Action Plan Template (Adopted Logic Model)
Service User(S) Independent Review – StEIS Ref 30766
Version 2.0

NHS
Mersey Care
NHS Foundation Trust

Recommendation	Desired Outcome	Action required	Deadline for completion	Person responsible	RAG Rating	Progress Update
1. The formulation of HCR20 risk assessments in the secure services should be aligned to best practice principles and there should be a quality assurance structure to audit the quality of risk formulations and management plans and ensure they are in line with HCR20 Version 3 Guide	Patient and team are aware of risks and the plans in place to these mitigate risks. The risk management plans are appropriate and proportionate and reflect current risks	Identify a lead from each division to develop best practice guidelines including peer review process in line with SA 10 policy. The best practice guidelines will include details about the process to ensure risk assessment and management is a dynamic process including how patients will be engaged and involved in managing their risks. Baseline audit of quality and accuracy of HCR-20 and related risk management plans. Introduce electronic recording system to monitor HCR-20 completion and update compliance. Review of Trust Policy SD 10 to ensure it meets	March 2017	Divisional Psychological Services Leads		The psychology teams from both Secure Division and Specialist Learning Disability Have had an away day on 15th February to agree best practice guidelines which includes clear processes to engage with patients and care teams to ensure risk assessment and management is a live process. The guidance will be available for service consultation by end Feb 2017. The date to complete this action has been amended to reflect the level of detail and consultation involved in this process. There is a plan with clear trajectories to ensure all current risk assessments are in date in accordance with service specifications by 10th March 2017. This is being monitored on a weekly basis. The electronic system for ongoing monitoring is not yet available. It is expected to be available by the end of March 2017. The Trust policy is under review, being led by Richard Whitehead for local services and Neil Jackson for SD and SpLD. It will be available for wider service consultation by end March 2017

		requirements for each Division				June 2017 Update: Best practice guidelines have been agreed and are in practice. The impact and effectiveness of these guidelines will be evaluated and formally reviewed at end of year. In Secure and Specialist Learning Disability Divisions HCR-20 risk assessments have been reviewed and updated in line with policy requirements. Systems are in place to ensure ongoing improved performance is maintained and reviewed at divisional governance meetings. The updated Trust Policy SD 10 is due to be ratified at Trust Policy Review group in July 2017.
2. The planning of victim safety in partnership with individuals concerned, especially where this involves a family member or partner, must form part of the core risk assessment and treatment planning On-going contact with family members or partners must form part of the core risk assessment and care planning by the care co-ordinator	Identified and current potential victims are aware, have been involved and have knowledge of the risks to themselves and what plans are in place to mitigate these risks	Review legal guidance about remit of new victim safety policy Roll out trust wide Implementation plan for new policy which should include clear processes for the involvement of potential victims. Audit of current practice Agree a programme of quality audit of policy standards	December 2016 March 2017 December 2016	Identified Lead from each division Head of Forensic Social Care/Nominated Officer for Safeguarding		Victim's policy has been agreed and is now ratified The implementation plan is in train, more detailed update will be provided in next action plan update Actions required from audit of practice in FOS team had been completed and shared and signed off by SD governance committee. June 2017: implementation plan is now complete, awareness sessions are ongoing and audit programme has been agreed in line with Trust audit programme, audit tool has been developed, next audit due at end of quarter 2
3. Where there is a question of responsibility for the welfare of the child, specific focussed risk assessments must be conducted in partnership with children's agencies	Risk to identified children are known, have been assessed and plans in place to mitigate risks	Review current child welfare procedures in conjunction with partner agencies to ensure risks to children are robustly	March 2017	Deputy Director of Nursing & Quality Head of Social Care		Named Nurse has reviewed and updated Child safeguarding Policy and has reviewed child safeguarding procedures in conjunction with CCG Designated Nurse for Safeguarding including assessment

and other statutory agencies with respect to assessing and managing any potential risk towards the child	that are reviewed and monitored	assessed and managed Clear understanding and compliance with the legislative framework Is embedded in practice		– Strategic Lead Named Nurse Safeguarding Children		protocol at each stage of access into the service e.g. A&E liaison. Wording on Epex is to be amended at assessment stage to ensure more robust consideration of Child/Parent needs particularly impact assessment during mental health crisis. Training roll-out for Child Safeguarding will ensure quality checks against improved knowledge and application to practice for all front-line staff. Quality Standard checks will be formally reviewed via quarterly Safeguarding Strategy Group and Named Nurse supervision with CCG Designated Nurse. The Named Nurse will also work in conjunction with and be supported on the above implementation and practice application by Barnardo's lead expert practitioner.
4. There should be a robust risk assessment of lone workers in the community, including any pregnant staff and risk management plans applied	Individual staff can articulate risks and are aware of plans to mitigate risks	Audit of practice in accordance with Lone Worker policy and implement actions arising from audit recommendations	December 2016	Director of Patient Safety		Complete Policy in place including processes to monitor compliance
5. There should be a programme of training for Section 12 doctors and AMHPs on risk assessment in forensic patients focusing on both the nature and degree of mental disorder	Section 12 Doctors and AMHPs have knowledge of and can articulate forensic component of mental health assessment	Training and awareness sessions at Trust AMHP forum following a training needs analysis to scope training requirements. Share this recommendation to address Section 12 training with Liverpool CCG Ensure this recommendation is included in Approved Clinician training in Trust	March 2017	Social Care Professional Lead Clinical Lead Medium Secure Service		Trust In house training programme is now in place and is managed by Emad Lilo NHSNW are currently reviewing the Section 12 approval / renewal training they commission across the region and consider how this can be improved to address this issue.

6. There should be a trust wide policy on prescribing high dose antipsychotic medication which includes standards for auditing which should be in line with the Royal College of Psychiatrists guidelines	Practice in line with Trust policy and NICE guidance, services understand prescribing differences between practitioners and between services	Trust wide audit of practice in line with policy standards Medical leads to agree and implement actions arising from audit recommendations	January 2017 March 2017	Clinical Lead – Liverpool Services Chief Pharmacist		Ratified Policy is now in place. Update June 2017: Audit of high dose and combination antipsychotics in Secure and Specialist Learning Disability Divisions has been completed Audit and actions required have been shared and discussed at audit and medical meetings, over seen by Associate Medical Director
7. An audit of the usage of depot medication in the Secure Division should be carried out and anomalies addressed	Establish variation in prescribing practice including routs of administration	Audit of use of depot medication and implement actions arising from audit recommendations which will need to include actions required to address unnecessary variation.	March 2017	Associate Divisional Medical Directors		Update June 2017: Audit of high dose and combination antipsychotics in Secure and Specialist Learning Disability Divisions has been completed Audit and actions required have been shared and discussed at audit and medical meetings, over seen by Associate Medical Director
8. Liverpool Clinical Commissioning Group and the Trust should ensure that there is a joint approach to physical health checks, and information sharing between GPs & mental health services regarding results of health checks	Physical health checks and information is shared between primary and mental health services, clear pathways and processes that are mutually understood	Develop clear pathways to agree how and what information will be shared with primary care services	March 2017	Divisional Lead Nurses Clinical Lead – Liverpool Services		This is being currently strengthened using the local CQUIN for collaborative working – Andrew Sedgewick is leading – Trust need to align the actions with progress to date. CQUIN has been achieved for 2016/17. Further improvement of physical health pathways and communication is include in 2017/18 CQUIN programme which will continued to be monitored on quarterly basis
9. The Trust should audit compliance with NICE guidelines CG178: Psychosis and schizophrenia in adults: prevention and management, with the Secure	Patients receive treatment in line with NICE guidance and deviations from guidance are	Review latest audit data to ensure the action plan is being progressed. Ensure process to agree	February 2017 March 2017	Deputy Director of Nursing Head of Governance		The audit has been added to the Trust Clinical Audit Programme and will be completed in Q! and report and action plan will be available by end June 2017

Division and implement findings	known and monitored and reviewed	deviation from guidance is established in practice Re audit of NICE guidelines as included in Trust Clinical Audit Programme	October 2017			Update June 2017: Trust wide audit in current progress looking at access to therapies and prescribing practices using NICE guidance. Due to report October 2017.
10. The Trust should provide quality performance information on services that consistently appear in the top five or other agreed quantity of quality indicators for two or more quality indicators to systematise the triangulation of performance information	Proactively identify any emerging concerns of safety, quality and performance to ensure actions are taken in a timely manner	3 Trust surveillance leads to review performance including feedback from MIAA internal audit and make recommendations to improve processes to address emerging concerns	March2017	Director of Patient Safety		The Executive Director responsible for the surveillance process has re written the Standard Operating Procedure to enhance the effectiveness of the process. This has included the process used to identify wards and teams that are not meeting set standards.
11. The Trust should ensure that care plans for patients with schizophrenia who are assessed as at risk of harming family members incorporate learning from the evidence on parricide	Staff have knowledge and review practice in light of evidence on parricide	To share learning across Trust teams and incorporate learning in risk management training for clinical staff	October 2017	Associate Medical Director Local Services		An OME is took place for Local division on 29th November. This recommendation has been discussed in more detail. Actions have been agreed to enhance staff training and induction programmes within teams.