Mersey Care NHS
NHS Trust

Action Plan - Independent Review Recommendations

Version 22 06.11.14

In April 2010 Mersey Care NHS Trust commenced an Internal Review, in June 2011, in response to this work commenced on the development of an action plan. In November 2011 the Independent External Review commenced and in October 2012 the Trust commenced work to identify actions to address the 14 Recommendations and to incorporate outstanding actions from the Internal Review.

The Internal Review and the Independent External Review highlighted key areas or work to address the recommendations:

- Risk assessment, formulation and risk management
- Treatment: Need to be in line with national best practice guidelines and NICE guidance.
- Discharge planning
- Communication: internal and external
- Care Programme Approach
- MDT Functioning
- Victims and Carers
- Standards of clinical record keeping

This action plan aims to address these areas in line with the recommendations. In addition the work and actions initiated following the Internal Review have been incorporated.

Contributory Factor One: There was a failure to understand Mr Y in his full diagnostic context. This in turn contributed to a failure to understand his risk and the future requirements of any care, treatment and management plan.

Recommendation 1: A systematic audit of diagnostic practice within the Scott Clinic should take place to provide assurance to the Trust Board and commissioning bodies six months following the publication of this report. The audit should include:

- an audit and assessment of formulation practice to include aspects of clinical profile and potential risk;
- an in-depth case study sample should be audited to check for compliance against accepted diagnostic criteria.

ACTION	AIM	LEAD	PROGRESS	RAG RATING Feb 14	Current	EVIDENCE
1.1 A panel comprising the Clinical Director of SaFE Partnerships CBU, a consultant psychiatrist from Liverpool CBU and the lead psychologist from Ashworth to undertake an audit of diagnostic practice within the medium secure services. This will evaluate the use of recognised diagnostic algorithms and the application of agreed definitions of psychopathology. Twenty-five per cent of the community case load has been identified.	To ensure that diagnostic practice within the medium secure service adheres to recognised national/international approaches (e.g. ICD-10).	Forensic Psychiatric Consultant	Commenced July 2013 Completed November 2013 and will be presented at the audit meetings.			See evidence 1.1 Summary and audits
Adherence to accepted approaches to diagnosis ensures that the understanding of the patients' problems is informed by the most relevant evidence base. This is particularly relevant to the first two of the above outcomes. Safer outcomes are likely if there is an informed and evidence based understanding of						

the psychopathology and this is necessary to make decisions about interventions. The relevant to engagement and communication with external agencies is that diagnostic information communicated is more likely to accurate.

Service Issue One: The Scott Clinic practiced an unacceptable level of medicine management in the case of Mr. Y. Whilst this cannot be cited as either a contributory or causal factors it demonstrates a lack of medicines management systems and understanding on the part of Scott Clinic.

Contributory Factor Two: Mr. Y did not receive treatment in line with national best practice guidelines. This represents a missed opportunity that left Mr. Y vulnerable.

Recommendation 2: The Trust medicines management policy should be reviewed/redeveloped to ensure that service users who have been conditionally discharged are managed effectively in the community. This review should include:

- the clarification of definitions between service user medication adherence and service user medication concordance;
- developing sections that set out the requirements for service user and carer education regarding medication purpose, usage and side effects;
- including the requirement for service users with a history of medication non adherence to have a medicines management care plan which is reviewed on a regular basis.
- sections that set out the requirements for the education and support to be provided to non statutory agencies involved in the care of service users in the community.

The reviewed/redeveloped policy should be audited 12 months after the date of its inception

ACTION	AIM	LEAD	PROGRESS	RAG RATING Feb 14	Current	EVIDENCE
2.1 The review of CPA documentation should ensure a section is included in the assessment document 'history of medication non adherence'		Forensic Integrated Resource Team Manager	Completed New CPA documentation implemented by June 2013			See evidence for recommendation 5. (MDT Assessment document)

2.2 Changes to the Mersey Care NHS Trust Medicines Management Policy to include the recommendations.		Chief Pharmacist Pharmacist	Policy updated July 2013.			See evidence 2.2 SD12 Policy and Procedure for handling medicine within Mersey Care NHS Trust

Service Issue One: The Scott Clinic practiced an unacceptable level of medicine management in the case of Mr. Y. Whilst this cannot be cited as either a contributory or causal factors it demonstrates a lack of medicines management systems and understanding on the part of Scott Clinic.

Contributory Factor Two: Mr. Y did not receive treatment in line with national best practice guidelines. This represents a missed opportunity that left Mr. Y vulnerable.

Recommendation 3: Service users at the Scott Clinic should receive a broad spectrum of treatment in line with NICE guidance. This treatment should be:

- delivered by therapists experienced and trained in the therapeutic interventions prescribed;
- mindful of the need for family-focused therapy requirements; this to be of particular note if there is a history of either violence or sexual abuse involving family members; in keeping with the therapy-service approach to be found in all other parts of the Trust.

ACTION	AIM	LEAD	PROGRESS	RAG Feb 14	Current	EVIDENCE
3.1 Conduct audit of Psychological treatment needs of Medium Secure Unit /Forensic Integrated Resource Team service users including primary and secondary diagnosis and current presenting difficulties and risk associated behaviours. The audit includes current therapeutic intervention. Audit to include the following: • Review relevant NICE guidelines • Schizophrenia		Enhanced Care Team Lead	Audit completed 15th May 2013 Audit report completed 30th June 2013 Review of guidelines completed 30th May 2013 Data to be incorporated into audit report, completed 30th			See evidence 3.1 An Audit of Psychological Need and the Implementation of NICE Guidelines within Medium Secure Psychiatric Services

• Self Harm • PTSD • Borderline Personality Disorder • Depression • Anti-social Personality disorder • Eating Disorder This will also include a review current psychological therapy provision within the Medium Secure Unit and the FIRT against level of need.			June 2013			
3.2 Secure Division to develop psychological standards in relation to access to appropriate therapies this will include CBT, Schema Therapy and other therapy's		Enhanced Care Team Lead	In April 2013, work commenced to agree psychological standards. This work has now been completed			See evidence 3.2 Secure Division psychological standards
3.3 Deliver a broad spectrum of treatment in line with NICE guidance		Enhanced Care Team Lead	To meet this recommendation the trust implemented the enhanced care service (see attached document). The service provides a full range of psychological treatments. Through an evolution and rationalisation of the			

			service Integrated Psychological intervention is provided for all service users by the ECS. As well as the specific treatments outlined below the psychological intervention provides comprehensive clinical formulations for all service users to inform treatment and care. This encompasses risk assessment. The service also works with ward staff to facilitate a systemic approach facilitating a cohesive understanding of the service users complex needs			

Contributory Factor Three: There were serious failures in the implementation of the terms of Mr. Y's conditional discharge. This meant that the conditions put into place by the Ministry of Justice to protect the public were rendered ineffective

Recommendation 4: The Trust should develop a specific set of clinical guidelines regarding the requirements for treating teams when receiving conditions for discharge on behalf of the patients in their care. These guidelines should include the need for:

- robust risk assessment;
- consultation and involvement of service users;
- consultation and involvement of carers and family members;
- clear and well communicated care plans;
- the clarification of roles and responsibilities for the implementation, monitoring and review of the conditions of discharge;
- a communication strategy that ensures all partners in care, multi agency personnel, and family members are kept informed and can provide feedback.

ACTION	AIM	LEAD	PROGRESS	RAG Feb 14	Current	EVIDENCE
4.1 Develop Clinical Guidelines as standards based on a literature review of best practice in risk assessment and management and NHS commissioning Board and Standards for Community Forensic Mental Health.	To implement Clinical standards for discharge in MDT process To provide all MDT's with Clinical Standards to inform discharge planning. To ensure MDT's have a standardised approach to the review the service user progress against identified treatment objectives in the care plan To contribute to the understanding of the service users existing needs and help identify how these will be met in future To identify and assess the impact of any service	Enhanced Care Team Lead Forensic Integrated Resource Team Manager	To be ratified by Clinical Governance January 2014 Implemented February 2014			see evidence 4.1 Literature Review May 2013 Clinical Guidelines and Standards

	users non-compliance with the care and treatment plan To maintain a focus on families and carers and consider the possible risk to previous and potentially future victims. To assist the team in identifying previous and potential victims both familial and non-familial and develop a plan for engagement with them in relation to discharge To assist the team in evaluating the complexities of risk factors when familial victims are also potential carers The clinical standards can be audited and therefore provide a further governance mechanism					

The guidelines and clinical standards provide a mechanism to review previous risk, progress, compliance/non compliance with treatment, unmet treatment objectives and developing risk factors. The MDT will review the service users offending history and their index offence; the guidelines assist the MDT in retaining a focus on families/carers/victims and consider their views and needs in relation to the service user's discharge. This should be part of and inform the CPA process particularly in relation to issues of risk

It is envisaged that the implementation of the full Clinical Standards for discharge will maintain these benefits. They will also provide a structured governance mechanism to enable review and audit of decision making processes about service user discharge

Did it change/improve anything
The Clinical standards implemented in February 2014. An audit of effectiveness is scheduled for September 2014

Contributory Factor Four: It was evident to the Independent Investigation Team that Care Coordination did not work to an optimal level and that disparate agencies and individuals inputting into the care and treatment of Mr. Y worked in silos to the detriment of Mr. Y overall case management, care and treatment.

Recommendation 5: The Independent Investigation Team acknowledges the quality of the work that the Trust has achieved to date regarding CPA. The Trust should review the effectiveness of its CPA policy at the Scott Clinic within six months of the publication of this report in order to provide assurance to the Trust Board and Commissioning Bodies.

ACTION	AIM	LEAD	PROGRESS	RAG Feb 14	Current	EVIDENCE
5.1 Audit of current CPA documentation completed on ePEX	To ensure that each service user has upto date completed CPA documentation.	CPA administrator - community CPA administrator – inpatients	**Community Audit** January 2013 Community Audit May/June 2013 Community Audit November/December 2013 Community Audit **In patient audit** June 2012 May 2013 July/August 2013			See evidence 5.1 CPA audits
5.2 Review and implementation of revised service specific CPA documentation and guidelines MDT Assessment Risk Assessment	Provide a framework that facilitates comprehensive assessment and understanding of each service user's risk to self and others. Allows recording and communication of that risk in a clear way to all those involved in	Forensic Integrated Resource Team Manager Clinical Lead Clinical	Completed April 2013 The new documentation implemented June			See evidence 5.2 CPA Guidelines and revised documentation

Care/Risk Management Plan	service user's care and presents both the MDT's and service user's perspectives of risk. Assessment to be used to produce a risk management plan as part of the overall multidisciplinary care plan, incorporating where possible the risk assessment processes and other relevant documents being used in routine multidisciplinary care (eg, risk formulation document used in clinical team meetings, my shared pathway my safety and risks document). A move towards a single care/risk management plan and an outcomes-based approach to planning.	Psychologist	2014.			
5.3 Training for Care Co-ordinators	Following completion of the training it was expected that staff would Understand the main elements of Refocusing the CPA (DH 2008) Apply the latest CPA guidance to their practice as a care co-	Forensic Integrated Resource Team Manager	Social Workers, Occupational Therapist and band 6 Nursing staff identified (as needed to complete this assessment following the training. In May			See evidence 5.3 data base captured the names and dates attended training.

	ordinator Acknowledge the significance of values in the CPA Work in partnership with others, conduct a comprehensive assessment and construct a care plan Identify transition points in care and plan to avoid potential gaps Apply best practice in management of risk Incorporate continuous review into CPA Demonstrate competence as a care co-ordinator		2010 **120 staff** across MSU, LSU and FIRT had been identified for CPA awareness training. Between September 2010 and March 2012 **94 of the identified staff received CPA awareness training.** No further training has been delivered since 2012 and there is currently no standard mandatory CPA training available within the trust.			
5.4 Assess the competency of Care Co-ordinators.	20 Staff identified from MDT's and FIRT, Band 6 and above. Assurance that staff understood CPA and could carry out: Comprehensive needs assessment;	Forensic Integrated Resource Team Manager	This is an on-going process 12 of the staff identified (OT, SW, Nursing band 6 and above)			See evidence 5.4 Care Coordination Core Functions and Competencies. Check list for assessment of

	Risk assessment and management; Crisis planning and management; Assessing and responding to carers' needs; Care planning and review; Transfer and discharge.		The process was fast tracked and enabled the assessment against descriptors of the performance criteria, knowledge and understanding that are required to undertake the role.			competency for Care Coordinators

Due to the robust approach to assessment and communication within MDT's and the sharing of documentation with outside agencies and provider services. This ensures a more effective approach to assessment and risk management, providing a safer service. Decision making is improved as it is informed by the assessment process. Specialist assessments and the outcomes of interventions are incorporated into the CPA process and documentation. Family history and background is gathered from relatives and the needs of recognised carers are documented within the MDT assessments and victim issue reflected in the MDT and risk assessment documentation. The Care/Risk Plan addresses the management of these. The views are families should be incorporated into the assessment and through the CPA meetings.

Improved assessment, understanding and communication of risk should ensure more effective risk management and therefore safer outcome for service users, families and staff. It should also guide decision making and the identification of areas for further assessment and intervention to reduce and manage risk. These documents can be shared with all those involved in the service user's care if appropriate and should communicate the risks in a clear and comprehensive way.

Did it change/improve anything

The documentation has been gradually replacing the old CPA documentation since June 2013 and is therefore in the initial stages of use. The impact of the change is difficult to assess at this point. . During CPAs and clinical team meetings more focus has been given to the recording of understanding of risk on the risk formulation guide, which is part of the risk assessment form, and this is used more frequently as a reference when making decisions. Effectiveness of it achieving the aims stated above can be assessed over time.

Evidence of the document being used to produce risk management plans can be seen in the CPA care and risk management plans document. Evidence of its use in making clinical and risk management decisions can be seen in CPA meeting minutes and clinical team meeting minutes. Evidence of the various

documents being consistent can be seen by examination of the various documents (risk formulation guide, HCR 20, my shared pathway) and evidence of safer outcomes and improved communication with external agencies may be seen as service user's progress over time and move into the community.

CPA documents are located within ePEX patient records and can be audited.

The training focused on 9 key areas within CPA

1. Personalisation, Values and the CPA
2. Refocusing CPA – key themes
3. Role, authority and Responsibilities of Care Co-ordinators
4. Transition points in care
5. Comprehensive assessment
6. Managing risk effectively
7. Care planning
8. Whole systems approach
9. Outcomes, evaluation and review of care

MDT members with knowledge and understanding of the CPA process improves the functioning and decision making of the team and an improvement in the practitioners ability to contribute to the assessment of needs and the planning, evaluation and review of care and risk management. Key workers and MDT members have a role in engaging with external agencies, families and carers. Assessment of their competency in this area leads to practitioners ensuring families have the opportunity to provide information and engage in the risk assessment process and discharge planning and involvement of external agencies. The combination of the assessment of competency and improved CPA documentation Ensure safer outcomes for patients, families and staff.
How the action supports theses outcomes

There is a greater understanding of CPA and the importance within the services as previously CPA was seen as an 'add on' to specialist assessments and interventions and not the core of information and documentation.

Contributory Factor Five: Mr. Y was not understood in the context of his full risk profile. Assessments of risk were undertaken in the absence of a robust formulation of the case. Consequently risk management plans and strategies were superficial and non-explicit. This, when taken alongside the failure to abide by the terms of the conditional discharge and decision not to consider MAPPA arrangements, ensure a critical lack of supervision and management. This was to the ultimate detriment for Mr Y's health, safety and wellbeing and to the continued safety of his mother.

Recommendation 6: The Independent Investigation Team acknowledges the quality of the work that the Trust has achieved to date regarding risk management processes. The Trust should review the effectiveness of its risk management processes at the Scott Clinic within six months of the publication of this report in order to provide assurance to the Trust Board and Commissioning Bodies.

ACTION	AIM	LEAD	PROGRESS	RAG Feb 14	Current	EVIDENCE
6.1 Develop MAPPA Guidance for MSU, LSU and FIRT.		Senior Nurse	Guidelines agreed in 2011 and reviewed in November 2012.			See evidence 6.1 Ratified and implemented Guidance
6.2 Develop a MAPPA data base		Mersey Care NHS Trust MAPPA lead	Mersey Care NHS Trust has a database capturing information for all service users across the Trust. This is updated at a local level for the MSU, LSU and FIRT			See evidence 6.2 Anonymised data base
6.3 Police National Computer (PNC) Markers should be reviewed for all MSU and FIRT service users		Senior Nurse Forensic Integrated	PNC Markers, MAPPA and ePEX warnings review template for use every 3 months has			See evidence 6.3 Blank template and completed example

		Resource Team Manager	been developed. This document and use is integrated into the CPA Guidelines for MSU, LSU and FIRT.			
6.4 Agree a protocol for working in partnership with MAPPA and Police liaison		Senior Nurse	Police Liaison meetings MAPPA liaison meetings			

Contributory Factor Six: The discharge process did not address in sufficient detail either the needs of MR. Y or the continued safety of the public, with particular reference to Mrs. Y Senior. The process appeared to have been rushed and coordinated poorly. As a consequence the essential safety nets of care were not put into place to the ultimate detriment of the care, treatment and supervision that Mr. Y received up until the time of killing his mother.

Recommendation 7: Both the Trust and Imagine internal reviews addressed the issues relating to referral, admission and discharge processes in a robust manner. The Trust and Imagine should review the effectiveness of their risk management processes with the Scott Clinic within six months of the publication of this report in order to provide assurance to the Trust Board and Commissioning Bodies.

ACTION	AIM	LEAD	PROGRESS	RAG Feb 14	Current	EVIDENCE
7.1 Develop a checklist for monitoring service providers (commissioned care packages): their interventions and adherence with care plans and agreed care packages, risk and concordance. Ensure providers are aware of the need to monitor provision of commissioned care packages and support hours. Community providers for supported accommodation have been asked to complete the provider information sheet on weekly basis to enable car coordinators to monitor care packages.	To monitor care packages as part of the Care/Risk Management plan with direct information from care providers detailing: • Mental health and evidence of any relapse • Compliance with medication • Evidence of substance use • Activities of daily living • Concerns around vulnerability and safeguarding issues • Visitors/significant others and the purpose of contact and identified risks • Number of failed visits due to service provider and service user As necessary concerns while be raised and shared with commissioners	Forensic Integrated Resource Team Manager	Implemented April 2013 All providers have engaged (apx 9). Quarterly reports are complied, there have been no concerns raised with commissioners and no noted failures to deliver care.			See evidence 7.1 Provider information document
7.2 On-going quarterly summary of information returned from providers. To be shared with CCG's if any concerns are raised or any gaps/failure in service			This will be an on-going action commencing Quarter1 2013			See evidence 7.2 Quarter 1 provider feedback report Q1 and Q2 completed for

provision.	Information is used to consider compliance with: Treatment CTO MoJ restrictions Information helps to monitor indication of early warning sings and contact with relatives and carers		Completed for: Q1 May June Q2 July August September Q3 October November December			evidence
7.3 Imagine and Mersey Care NHS Trust to develop guidelines for failed visits to Forensic Integrated Resource Team service users.	• To ensure that staff ensure the service users safety in the event of the Service user not attending an arranged meeting • To monitor the commissioned care plan and package of care • Ensure appropriate communication between Imagine and Mersey Care NHS Trust • To assist in discussions regarding risk management through care plan • To be reviewed at CPA reviews	Forensic Integrated Resource Team Manager Imagine				See evidence 7.3 Imagine Procedure
7.4 Prior to a CPA Review. Providers should complete a summary to contribute to the sharing of information.		Forensic Integrated Resource Team				See evidence 7.4

		Manager				
7.5 CPA Care plans to detail (a) Community care providers, support hours and role. (b) CTO conditions (c) MOJ restrictions All FIRT Care Coordinators to review existing CPA documentation.	• To ensure the FIRT Care Plans promoted effective risk management • A clear understanding of expectations and roles in the Care Plan in addition to clearly documented restrictions (CTO or MoJ) •Effective communication relating to Care Plan and restrictions	Forensic Integrated Resource Team Manager	Completed July 2013 All FIRT Care Coordinators reviewed existing CPA documentation. July 2013 ePEX documentation demonstrated that A, B and C information is available.			See evidence 7.5 examples
7.6 Provide GP's and services involved in delivering care with updated CPA documentation.		Forensic Integrated Resource Team Manager				See evidence 7.6 Letter to GP Letter to service provider
Monitoring the details and implementation of a care providers care plan adds another layer of assurance that risk are being managed in the community. This feed back sheet provides details that mental health service may not routinely get when visiting a service user due to staff availability. The information together with information gathered by other professionals involved ensures safer outcomes for patients, families and staff as there is increased communication and information sharing. The feedback forms have improved engagement and communication with care providers. **Did it change/improve anything** Prior to the implementation of the feedback form concerns had been raised by care co-ordinators that failed visits and details had not been shared and service users had not received full commissioned/funded hours. There was a risk that the CPA Care Plan was not fully implemented						

and risk not managed. Once feedback was requested and details of compliance with care plan and failed visits requested, the number of failed visits greatly reduced. This has improved communication and information sharing.	

Recommendation 8: Guidance should be provided to clinical staff as a part of the Clinical Risk and CPA policy documentation which sets out requirements for service user engagement in therapeutic work and long-term care planning. Guidance should be provided in the following areas:

- when taking positive risks;
- When balancing aspects of a recovery programme with an individual service user's choices and wants which may run counter to that person's best interests.

ACTION	AIM	LEAD	PROGRESS	RAG RATING	EVIDENCE
8.1 Recommendation 5 and the development of CPA guidelines include guidance for staff for the completion of the newly developed risk assessment and risk formulation CPA document, in addition the new care plan incorporates My Shared Pathway with an emphasis on recovery but also includes the management of risk. CPA Guidelines link to • SA10 Risk Policy. • My Shared Pathway and Recovery Outcomes.		Forensic Integrated Resource Team Manager Consultant Occupational Therapist Nurse Consultant	Reviewed and updated August 2013		Links to recommendation 5
8.2 Local guidelines to be developed	For a local interpretation of the SA10 policy to be	Nurse Consultant	December 2013.		

based on SA10 Policy and Procedure for the Use of Clinical Risk Assessment Tools through discussions with the Psychological Practice Group and Quality and Effectiveness Group	developed in collaboration with various clinical and operational groups within the service. The aim is to refocus practitioners thinking to ensure that risk assessment and subsequent formulation and management although captured within a separate policy should run in parallel with the CPA Policy and practice. That formulation is a central aspect of the CPA process.				
8.3 HCR-20. (Version 3) training		Nurse Consultant	HCR-20 Version 3 training delivered by Dr Doyle (University of Manchester) on 17 January 2014.		
The introduction of local interpretation of SA10 has ensured • Formulation of risks are developed by the MDT and are a recognised output from the CPA process • This ensures more informed decision making for patients, family and staff • Provides a better understanding of risk and decision making through increased access to a boarder spectrum of specialist assessments • Improved structure and format of risk related communication with external agencies • Allowed for refinement for pre admission documentation as well as timescales and focus of immediate risk assessments such as START and HCR-20					

Contributory Factor Eight: The Scott Clinic failed in its duty of care to Mrs. Y Senior. This left her unsupported and ultimately unprotected.

Recommendation 9: The Independent Investigation Team acknowledges the quality of the work that the Trust has achieved to date regarding carer assessment and involvement processes. The Trust should review the effectiveness of its risk management processes at the Scott Clinic within six months of the publication of this report in order to provide assurance to the Trust Board and Commissioning Bodies.

ACTION	AIM	LEAD	PROGRESS	RATING	EVIDENCE
9.1 Audit carer involvement and the offer of carer assessments. Audit to be used for the development of an action plan to address gaps		Consultant Occupational Therapist Forensic Integrated Resource Team Manager	Community audit completed February 2013		See evidence 9.1. Inpatient and Outpatient Carer audits
9.2 Set up a data base to identify known victims and victim liaison details. In addition to this, this database will also capture carers of family members who have either been injured or traumatised.		Forensic Social Worker PA to Forensic Integrated Resource Team Manager MHLaw Administrator	Database has been devised and agreed and the transfer of information has commenced December 2013		
9.3 Letters to be sent to carers informing		Forensic Integrated	End of May 2013		

them of right to assessment.		Resource Team Manager Consultant Occupational Therapist			
9.4 Ensure CPA, risk formulation and HCR20 robustly assess the risk to previous or identified potential victims and management strategies are evidence is CPA Care/Risk Management Plan		Forensic Integrated Resource Team Manager	May 2013		
9.5 Complete Triangle of Care Action Plan.		Consultant Occupational Therapist	Triangle of Care Audit has been completed integrate action next stage is to integrate the action plan from Triangle of Care Audit into current Independent Review Action Plan The Triangle of Care is now being audited on a monthly basis across the CBU by the AMMs/Clinical Leads.		See evidence 9.5 Triangle of Care

Contributory Factor Eight: The Scott Clinic failed in its duty of care to Mrs. Y Senior. This left her unsupported and ultimately unprotected.

Recommendation 10: When carers or family members are either injured or traumatised by a Trust service user the Trust should make available to the carer or family member a support package that address on-going needs and the offer of a therapeutic input/counselling etc. If deemed appropriate.

ACTION	AIM	LEAD	PROGRESS	RATING	EVIDENCE
10.1 Develop Victim Liaison Guidelines (Domestic Violence, Crime and Victims Act 2004)		Forensic Social Worker			
10.2 A Policy to support carers or family members who are either injured or traumatised by a service user of Mersey Care to be developed		External Consultant			

Contributory Factor Nine: Significant failures to manage Mr. Y Section 117 aftercare arrangements and terms of his conditional discharge meant that his Supported Living provision was inadequately planned from the outset. This had the effect of creating a degree of instability in the life of a person who required structure and certainty and also prevented realistic proactive measures being put into place.

Recommendation 11: The Local Authority, Supporting People, Commissioning Bodies, Imagine and Mersey Care NHS Trust should ensure the following actions take place.

- Contracts must be more robust and reviewed regularly in terms of performance and cost by all agencies involved in the contract and/or the care of the client, at least annually with all agencies present. The principal objective must be to establish the primacy of the safety of clients, staff and the general public.
- The relationship between funders, social care and residential care providers and mental health care providers must be discussed, agreed and recorded in service contracts.
- Decisions about long-term packages of care for individuals eligible for Section 117 aftercare MUST be based upon clinical assessment and need and MUST not be made by any single agency outside of the appropriate multi-agency arrangements.
- Ministry of Justice requirements must be complied with at all times, specifically in this case residential requirements. The environment at 133 Moscow drive did not contribute directly to this event, however, on reflection some changes to the physical environment may improve the safety and effectiveness of the property.
    - Move the staff flat to the ground floor; this will improve the staffs' awareness of whether residents are in or out of the premises and whether visitors are present.
    - Install an intercom system between the staff flat and the residents' flats to allow residents to call staff or vice versa.

Modify tenancies to allow staff to retain a copy of residents' keys for use in emergencies e.g. a resident being ill and unable to leave the flat.

ACTION	AIM	LEAD	PROGRESS	RATING	EVIDENCE
		Chief Nurse/Head of Quality (CCG) Divisional			

		Manager (Local Authority)			

Contributory Factor Ten: The Standards of clinical record keeping and interagency communication were poor. This made a significant contribution over time to Mr. Y being neither understood nor managed in the full context of his mental illness in a multiagency arena.

Recommendation 12: The Trust should conduct a clinical records audit at the Scott Clinic in order to assure both compliance and quality. This audit should include:

- risk assessment and risk care planning documentation;
- CPA documentation;
- ward round discussions;
- diagnostic and risk formulation;
- rationales for decisions taken;
- evidence of a dynamic approach taken regarding evaluation and review.

ACTION	RATING
Tony Ryan associates carried out the following audits: Audit 1 MDT attendance Audit 2 HCR20 completion Audit 3 HCR20 quality Audit 4 HCR20 formulation Audit 5 Staff knowledge of index offence Audit 7 Risk assessment and management Audit 8 Working with community providers Audit 9 CPA reviews Audit 10 Record keeping, quality and compliance with good practice Carer Engagement analysis replaced initial agreed audit 6	

Contributory Factor Ten: The Standards of clinical record keeping and interagency communication were poor. This made a significant contribution over time to Mr. Y being neither understood nor managed in the full context of his mental illness in a multiagency arena.

Recommendation 13.1: The minutes of meetings between agencies, e.g. Section 117 planning meetings etc. should be documented clearly within service users' clinical records. A clear audit trail should be created at each juncture on a service users' care pathway where one or more agencies are involved. With particular regard to Imagine Services the Scott Clinic should:

- be required to make a recording in Imagine notes on every visit;
- ensure clinical risk assessment documentation be clearly separated from social care and support assessments to give clarity of responsibilities to staff from all agencies; risk and CPA documentation must be sent out to Imagine at the same time this documentation is forwarded on the GP.

ACTION	AIM	LEAD	PROGRESS	RATING	EVIDENCE
13.1.1 All updated CPA documentation to be shared with providers, GP and all relevant agencies involved in providing care.	Provide up to date risk assist and care plan Contact details updated Care plan and intervention details Improve communication and decision	Forensic Integrated Resource Team Manager	To be completed end of July 2013 Progress This has been fully implemented and standard practice within the service Where can the evidence be seen or how can you provide evidence This is noted on ePEX and covering letter is saved in patient documents on ePEX. Blank template is included in the evidence file.		

	making with external agencies				
13.1.2 All staff informed that following contact with service user in the community notes must be made on the providers case note entry system		Forensic Integrated Resource Team Manager			Minutes of meeting 02.05.13

Contributory Factor Eleven: Policy non adherence made a significant contribution to the poor overall management of Mr. Y's case which was to the overall detriment of his health, safety and wellbeing.

Recommendation 13.2: The Independent Investigation Team acknowledges the quality of the work that the Trust has achieved to date regarding governance and policy adherence processes. The Trust should review the effectiveness of its risk management processes at the Scott Clinic within six months of the publication of this report in order to provide assurance to the Trust Board and Commissioning Bodies.

ACTION	AIM	LEAD	PROGRESS	RATING	EVIDENCE
Review Clinical Governance arrangements for Medium Secure Services		Acting Service Director Forensic Psychiatric Consultant	A document was created for Governance Arrangements, SaFE CBU, during its pilot phase highlighting the governance model; structure that would support governance; individual service governance structures etc dated August 2009. The final version of the Clinical Business Units – Accountability Framework was submitted on the 23rd March, 2010. This document informed our new Governance Arrangements. The SaFE Partnerships CBU Integrated Governance Framework was confirmed on the 20.01.11 with Terms of Reference for all the Groups.		

			In October 2012 the Integrated Governance Framework was reviewed to streamline and include CQC Standards and Outcomes. Currently the new Secure Services Division has created a new current framework – work is on-going with the Interim Service Director to inform our now Governance arrangements.		

Causal Factor One: There was a failure by the Scott Clinic treating team to ensure that best practice clinical policy guidance was applied to the care and treatment of Mr. Y consequently Mr. Y case was managed in an unstructured fashion which placed and over reliance upon 'gut instinct' over and beyond clinical formulation. This was compounded by the weak discharge planning process that ensured when Mr. Y went to live at Moscow Drive. Protective measures were not put into place in accordance with statutory expectations to the ultimate detriment of Mr. Y's recovery and the health and safety of his mother.

Recommendation 14: The Independent Investigation Team acknowledges the quality of the work that the Trust has achieved to date regarding team working and operational processes. The Trust should review the effectiveness of its risk management processes at the Scott Clinic within six months of the publication of this report in order to provide assurance to the Trust Board and Commissioning Bodies.

ACTION	AIM	LEAD	PROGRESS	RATING	EVIDENCE
14.1 Implementation of action plan (Dennis Cullen 2012) from internal review into the care and treatment of Mr Y. This highlighted a key area of work: **MDT function** A formal review of the working of the multidisciplinary teams throughout SaFE Partnerships Clinical Business Unit (CBU) was carried out by Dennis Cullen (need date) with a focus on decision making processes and evidence of collaborative working within the team. Actions from this included the introduction of an operational procedure for all MDT's included the following:		Acting Service Director Forensic Psychiatric Consultant Cognitive Behavioural Psychotherapist Service Development Manager	Fully implemented as of January 2013		See evidence 14.1 6 sources of evidence SaFE Partnerships CBU , a review of Multi Disciplinary Team working. A Review of Multi Disciplinary team working LSU and MSU Presentation: A Review of Multi Disciplinary team working across Merseyside

• Introduced MDT Chair • MDT terms of reference • CPA Review Agenda					MDT Chair Job description MDT ToR and Operational Procedure CPA review agenda
14.2 **Psychological Informed Wards** Reorganisation of the allocation of psychologists has lead to the move towards ward based psychologists working across MDT's but offering a consistent approach to each ward	Enhanced Care Team Lead				
14.3 **Risk Formulation** The development of CPA guidelines for MSU, LSU and the community service has enabled risk formulation to be incorporated into the new risk assessment document to be used within the service.	Clinical Psychologist				See recommendation 5

Outcomes Recommendation 14	RAG rated against recommendation
How the action supports the agreed outcomes **Did it change/improve anything**	