as per Zoning guidance using developed audit tool.	1. Head of Nursing 2. Team Manager	1. Completed - Ongoing core business 2. Completed - Ongoing core business.	1. Outcome of the Audit reported.	Quality Governance Group - monthly.
5	SWLStG	EIS should consider using urine or saliva testing as part of care planning where it is known that the service user regularly takes drugs.	1. Urine testing to continue to be incorporated into the care planning process. 2. Trust care plans are coproduced and this action will be done in collaboration with the service user unless stipulated within a Community Treatment Order where it is compulsory.	1. Team Leader	1. Completed - Ongoing Core Business	Collaborative Care Plans will be monitored through the monthly Case Notes Audit process in conjunction with monthly supervision.	Supervision - monthly. Case note audit - monthly. MDT case discussions - weekly.
6	SWLStG	EIS should ensure that they engage all sources of information including families when trying to visit service users that are hard to engage.	1. Session to be held with staff on the Clinical Disengagement and Did Not Attends Policy for staff in EIS Services to support the engagement and involvement of families in particular for those service users who are difficult to engage. 2. Compliance with policy to be reviewed via staff supervision which reinforces family engagement.	1. Team Manager 2. Team Manager	1. Completed - October 2019. 2. Completed - Ongoing Core Business.	Event held Clinical Disengagement, Did Not Attend & Was Not Brought Policy. Supervision notes. MDT meetings and case reviews.	Monitored through Cluster Governance Meeting
7	SWLStG	EIS and the housing charity should ensure that all staff are aware of all emergency accommodation options available to them.	1. A Standard Operating Procedure to be developed jointly with key stakeholders. 2. Clear escalation process with the Local Authority where emergency accommodation needs to be accessed. This should include what to be done if emergency accommodation is not available. 3. New SOP and escalation process to be shared internally and externally. Externally through the Mental Health Housing forum and Internally via Supervision and ACCC.	1. Head of Nursing 2. Head of Nursing 3. Head of Nursing	1. Completed - May 2019 2. Completed June 2020. 3. Completed June 2020.	1. SOP agreed jointly with stakeholders and is in place. 2. Agreed escalation process how emergency accommodation will be accessed is as follow:- **Firstly**, Housing Charity/Providers existing housing stock - **Secondly**, Sourcing emergency accommodation through Local Authorities - **Finally**, The Trust Acute Care Coordination Centre who have the authority to commission accommodation 24/7. This has been written into our community and EIS Operational Policies 3. SOP noted at external meeting and at ACCC and mbedded inot boh Operation Policies	Internally through the MDT Meetings and Supervision. Externally monitored at Mental Health Housing forum.
8	SWLStG	EIS should ensure that all incidents that meet the criteria are reported and investigated so improvements can be put in place where necessary.	1. All Incidents that occur to be reviewed in supervision/MDT meetings and reinforced to staff that near misses should be reported as per Trust Policy. 2. Post Incident Reviews and Actions to be shared at Business meetings and Cluster Governance Group to support learning and improvements (applicable to SI's only)	1. Team Manager 2. Clinical Manager	1. Completed - Ongoing core business. 2. Completed - Ongoing core business.	1. Supervision records/MDT notes 2. Post Incident Review (PIR) discussion at weekly Quality Matters Meetings where Serious Incidents are discussed and meeting is chaired by the Director of Nursing.	Quality Matters - weekly. Quality Governance Group - monthly.

9	SWLStG	The trust should ensure that those affected by an incident are offered support in a timely manner.	1. Trust Policy to be updated with specific details of support to be offered to staff. To include a flowchart on Post Incident Actions. 2.Staff Survey to be carried out for feedback on effectiveness of the support offered 3. As part of the Trauma Informed strategy the Service Line has identified staff to complete the trustwide debriefing training	1. Trust Staff Support Advisor 2. Patient Safety Manager 3. Head of Nursing & Quality.	1. Completed - August 2019 2. Completed - November 2020 3. Completed June 2020	1. Support for Staff involved in a traumatic event, complaint or claim policy ratified 28 August 2019. Flowchart included at Appendix G 2. During the suicide prevention summit a survey was carried out with those in attendance, a presentation from a staff member who was involved in an incident and the support offered to them and how to improve this. Trust policy on supporting staff and policy in place. 3. The Service Line will identify 4 staff who will receive 2 day debrief training to support teams following traumatic events or incidents. In addition, The Trauma Skills Practice training is now available on the Trust's Compass trainign system and staff from across the Trust are accessing it. If is now part of the Band 6 Development programme for all Care Coordinators.	Trust Quality Governance Group chaired by Director of Nursing Relevant documents and lists will be available.
10	SWLStG	The trust must ensure that they use the systems in place for complying with duty of candour and carry out regular audits to ensure they are meeting the requirements of the act.	1. Masterclass to be held at the monthly Leadership Conference to remind staff of their obligations to comply with the Duty of Candour. 2. Trust to provide a monthly and 6 monthly compliance report against Duty of Candour	1. Family Liaison Officer 2. Patient Safety Manager	1. Completed - November 2019 2. Completed - Ongoing core business.	1. Masterclass Completed at November 2019 leadership event. 2. Monthly Performance Report and 6 monthly report detailing the Trust compliance against DoC which is approved at the QGG.	Quality Matters report reviewed at Quality Governance Group monthly. Claims and Inquests Quarterly report reviewed at Quality Governance Group Quarterly.