niche
HEALTH & SOCIAL CARE CONSULTING

An independent external quality assurance review following an internal investigation into the care and treatment of mental health service user A in North East London Foundation Trust

February 2020

Author: Sue Denby, Senior Consultant, Investigations and Reviews.

Niche Health & Social Care Consulting is an independent management consultancy that specialises in supporting health care providers with all issues of safety, governance and quality, including undertaking independent investigations following very serious incidents.

Niche Health & Social Care Consulting Ltd
4th Floor
Trafford House
Chester Road
Old Trafford
Manchester
M32 ORS

Telephone: 0161 785 1000
Email: info@nicheconsult.co.uk
Website: www.nicheconsult.co.uk

CONTENTS

1 Executive summary

1.1 North East London Foundation Trust (NELFT or the Trust) provides mental health services in North East London for all ages from children, to perinatal care for mothers, through to services for older adults with mental illness or dementia in a variety of settings.

1.2 Service user A received care from the Trust following episodes of self-harm from June 2011 until his discharge in February 2015. On the 16 April 2015 he fatally stabbed a member of the public in a restaurant, was found guilty of manslaughter and sentenced to 14 years. He remains in prison.

1.3 Service user A was 44 years old at the time of the incident. Due to the political instabilities in Albania he came to the UK (date unknown) and shortly after this he was joined by his wife.

1.4 He first became known to the Trust in June 2011 on his admission via A&E following an overdose of multiple medications. Following assessment, he was admitted with a diagnosis of reactive depression and adjustment disorder. The main risks identified were self-harm, gambling with large accrued debts and alcohol misuse.

1.5 He was discharged to the Community Mental Health Team (CMHT) in August 2011 after meeting his goals of establishing strategies to manage his self-harm, gambling and alcohol.

1.6 He was followed up at home by his Community Psychiatric Nurse (CPN) and attended Cognitive Analytical Therapy (CAT) sessions. His diagnosis at this time was recorded as a depressive disorder with a gambling addiction.

1.7 In January 2012 he informed the duty worker that he had been in prison between November and December 2011 following an incident at his ex-partner's home.

1.8 He took further overdoses in January and November 2013 and was noted as a frequent A&E attender. He had a multi-agency plan in place.

1.9 Between 2014 and 2015 he attended appointments irregularly although when he maintained contact with the CMHT he reported feeling well. He was discharged from the Trust in February 2015.

1.10 However, in March 2018 the Trust were contacted by the National Confidential Enquiry into Suicides and Homicides, as part of the process for collecting data for statistical purposes, requesting information relating to service user A and were informed of the incident.

1.11 A comprehensive internal investigation was commissioned in March 2018 on behalf of the Trust Board of Directors to carry out a comprehensive, internal investigation in accordance with the NHS England Serious Incident Framework (March 2015).[1]

[1] *NHS England Serious Incident Framework March 2015. https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framework-upd.pdf*

1.12 The internal investigation panel was chaired by a Trust Non-Executive director and comprised the Director of Nursing and Patient Experience, a Consultant Psychiatrist, the Older Adults Clinical Lead nurse and the Serious Incident Investigating Officer.

1.13 The internal investigation was completed using root cause analysis methodology with the purpose of establishing any lessons that could be learnt in order to prevent future, similar incidents.

1.14 The internal investigation concluded in July 2018 and made eight recommendations detailed as:

- a review of the current process for access to police information to be undertaken by the community recovery team (CRT) in collaboration with the forensic outreach service to ensure it meets the needs of CRT;
- an audit of CRT cases involving criminal justice agencies to be undertaken to establish the level of engagement and referral for forensic assessment where appropriate;
- an audit of CRT zoning[2] minutes to be cross reference with the electronic patient record (EPR) entries to establish that clinical reasoning has been transferred to the EPR and is available to staff at the point of care;
- an audit of Multi Agency Public Protection Arrangements (MAPPA)[3] attendance and the feedback process to relevant care coordinators;
- an audit of CRT cases to establish the service users that miss appointments are seen within one month;
- an audit of CRT cases to establish the level of compliance with the requirement that when service users have disengaged a plan to improve engagement was in place and a crisis plan is in place before discharge;
- CRT to improve the current 75 percent compliance rate for risk assessment training to the Trust standard of 85 percent; and
- CRT to establish the current compliance rates for supervision.

1.15 In addition, the internal investigation made two recommendations for 'consideration by the mental health community of practice (COP)'. These recommendations are detailed as:

- consideration of forensic awareness training for CRT staff; and
- consideration of a protocol to support clinicians in their work with criminal justice agencies.

[2] *https://www.scie-socialcareonline.org.uk/zoning-a-system-for-managing-case-work-and-targeting-resources-in-community-mental-health-teams/r/a1CG0000000GcJpMAK*
[3] *https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa--2*

1.16 We are not clear how these would be addressed, and there is no detail in the action plan provided. However, we reviewed these in conjunction with Trust action 5 (3.95 – 3.109) and Trust action 1 (3.51 – 3.59).

1.17 Finally, the Trust has two standard (fixed) actions following a serious incident detailed as:

- the investigation findings to be shared with the service user in accordance with Duty of Candour[4] (DoC) requirements; and
- the investigation findings to be shared with the victim's family in accordance with DoC requirements.

1.18 NHS England London commissioned Niche Health & Social Care Consulting (Niche) to undertake an external quality assurance review, specifically to:

- review Trust progress on the implementation of action plans developed from the internal report:
- review the processes for embedding learning across the Trust and WF Clinical Commissioning Group (CCG), and whether those changes have had a positive impact on the safety of the Trust's services;
- comment on the WF CCG monitoring of the action plan; and
- highlight areas for further improvement, making recommendations as appropriate.

1.19 Niche is a specialist safety and governance organisation undertaking investigations into serious incidents in healthcare. Sue Denby, Senior Consultant, Investigations and Reviews for Niche carried out the external quality assurance review, with expert advice and peer review provided by Kate Jury, Niche Partner for Governance and Assurance. The investigation team will subsequently be referred to in the first person plural in the report.

1.20 The external quality assurance review has focused on the following key lines of enquiry:

- evidence of the completion of the internal investigation recommendations;
- evidence of the impact of the action plan recommendations; and
- the governance and systems within the Trust.

1.21 The external quality assurance review commenced July 2019 and was completed in October 2019.

1.22 We used the Niche Assurance Review Framework (NARF), to provide a well evidenced and rigorous assurance process.

---

[4] https://www.nmc.org.uk/standards/guidance/the-professional-duty-of-candour/read-the-professional-duty-of-candour/ *Duty of Candour is the requirement of every healthcare professional to be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause harm or distress.*

1.23 In order to complete the review, we carried out a range of tasks including site visits, staff meetings, reviewing policies and procedures, and minutes of meetings and various reports.

1.24 NHSE contacted the perpetrator directly to inform him of the review taking place to seek his engagement. The perpetrator did not respond to the letter and there are no contact details available for other family members.

1.25 NHSE also contacted the victim's family through the Trust Family Liaison Officer (FLO) and is awaiting a response.

1.26 The terms of reference for this external quality assurance review are given in full at Appendix A. Staff interviewed are referenced at Appendix B. Documents and policies reviewed are referenced at Appendix C. The Trust governance structure is referenced at Appendix D and the Trust quality improvement progress is referenced at Appendix E. Appendix F lists the abbreviations used in the report.

1.27 We have graded our findings using the following Niche criteria:

Score	Assessment category	RAG
1	Insufficient evidence	
2	Recommendation incomplete	
3	Recommendation complete	
4	Recommendation complete and embedded	
5	Complete, embedded, impactful and sustained	

Structure of the report

1.28 Section 2 describes the process of the review.

1.29 Section 3 focusses on the implementation of the Trust's internal investigation action plan to identify progress made against the action plan, to review processes in place to embed any lessons learnt and whether those changes have had a positive impact on the safety of Trust services.

1.30 In section 3 we have also included our review of the WF CCG monitoring of the action plan and the ensuing gaps in the process.

1.31 Further residual recommendations for improvement as appropriate are summarised both under each recommendation in turn and in the residual recommendations section of the report.

1.32 A summary is provided in section 4.

Assurance summary

1.33 We have summarised the Niche score totals as follows:

Score	Assessment category	RAG
1	Insufficient evidence	0
2	Recommendation incomplete	3
3	Recommendation complete	3
4	Recommendation complete and embedded	3
5	Complete, embedded, impactful and sustained	1
	Total number of actions	10

1.34 Where the action resulted in a grading of 2, 3 or 4 we have made residual recommendations for the Trust to seek formal assurance of the completeness, embeddedness and impact against each action as appropriate.

1.35 Given the similarities, we have incorporated the two recommendations for consideration (9 and 10) into Trust actions 2 and 1 respectively.

Summary and residual recommendations

Processes for embedding of learning across the Trust

1.36 Our view is that the Trust has appropriate structures in place for embedding learning and driving change and improvement

1.37 However, in terms of local WF governance structures, we found assurance that follow up actions are monitored through the Divisional Business Meeting (DBM) reporting into the Quality Leadership Meeting (QLM) were not always available. We found that there were gaps in the assurance required for some of the actions and undated audits.

1.38 We were informed that the governance of the DBM had not been as robust as required for the period of time associated with this serious incident.

1.39 We therefore make a general residual recommendation that the governance processes (including the issue of undated audits) associated with the WF DBM and QLM is reviewed within three months. We understand this to be the responsibility of the WF Associate Director.

Review of the WF CCG monitoring of the action plan

1.40 We found that this incident was discussed at the April 2019 WF Clinical Quality Review Meeting (CQRM) through a paper written by the Integrated Care Director. Lessons learnt, recommendations, actions taken and evidence of completion were clearly outlined. The paper stated that the original action plan had been completed, however, the process of completing these actions

had identified further action to ensure that the learning had been embedded into practice.

1.41 The new action plan is scheduled to be completed by October 2019 with a recommendation that an update on the further action plan is presented to WF CQRM for final closure in November 2019.

1.42 Our view is therefore that there are appropriate structures in place for the WF CCG monitoring of the action plan.

Fixed recommendations

1.43 With reference to the first fixed recommendation, we have been provided with appropriate assurance that the Trust attempted to share the investigation findings with the patient (as appropriate) and the patient's family. We note the Trust Serious Incident Policy requirements to prioritise the needs of those affected, and the Trust's undated letter to the victim's wife in respect of this.

1.44 Given this is a fixed Trust recommendation for all serious incidents, we have graded this action as 4, being completed and embedded. However, we recommend the Trust reviews the supporting administration so that appropriate assurance is available for audit and review.

1.45 As neither the patient or the victim's wife wished to be involved or to contribute to the investigation, we have been unable to assess the impact of the action and have no residual recommendation to make in respect of this.

1.46 With reference to the second fixed recommendation we found it is clear that the initial investigation findings, lessons learnt, initial action plan and subsequent audits were shared for the purposes of learning at a CQRM and adult Community of Practice (COP) level. We note that the Trust has identified further learning with review and closure dates beyond the scope of this review.

1.47 However, we have not been provided with assurance that the initial investigation findings have been shared at a COP sub group or Trust wide. Given this, we have graded this action as 2 being incomplete at this point.

1.48 However, as the new action plan is scheduled to be completed by October 2019 and presented to CQRM for final closure in November 2019, we have made a residual recommendation that the closure plan provides the appropriate assurance required to ensure the action is embedded and impactful.

Trust action 1

1.49 We have been provided with assurance that there is both a protocol in place to assist staff in requesting police and forensic support for service users with known criminal records and a Trust and East London Forensic Trust (ELFT) Forensic Partnership Group which supports clinicians in their work with criminal justice agencies.

1.50 We have therefore graded this action as 4 being completed and embedded. We have not received assurance which would enable us to review the impact of this action and have therefore made a residual recommendation to include this in the protocol review 3 February 2020.

Trust action 2

1.51 We found that the initial action was completed, although the audit was undated, and the follow up actions were partially completed. We have therefore graded this action as 2. Due to the timescales of this review, we were not in a position to assess the outcome of the planned further CRT audit by 15 September 2019.

1.52 We note the follow up actions are to be monitored through the DBM reporting into the QLM and we make a residual recommendation that the embeddedness and impact of the action is assured through this process.

Trust action 3

1.53 We were informed that recording the zoning meeting minutes in the electronic patient record (EPR) has been difficult and WF has not found a sustainable way of doing this as yet due to capacity. As a result, the Trust information technology department has been asked to assist with an electronic means of doing this directly.

1.54 As a result, and noting that the audit was undated, we have graded this action as 3 being complete but not embedded. Given this, it was not possible to consider the impact of this action. We note that a follow up audit is due in October 2019 and we have therefore not made a residual recommendation.

Trust action 4

1.55 We viewed MAPPA email correspondence from the Recovery and Complex Care Pathway Lead to relevant team members as assurance. In summary, we found the correspondence to be clear and detailed and in terms of impact, we found the correspondence included advising staff about the inclusion of patients on the high risk register, patients being seen in safe premises, a reassessment of needs and management of risks to staff.

1.56 We have therefore graded this action as 5 being completed, embedded and having an impact and have not made a residual recommendation in respect of this.

Trust action 5

1.57 We found that the initial action was completed and have therefore graded this action as 3. However, as the follow up action was inconclusive, we found the action not yet embedded and having an impact. We have made a residual recommendation that the follow up audit outcome is discussed at the DBM for further agreement to determine the most appropriate action and that this is monitored through the QLM.

Trust action 6

1.58 We were informed that the audit has not been repeated due to capacity issues. Given this, and the small sample size of the initial audit, we have graded this action as 2 not being completed.

1.59 We have therefore made a residual recommendation that the initial audit and the lack of capacity to repeat the follow up audit is discussed at the DBM to determine the action required, and that this is monitored through the QLM.

Trust action 7

1.60 We note that clinical risk assessment and management training became mandatory for all clinical staff, at a grading of bands five and above, in February 2018 and that the Trust is now above 90 percent compliant with this training.

1.61 We note that Care Quality Commission (CQC) compliance specifically in terms of clinical risk assessment is reported as a strategic managed risk being managed through the quality safety committee.

1.62 We have therefore graded this action as 4 being completed and embedded. We have not assessed the impact of this action as we note that that this will be addressed as one of the Trust quality improvement work streams being progressed during the year to reduce risk and improve patient safety.

Trust action 8

1.63 We were provided with an audit of supervision compliance in the WF CRT's between March and September 2019 for practitioners at grading bands four to seven and found the compliance to be between 92 and 100 percent.

1.64 We have therefore graded this action as 2 being completed and embedded within WF however, the follow up actions to the audit remain outstanding. As a result, we have not been able to assess the impact of the action and suggest that this is assessed in due course locally and as required through the Trust Quality and Safety Committee.

Trust recommendation 9

1.65 We reviewed this recommendation in conjunction with and incorporated into Trust action 5 (3.95 – 3.109) to establish the level of engagement and referral for forensic assessment as our view is that this action requires CRT staff to have an appropriate level of forensic service awareness.

Trust recommendation 10

1.66 We reviewed this action in conjunction with and incorporated into Trust action 1 (3.51 – 3.59) to review the current CRT process for access to police information as the Trust action was to put a system in place as a result.

Summary of the Niche scores

1.67 The summary of the original report recommendations, the Trust actions and Niche scores are as follows:

Number	Original Report Recommendation	Trust Action	Niche Score
N/A	Fixed	Share the investigation findings with the patient (as appropriate) and the patient's family.	4
N/A	Fixed	Share the investigation findings and action plan with all those involved in the care and treatment of the patient and with other teams/services as applicable for the purposes of learning.	2
1	A review of the current process for access to police information to be undertaken by CRT in collaboration with the Forensic Outreach service to ensure it meets the needs of CRT.	The CRT will put in place a system in collaboration with the local police liaison officer, and the forensic team on requesting information from the police national computer (PNC).	4
2	An audit of CRT cases involving criminal justice agencies to be undertaken to establish the level of engagement and referral for forensic assessment where appropriate.	The team will devise an audit schedule using the forensic assessment referral criteria standards. Complete an audit of sample of clients with known criminal justice involvement.	2
3	An audit of CRT zoning minutes to be cross referenced with the electronic patient record (EPR) entries to establish that clinical reasoning has been transferred to the EPR and is available to staff at the point of care.	The team leads to devise an audit schedule and complete a peer audit of their zoning minutes and the EPR against the standards in the zoning protocol with a specific focus on recording of decisions in the EPR.	3
4	An audit of MAPPA attendance and the feedback process to relevant care coordinators.	To review the MAPPA attendance and feedback information based on known clients discussed at the MAPPA.	5

Number	Original Report Recommendation	Trust Action	Niche Score
5	An audit of CRT cases to establish the service users that miss appointments are seen within one month.	The team will obtain a report for the previous six months of clients that have missed appointments and audit a random sample of no less than 50 percent against the standard in the missed appointments policy – clients to be seen within one month of a missed appointment.	3
6	An audit of CRT cases to establish the level of compliance with the requirement that when service users have disengaged a plan to improve engagement was in place and a crisis plan is in place before discharge.	The team will identify clients that have disengaged in the last six months based on the team zoning data and complete an audit of a random sample of no less than 50 percent of these cases to check if a crisis plan was put in place following reported disengagement.	2
7	CRT to improve the current 75 percent compliance rate for risk assessment training to the Trust standard of 85 percent.	The team leads will identify the cohort of staff requiring training and proactively book staff onto training dates.	4
8	CRT to establish the current compliance rates for supervision.	The team leads to complete a peer audit of supervision compliance against the Trust standards in relation to the frequency of supervision the CRT will complete.	3
9	Consideration of Forensic Awareness training for CRT staff.	No detail available.	N/A Incorporated into Trust action 2.
10	Consideration of a protocol to support clinicians in their work with criminal justice agencies.	No detail available.	N/A Incorporated into Trust action 1.

2 Assurance review

Approach to the review

2.1 The external quality assurance review has focused on the implementation of the Trust's internal investigation action plan to identify progress made against the action plan, to review processes in place to embed any lessons learnt and whether those changes have had a positive impact on the safety of Trust services.

2.2 We have also included our review of the WF CCG monitoring of the action plan and the ensuing gaps in the process and made further recommendations for improvement as appropriate.

2.3 The external quality assurance review commenced in July 2019, was completed in October 2019, and was carried out by:

- Sue Denby, Senior Consultant, Investigations and Reviews.
- Kate Jury, Niche Partner for Governance and Assurance.

2.4 This external review was comprised of a review of documentary evidence supplied and interviews with key clinicians and senior staff from the Trust.

2.5 We have graded our findings using the following criteria:

Score	Assessment category	RAG
1	Insufficient evidence	
2	Recommendation incomplete	
3	Recommendation complete	
4	Recommendation complete and embedded	
5	Complete, embedded, impactful and sustained	

2.6 The terms of reference for this external quality assurance review are given in full at Appendix A. Staff interviewed are referenced at Appendix B. Documents and policies reviewed are referenced at Appendix C. The Trust governance structure is referenced at Appendix D and the Trust quality improvement progress is referenced at Appendix E. Appendix F lists the abbreviations in the report.

2.7 The draft report was shared with NHS England, the Trust and WF CCG. This provided opportunities for those organisations that contributed significant pieces of information to review and comment upon the content.

3 Action plan progress

Processes for embedding of learning across the Trust

3.1 In order to understand the governance processes for embedding learning and driving change and improvement, we spoke to staff, and viewed the Trust Quality Improvement Approach, the Board Assurance Framework (Appendix D) and the Trust Quality Report June 2019.

3.2 WF staff told us that previously there was a regular WF forum for clinical risk and review of serious incident learning, however the forums had not taken place in the last few months as it was thought that these issues could be addressed in other meetings. We were informed that this was not the case and the directorate have since decided that specific forums for learning will be recommenced by December 2019.

3.3 We were informed that currently, discussions are taking place at a WF directorate level to review how best to further embed learning through the clinical zoning meetings within the CRT's. This was tried out last month and the ensuing discussions were seen to be much more productive.

3.4 For more serious cases we were told that the Trust holds many forums for all staff to discuss lessons learnt. We were informed that there is a cascading learning system from directorate to team business meeting level. Team leads also take actions from serious incidents through to supervision meetings. We were provided with verbal examples of learning.

3.5 We were informed that WF CCG has asked the Trust to consider how best to share learning Trust wide by October 2019. We note that the Quality and Safety Committee terms of reference state that Trust wide learning is being strengthened through improved accountabilities at the clinical executive group and COP's.

3.6 We viewed the Trust Board Quality Report June 2019 to understand how the governance structure supports the embedding of learning. We found assurance that:

- the Quality and Safety Committee has reviewed its terms of reference and cycle of business to ensure that the membership and agenda fit the Trusts good governance regulation and well led framework requirements;
- quality controls, audit and assurances are in place to monitor inconsistencies and variation at each level of the organisation. Where variation or deviation from the standard is identified, the responsible officer takes prompt action to analyse the cause of the variation to enable corrective actions to be put in place;
- improvements are monitored and minuted. Flows of risk and controls are evident. Where system or Trust wide change is required, executives responsible, the Chief Nurse and Executive Medical Director have oversight to drive the improvements required;

- triggered quality visits by the directors of nursing provide further understanding of the causation and guide the corrective actions. In addition to strengthen this the Non-Executive Directors are now included in these visits providing wider oversight and scrutiny; and

- investment into a technologically advanced inspection audit tool enables Trust wide inpatient reporting, internal benchmarking and ownership at local level. A quality dashboard indicators, triggers or intelligence can indicate a variance from the norm, or that the Trust's norm is out of kilter with other comparators. Further analysis and work is undertaken to understand risks to patient safety.

3.7 With specific reference to this assurance review we note that the Trust mortality review panel has been established to scrutinise unexpected deaths for themes and additional learning and that the Quality and Safety Committee continues to monitor the risks and progress of work streams to:

- improve the Trust's clinical record keeping standards; and

- learn from serious incidents, serious case reviews, domestic homicide reviews, coroners reports, deaths, clinical reviews, complaints and patient experience.

3.8 We note that the quarterly Trust board mortality Reports have a specific section on learning, and that in January 2019 the Non-Executive Director lead on mortality informed the Trust board that the Mortality Committee had an overview of patient reviews and the Board could be assured of the process.

3.9 In terms of the Trust approach to quality improvement we were told that there is a Trust audit department and junior doctors have a huge amount of support to undertake audit projects which are then logged. We were informed that local audits are not thought however, to be always logged.

3.10 The audit department presents audits to teams and provides feedback on areas in which they need to improve. We were provided with a verbal example of the current Trust work being undertaken to improve the quality of risk assessments.

3.11 We note the June 2019 Trust board progress report (Appendix E) on the Quality Improvement Approach which has involved building capacity, assessing the quality of training and sharing learning over the past three years.

3.12 In summary our view is that the Trust has appropriate structures in place for embedding learning and driving change and improvement.

3.13 However, in terms of local WF governance structures, we found assurance that follow up actions are monitored through the DBM reporting into the QLM were not always available. We found that there were gaps in the assurance required for some of the actions and undated audits.

3.14 We were informed that the governance of the DBM's had not been as robust as required for the period of time associated with this serious incident.

3.15 We therefore make a general residual recommendation that the governance processes associated with the WF DBM and QLM's is reviewed.

Review of the WF CCG monitoring of the action plan

3.16 To review the CCG monitoring of the action plan we spoke to the WF CCG Quality and Patient Safety Lead, WF staff and reviewed the April 2019 WF CCG Clinical Quality Review Meeting (CQRM) minutes and the May 2019 minutes of the WF CCG Performance and Quality Committee.

3.17 We asked the WF CCG Quality and Patient Safety Lead how they sought assurance that the Trust are completing investigations in a timely way and that the findings are robust and appropriate.

3.18 We were informed that the Trust provide WF CCG with a real time alert for serious incidents for review and a weekly spreadsheet lists the serious incident type, site, date, description of what happened and the date on which the serious incident internal investigation report is due.

3.19 In addition there is a monthly Trust held tracker system which provides details of ongoing serious incidents and details numbers of serious incidents closed without the requirements for further review, ongoing serious incident internal investigation reports, which reports are due, any reports outstanding, reports in the quality assurance phase, initial feedback, report extensions, de-escalations and reports closed.

3.20 WF CCG may ask the Trust further questions based on the initial serious incident internal investigation during the quality assurance phase. These further questions would be subject to a timeline. The CQRM discusses the serious incident internal investigation and requests the assurance on the action plan.

3.21 We viewed the April 2019 CQRM minutes and found the associated papers contained a briefing report from the WF Integrated Care Director on this specific case. The minutes indicated that a general discussion took place on learning from serious incidents, serious case reviews, domestic homicide reviews and coroner's inquests. We note a separate item on learning from deaths.

3.22 We found a detailed WF quality and patient safety report from the Integrated Care Director provided oversight of risks and issues impacting on the quality and safety of services provided. We found that this report contained serious incident exceptions, emerging incident themes and evidence of learning or best practice.

3.23 We note the associated CQRM papers also contained a quality contract requirements spreadsheet for WF including monthly serious incident duty of candour reporting with nil breaches reported and mandatory training, not including risk assessment.

3.24 In terms of the structure of the Performance and Quality Committee we note that a monthly WF quality report is received indicating by exception where

quality does not meet agreed targets. We found a detailed action log of actions taken, items awaiting outcomes and closed actions.

3.25 We noted that the quality report detailed that the CQRM discussed a homicide serious incident amended action plan and we found a detailed report on this specific case.

3.26 In terms of the structure of the meeting we found that the agenda included an organisational data quality report, reports on serious incidents and duty of candour by exception. We note a detailed action log indicating actions, lead, due date, status and completion dates.

3.27 In summary our view is that there are appropriate structures in place for the WF CCG monitoring of the action plan.

First fixed recommendation

Number	Original Report Recommendation	Trust Action	Niche score
N/A	Fixed	Share the investigation findings with the patient (as appropriate) and the patient's family.	4

3.28 In terms of the fixed action to share the investigation with the patient (as appropriate) and the patient's family we viewed the WF action plan version 3, 21 May 2019, which indicated more specifically that the findings of the investigation should be shared in writing with the service user within ten days of executive approval.

3.29 We viewed the SI Policy (approval date 27 October 2016; review date 27 October 2019) and found that this applies to incidents where moderate harm, significant harm or death has occurred and states that it is designed to support organisational openness, candour, continuous learning and service improvement.

3.30 The SI Policy details that the purpose of an investigation is to identify the cause of an incident and share the lessons learnt so as to prevent or minimise the chances of any repetition. The needs of those affected should be a primary concern, including the patient, victims, perpetrators, families and carers.

3.31 We also viewed the Trust's DoC Policy (approval date 18 August 2017; review date 18 August 2020). This states that a letter, signed by the Service Director or nominated deputy, should be sent to the relevant person together with the anonymised investigation report and action plan with a supporting letter providing information in the event that the individual wishes to pursue legal action against the Trust.

3.32 We viewed the internal investigation (approved 26 July 2018) and subsequent correspondence (3 August 2018) from the Integrated Care Director to the patient advising that the investigation had concluded and providing direction if he wished to receive the findings of this. We found that

the action plan stated that contact with the patient was completed on 14 August 2018.

3.33 We viewed assurance in the form of email correspondence from the Trust to NHSE which stated that the Trust contacted the patient via the FLO both during the investigation and following completion of the report offering to share findings of the report but received no response to this letter.

3.34 We were informed that the Trust also contacted the victim's wife both during and following completion of the investigation via the FLO and were told that the family did not wish to contribute to the investigation nor to receive the findings of the investigation. We found an undated letter in respect of this to the victim's wife and we have not therefore been provided with the appropriate assurance to evidence that this specific action was completed.

3.35 We found that the WF action plan detailed that evidence of the above was to be documented in the patient's records and emailed to the serious incident department confirming the date and method of sharing the findings within one working day of completion. We have not been provided with the appropriate assurance to evidence that this specific action was completed.

3.36 In summary, we have been provided with appropriate assurance that the Trust attempted to share the investigation findings with the patient (as appropriate) and the patient's family. We note the SI Policy requirements to prioritise the needs of those affected, and the Trust's undated letter to the victim's wife in respect of this.

3.37 Given this is a fixed Trust recommendation for all serious incidents, we have graded this action as 4, being completed and embedded. However, we recommend the Trust reviews the supporting administration so that appropriate assurance is available for audit and review.

3.38 As neither the patient or the victim's wife wished to be involved or to contribute to the investigation, we have been unable to assess the impact of the action and have no residual recommendation to make in respect of this.

Second fixed recommendation

Number		Trust Action	Niche score
N/A	Fixed	Share the investigation findings and action plan with all those involved in the care and treatment of the patient and with other teams and services as applicable for the purposes of learning.	2

3.39 In terms of learning, we viewed the overall WF action plan version 3, 21 May 2019 which indicated that a report was to be presented to the adult mental health community of practice (COP) and the Community Recovery Services (CRS) COP sub group by 30 November 2018.

3.40 We viewed minutes of an adult mental health and learning disability COP steering group 8 April 2019. However, we have not been provided with assurance which indicates that the incident was discussed at the CRS COP sub group.

3.41 We found that the 8 April 2019 Adult Mental Health and Learning Disability COP steering group minutes contained a section headed learning lessons under which this incident was detailed. The section stated that the action plan had been completed and signed off by the Quality and Safety Leadership Team (QLT) and that the audits undertaken had been shared and had identified further points of learning. In respect of these further learning points, a revised action plan had been agreed and was to be monitored by QLT.

3.42 We viewed the QLT meeting minutes of 10 April 2019 chaired by the Integrated Care Director. The minutes state that the original action plan was closed on the basis that there was a new action plan opening. The learning, action plan completion and ongoing action plan was to also be discussed at the WF CCG CQRM.

3.43 We found that this incident was discussed at the April 2019 CQRM meeting through a paper written by the Integrated Care Director. Lessons learnt, recommendations actions taken and evidence of completion were clearly outlined. The paper stated that the original action plan had been completed, however, the process of completing these actions had identified further action to ensure that the learning had been embedded into practice.

3.44 The new action plan is scheduled to be completed by October 2019 with a recommendation that an update on the further action plan is presented to CQRM for final closure in November 2019.

3.45 We understand that the Trust have been asked by WF CCG to consider how best to share learning Trust wide for the October 2019 CQRM.

3.46 We viewed the attendance at a general lessons learnt event held for all staff on 1 and 15 February 2019 presented by the deputy Medical Director. We found that on 1 February 2019, 165 staff were registered to attend and 110 attended. On 15 February 2019, 44 staff were registered to attend and 93 were recorded as attending.

3.47 We have not been provided with the details of this event, however we have been informed that due to time constraints this specific incident was not discussed and a further event is planned (no date for this event has been provided).

3.48 In summary, it is clear that the initial investigation findings, lessons learnt, initial action plan and subsequent audits were shared for the purposes of learning at a CQRM and adult COP level. We note that the Trust has identified further learning with review and closure dates beyond the scope of this review.

3.49 However, we have not been provided with assurance that the initial investigation findings have been shared at a COP sub group or Trust wide. Given this, we have graded this action as 2 being incomplete at this point.

3.50 However, as the new action plan is scheduled to be completed by October 2019 and presented to CQRM for final closure in November 2019, we have made a residual recommendation that the closure plan provides the appropriate assurance required to ensure the action is embedded and impactful.

Trust action 1

Number	Original Report Recommendation	Trust Action	Niche score
1	A review of the current process for access to police information to be undertaken by community recovery team (CRT) in collaboration with the forensic outreach service to ensure it meets the needs of CRT.	The CRT will put in place a system in collaboration with the local police liaison officer, and the forensic team on requesting information from the police national computer (PNC).	4

3.51 We reviewed this action in conjunction with and incorporating recommendation 10 to consider a protocol to support clinicians in their work with criminal justice agencies, given that the action for recommendation 1 includes putting a system in place.

3.52 We found that the WF action plan version 3 dated 21 May 2019 indicated this action was completed by 31 October 2018.

3.53 We viewed a WF Community Mental Health Services March 2019 protocol for requesting police and forensic support for service users with known criminal records. We were informed that the protocol review date is 3 February 2020.

3.54 This included details for the team to contact and request information from the police, the police liaison and advice officer, the safer neighbourhood police team, probation and, or youth offending services for joint working purposes.

3.55 In addition, the protocol states that there should be a multidisciplinary team discussion documented in the patient records to assess whether a referral is required to the local MAPPA, or for a specialist forensic assessment.

3.56 We also viewed a forensic partnership agreement between East London Forensic Trust (ELFT) and the Trust (approved 24 January 2019; for review 24 January 2021). A joint group meets bi-monthly and works to develop a clear pathway for service users moving from secure services back into the community through clear structures and process.

3.57 The group reports to the mental health leadership team as required and holds meetings with the agenda driven by the requirements of the service and commissioning changes. The purpose of the group is:

- to improve service-users care pathway and the quality of care that service users receive through working jointly with clear definition of roles and purpose;
- to review processes and systems;
- to improve communication across the Trust and ELFT;
- to provide a forum to share views from senior management and clinical staff from both organisations in regards to operational issues affecting the partnership or service delivery;
- to make recommendations that may assist in service improvements and care pathway issues;
- to ensure consistency of provision across the boroughs;
- to monitor quality of provision and statistical information; and
- to ensure both organisations have appropriate representation in order to develop effective links.

3.58 In summary, we have been provided with assurance that there is both a protocol in place to assist staff in requesting police and forensic support for service users with known criminal records and a Trust and ELFT forensic partnership group which supports clinicians in their work with criminal justice agencies.

3.59 We have therefore graded this action as 4 being completed and embedded. We have not received assurance which would enable us to review the impact of this action and have therefore made a residual recommendation to include this in the February 2020 protocol review.

Trust action 2

Number	Original Report Recommendation	Trust Action	Niche score
2	An audit of Community Recovery Team (CRT) cases involving criminal justice agencies to be undertaken to establish the level of engagement and referral for forensic assessment where appropriate.	The team will devise an audit schedule using the forensic assessment referral criteria standards and complete a sample audit of clients with known criminal justice involvement.	2

3.60 We reviewed this action in conjunction with and incorporating recommendation 9 to consider forensic awareness training for CRT staff as our view is that establishing the level of engagement and referral for forensic assessment requires this.

3.61 To review this action we spoke to the WF Associate Director, WF CRT staff and viewed the audit specified.

3.62 We found that the WF overall action plan version 3 dated 21 May 2019 indicated this action was completed 31 August 2018 with the follow up actions due for completion 15 September 2019.

3.63 We found an undated Trust audit of CRT cases involving criminal justice agencies with the aim of establishing the level of engagement between CRT and forensic services and the number of cases referred for a forensic assessment.

3.64 The audit looked at a random sample of CRT service users known to the criminal justice system and checked if they were referred to the forensic services. The electronic patient record was audited using the criteria for referral to the forensic service.

3.65 The results concluded that a significantly lower than appropriate number of cases known to the criminal justice service were referred to the forensic service for additional input and, or advice in management.

3.66 As a result, the audit detailed follow up actions with identified leads and completion dates, and stated that the actions would be monitored through the DBM reporting into the QLM.

3.67 We were informed that each DBM monitors the action plan completion dates through a tracker system. The action plan leads bring completed action plans for sign off at the meeting.

3.68 The follow up actions were as detailed as:

- audit findings to be presented to CRS COP to share learning across the Trust and WF CRT team members by 29 April 2019;
- each CRS to ask their local forensic practitioner Community Psychiatric Nurse (CPN) to deliver training and awareness sessions on forensic risk assessments and access to forensic services;
- CRT's to be reminded of the caseload zoning guidance when discussing high risk cases by 26 April 2019;
- to develop guidance for staff on making referrals to the forensic service and share at next team business meeting by 17 May 2019;
- develop a joint working protocol with Change Grow Live[5] (CGL) by 31 May 2019; and
- CRT to re audit in six months by 15 September 2019.

[5] https://www.changegrowlive.org/content/cgl-waltham-forest *CGL Waltham Forest is a free and confidential drug and alcohol service for adults aged 18+.*

3.69 We found CRS COP minutes 1 April 2019 which discussed learning from homicides and a specific request to provide training and awareness sessions on forensic risk assessments and access to forensic services.

3.70 The minutes detail that a discussion ensued regarding the benefits of a specific type of risk training called the historical clinical risk management-20 (HCR20)[6], however, it was agreed that the best approach to engage most staff and have most impact was to have more generalist forensic training provided by local forensic services. The team agreed that future HCR20 training could be undertaken by new Trust specialist community forensic psychology service practitioners once recruited and if still considered necessary.

3.71 We discussed CRT and forensic services engagement with WF team members. We were informed that the Trust has a forensic contract with ELFT which includes access to a forensic liaison meeting once per month, contact with a Consultant Forensic Psychiatrist in between these times with any patient concerns (either through email or 'phone contact) and the secondment of an ELFT forensic liaison CPN who holds a caseload of ELFT patients who reside in WF on Section 41[7] orders.

3.72 We discussed the provision of training and awareness sessions on forensic risk assessments and access to forensic services with the ELFT employed forensic liaison CPN seconded to work in WF. Staff can approach the forensic liaison CPN for advice, however he does not become directly clinically involved, or undertake joint working as he previously did, as this is not now part of the contract. We were informed that the post is not seen as being as integrated as it used to be within WF and as a result, care-coordinators may not feel as supported managing complex forensic cases as they might have done in the past.

3.73 The CPN informed us that he delivered awareness sessions to the three CRTs and has been requested to deliver further sessions in the CRT zoning meetings which have more of a clinical focus. The session delivered is basic awareness about his role, the forensic liaison service and other forensic service specifics as requested.

3.74 We found the three CRT monthly business meeting minutes 25 April 2019 mentioned that the protocol for accessing police records for dangerous clients was circulated to staff and provided details of generic emails for police liaison officers for help and advice.

3.75 We did not receive assurance that CRT's were reminded of the caseload zoning guidance when discussing high risk cases by 26 April 2019 and although we were informed that a draft joint working protocol with CGL was developed by 31 May 2019, we did not receive the appropriate assurance in respect of this.

---

[6] http://hcr-20.com/about/ *The Historical Clinical Risk Management-20, Version 3 (Douglas, Hart, Webster, & Belfrage, 2013) is a comprehensive set of professional guidelines for the assessment and management of violence risk.*

[7] https://www.legislation.gov.uk/ukpga/1983/20/section/41 *A Section 41 is also called a "restriction order" and operates like a community section.*

3.76 In summary, we found that the initial action was completed, although the audit was undated, and the follow up actions were partially completed. We have therefore graded this action as 2.

3.77 Due to the timescales of this review, we were not in a position to assess the outcome of the planned further CRT audit by 15 September 2019. As a result, we make a residual recommendation that appropriate assurance is received to monitor both the completeness, embeddedness and impact of the action is assured through this process.

Trust action 3

Number	Original Report Recommendation	Trust Action	Niche score
3	An audit of CRT zoning minutes to be cross referenced with the electronic patient record (EPR) entries to establish that clinical reasoning has been transferred to the EPR and is available to staff at the point of care.	The team leads to devise an audit schedule and complete a peer audit of their zoning minutes and the EPR against the standards in the zoning protocol with a specific focus on recording of decisions in the EPR.	3

3.78 We found that the overall WF action plan version 3 dated 21 May 2019 indicated that this action was completed 30 October 2018 with the follow up actions due for completion by 15 October 2019.

3.79 The actions were to be monitored through the DBM; CRT leads were to implement live EPR recording of zoning discussion during the meeting or before the end of the working day in accordance with the guidance by 30 April 2019 with a follow up audit in six months.

3.80 Pending the follow up audit, we were informed that the immediate actions included a discussion with the team leaders and administration manager to confirm that EPR entries needed to be completed during zoning, administrators would continue to take minutes of the meeting and practitioners would document actions directly onto EPR during clinical meetings.

3.81 The final decision on responsibility for this task was to be made in the clinical leads meeting on 7 August 2018 with a view to being implemented the following week.

3.82 We found an undated audit of CRT zoning minutes cross referenced with the EPR entries with the aim of establishing that minutes of CRT zoning meetings were in line with the protocol and that they had been transferred to patient records to be available at the point of care. A random sample of zoning minutes from the three CRT teams were cross checked against the EPR of ten patients over a six-month period.

3.83 The audit found that 90 percent of recorded minutes were transferred to the EPR with identified plans in place. All minutes had been uploaded to the team shared drive which staff members can access. However, there was a delay of one to three weeks of transferring information from minutes to the EPR.

3.84 The zoning protocol states that the team administrator, or a nominated member of secretarial staff, is responsible for updating the EPR while in the zoning meeting to ensure that it is live. If this is not possible the care coordinator must update the zoning status of their service user at least one hour before the end of each working day.

3.85 Despite these audit findings, we were informed that recording the zoning meeting minutes in the EPR has been difficult and WF has not found a sustainable way of doing this as yet due to capacity. As a result, the Trust information technology department has been asked to assist with an electronic means of doing this directly.

3.86 We have not been provided with assurance that the actions were monitored through the divisional business meeting and we note that the audit was undated.

3.87 However, given that an audit was undertaken as required, we have graded this action as 3 being complete but not embedded. Given this, it was not possible to consider the impact of this action.

3.88 We note that a follow up audit is due in October 2019 and we have therefore not made a residual recommendation in respect of this, as we would expect that the audit findings would consider how to address both the embeddedness and impact of the action.

Trust action 4

Number	Original Report Recommendation	Trust Action	Niche score
4	An audit of MAPPA attendance and the feedback process to relevant care coordinators.	To review the MAPPA attendance and feedback information based on known clients discussed at the MAPPA.	5

3.89 We found the overall WF action plan version 3 dated 21 May 2019 indicated that the actions were completed 30 October 2018.

3.90 We found an undated audit of MAPPA attendance and the feedback process to relevant care coordinators, undertaken using the EPR and minutes of cases discussed at MAPPA. The auditor looked at all of the mental health cases discussed in the last four months.

3.91 The audit found that the monthly MAPPA meeting is attended regularly by the CRS Service Lead. The minutes of this meeting are restricted and not uploaded onto the EPR. A written record of the multi-agency risk

management plan and service actions are recorded by the CRS Service Lead in the EPR and an update provided to the appropriate care coordinator.

3.92 We were informed that at present, the WF Recovery and Complex Care Pathway Lead attends the MAPPA and the role is to contribute and feedback any relevant information on the case discussions and act as an advisor.

3.93 Once the meeting is completed the WF MAPPA representative must feedback the discussion and actions to the relevant team members via email and document a brief summary in the EPR including updating risk assessments, if required. If there isn't a care coordinator (due to the patient being in access services) then the Recovery and Complex Care Pathway Lead will provide the information to the access services as a whole.

3.94 We viewed MAPPA email correspondence from the Recovery and Complex Care Pathway Lead to relevant team members as assurance. In summary, we found the correspondence to be clear and detailed and in terms of impact, we found the correspondence included advising staff about the inclusion of patients on the high risk register, patients being seen in safe premises, a reassessment of needs and management of risks to staff.

3.95 We have therefore graded this action as 5 being completed, embedded and having an impact.

Trust action 5

Number	Original Report Recommendation	Trust Action	Niche score
5	An audit of CRT cases to establish the service users that miss appointments are seen within one month.	The team will obtain a report for the previous six months of clients that have missed appointments and audit a random sample of no less than 50 percent against the standard in the missed appointments policy – clients to be seen within one month of a missed appointment.	3

3.96 We found the overall WF action plan version 3 dated 21 May 2019 indicated that the actions were completed 30 October 2018 with follow up actions due for completion 15 May 2019.

3.97 Actions to be monitored through the divisional business meeting included:

- audit findings to be shared with CRT team members and CRT COP;
- staff to be reminded of the need to contact the GP practice when an appointment is missed;

- protocol for missed appointments to be shared in team meeting and circulated to staff;
- benchmark the number of missed appointments in the WF CRT against other CRT services in the Trust; and
- conduct further analysis of missed appointments according to specific clinical area.

3.98 We have not been provided with assurance that the actions were monitored through the divisional business meeting.

3.99 We found an undated audit of CRS cases to establish whether service users who have missed appointments are then followed up and seen within one month with the aim of establishing if CRT staff are following the missed appointments guidelines within Trust policies and follow up within one month.

3.100 The audit focused on February 2019 due to the volume of missed appointment across the service. A random sample of 40 cases (20 percent) was audited to establish if the correct process with regard to follow up was followed.

3.101 The results show following a missed appointment staff are making initial contact with service users and their carers as appropriate. The team are also consistently having a multi-disciplinary team (MDT) discussion following a missed appointment.

3.102 We were informed that the service recently introduced a specific agenda item on missed appointments within the team zoning meeting. This agenda item then prompts the team and the practitioner to follow the guidance on missed appointments. We were provided with zoning meeting minutes for assurance purposes.

3.103 We were informed that there has been a huge change in practice concerning patients that don't turn up to appointments. The care coordinator follows up with the patient by telephone and letter if they haven't been heard from and through contact with the next of kin, the GP and the police.

3.104 There is a regular morning meeting in all CRT's called a 'huddle' that discusses high risk cases which may include patients not engaging, and the in zoning meetings the first topic of discussion via the care coordinators are the patients who are not engaging. There is a section in the zoning minutes that prompts staff to highlight in the meeting if they aren't engaging. Additionally, we were told that engagement issues and face to face contacts are discussed in managerial supervision.

3.105 The Recovery and Complex Care Pathway Lead told us that she receives a business support generated monthly report concerning patients that haven't been seen. This may be simply because they haven't been administratively discharged from the system however the Recovery and Complex Care Pathway Lead would still examine the EPR to see what the issues are and ensure that appropriate action is taken. Action plans are put in place for the non-engaging patients before discharge.

3.106 As a result of the daily 'huddles', zoning meetings and monthly engagement reports, we were informed that regular patient engagement audits do not take place as this way of working is now integrated into practice.

3.107 However, we were told that there is a high volume of missed appointments in the service and there is a need for further analysis of the data to identify any systematic issues that are contributing to this.

3.108 We found a June 2019 audit to establish what percentage of appointments are not attended in the CRS teams and the level of variance across the services. The sample included all appointments for CRS, either face to face or telephone, for the period of January to March 2019.

3.109 The results showed a consistent non-attendance rate across three of the services. However, the current information system was unable to provide additional granular detail at a team or individual level, therefore the audit was unable to identify any systemic issues or contributing factors as to the reasons for rates of non-attendance.

3.110 In summary, given that the initial action was completed, we have graded this action as 3 being completed, however as the follow up action was inconclusive, we found that the action not yet embedded and having an impact. We have made a residual recommendation that the follow up audit outcome is discussed at the divisional business meeting for further agreement to determine the most appropriate action and that this is monitored through the QLM.

Trust action 6

Number	Original Report Recommendation	Trust action	Niche score
6	An audit of CRT cases to establish the level of compliance with the requirement that when service users have disengaged a plan to improve engagement was in place and a crisis plan is in place before discharge.	The team will identify clients that have disengaged in the last six months based on the team zoning data and complete an audit of a random sample of no less than 50 percent of these cases to check if a crisis plan was put in place following reported disengagement.	2

3.111 We found the overall WF action plan version 3 dated 21 May 2019 indicated that the actions were completed 30 October 2018 with follow up actions due for completion 30 June 2019.

3.112 We found an undated audit to review the actions taken when service users do not engage with the team with the aim of establishing the level of compliance with the required actions to be undertaken when service users do not engage.

3.113 A random sample of EPR service users identified in zoning as "not engaging" was audited to establish if an engagement improvement plan was

in place and the crisis plan had been updated. This sample was for a three-month period from November 2018 - January 2019. The disengagement action plan was measured against the Trust CPA policy.

3.114 The results showed a good level of compliance with the follow up actions required when service users do not engage with their care plan.

3.115 The sample of six patients showed that clinicians are recording levels of engagement and this is considered within the team zoning meeting. However, it was noted that the sample size was small and did not give assurance of good validity.

3.116 We were informed that the initial audit was presented to the COP where leads from each CRT come together to discuss concerns.

3.117 Follow-up actions included:

- repeat audit in three months with larger sample of cases;
- share results with the CRT through the business meeting; and
- present to CRS COP and recommend this is repeated for all Trust wide CRT's.

3.118 However, we were informed that the audit has not been repeated due to capacity issues. Given this, and the small sample size of the initial audit, we have graded this action as 2, not being completed.

3.119 We have therefore made a residual recommendation that the initial audit and the lack of capacity to repeat the follow up audit is discussed at the divisional business meeting to determine the action required, and that this is monitored through the QLM.

Trust action 7

Number	Original Report Recommendation	Trust Action	Niche score
7	CRT to improve the current 75 percent compliance rate for risk assessment training to the Trust standard of 85 percent.	The team leads will identify the cohort of staff requiring training and proactively book staff onto training dates.	4

3.120 We found the overall WF action plan version 3 dated 21 May 2019 indicated that the actions were completed 30 September 2018.

3.121 We found an undated audit of clinical risk training compliance for clinical staff who are employed in the WF CRT with the aim of improving the current 75 percent compliance rate for risk assessment training to the Trust standard of 85 percent.

3.122 The audit indicated that WF compliance rate was at 85 percent, with four staff members being non-compliant and one staff member on long term sick leave.

3.123 We were informed that new staff commencing employment in the Trust complete this training as part of their induction and that there has been a good improvement in the update of staff completing the training which is mandatory.

3.124 The follow up action was to ensure that non-compliant staff completed their training. We were informed that these particular staff members were locum and have now left Trust employment.

3.125 We were provided with the mandatory training summary for WF CRT's and although undated the document indicates an end of month 92.86 percent compliance rate for clinical risk assessment training at an advanced level.

3.126 We note the June 2019 Trust Board Quality Report which states that clinical risk assessment and management training became mandatory for all clinical staff, at a grading of bands five and above, in February 2018 and that the Trust is now above 90 percent compliant with this training.

3.127 The Trust Board Quality Report states that improvement in clinical risk assessment and management training is still required and as well as the mandatory training the clinical effectiveness and quality improvement teams are delivering training in each locality on this topic to ensure that staff are aware of the requirements and clear on the use of the risk tools in the electronic patient records.

3.128 We also note that since the new Trust Learning Management System (called STEPS) was introduced, mandatory training compliance has increased and that in addition a work stream has been established to review the electronic notes to improve the clinical risk assessment templates to ensure the technological solution is effective and user friendly.

3.129 We note that Care Quality Commission (CQC) compliance specifically in terms of clinical risk assessment is reported as a strategic managed risk being managed through the quality safety committee.

3.130 We have therefore graded this action as 4 being completed and embedded. We have not assessed the impact of this action as we note that that this will be addressed as one of the Trust quality improvement work streams being progressed during the year to reduce risk and improve patient safety.

Trust action 8

Number	Original Report Recommendation	Trust Action	Niche score
8	CRT to establish the current compliance rates for supervision.	The team leads to complete a peer audit of supervision compliance against the Trust standards in relation to the frequency of supervision the CRT will complete.	3

3.131 We found the overall WF action plan version 3 dated 21 May 2019 indicated that the actions were completed 30 October 2018 with follow up actions due for completion 30 July 2019.

3.132 We found an undated CRT audit to establish the current compliance rates for supervision undertaken through a review of all care coordinator staff supervision over a 12-month period. The auditor reviewed the use of both electronic records and paper records held by line managers. We were informed that the type of supervision audited was managerial supervision.

3.133 The audit results reported a very good level of compliance with supervision for the CRT staff with their line manager and stated that in addition to line management supervision all care coordinators have access to professional group supervision and have quarterly caseload reviews with their line manager and responsible clinician on complex cases.

3.134 A follow up action for CRS to develop a checklist to monitor the qualitative content of supervision was to be monitored through the divisional business meeting and reported to the quality leadership team. We have not received the minutes of the meeting as assurance in this regard.

3.135 We were provided with an undated supervision checklist which included the following points:

- Is the supervision planned in advance, in a quiet location and free of interruptions?
- Has the supervisee prepared for supervision by completing the steps form?
- Has the supervisee prepared for supervision and completed and up-to-date caseload key performance indicator checklist?
- Does each service user have an up-to date CPA review, care plan, risk assessment and crisis plan in place?
- Is there evidence of service user involvement in their care?
- Has the service user and next of kin been updated in the past 12 months?
- If there are concerns, has the service user had a capacity assessment in the past 6 months?
- Has the service user had face to face contact with their care coordinator in the last month?

- Are all clinical notes legible, accurate, validated and in date with clear action plans in place?
- Are clear timelines for outstanding actions agreed?
- Date of next face-to-face contact and CPA review.
- Have all learning needs been identified and action plans in place?

3.136 Further follow up actions were to share the supervision checklist at the CRS COP and consider the use of this across the Trust, and for team managers to conduct a peer qualitative audit of supervision of five staff across the teams.

3.137 We were informed by the Recovery and Complex Care Pathway Lead that the draft supervision checklist is still being developed and CRS COP members are being consulted about this.

3.138 The Recovery and Complex Care Pathway Lead collects the WF supervision information monthly and takes action if it is found that staff supervision hasn't taken place.

3.139 The Recovery and Complex Care Pathway Lead told us that where this is the case, she would speak to the supervisor to ensure supervision takes place and put performance and capability plans in place with staff as required.

3.140 We note the June 2019 Trust board quality paper which states that, following receipt of the CQC provider quality report published in January 2018, four of nine remaining risks are due to slippage in compliance with supervision and appraisal and are being managed locally and through commissioning meetings.

3.141 We were further provided with an audit of supervision compliance in the WF CRT's between March and September 2019 for practitioners at grading bands four to seven and found the following:

- September 100 percent
- August 96 percent
- July 98 percent
- June 96 percent
- May 92 percent

3.142 We have therefore graded this action as 2 being completed and embedded within WF however, the follow up actions to the audit remain outstanding. As a result, we have not been able to assess the impact of the action and suggest that this is assessed in due course locally and as required through the Trust Quality and Safety Committee.

Recommendation 9

Number	Original Report Recommendation	Trust Action	Niche score
9	Consideration of Forensic Awareness training for CRT staff.	No detail available.	N/A Incorporated into Trust action 2.

3.143 We reviewed this action in conjunction with Trust action 5 (3.95 – 3.109) to establish the level of engagement and referral for forensic assessment as our view is that this action requires CRT staff to have an appropriate level of forensic service awareness.

Recommendation 10

Number	Original Report Recommendation	Trust Action	Niche score
10	Consideration of a protocol to support clinicians in their work with criminal justice agencies.	No detail available.	N/A Incorporated into Trust action 1.

3.144 We reviewed this action in conjunction with Trust action 1 (3.51 – 3.59) to review the current CRT process for access to police information as the Trust action was to put a system in place as a result.

4 Summary

4.1 In terms of the two fixed recommendations and the 8 remaining original report recommendations and associated Trust actions, we have summarised the Niche scores as follows:

Score	Assessment category	RAG
1	Insufficient evidence	0
2	Recommendation incomplete	3
3	Recommendation complete	3
4	Recommendation complete and embedded	3
5	Complete, embedded, impactful and sustained	1
	Total number of actions	10

4.2 Where the action resulted in a grading of 2, 3 or 4 we have made residual recommendations for the Trust to seek formal assurance of the completeness, embeddedness and impact against each action as appropriate.

Residual recommendations

Processes for embedding of learning across the Trust

4.3 We make a residual recommendation that the governance processes associated with the WF DBM and QLM is reviewed.

Review of the WF CCG monitoring of the action plan

4.4 We have not made a residual recommendation in respect of this as our view is that there are appropriate structures in place for the WF CCG monitoring of the action plan.

Fixed recommendations

4.5 With reference to the first fixed recommendation, we recommend the Trust reviews the supporting administration so that appropriate assurance is available for audit and review.

4.6 With reference to the second fixed recommendation, we make a residual recommendation that the closure plan provides the appropriate assurance required to ensure the action is embedded and impactful.

Trust action 1

4.7 We make a residual recommendation to include assessing the impact of this action in the Trust and East London Forensic Trust (ELFT) Forensic Partnership Group protocol review 3 February 2020.

Trust action 2

4.8 We make a residual recommendation that the embeddedness and impact of the action is assured through this process.

Trust action 3

4.9 We have not made a residual recommendation in respect of this action given that a follow up audit is due in October 2019.

Trust action 4

4.10 We have not made a residual recommendation in respect of this as the action is completed, embedded and having an impact.

Trust action 5

4.11 We make a residual recommendation that the follow up audit outcome is discussed at the DBM for further agreement to determine the most appropriate action and that this is monitored through the QLM.

Trust action 6

4.12 We make a residual recommendation that the initial audit and the lack of capacity to repeat the follow up audit is discussed at the DBM meeting to determine the action required, and that this is monitored through the QLM.

Trust action 7

4.13 We have not made a residual recommendation in respect of this as the impact of this action will be addressed as one of the Trust quality improvement work streams being progressed during the year to reduce risk and improve patient safety.

Trust action 8

4.14 We make a residual recommendation to assess the impact of the action in due course locally and as required through the Trust Quality and Safety Committee.

Trust recommendation 9

4.15 We reviewed this recommendation in conjunction with and incorporated into Trust action 5 (3.95 – 3.109) to establish the level of engagement and referral for forensic assessment as our view is that this action requires CRT staff to have an appropriate level of forensic service awareness.

Trust recommendation 10

4.16 We reviewed this action in conjunction with and incorporated into Trust action 1 (3.51 – 3.59) to review the current CRT process for access to police information as the Trust action was to put a system in place as a result.

Appendix A - Terms of reference

Purpose of the Review

To independently review:

- The Trust's current practice and the implementation of the Trust's internal investigation action plan.
- The embedding of learning across the Trust and identify any other areas of learning for the Trust and/or CCG.

The outcome of this review will be managed through governance structures in the clinical commissioning group and the provider's formal Board sub-committees. The CCG will provide assurance to NHS England of completion of any actions/outcomes from the completed report.

Terms of Reference

To independently review:

- The implementation of the Trust's internal investigation action plan.
- The embedding of learning across the Trust and identify any other areas of learning for the Trust and/or CCG.
- The processes in place to embed any lessons learnt.
- Whether those changes have had a positive impact on the safety of Trust services.
- Comment on the CCG monitoring of the action plan.
- Make further recommendation for improvement as appropriate in relation to any residual recommendations.
- To consider making further recommendations locally, regionally and nationally for improvement as appropriate.

Timescale

The review process starts when the investigator receives the Trust documents and the review should be completed within six months thereafter.

Initial steps and stages

NHS England will:

- Ensure that the victim and perpetrator families are informed about the review process and understand how they can be involved including influencing the terms of reference.
- Arrange an initiation meeting between the Trust, commissioners, investigator and other agencies willing to participate in this review.

Outputs

- A final report that can be published, that is easy to read and follow with a set of measurable and meaningful recommendations, having been legally and quality checked, proof read and shared and agreed with participating organisations and families (NHS England style guide to be followed).

- At the end of the review, to share the report with the Trust and meet the victim and perpetrator families to explain the findings of the review and engage the clinical commissioning group with these meetings where appropriate.
- A final presentation of the review to NHS England, Clinical Commissioning Group, provider Board and to staff involved in the incident as required.
- We will require monthly updates and where required, these to be shared with families, CCGs and Providers.
- The investigator will deliver learning events/workshops for the Trust, staff and commissioners if appropriate.

Appendix B – Staff Interviewed

Designation	Date
WF Recovery and Complex Care Pathway Lead	15 August 2019
WF CRS Consultant Psychiatrist	15 August 2019
ELFT/TRUST Forensic Liaison CPN	15 August 2019
WF Clinical Lead CRT North	15 August 2019
WF Community Recovery and Review Manager	15 August 2019
WF CCG Quality and Patient Safety Lead	16 August 2019
WF Associate Director	13 September 2019
WF Integrated Care Director	23 September 2019

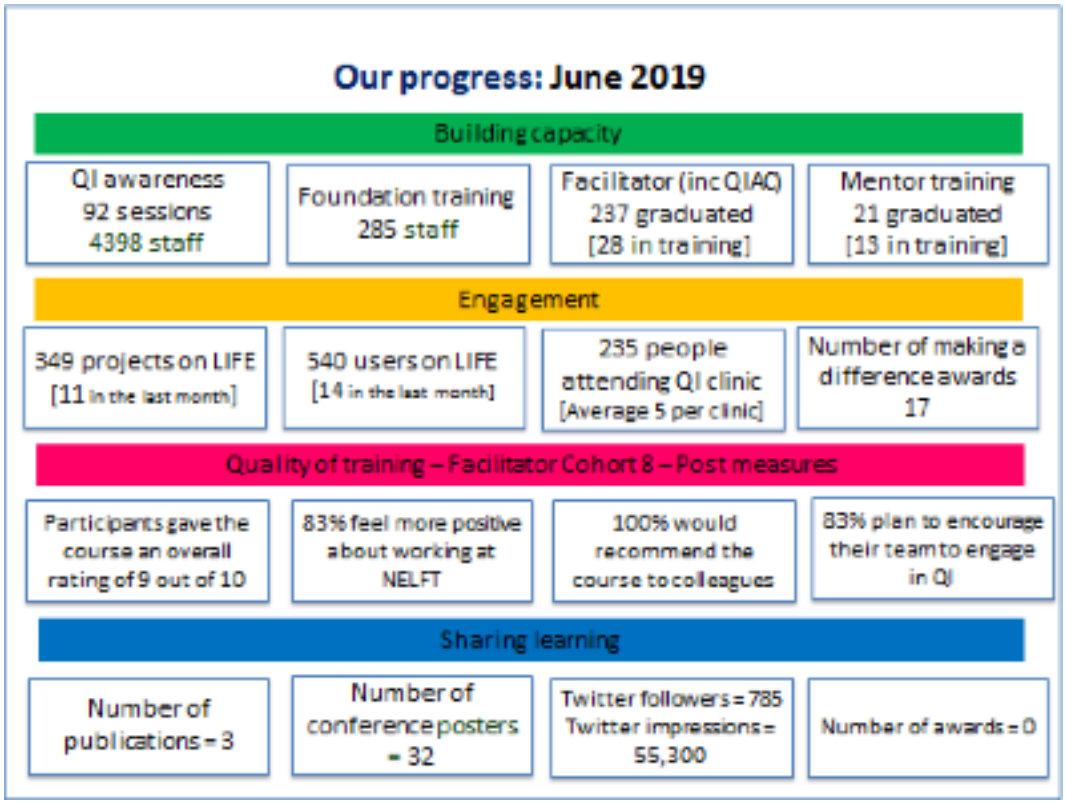
Appendix C – Documents reviewed

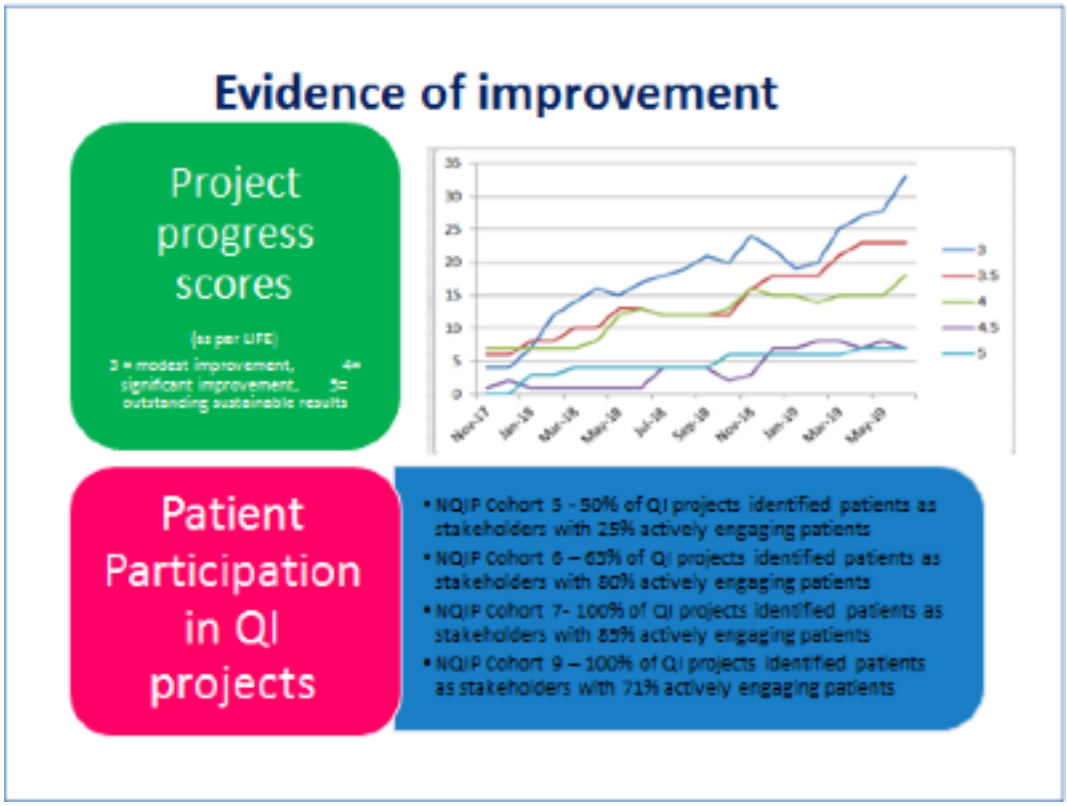
	Document	Date
1	Serious Incident Policy	March 2015
2	Duty of Candour Policy	18 August 2017
3	Missed Appointments Policy	September 2017
4	Trust and ELF forensic partnership group terms of reference	24 January 2019
5	Lessons learnt homicide event	1 and 15 February 2019
6	Lessons learnt register	1 and 15 February 2019
7	Team business meeting minutes	28 March 2019
8	WF protocol for requesting Police and Forensic support	March 2019
9	Zoning meeting minutes	28 March, 16 and 28 May, 13 September 2019
10	WF supervision compliance audit	March – September 2019
11	CRS COP minutes	1 April, 5 August 2019
12	WF Quality and patient safety leadership team meeting	10 April 2019
13	WF CCG performance and quality committee	8 May 2019
14	Draft divisional business meeting minutes	8 May 2019
15	Serious incident investigation action plan	Version 3 21 May 2019
16	Email correspondence regarding family contact	March and May 2019
17	Trust quality report	June 2019
18	Letter to perpetrator	6 July 2017
19	WF CCG clinical quality review meeting	3 August 2019
20	MAPPA email correspondence	Various
21	Trust board papers	Various
22	Mandatory training compliance snapshot	Undated
23	Audit of CRT cases involving criminal justice agencies and follow up actions	Undated
24	Audit of CRT zoning minutes cross referenced with the EPR and follow up actions	Undated
25	Baseline DNA audit	Undated
26	Audit of MAPPA attendance and feedback process to CC's	Undated
27	Audit of CRS cases, missed appointments and follow up actions	Undated
28	Audit of actions taken when service users do not engage and follow up actions	Undated
29	WF CRT clinical risk training compliance	Undated
30	A review of CRT care co-ordinator staff supervision over a 12 month period and follow up actions	Undated

Appendix D – Trust Governance Structure

Board of Directors in Public Review: Board Assurance Framework – all risks that would impact strategic goals. Other risks reported up from sub-committees via exception reports. Quality and Patient Safety Committee (QSC) – Chaired by NED Review: Risks 15+.
Audit Committee – Chaired by NED Review: All Risks 15+ (clinical and corporate)..
Quality Senior Leadership Team (QSLT) – Chaired by ED. Review: Risk exception reports from each directorate except corporate.
Corporate Senior Leadership Team (CSLT) – Chaired by ED Review: Risks 15+ for corporate directorate.
Quality Leadership Team (directorates) - Chaired by ICD. Review: Risks 15+, risks that need to be opened or closed and risks that need to be escalated to QSLT.
Corporate Team meetings including: Estates Strategy Group, Procurement Departmental Meeting, Senior Finance Team Meeting, Business Development and Transformation Team Meeting. Review: Discuss risks at each team meeting and open them on Datix.
Divisional Business Meeting (divisions within directorates) – Chaired by AD. Review: All team risks which are opened on Datix at this point.

Appendix E - Trust Quality Improvement approach June 2019





Appendix F – List of abbreviations

NELFT report:

‘A’	Service user referred to ‘A’ in this report
CAT	Cognitive Analytical Therapy
CCG	Clinical Commissioning Group
CGL	Change Grow Live
CMHT	Community Mental Health Team
COP	Community of Practice
CPN	Community Psychiatric Nurse
CRT	Community Recovery Team
CRS	Community Recovery Services
CQC	Care Quality Commission
CQRM	Clinical Quality Review Meeting
DoC	Duty of Candour
ELFT	East London Foundation Trust
EPR	Electronic Patient Record
FLO	Family Liaison Officer
HCR20	The Historical Clinical Risk Management-20,
NARF	Niche Assurance Review Framework
NELFT	North East London Foundation NHS Trust
NHSE	National Health Service England
MAPPA	Multi Agency Public Protection Arrangements
MDT	Multidisciplinary Team
PNC	Police National Computer
QLM	Quality Leadership Meeting
QLT	Quality Leadership Team
STEPS	Trust learning management system
WF	Waltham Forest

In the appendices:

QSLT	Quality Senior Leadership team
ED	Executive Director
CSLT	Corporate Senior Leadership Team
ICD	Integrated Care Director