Northumberland, Tyne and Wear NHS
NHS Foundation Trust

ACTION PLAN POST INDEPENDENT INVESTIGATION – Published on Websites

Serious Incident Review Proforma			
Patient ID/Other	**Date of Incident**	**Service**	**StEIS Number**
Patient E	24 June 2008	Bede 2, South Tyneside District General Hospital	2008/5460
Summary of Incident: Female patient was arrested and charged with murder following the unexpected death of her 84 year old mother. She was subsequently convicted of manslaughter.			

Recommendations following Independent Investigation	**Actions Undertaken / Planned**	**Lead / Timescale / Date Completed**
1. The investigation panel considers that the CPA policy of Northumberland, Tyne and Wear NHS Foundation Trust should contain a specific provision that during inpatient admissions, patients with no previous community input should be placed on enhanced care coordination. (Under the latest Department of Health CPA guidance this would mean placing all these individuals on CPA, without having to make the decision at which level they would be placed on, as the process has been simplified	**Policy and Procedure** Trust Care co-ordination policy updated in Feb 2009 incorporating the requirements of Refocusing CPA with an associated Practice guidance note for adults sets out that for admission to wards : 1. Where there is no care co-ordinator in place this role and responsibility is taken on by the ward manager 2. That the in patient team notifies the relevant CMHT of the admission and makes a referral for allocation within one working day of admission 3. The CMHT will allocate a care coordinator within 7 working days of receipt of the referral. 4. The community care coordinator contacts the ward within 1 working day of allocation to agree hand over of responsibilities prior to discharge with the ward manager. 5. The expectation that the community care co-ordinator from the CMHT attends the discharge planning meeting	Completed

since 2008). 2. In light of the above recommendation, the investigation panel further recommends that inpatient services should identify a CPA coordinator within three working days of a patient's admission. This should be written into the acute inpatient services operational policies. It should firmly place the responsibility on the inpatient team to identify a CPA coordinator. Furthermore, it is recommended that the CPA coordinator should be present at the discharge meeting to agree and arrange an aftercare package of care. 3. The investigation panel recommends that community mental health teams respond urgently to requests from inpatient services for the allocation of a CPA coordinator and that within five working days from the time of referral the allocated CPA coordinator makes contact with the patient. This minimum standard will require adding to the CMHTs current operational policies.	6. The discharge planning meeting formulates the discharge care plan identifying the patient's care needs for their immediate discharge and successful reintegration into the community, with particular reference to immediate needs, support in the first week of discharge including 7 day follow up arrangements and the subsequent 3 months. If needed Care co-ordination change of circumstances registration form completed to formalise hand over of care co-ordination responsibility. Care plan to identify section 117 services if S3 and any required locality 117 forms completed. If a service user has children who are subject to a child protection plan or identified as child(ren) in need with a social worker working with the child/ family from children's services, the social worker must be invited to the discharge planning meeting. This is to enable consideration of the impact of discharge on the children including the assessment of the risk and to ensure that appropriate plans are made. Care plan documented by designated member of care team. All discharge planning documentation circulated to care team at least one working day prior to the patient being discharged. In 2012 / 13 in the context of service development and reduction of inpatient beds further work to facilitate a safe and smooth transition between in patient and community services was undertaken with the aim of the process continuing to be standardised across all services whilst being based on patient's individual need and strengthening existing standards. The role of a Community Liaison Nurse was established with key responsibilities, including in relation to service users admitted out of their home locality and when care co-ordinators are unable to attend a clinical meeting These standards and requirements have been implemented, reviewed and audited resulting in version 7 of the transitions guidance which will also be incorporated in to the next Care co-ordination policy and PGN update in 2014. The transitions guidance clearly sets out that:	

	○ all patients being admitted into an inpatient area will have their care managed via the Care Co-ordination (Care Programme Approach (CPA)) process, and will require a Care Co-ordinator ○ Where there is not already a Care Co-ordinator, the admitting nurse will liaise with the Community Treatment Team Manager, so that a Care Co-ordinator can be allocated and subsequently recorded on RIO as such. The Community Treatment Team Manager will look to allocate a Care Co-ordinator within 24 hours of being notified by the ward Until such time as a Care Co-ordinator has been identified, responsibility for Care Co-ordination sits with the Ward Manager **Training and Awareness** All staff are contractually obliged to have a working knowledge of the Trust policies that affect their day-to-day delivery of care. Team managers are required to have a local system to ensure that staff are aware of new policies and procedures. This is consolidated and reinforced within regular supervision. A programme of training is available that is mandatory for all qualified staff that have contact with service users and is detailed within the Trust training prospectus. **Audit and Outcomes** Clinical audit to ensure appropriate implementation of Care Co-ordination is undertaken e.g. the annual Trustwide Quality Monitoring Tool. The Trust's electronic patient record (RiO) produces reports for managers for the supervisory process that identify if key components of Care Co-ordination have been completed. Within the CQC Essential Standards of quality and safety there is a requirement under Outcome 14 for Trusts to ensure that staff receive among other things regular supervision to ensure that appropriate levels of	

	care and treatment are provided and policy and procedure are being observed. Sub groups have been established to look at outcomes 13 and 14 and they have developed an audit tool for wards and departments to complete. This is then sent to the audit department so that the results can be collated and a report produced. A copy of the audit tool is attached below:  CQC outcomes 13 14 audittool _ There is also a programme of mock visits established which includes an in depth look at the dashboards which includes supervision information. In addition each ward/department displays a supervision chart so that supervision dates are visible. This is attached below and forms an appendix to the Trust's supervision policy.  383323477App05 Annual Record _	
4. The criteria for acceptance into the Community Mental Health Teams and the allocation of a CPA coordinator, should operate on the basis of a patient's needs and not be simply led by the diagnosis. An inclusion criteria runs the risk of excluding patients who may well benefit from a service. In this case, the rigidity of working solely with diagnostic led criteria (as opposed to addressing patient E's complex	**Policy and Procedure** Community and Inpatient Transitions of Care Guidelines have been produced as part of the Principal Community Pathways work (current version 7, October 2013 attached)  inpatient and community transi.. This states in section 4.5 that, 'the Community Treatment Team Manager will prioritise the allocation of a Care Co-ordinator to patients admitted to inpatient wards when there is not already a Care Co-ordinator.'	Completed

needs) resulted in the exclusion of patient E from follow up mental health care in the community. The investigation panel recommends that the operational polices of community mental health teams are adapted to remove such restrictions and to institute a more holistic approach to the criteria for admission to these services.		
5. Specifically, a diagnosis that a patient is suffering from a personality disorder and/or alcohol related difficulties should not result in any exclusion of the patient from community services following their discharge from hospital.	**Policy and Procedure** Trust Care co-ordination policy updated in Feb 2009 incorporating the requirements of Refocusing CPA (2008) in line with this guidance from the DOH the Trust does not accept an diagnosis of PD as diagnosis of exclusion and dual diagnosis is part of the CPA criteria. The Trust has established a working group to look at service users with personality disorders and has appointed a Pathway Lead. The Trust has established a Personality Disorder Pathway Development & Implementation group. The draft terms of reference are saved on the database. This group has a key role to play in the strategic direction the Trust takes in relation to Personality Disorder plus a supporting role to its clinical governance structures Copy of the PD business case and a brief outline of its purpose and aims are saved on the database. The Trust has developed a business case for the development of a Specialist Augmentation Personality Disorder Hub team. This team will form part of the overall care pathways for service users within clusters 6 or 8 and who may have a diagnosis of emotionally unstable personality disorder or other personality disorder. The team will deliver the first 3 stages of a 5 stage model of care, focused on safety, containment and emotional control. The team will provide direct care co-ordination, treatment and management to up to 84 service users who present with	Completed

	personality disorder and high levels of risk, chaos or complexity. The team will be Trust-wide, and based centrally in Newcastle, but will provide assessments and advice, support and supervision to community staff, inpatient staff and crisis teams within each locality. They will also run therapeutic groups, contribute to a telephone support service for service users managed within the team and work closely with peer support workers to develop peer support groups in each locality alongside voluntary agencies and other community support structures. Once the hub team is operational, it is envisaged that the team will develop a partial day programme in order to prevent admission to hospital through more intensive therapeutic work, facilitate early discharge from hospital and promote positive social functioning and recovery through meaningful structured therapeutic and occupational activities. The business case is currently being discussed with commissioners across the Trust CCGs. The draft business case version 3 dated 23.08.13 is saved on the database. In addition, there are several members of Trust staff who have expertise in managing patients with personality disorder. These staff help and support staff with the management of such patients which includes the attendance at strategy meetings for complex cases. The joint working protocol outlined in recommendation 2 includes the Forensic Community Personality Disorder Team. The Trust has also established an Advice Consultation and Engagement process (ACE) to help staff when dealing with service users who have a diagnosis of personality disorder. **Primary Role of the ACE Team**: To provide a rapid assessment of diagnosis, formulation, risk, psycho-pharmacology, psychotherapy and social management options for inpatients with Cluster 8 Personality Disorder. To prevent deterioration in Cluster 8 patients whilst in in-patient care by facilitating prompt discharge.	

Secondary Role of the ACE Team:

- To prevent an escalation in self harm and/or suicide attempts whilst in in-patient care.
- To reduce copycat behaviours.
- To prevent delayed discharge and support the role of CRHT EDP.
- To provide support and second opinion without the need for complex case panel (with regards to; diagnostic formulation, positive risk taking, prescribing and signposting to alternative care pathways)


ACE description.doc


ACE Operational Plan.doc

Dual Diagnosis

North of Tyne Services

Community Mental Health Teams can access specialist clinical advice and support from Trust Addiction services.

In addition there is 1 full-time Dual Diagnosis Clinician embedded into North Northumberland Community Mental Health Team and 1 further specialist part – time alcohol clinician based within West Northumberland Community Mental Health Team.

South of Tyne Dual Diagnosis Services

Within Trust South of Tyne Planned Care services there are 7 full-time “Dual Diagnosis” Therapists. All Dual Diagnosis Therapists are highly experienced clinicians in their own right, having now had several years’ clinical experience of working with complex substance misuse issues and co-occurring mental health concerns.

	These clinicians provide expert clinical advice and support across Trust care teams in South of Tyne and are embedded into existing Community Treatment Teams to promote and augment Team clinical skills and expertise whilst working with substance misuse issues and to mitigate clinical risk. All Dual Diagnosis therapists referred to above in both North and South of Tyne Services are in receipt of monthly 1 to 1 clinical supervision from the Planned Care Dual Diagnosis Nurse Lead. **Training and Awareness** <u>Essential Awareness Training</u> Since June 2010 essential awareness NTW dual diagnosis instructor led training has been rolled out for all NTW clinical staff. With Dual Diagnosis Therapists now in post and all contributing to the instructor led training: dual diagnosis essential awareness staff training completion target rates are available on request. <u>Specialist Dual Diagnosis Clinical Training</u> 1. Motivational Interviewing training has been commissioned and hosted in South of Tyne during 2011, 2012 and 2013. 2. For all South of Tyne Trust clinicians there are also now a range of regular “open training events” facilitated by the Dual Diagnosis Therapists in each South of Tyne locality area: e.g. Substance Misuse and Mental Health. A Dual Diagnosis Training Plan for Planned Care services has been developed and submitted to Planned Care Clinical Director for further consideration and potential roll out under the Trust Quality Priority Training	

	plans associated with Transforming Services and Skills Programme. **Audit and Outcomes** The Trust has a dashboard system which is used as a performance tool and training figures are discussed regularly at group Quality and Performance meetings and are reviewed on a weekly basis by the Senior Management Team. The live dashboard percentage for staff who have completed dual diagnosis training at any point in time is available on request. Training figures are discussed at Quality and Performance meetings and are reviewed on a weekly basis by the Senior Management Team.	
6. The Sainsbury risk assessment tool used at the material time considered by the investigation panel was weak in relation to the protection of vulnerable adults. There should be provision within the risk assessment process to prompt and record issues relating to the safeguarding of vulnerable adults and children.	**Policy and Procedure** Trust Care Co-ordination and CPA policy NTW(C)20 ratified in November 2010 incorporates the requirements of Refocusing CPA. The Trust uses the FACE risk assessment which specifically addresses issues relating to the protection of vulnerable adults. The Sainsbury risk assessment tool is no longer used. See safeguarding policies and procedures outlined in recommendation 7. **Training and Awareness** The Trust has reviewed its approach to risk assessment and management training since 2006. Training programmes are continually reviewed and strengthened using evaluations from participants and in line with best practice.	Completed
7. The panel recommends that the risk assessment tool which is adopted is a dynamic tool with the capacity to record on-going incidents of risk and warnings so as to enable a more cohesive and comprehensive risk management plan to be developed, monitored and	**Policy and Procedure** As above, in addition the Trust has reviewed the appropriateness of the tool and an enhanced narrative risk assessment template has been designed to help clinicians be more reflective when assessment and managing risk. The Trust has a designated Safeguarding and Public Protection team which supports all staff in identifying and managing all aspects of this work. The team has been fully operational since January 2012.	Completed Completed

reviewed throughout a patient's admission. Reliance upon mechanistic tick box risk assessments should be avoided	The team is responsible for policy development, training and supervision relating to safeguarding and public protection issues. Where domestic abuse is suspected staff are supported to make appropriate referrals to MARAC (Multi Agency Risk Assessment Conference) and safeguarding (adults and children). Where a patient poses risk to others support is provided to consider risk of serious harm and the need to refer to MAPPA (Multi Agency Public Protection Policy) / PDP (Potentially Dangerous Persons) processes. The following policy and procedures are in place to support staff: NTW (C) 4 Safeguarding Children Policy NTW (C) 24 Safeguarding Adults at Risk Policy NTW (C) 25 Multi Agency Public Protection Arrangements Policy NTW (C) 54 Domestic Abuse Policy	
8. The panel has established that the expressions of concern, alerts and relevant risk incidents were not recorded consistently within the risk profile documentation. Instead, the panel found that although records were made of these warnings, they were distributed throughout the nursing records and as such it would be very difficult for staff to assess the developing overall picture in relation to risk and this therefore hindered the effective review of ongoing risks. The investigation panel recommends that third party information relating to risk should be kept as a composite record which is updated and is immediately available to all health professionals who have access to the records.	**Policy and Procedure** The Trust has an electronic patient record (RiO) which is the patient's principle record and is used by all clinicians. The progress notes section enables any entry to be designated as third party information and / or risk information. All progress notes that are designated as risk information are pulled through onto the record time line. This is in addition to the expectation that clinical staff re-assess risk when new / additional information is provided, from whatever source, and where appropriate update the risk assessment record or record in progress notes where the outcome is no change to assessed risk. The electronic patient record is configured so that each time a new risk profile is created all the information recorded on the previous version atomically pre populates the new record. The process and recording format for each MDT requires consideration of risk information. This has been in place in the paper record via the review form since February 2009 and since the inception of the electronic patient record. The electronic patient record was rolled out to inpatient wards in multiple phases. The first work stream was for performance information, in which all	Completed

This record should routinely be considered at MDT meetings 9. There was little evidence of written records of risk assessment and management plans made within the medical notes. The panel recommends that a minimum standard is set for medical staff that at every MDT meeting (or at least weekly) a joint risk review is conducted by members of the MDT and recorded within the medical notes. The panel further recommends that the Trust undertakes clinical audits of MDT records to assess the quality of risk assessment and management plans that are being considered and recorded therein.	NTW wards began to record admissions, transfers and discharges. There was no clinical information included within this work stream. The clinical phases were rolled out in directorates. All South of Tyne wards went live for performance recording on 13 September 2007. The South Tyneside inpatient wards went live with the use of the clinical record and recording on 24 August 2009. The ward holds a daily review which is a structured multidisciplinary meeting that occurs at the same time each day, seven days a week. The aim of the daily review is to ensure that the patients stay in hospital is focussed and actions needed to support their progress are carried out in a timely manner, whilst at the same time ensuring safety and quality of care are a priority. In order to ensure a standard approach across all areas, guidelines have been produced and are attached below:  Daily review guidelines with templa **Audit and Outcomes** The Trust's Quality monitoring tool supports the clinical audit process in relation to patient records including risk assessment and management. The audit tool has been revised several times since its inception in 2009. In early 2012 a significant review of the Quality Monitoring tool was undertaken, removing content no longer required due to new audits in place, identifying the elements that the electronic health record reports on via the performance monitoring process and associated dashboards and also developing these into a clinical audit dashboard. This allows the clinical audit process by ward / team managers / clinical leads to be much smaller and focus on the qualitative elements of the record including risk assessment and risk management plans. Current audit results are available on request.	

10. The panel considers it would be appropriate for a review/audit to take place in relation to the quality of the mental health nursing care planning process. This should include: o the dating and signing of the care plan by both the nurses and patient; o a change in the care planning documentation, to include a section for making day to day progress recordings in relation to nursing interventions and a separate section to record the evaluations of the effectiveness of the care plan interventions; o consideration of whether or not the MDT care plan adds value to the nursing care planning communication process. 11. There was a considerable amount of information held in the nursing communication sheets relating to identified care plans rather than in the care plans themselves. The panel considers that this detracted from the effectiveness of the nursing care planning process. It is therefore recommended that consideration be given to a review of the use of this	**Policy and Procedure** Since February 2009 and in line with DOH guidance Refocusing CPA (2008) which sets out "To reduce documentation and cut down on duplication, services should aim to develop one assessment and care plan that will follow the service user through a variety of care settings to ensure that correct and necessary information goes with them." The Trust has continued to have a care plan for each service user which sets out the intervention(s) and associated goals of each member of the care team and has discontinued separate nursing care plans that were in use in some services south of Tyne. This approach has been reviewed both through policy review and the review of the electronic patient record. These reviews had led to the discontinuation of patients signing care plans, based on feedback from service users and clinicians that this did not indicate an understanding of the care plan and did not take account of capacity issues. The Trust requires clinicians to share care plans, discuss / explain potential benefits/risks and offer the Service user a copy of the care plan. This approach has been accepted by CQC within their inspection / regulation framework. The Trust's electronic patient record (RiO) has the facility to link any contemporaneous entry to the care plan problem / need types. Additionally the Inpatient care plan format enables the entering of comments (evaluation) when an intervention is closed.	Completed

documentation to ensure that information is recorded in the most appropriate place.		
12. The clarity and legibility of all clinical records are essential qualities to enable appropriate and effective treatment to be delivered. The investigation panel recommends that standards of record keeping are subject to regular review.	**Policy and Procedure** Highlighted in Management of Records policy NTW(O)9, ratified in October 2012 which is NHSLA compliant This includes a practice guidance note on record keeping standards for clinicians, which was ratified in December 2012. NTW is the only trust which has implemented a standard for time in relation to contemporaneous record keeping. **Audit and Outcomes** All information relating to the care and treatment of patients is entered onto the electronic health record. In addition, clinicians have caseload management with their clinical supervisors on a regular basis, which includes a record check of three random open cases. The QMT audit specifically requests information on the content of records and looks for the use of abbreviations, whether the records are contemporaneous and have been validated appropriately. The electronic health record automatically attributes the entry to the person who has logged into the system and dates when the entry was made and validated. Electronic records by their very nature ensure legibility. QMT audit results are available on request. The structure for clinical records (progress notes) developed and used by the Trust's Liaison Psychiatry Service and Crisis and Home Treatment Teams has been shared across the Trust as a model of good practice and is now incorporated into the Trust's training on clinical record keeping. o Present o Update o Mental state examination o Risk factors	Completed

	○ Current medication ○ Plan	
13. The panel recommends that where a vulnerable adult is identified within the risk assessment process as being cared for by a patient, a carers' assessment must be offered as part of the patient's management plan. If the assessment cannot be carried out the reasons for this must be clearly stated within the risk assessment and MDT notes and consideration should be given to registering an alert under the safeguarding procedures.	**Policy and Procedure** Trust Care Co-ordination and CPA policy NTW(C)20 ratified in November 2010 incorporates the requirements of Refocusing CPA which includes taking into account carer/relative views, exploring issues and signposting as appropriate for carers' assessment. Staff need to identify where carers may benefit from a carers assessment and make necessary referrals to the local authority who complete the assessment.	Completed
14. The panel recommends that whenever a social or health care service has any concerns in relation to a service user, insofar as the potential risks that that individual may pose to a vulnerable adult or child, this information should be passed onto all the services involved, including the GP's involved with the patient and the vulnerable person.	**Policy and Procedure** In line with Trust policy in relation to Safeguarding Adults NTW (C) 24, where staff identify a patient poses a risk to their carer then a safeguarding adults referral needs to be made to the local authority. The local authority safeguarding procedures are then applied dependant upon the risk of significant harm with decisions made by the appropriate safeguarding manager. Staff also need to consider a MARAC assessment in line with Trust Domestic Abuse policy NTW (C) 54. Staff can obtain advice and support from the Safeguarding and Public Protection Team. Professionals involved in the care of the patient posing risk to others also need to consider which agencies need to be informed of relevant risk issues – this may be out with the professionals involved in the patient's care but may also need to include those professionals involved in the care and	Completed

	support of the carer. Referrals to external safeguarding and public protection procedures are recorded on an IR3 incident reporting form.	
15. When meetings are held at hospital to consider the discharge arrangements for a patient, it is important that all the agencies who are likely to be involved in the discharge arrangements are invited to attend and do attend insofar as this is practicable.	**Policy and Procedure** The Trusts current Care co-ordination policy incorporating CPA) that was ratified in November 2010 sets out:- 9.11 All service user's will have a pre-discharge meeting involving the service user carers and/or advocates as appropriate, who in partnership with the multi-disciplinary team, including the Care Coordinator or Lead Professional, community staff and other relevant external agencies, will review the service users needs including reassessment of risk and formulate a discharge care plan a copy of which should be offered to the service user and any carer as appropriate. This builds on the policy in place in February 2009 (sees action point 1)	Completed
16. When a patient is discharged from hospital following an inpatient admission, on the day of discharge there should be a preliminary discharge letter sent to the patient's GP outlining the discharge medication and follow up arrangements. A full account should be sent to the patient's GP by the discharging medical team within seven days of discharge describing the patient's progress during the admission, the medication the patient has been prescribed, the	**Policy and Procedure** The transition from hospital to community care has been identified as a time of increased risk by the safety team with the quality and timeliness of discharge communication a key factor in improving patient safety. A new Mental Health Discharge Summary (MHDS) has been developed to create a set of standard headings to capture the information that GPs receive when a patient is discharged from inpatient mental health care. The MHDS was developed in a collaboration between the Royal College of Psychiatrists, General Practitioners and Physicians and facilitated through the Department of Health. The use of the MHDS has been agreed for use within NTW, not only to improve the safety and quality of discharge notifications to GPs, but also within NTW CQUIN targets for 2013. The use of the MHDS allows the Trust	Completed

follow up treatment which has been arranged and any risks that have been identified.	to capture the information that is already being collated and sent to GPs in one place. The new MHDS went live on the electronic record system with effect from 4 December 2013. This replaces all other inpatient discharge summary forms that are currently used by clinicians within urgent care wards, planned care wards and some ward areas within specialist services. Details of the new MHDS were outlined in the Chief Executive's Bulletin published on 10 December 2013.	
17. Where there are concerns in relation to a vulnerable adult living at the patient's home, it would invariably be appropriate for there to have been some professional oversight of home leave in order to inform the decision making process prior to discharging a patient. This should not be confined to self-reporting from the patient but should include full inquiries being made of family members whose views should be given such weight as is considered to be appropriate. When undertaking any such assessment the duty of care owed by health professionals extends beyond the patient so as to include consideration of the risk to others.	**Policy and Procedure** In line with the Trust's leave policy NTW(C) ratified 03 February 2013, prior to going on leave, staff must ensure where the patient is going and what support will be provided during the leave from family, friends and carers. When the patient returns from leave, staff must ensure that the patient is approached and feedback is received regarding the leave, which would also include feedback from family and carers if applicable. The policy also includes a checklist (appendix 7) for leave which prompts staff to consider: 'have carers/relatives/friends been involved in the leave planning and agreed to dates, times conditions of leave'; and, 'have issues of patients coming into contact with vulnerable adults been considered.' In addition, the structured daily ward review as outlined in recommendation 8-9 includes a summary of current risk, family/carer requests and changes to care plans which would include leave consideration / arrangements. Where a patient is identified as posing a risk to those in the family home any leave must consider required risk management strategies, safety planning and sharing information with other relevant agencies. Leave arrangements need to include involvement of the potential victim. Any reported incidents which occur during home leave need to be recorded on the appropriate Trust mechanism. Where this related to risk to others	Completed Completed

	then an IR3 must be completed. Consideration must also be given to reporting this as a safeguarding concern to the relevant local authority to ensure that safeguards are considered for the victim. Review of the leave needs to obtain information from those affected by the leave, not just the patient. This should be incorporated into risk assessment, management and care planning. Support can be provided from the Safeguarding and Public Protection Team Safeguarding processes linked to home leave. Completion of IR3 incident report forms for safeguarding alerts. Multidisciplinary meetings – family members invited	
18. The investigation panel recommends that mandatory training in relation to safeguarding vulnerable adults should be offered to practitioners across all agencies, including GPs, to foster a collaborative approach (involving collective responsibility) when issues arise which relate to safeguarding vulnerable adults. There should be a robust audit of the efficacy of the delivery of this training.	**Policy and Procedure** The Trust has policies in place for Safeguarding Children NTW(C)04 ratified in November 2009 and Safeguarding Vulnerable Adults NTW(C)24 ratified in September 2013. **Training and Awareness** The Trust has comprehensive training programmes in place which are mandatory for all Trust staff and need to be undertaken every three years. Level 1 is for all staff Level 2 is for all clinical staff Level 3 is for staff working predominantly with children and young people (Safeguarding Children) and for senior managers / safeguarding leads (Safeguarding Vulnerable Adults). **Audit and Outcome** Training percentages are monitored on an ongoing basis by senior	Completed

	managers and by individual line managers via staff training dashboards.	
19. All agencies should be mindful of their individual responsibility to initiate safeguarding procedures in relation to vulnerable adults where appropriate. There should be no assumptions made that other agencies will necessarily have done so.	**The information outlined below relates to the current position in relation to Northumberland Tyne and Wear NHS Foundation Trust.** When staff suspect a vulnerable adult is at risk of abuse consideration is to be given as to the need to raise a safeguarding alert to the relevant local authority. Where safe and appropriate to do so this should be completed with the consent of the individual concerned. It must be noted however that this can be overridden where proportionate to the assessed risk. Where safeguarding alerts are raised there is an expectation that the outcome of the alert is pursued and where an alert is not progressed to strategy meeting this must not prevent future alerts being raised. An IR3 incident report form must be completed in all cases where a referral to the Local authority is made.	Completed
20. When a MDT identifies that a patient is implicated in concerns relating to a vulnerable adult this issue should become a standard item for review within the MDT meetings.	**Policy and Procedure** The process and recording format for each MDT requires consideration of risk information, whatever its nature. This has been in place in the paper record via the review form since February 2009 and since the inception of the electronic patient record (RiO).	Completed
21. When a patient is considered to present a risk to a vulnerable adult, unless it is considered inappropriate to do so, consideration should always be given to involving that patient directly in any safeguarding procedures which relate to the vulnerable adult.	**Policies and Procedures** The decision to involve alleged perpetrators in safeguarding procedures is that of the identified Safeguarding Manager and relevant multi-disciplinary team, as part of inter-agency arrangements. This needs to take account of the presenting risks from the patient and consent of the vulnerable adult affected. Where a case is discussed within the MARAC process this will not occur (as per National guidance).	Completed

22. Before discharging a patient to a home environment in which a vulnerable adult is believed to reside, consideration should be given to exploring issues of the mental capacity of the individuals involved and whether they are capable of self-determination in relation to the decision to live together.	The Mental Capacity act details five guiding principles which health and social care staff must have regard to at all times when dealing with a person who lacks or may lack capacity in relation to a matter: **The presumption of capacity** Every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise **Individuals being supported to make their own decisions -**A person must be given all practicable help to reach their own decision before anyone treats them as not being able to make that decision **Unwise decisions -** Just because a person makes what might seem an unwise decision, they should not be treated as lacking in capacity to make that decision **Best interests -** An act done or decision made under the MCA for or on behalf of a person who lacks capacity must be done or made in their best interests **Least restrictive option -** Anything done for or on behalf of a person who lacks capacity should interfere with that person's basic rights and freedoms as little as possible These principles would inform the exploring of any issues of the mental capacity of the individuals involved when discharging a patient to a home environment in which a vulnerable adult is believed to reside in the context of the safeguarding process outlined in this plan.	Completed
23. The effective functioning of the safeguarding vulnerable adults procedure relies upon accurate recording of information shared at safeguarding meetings and effective	**Policy and Procedure** In cases where a member of Trust Safeguarding Team is chairing the meeting, the role of the Safeguarding Manager would be to co-ordinate actions from the meeting and ensure that minutes are distributed appropriately.	Completed

distribution of minutes to all of the professionals involved in the multiagency process. To enable the protection procedures to function appropriately, safeguarding duties should be a priority for the individual practitioners concerned, including attendance at meetings.	Where members of the care team are invited to attend inter –agency meetings related to safeguarding and public protection meetings they are required to attend. If individuals are not able to attend then a suitable representative must be provided or written report submitted. Information relating to risk to others must be shared in order to develop a robust risk management plan. Staff must also be able to comment where the risk is related to (or not) the patient's mental health and what care and treatment can be provided.	Completed
24. Where risks have been identified and safeguarding procedures have been initiated, cases should not be closed by social services or other agencies until there has been a satisfactory resolution of the concerns. In any event all decisions should be clearly recorded and shared with all agencies involved.	**This recommendation is for the Local Authority.**	
25. Safeguarding adults boards are encouraged to utilise the Association of Directors of Adult Social Services (ADASS) guidance note, *'Carers and Safeguarding Adults – Working Together to Improve Outcomes*' (2011) to review local practice and learn from the findings of this investigation.	**This recommendation is for the Local Authority.**	

26. When a patient, who has been subject to detention under Mental Health Act 1983, becomes an informal patient (either by being discharged from the detention or as a result of the expiry of the section) there should be a clear record made in the patient's clinical notes as to the reasons for the change in status.	**Policy and Procedure** The Trust has a comprehensive Mental Health Act Policy NTW(C)55 which was reissued on the intranet December 2013. Although the policy does not specifically state that this should be recorded in the patient's clinical record, it is clearly outlined in the Mental Health Code of Practice: 'The responsible clinician's power of discharge Reference Guide 12.113-12.116 29.15 Section 23 of the Act allows responsible clinicians to discharge most detained patients and all SCT patients by giving an order in writing.' Trust policy does include a section around renewal in **MHA-PGN-03** (part of NTW©55 – MHA Policy) which is tentatively linked and states: **Recording** 7.1 The report (and the statement of agreement by the second health professional) must be made using form H5 and sent to the hospital managers, who must record their receipt of it in part 4 of the form. 7.2 The effect of the report is to renew the authority for detention (i.e. the relevant application, order or direction) for a further six months or a year (as applicable) from the date it would otherwise expire (not the date of the report itself). The Trust has a Records Management policy NTW(0)09 ratified in October 2012 which includes a practice guidance note on record keeping standards for clinicians, which was ratified in December 2012. This clearly states that all information necessary to inform others and provide a record about the ongoing care of the patient, must be recorded on the electronic health record, according to existing standards. **Audit and Outcomes** All information relating to the care and treatment of patients is entered onto the electronic health record. In addition, clinicians have caseload management with their clinical supervisors on a regular basis, which	Completed

	includes a record check of three random open cases. Any errors relating to Mental Health Act paperwork are reportable as incidents and a bi-monthly report is sent to the Mental Health Act Legislation Committee to inform them of these.	
27. All clinical notes, including psychology, should be integrated within the patient's records and be readily accessible to all professionals involved in the individual's care.	**Policy and Procedure** The Trust has a Records Management policy NTW(O)9, ratified in October 2012 which is NHSLA compliant. This includes a practice guidance note on record keeping standards for clinicians, which was ratified in December 2012. The Practice Guidance Note clearly states that all information necessary to inform others and provide a record about the ongoing care of the patient, must be recorded on the electronic health record, according to existing standards. Some psychological records are kept in a separate paper therapy support file and not entered onto RiO. Practice Guidance Note Number 10 – Psychological Practitioners Record Keeping issued in May 2013 forms part of the Records Management Policy and clearly outlines what type of information can be kept separately. This would include working formulation documents, diaries completed by service users, artwork produced as part of art therapy work and very detailed information relating to traumatic experiences which is needed for therapy but should not be kept in the shared clinical record. **Audit and Outcomes** Information relating to the care and treatment of patients is entered into the electronic health record which is used by all members of the clinical team. In addition, clinicians have caseload management with their clinical supervisors on a regular basis, which includes a record check of three random open cases.	Completed

28. GP surgeries should consider the viability of instituting a 'usual doctor' system whereby a patient is assigned to a particular GP within the practice to assist in the continuity of care and communication with external agencies.	**This recommendation is for Primary Care services.**	
29. The investigation panel was informed of an eight day delay in the processing of important information sent by fax to GP 6 by patient E's Counsellor 1 in January 2008. GP practices should review internal communication systems to ensure that information is received by the patient's GP promptly.	**This recommendation is for Primary Care services.**	