Action Plan following Niche Independent Homicide Investigation for Service user Mr A

Updated 11/11/19

Action Priority Levels identified following Niche Independent Homicide Investigation report

Priority Level	
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
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.
Three	the recommendation addresses areas that are not considered important to the achievement of systems or process objectives. The area of concern relates to minor improvements in relation to the quality of service provision.

Action No	Priority level	Recommendation	Responsible Trust action Lead	Progress against action	Expected completion date	RAG
1	One	The Trust must ensure that clarity is provided to early intervention team staff about what approach to take when there is diagnostic uncertainty (either within a single team or between teams involved in a patient's care and treatment).	Trafford Head of Operations & Early Interventions Consultant	All staff have been made aware that there must be a full MDT discussion, including presence from the medical representative, when deciding to discharge someone from Early Intervention (EI) services. This is regardless of whether the rationale for discharge is due to diagnostic uncertainty or the end of the expected pathway. The Trafford service have carried out local audits to evidence this has been embedded into practice of the EI Team staff are aware to arrange multi-agency meetings if there is uncertainty of which agency will best meet someone's needs and that outcomes of them are clearly recorded. staff have been made aware through local forums that service users are not discharged if staff do not know the outcome of onwards referrals. A Team away day has also taken place in Trafford to raise awareness of the importance of this. Senior managers have also raised this via the Team business meetings and staff supervision records. In addition to this, the Early Intervention Operational Policy for all divisions is currently being strengthened in order to ensure there is robustness around the learning and clear guidance for staff. This will include how cases will be managed if there is diagnostic uncertainty or uncertainty which service should be responsible for leading care. There will also be guidance on expectations regarding second opinions and/or formal consultation from other services such as Forensic Services. The final updated Operational Policy will then be ratified by the Trust Early Intervention Steering Group meeting on 11th December 2019. The Trust are currently planning a Multi-Agency learning Event to take place in early 2020 to share the key findings and areas for learning from the Niche Independent Review into the care and treatment of Mr A.	31/10/19	

Action No	Priority level	Recommendation	Responsible Trust action Lead	Progress against action	Expected completion date	RAG
2	One	The Trust must ensure that clarity is provided to the early intervention team about the process for seeking a second opinion and/or formal consultation with another clinician or team (in particular the forensic team) when a patient has not responded to treatment for a prolonged period of time and where risks are escalating.	Trafford Head of Operations and Adult Forensic Consultant Psychiatrist Dr AH	The EI Team is able to demonstrate how the team are referring to forensic services for clinical opinion/risk management guidance where a service user is not responding to treatment for a period of time and where risks are escalating. Systems are in place across services whereby difference of opinions within teams regarding the use of the Mental Health Act. Initial resolution of any conflicting opinions will take place within multidisciplinary meetings that are recorded on Paris. AMHPs within the team are involved in such discussions. Learning from AB in relation to the Recommendations made by Niche has been raised at the Trust wide Early intervention Steering Group on 14/05/2019	31/5/19	
3	One	The Trust and relevant local authorities must ensure that where systems do not already exist: • when there are doubts or differences of opinion about the use of the Mental Health Act, a formal discussion that involves an AMHP takes place and is properly recorded; • the AMHP teams on duty during normal working hours and out of hours have a system to record all requests for Mental Health Act assessments, even when it is expected that a clinical team will contact the next shift.	Trust Head of MHA Legislation	Requests made to AMHP teams during normal working hours go through a single point of access in each division and referrals are recorded on the clinical system. Services also have 'trackers' in place to monitor the progress of referrals. Out of hours services keep a record of activity including MHA referrals and divisions' EDT services can record progress notes on the Trust clinical record. For any divisions where the EDT service is not yet able to record on the clinical record, training and access to the system is being arranged. In the interim, EDT services ensure that details of assessments are fully recorded and communicated to relevant professionals. Compliance with the MHA and AMHP related matters are monitored via the Trust's Mental Health Act and Mental Capacity Act Compliance Committee.	31/5/19	

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4	One	The Trust must ensure that all clinical teams follow trust safeguarding policies when they are made aware of safeguarding concerns about children or adults, and that appropriate referrals are made to the relevant social care department.	Trust Head of Safeguarding	The Trusts suite of Safeguarding Policies and Procedures developed by the organisations Safeguarding Team ensures that the Trust complies with relevant legislation and guidance on the safeguarding of its service user population. These policies are supported by a comprehensive Mandatory Training programme in order to raise awareness on how staff can raise a safeguarding referral where services users may be at risk. Abuse/neglect indicators are also discussed within the training alongside referral pathways. Compliance against staff accessing safeguarding training is monitored by the Trust Safeguarding team, and Trust Learning and Development department. The Trusts Safeguarding intranet page has been updated which provides tools and resources for all staff to access. Divisional/service safeguarding leads are also in place to provide local advice and guidance within teams. Internal audit of staff awareness of safeguarding policies and processes is currently being completed.	30/4/19	

5	One	The Trust and Salford Royal NHS Foundation Trust must ensure that when recording that a patient is being treated under the DoLS framework the appropriate documentary detail is in place to apply the Mental Capacity Act lawfully.	SRFT Associate Director of Governance and GMMH Head ofMHA legislation	A clear procedure is now in place within GMMH for recording when a patient is being treated under the DoLS Framework. The Trust now has a Mental Capacity Act and DoLS policy that provides clear guidance for staff in terms of the legal frameworks, assessment documentation and recording processes. A centralised email address has been established to ensure that DoLS applications are received centrally to facilitate oversight and monitoring of the authorisation processes and ensure that supervisory bodies are regularly contacted in regards to statutory timescales and assessments. Contact with supervisory bodies is now also recorded in the clinical record to evidence that authorisations are being pursued and new legal categories relating to DoLS have been added to the clinical record system to ensure that the legal framework is accurately recorded. Notifications to the CQC for authorised DoLS are also completed centrally within the Trust. In respect of SRFT, processes have been improved and staff are more confident in recognising when there is a need for DoLS and MCA. Staff are adhering to processes and further work is being undertaken in relation to the documenting of actions, decision-making etc. The DoLS team at SRFT was also being strengthened via the development of a Named nurse for Safeguarding along with two further posts. There is central oversight of DoLS and these are actively monitored to ensure that the legal frameworks are in place. A long-term strategy is to harmonise DoLS processes across the Care Alliance.	30/6/19	

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6	Two	The Trust must assure itself and its commissioners that when actions are implemented there is sufficient evidence of the effectiveness of the outcome or change in practices.	GMMH Medical Director	The Trust Post Incident Review Panel monitors progress against action plans that support Trust Investigations. Actions outstanding beyond their due date are escalated to the service Head of Operations and Divisional Associate Director for clarification on how actions are being progressed and expected completion date. Heads of Operations are invited to present back to the PIR panel to assure the panel of the effectiveness of actions implemented and how these will change local practice. Multi-Disciplinary Learning Events take place after all Serious incident Reviews and service managers leading these events provide feedback to the Trust PIR panel regarding how learning has been shared. Quarterly Quality and Performance meetings with our commissioners also provide opportunity for discussion and assurance on progress on action plans supporting serious incidents	30/6/19	
7	Two	The Trust must ensure that it fulfils its responsibilities under Duty of Candour and that appropriate guidance and oversight is provided to staff to enable them to execute the responsibility appropriately.	Deputy Director of Governance	The Trust Being Open and Duty of Candour policy is clear in highlighting staff roles and responsibilities in relation to the Trust meeting its statutory obligations in accordance with Duty of candour. The Trust Being Open policy has been strengthened following the Niche Review into Mr As care and treatment in relation to how review teams engage with families following a serious incident. The Trust has an open, honest and transparent culture in saying sorry following a serious incident where harm occurs to a service user in our care. Training and awareness raising has been delivered to front line teams and SLTs across divisions in relation the Duty of Candour requirements. In December 2018 GMMH introduced a Bereavement Liaison role who is responsible for supporting service users, carers and staff who have been affected or bereaved following a serious Incident resulting in an individual's sudden unexpected death. This role has enhanced how GMMH executes its statutory Duty of candour in a timely manner. Carers/relatives are invited to participate in the Trust internal investigation process and are provided with a supportive reading and copy of the final investigation report with a formal written apology offered where care delivery concerns have been identified during the investigation process.	31/5/19	

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8	Two	The Trust must ensure that an appropriate prescribing plan is developed and implemented when patients are at risk of becoming homeless or not registered with a GP.	GMMH Medical Director	The Trust is a key partner in the Manchester Homelessness Task Group which feeds into the GM Homelessness Action Network. The Trust have developed pathways that address the specific prescribing/ dispensing plans for this vulnerable group of individuals who are at risk of becoming homeless. These pathways have enabled us to identify the enhanced requirement to engage and support service users and enhanced efforts are in place to enable patients to register with a GP as part of the pathway for those homeless or vulnerable of becoming homeless. Prescribing to individuals who are homeless are or at risk of becoming homeless is now built into care planning of this service user group and where required the homelessness team will then support. The Trust will complete an audit into to how prescribing plans are being implemented in accordance with the homeless pathway. The Trust have also introduced IAPT services and Community Prevention Services who are now based within the key community and voluntary sector organisations to support individuals who are homeless. The Trust Mental Health and Homelessness Operational Group have developed pathways following discharge from inpatient services back into the community and are now developing prison discharge plans for service users being released from prison. We are also developing best practice models around IAPT for homelessness and Prison releases who are at risk of homelessness. The Trust are also in final stages of agreeing a hospital discharge plan between GMMH and MFT. The Trust are working in partnership with housing providers and we have introduced dedicated staff to deliver relevant training workshops to housing providers teams in relation to individuals at risk of homelessness. The Trust are also participating in research being led by the peer Led Mental health Action Group who are leading research with 'Shelter' in relation to 'The prescribing of medication for those at risk of becoming homeless '	30/11/19	
9	Two	The Trust must ensure that when care plans are developed patients and their carers are given the opportunity to contribute to the content, in accordance with Trust policy.	Associate Director of Rehab, IAPT Bolton and Salford services	Service user and carer engagement is one of the Trusts core values and our recently published Service User and Carer strategy highlights how working collaboratively with service users and carers to develop meaningful care plans that support recovery is fundamental, providing service users and carers with the opportunity to feedback on the quality of care they have received so that the Trust can continually improve its services. Care plans are frequently audited by all teams to demonstrate where these are completed collaboratively with services users and carers	30/4/19	
10	Two	The Trust and their commissioners must be assured that the investigation, management and oversight of serious incidents is appropriately undertaken.	Deputy Director of Governance And commissioners	Regular quarterly meetings with our commissioners enable the Trust and Commissioners to have oversight of serious Incidents and to agree closure of serious incidents reported through the STEIS system. Assurance in relation to how serious Incidents are managed is provided back to commissioners via their monthly CCG Serious Incident oversight groups. Escalation reports are provided to the Trusts Post Incident Review Panel and Associate Directors for action taken in response to outstanding actions recommended through SUI investigation reports	31/5/19	
11	Three	The Trust must assure themselves that when patients are entered into a clinical trial there is evidence to indicate that they are an appropriate candidate for that trial.	Head of Research and Innovation	The Trust's Research Conduct Policy ratified in January 2018 highlights the standards to be implemented to ensure that each study or clinical trial carried out complies with current legislation and guidance for research involving Greater Manchester Mental Health NHS Foundation Trust (GMMH) staff, facilities, patients and/or patients' data. The Trust Research & Innovation Standard Operating Procedure incorporated into this policy also provides clear guidance in relation to the appropriateness of individuals involved in any Trust research or Trial.	31/5/19	