Independent Investigation Action Plan for Mr J

STEIS Ref No: 2014/13686

Report published: November 2017

South London and Maudsley NHS Foundation Trust Statement

We offer our full condolences to the family of Mr V. The Trust are addressing the recommendations made in the independent investigation by ensuring actions are implemented to improve practice and to embed the lessons learned. The actions will be reviewed by lead clinicians in the Quality Sub-Committee and directly monitored by the Trust Board of Directors. We hope this offers some assurance that lessons have been learnt from this very tragic incident.

Croydon Clinical Commissioning Group Statement

Croydon CCG will seek assurance and regularly monitor the action plan through the bi – monthly local Clinical Quality Review Group (CORG) and Serious Incident (SI) meeting . The CORG/ SI meetings provides commissioner assurance by reviewing a range of evidence, provided by the Trust, to receive assurance that services are clinically safe, effective, promote patient experience and are responsive and well led in line with the requirements stipulated within the contracts held between the Croydon CCG and the Trust, the NHS Constitution and Fundamental Standards of Care regulations.

The meeting regularly receives reports on the Trusts compliance with the National Framework for Serious Incidents, application of the duty of Candour and identification and dissemination of learning from investigation findings. In this context the meeting will be able to monitor and receive assurance on the Trust's implementation of specific SI investigations such as Domestic Homicide Reviews and Mental Health Homicide Reviews and the action plans that are part of these reviews.

Rec No.	Organisation	Recommendation	Actions to achieve recommendation	Implementation Lead	Implementation by when	Evidence of Completion	Monitoring & evaluation arrangements
1	SLaM	The Croydon Early Intervention Service (COAST) managers must undertake a case note audit to assure themselves that service user records are being completed in line with trust policy. This audit should assess risk assessment, and care planning.	1. The Team Manager to undertake random qualitative audits of risk assessments and care plans/ risk management plans on a quarterly basis.	Croydon Early Intervention Service Team Manager, Psychosis Clinical Academic Group (CAG)	First quarterly audit due end quarter two (30/09/2016), repeated each quarter for one year Final review of audit September 2017 **Action Complete**	• Random qualitative risk audit completed for each quarter • Final audit completed in September 2017 • Findings discussed with staff within team meetings with learning identified around updating risk assessments when there is a change in risk i.e. transition from Home Treatment Team to the service. Team are focussing on improving the quality of information they record in risk assessment e.g. criminal justice contact • Findings indicated that safeguarding issues to be reflected in Care Plans and risk assessments were completed appropriately • The final audit demonstrated that the quality of care plans and risk assessment had improved with clear links between risk assessments and care management plans.	Psychosis CAG Care Pathways and Governance Exec. Trust Serious Incident Review Group (monthly)
			2. Quantitative reports are reviewed at supervision and any gaps in individual performance will be addressed on a monthly on-going.	Croydon Early Intervention Service Team Manager, Psychosis CAG	Monthly for one year from September 2016 12 month review September 2017 **Action Complete**	• Quantitative audits completed on a monthly basis • The Trust uses the Insight reporting system to provide data to support monitoring by the Team Manager within supervision • Exception reports provided to the Clinical Service Lead within Team Manager meetings as standing agenda items. • The final audit identified evidence of improved practice in this area	
			3. Completion and quality of risk assessments and care plans/ risk management plans to be monitored through Supervision to ensure actions are being taken.	Croydon Early Intervention Service Team Manager, Psychosis CAG	On-going as part of supervision **Action Complete**	• Supervision templates now include risk assessment for each staff member to ensure that the completion and quality is monitored and the learning from audits shared • Supervision is monthly with the Team Manager addressing any identified gaps • Learning identified from the audits - what have the service learned	

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			4. Monitoring of this recommendation is through the Early Intervention Pathway performance meeting chaired by the Deputy Director of Early Intervention and Complex Care.	Deputy Director, Early Intervention Pathway, Psychosis CAG	Monthly for one year from September 2016 12 month review September 2017 **Action Complete**	The main learning has been using the audits process including completion of final audit to improve the quality of the content of care plans and risk assessments by ensuring that; • Care plans are kept up to date and reflect current needs • Care planning leads to coherent risk management plans • Care plans reflect current risk especially when there is a transfer of care between services or change in the individuals circumstances • When an individual in placed in our Red zone (A risk management tool-red being high risk), this is reflected in all care plans and risk assessments is also updates. • Clear crisis plans are in place on risk assessment and are now regularly reviewed as part of the supervision process The audit process established that the quality of care plans and risk assessments has improved.	
2	SLaM	Service managers must ensure that service user records are completed in line with the trust discharge policy.	1. Psychiatric Intensive Care Unit (PICU) Operational policy to be updated to include expected standards and audit arrangements in relation to discharge and transfers including Home Treatment Team involvement.	Service Director, Acute Care Clinical Academic Group (CAG)	30/11/2017	• Revised operational policy • Ratified at Acute CAG Governance Exec.	Acute CAG Governance Exec. Trust Serious Incident Review Group (monthly)
			2. HTT Operational policy to be updated to include the process for referral from PICU	Deputy Director Acute & PICU Deputy Director Crisis Services	Completed on 31/03/2017 **Action Complete**	• Specific reference to discharge from PICU added to HTT Policy (P48 of policy ratified in March 2017) • Inclusion of PICU referral process will ensure that there is a more consistent approach to the referral processes between PICU and the HTT	
			3. The Acute Clinical Academic Group (CAG) Audit of last 6 months of discharges to home from each Trust PICU Ward	Clinical Service Lead for PICU, Acute Care CAG	31/12/2017	• Completed audit • Audit findings reviewed at Acute CAG Governance exec to identify any further learning and changes in policy	
3	SLaM	The Trust should assure itself that the correct systems are in place to enable staff to readily access advice from trust forensic services.	1. Early Intervention Pathway Leadership team to ensure that Early Intervention services are fully appraised on how to refer and access Forensic advice.	Deputy Director, Early Intervention Pathway, Psychosis Clinical Academic Group (CAG) in conjunction the Clinical Director, Behavioural and Developmental Psychiatry (BDP) CAG	Completed on 20/09/2016 **Action Complete**	• Meeting held between the Deputy Director, Early Intervention Pathway and the Forensic Pathway to clarify the forensic referral process as planned and how the team will be supported with complex cases. An agreed pathway was completed. • Learning from this meeting was shared with the Croydon Early Intervention Service (COAST) on 20/09/2016. A forensic team member met with the team to clarify their criteria for acceptance on forensic team caseload and how to make referral to the team. All COAST team members can access to the forensic leaflets, referral forms and referral guidelines through the COAST team shared folders on the ICT network. • The CAG are confident that the COAST team can access forensic support and advice as required.	Psychosis CAG Care Pathways and Governance Exec. Trust Serious Incident Review Group (monthly)
			2 Forensic services review to ensure there are adequate systems to provide advice to other clinical teams within the Trust. The system should be documented in each team's local operational protocol.	Service Director and Clinical Director of BDP CAG	Completed on 31/03/2017 **Action Complete**	• The Forensic Community Service Operational Policy was updated in March 2017, this details the referral process into Forensic Community Services which includes Assessment Clinical Reviews which support referrers where a patient does not meet the criteria for the Forensic Community Services. • Each Forensic Community Team Leader has shared any changes in local protocol with their local community mental health teams. Assurance is in place that local protocols are working well with team leaders being contacted to provide advice.	Quality Senior Management Team Meeting Trust Serious Incident Review Group (monthly)
			3. To provide assurance on the current systems, an audit will be undertaken to check the knowledge of 2 Team Leaders from each SLaM Borough on how to access Forensic Advice.	Director of Nursing	31/12/2017	• Audit to be drafted • Findings of audit to be reviewed in the Trust Serious Incident Review Group with agreement for additional actions as required.	Trust Serious Incident Review Group (monthly)

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4	SLaM	The Trust should assure itself that guidance and information is available to frontline staff in relation to engaging with the police and probationary services.	1. The Trust has developed close links with the police as evidenced in policy guidance, committees and onsite police presence.	Local Security Management Specialist and Service Director linked to Police Liaison	Completed on 30/09/2017 **Action Complete**	**Accessing and engaging with police to inform risk assessments.** • Blue Light Bulletin - Police Disclosure to Inform Risk Assessment - sent in July 2015. A bulletin was disseminated to all clinical teams providing guidance on how to access police information for risk assessments. • The Local Security Management Specialist maintains intranet pages with current link to the Borough commanders who are linked with each SLaM Borough. **Operation Metallah** • Management of emergency situations – in place. Operation Metallah has been running for a considerable time on the Bethlem site and is well embedded. The Lambeth, Southwark and Lewisham sites rolled it out in the last 8 months. SLaM signed a MoU with the police re attendance on site this month (September 17). This takes place via Operation Metallah. Operation Metallah is primarily a system/structure which is embedded within inpatient units. The ideology behind Operation Metallah is to improve communication, risk assessment of any immediate risks and joint planning/working to safely co-ordinate resources and manage any given situation. This applies to all persons reported missing from hospital. **Police liaison committee and local Police liaison groups** • Held on a quarterly/ bi monthly basis with fixed agenda items for example Operation Metallah, AWOLS and prosecution**s.** **PSTS training incorporates guidance on liaison with the police** • All staff undergo a level of Promoting Safe and Therapeutic Services training. Liaison with the police is included in the course content.	Trust Serious Incident Review Group (monthly)
			2. The Trust's current engagement with probation is on a case by case basis. To improve the interface between the Trust and probation a meeting with be arranged with each of the Local Probation areas to identify any keys areas to improve working relationships. The Trust will review the learning from this and share through the next team leader event.	Director of Nursing	31/12/2017 31/03/2018	• Agenda and actions from meeting with probation. • Action plan to be taken forward to address any identified areas for improvement. • Learning to be disseminated across the Trust • Item to be presented at next Team Leader event to share with team leaders from all CAGs.	Trust Serious Incident Review Group (monthly)
5	SLaM	The trust should assure itself that it has appropriate support and guidance in place for staff to explore treatment and management options for high risk service users.	1. The medicines management policy has been updated to reflect that poor insight should be highlighted as a predictor of poor compliance to early intervention teams, when identified it is important that all medication monitoring options are explored.	Deputy Director of Pharmacy	Completed on 30/06/2017 **Action Complete**	• The Medicines Management Policy was strengthened in June 2017 Section 7.13 Medicines Adherence was updated to include "Clinicians must assess for individual patients the risk of non-compliance with medication. Clinicians must evaluate the risk and ensure that both the appropriate medication is prescribed and that the patient is supported to continue treatment." • Changes in policy communicated through Policy Bulletin and dissemination to key stakeholders. • All services have access to medicines information from the SLAM pharmacy team for advice and guidance. For prescriptions that the SLaM pharmacy dispense they will assess prescriptions for safety (clinical screen) before dispensing.	Trust Serious Incident Review Group (monthly)
			2. The Trust commissions a Medication Management course through Kings College London (KCL). The Trust will ensure that this recommendation is reviewed with KCL to ensure that the course addresses treatment options.	Assistant Director of Nursing, (Professional Development)	31/12/2017	• To be taken to next key account meeting on 25/10/2017 for discussion and inclusion in the course material • Minutes to be provided as evidence with details of any changes to the course	Trust Serious Incident Review Group (monthly)

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			3. The Trust has updated the way community care plans are recorded on the electronic clinical notes system (ePJS). A single Recovery and Support plan is now used which includes • early warning signs and triggers • accessing help in a crisis • how and who the plan should be communicated to	Professional Head of Occupational Therapy and Trust Social Inclusion & Recovery Lead	**Action Complete**	• Updated care plan has provided a holistic view of a patient's care, when interventions should be increased and who this should be communicated with.	Trust Serious Incident Review Group (monthly)
			4. To provide assurance on the current systems, the Trust will audit the knowledge of 2 Team Leaders from each SLaM Borough on how to access advice from pharmacy	Director of Nursing	31/12/2017	• Audit to be drafted • Findings of audit to be reviewed in the Trust Serious Incident Review Group with agreement for additional actions as required.	Trust Serious Incident Review Group (monthly)
6	SLaM	The trust should assure itself that members of the Croydon Early Intervention Service (COAST) understand and can effectively implement the trust safeguarding policy as part of their assessment of patients, their families and/or carers.	1. Audit of safeguarding mandatory training of team members.	Team Leader and Clinical Service Lead	Completed on 30/11/2016 **Action Complete**	• The Trust moved to a new training monitoring platform on 30 November 2016 which provides a full overview of learning and performance data on a single platform. • The Croydon Early Intervention Service (COAST) are supported to comply with training by the Psychosis Clinical Academic Group Business Manager who provides monthly updates to the Team Manager. • The COAST team has a designated Safeguarding lead who oversees Adult and Child safeguarding referrals. • A local Adult safeguarding folder and Children Development of local safeguarding tracker is now maintained on the COAST team shared folders on the ICT network which all staff can access. • Safeguarding is part of the supervision structure within COAST with records reviewed in supervision The audit has provided assurance that a high quality of care is provided and that the policy is understood and embedded effectively.	Psychosis CAG Care Pathways and Governance Exec. Trust Serious Incident Review Group (monthly)
			2. Training dates to be booked and confirmed for all team if gaps in mandatory training discovered	Clinical Service Lead with Deputy Director	Completed on 31/03/2017 **Action Complete**	• All team training is up to date for Safeguarding Children Level 1/level2 and Safeguarding Adults Alerters Plus (3 years) with exceptions for unexpected staff absence	Psychosis CAG Business and Performance Meeting Trust Serious Incident Review Group (monthly)
			3. The Trust has updated the electronic clinical notes system (ePJS) to ensure that all staff are aware of safeguarding requirements and that risk information is recorded and updated on ePJS.	Safeguarding Adults Lead	Completed in July 2016 **Action Complete**	• In July 2016, the Trust updated the electronic clinical notes system (ePJS) to ensure there is better recording of Safeguarding concerns. New forms and guidance is in place o ePJS Safeguarding Children Form o ePJS Safeguarding Adults Form o Help with the Safeguarding Adults Template o Help with the Safeguarding Children Template	Safeguarding Adults Committee Trust Serious Incident Review Group (monthly)