Independent Investigation Assurance Review
ELFT Mr L

Ref: 2013-17516

October 2021

insight integrity impact

Niche Investigation Assurance Framework

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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.

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1. Summary

Background to the initial event

Mr L had been under the care of the East London NHS Foundation Trust (ELFT/ the Trust) since 2009, having become mentally unwell while away at University. He was diagnosed with schizophrenia and depression in late 2009, and found the symptoms distressing. He was under the care of Newham Early Intervention Team (EIT), and was treated with antipsychotic medication and psychological therapy. He was reluctant to take oral medication, so this was changed to a monthly depot injection every two weeks in 2010.

He reported receiving messages from the television, and was restless, believing this was the result of evil spirits. Mr L was reluctant to take medication and was regularly discouraged from reducing doses. His father attended Care Programme Approach (CPA) review meetings with him and supported him to change to oral risperidone after he developed an abscess in the injection site in early 2012. He reduced the medication further without telling anyone in the two weeks before his fathers death.

On 13 June 2013 Mr L phoned his brother to tell him that he had killed their father. Mr L was arrested at the scene, and on 12 March 2014 he pleaded guilty to manslaughter due to diminished responsibility. Mr L was detained indefinitely under Sections 37 and 41 of the Mental Health Act (1983).

Context for this review

The Trust conducted a serious incident internal investigation into the care and treatment of Mr L in 2013. The Trust conducted a serious incident internal investigation into the care and treatment of Mr L in 2013. The internal investigation was commissioned by the Medical Director to carry out a comprehensive internal investigation in accordance with the NHS England Serious Incident Framework (March 2015). The internal investigation team concluded that there were no care or service delivery problems identified; no contributory factors identified; and the root cause was listed as 'it therefore seems likely that the root cause of the incident was that the patient suffered a relapse in his psychotic illness'.

NHS England, London commissioned Niche to carry out an independent mental health homicide investigation into the care and treatment of Mr L in 2015.

As part of the original terms of reference, Niche have been asked to provide an assessment of the Trust's resultant action plan against the Niche Investigation and Assurance Framework (NIAF), specifically to:

- undertake an assurance follow up and review, six months after the report has been published, to independently assure NHS England and the commissioners that the report's recommendations have been fully implemented; and
- produce a short report for NHSE, commissioners and families that may be made public.

Independent investigation and implementation of recommendations

The Trust action plan was developed following receipt of the independent investigation report and in response to the five recommendations made. This report provides a detailed assessment of completion against all actions described in the plan.

Action owners were assigned to each recommendation and all had implementation dates that have now passed.

Our review has found that all five actions have been progressed to completion.

The evidence provided by the Trust to support their position is robust, however in four areas there is a lack of detail on evidence of the impact of changes made.

Of the five recommendations, we have rated four as being completed but not tested. We have rated one (recommendation 1) as action completed, tested and embedded.

Review method and quality control

Our work has comprised a review of documents and some staff interviews.

We used information from ELFT and NHS Newham Clinical Commissioning Group* (the CCG).

At Niche we have a rigorous approach to quality standards. We are an ISO 9001:2015 certified organisation and have developed our own internal single operating process for undertaking independent investigations.

Our final reports are quality assured through a Professional Standards Review process (PSR) and approved by an additional senior team member to ensure that they have fully met the terms of reference for review.

* NHS Newham CCG is now part of NHS North East London CCG.

Clinical commissioning group oversight, governance and systems

The CCG provided oversight of the internal investigation action plan, and in February 2018 the Trust submitted evidence that the action plan had been implemented.

The plan has been ‘signed off’ as completed, and this was agreed with NHS England in February 2018.

Ongoing monitoring is provided by Quality Assurance (QA) visits and Clinical Quality Review meetings (CQRM).

2. Summary assessment on progress

The Niche Investigation Assurance Framework (NIAF)

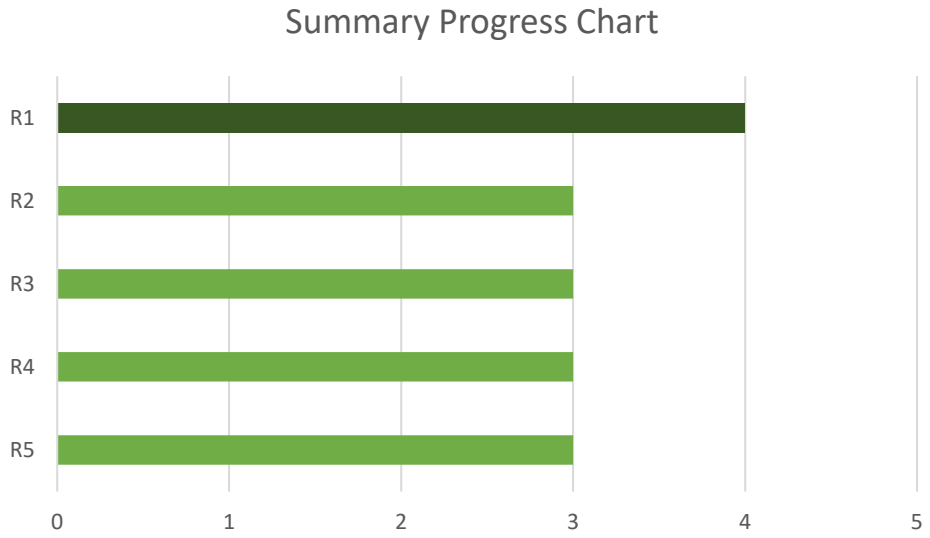
Assessing the success of learning and improvement can be a very nuanced process. Importantly, the assessment is meant to be useful and evaluative, rather than punitive and judgemental. We adopt a useful numerical grading system to support the representation of 'progress data'. We deliberately avoid using traditional RAG ratings instead, preferring to help our clients to focus upon the steps they need to take to move between the stages of completed, embedded, impactful and sustained – with an improvement which has been 'sustained' as the best available outcome and response to the original recommendation.

Our measurement criteria includes:

Score	Assessment category
0	Insufficient evidence to support action progress / action incomplete / not yet commenced
1	Action commenced
2	Action significantly progressed
3	Action completed but not yet tested
4	Action complete, tested and embedded
5	Can demonstrate a sustained improvement

Our assurance review has focussed on the subsequent action plan, and assurance of the action plan by the CCG.

In relation to progression of actions which have been agreed from the five recommendations made from the internal investigation report. We have rated the findings which are summarised below:



Summary

The Trust has made excellent progress in relation to some actions, however, structures have changed since the recommendations were made and the action plan updates reflect this.

Assurance review findings

3. Assurance review of the Trust action plan

The terms of reference for this assurance review require Niche to:

Undertake an assurance follow up and review, six months after the report has been published, to independently assure NHS England and the commissioners that the report's recommendations have been fully implemented.

Action plan methodology

Our review has found that each recommendation was supported by a named implementation lead with target dates for completion, and detailed actions to achieve each recommendation.

There is a list of evidence for completion, and monitoring and evaluation arrangements are described.

Action owners were assigned to each recommendation, with implementation dates. Serious incident action plans in ELFT are held by Divisional Management Teams, and as such the Borough Director, Newham was responsible for the local actions 1-4.

The Trust wide action (recommendation 5) was assigned to a corporate post; the Associate Director of Governance and Risk Management. This post had recently become vacant when we commenced our review, due to a reorganisation of internal roles, and was being actively recruited to in summer 2018.

Oversight of the action plan was the responsibility of the CCG.

The action plan was published in August 2017, and is not RAG rated. The completion dates, which were all before the end of 2017, have now passed and the action plan is regarded as completed.

We recognise that the Trust had the final draft for some months prior to this, and actions had already been commenced. The homicide was committed in 2013, and since then there have been significant changes in how the Trust manages information in relation to performance and quality assurance indicators. These changes are reflected in how the action plan is monitored, through the Newham Directorate Management Team for recommendations 1-4, and the Trust Quality Committee and CQRM for recommendation 5.

Our full assessment of the progress the Trust has made in making and embedding change can be found from page 10.

The Newham Directorate Management Team meets monthly and reviews the Performance Report which includes data on compliance with monthly contacts.

The monthly Newham Directorate Healthcare Governance meeting also reviews performance and is attended by all managers. Any reduction in compliance and reasons for this is picked up at this meeting and a remedial plan is put in place.

The SI Review Committee Meeting is a sub committee of the Board and is chaired by the Medical Director.

Recommendation 1: The Trust must provide assurance that carer's assessments and support are offered and documented in line with the Trust strategy and that there is a system for care co-ordinators to initiate monthly contact with carers of clients who are on Care Programme Approach.

Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
At the time of the incident social care was provided by the Trust under a Section 75 agreement with the local authority but responsibility for social care has now been transferred back to the local authority. The Trust therefore does not undertake carer's assessments as these are the responsibility of the local authority. The Trust will ensure there is a system for ensuring monthly contact for carers of patients who are on CPA. The Trust will ensure drop in sessions are available at the Recovery teams.	• Carers' strategy. • Information leaflet advertising monthly Carers Group in the hospital. • Performance report showing monthly contacts. • Directorate Learning Lessons Bulletin. • Learning events material. • Copy of minutes from Joint Implementation Board Meeting(s). • The Newham Directorate Management Team meets monthly and reviews the Performance Report which includes data on compliance with monthly contacts.	• There is a report in the Quality Dashboard which shows whether carer views have been ascertained. The report on a CPA audit in July 2017 shows that carer views were sought in just over 80% of cases. The target is 80%. • Learning Lessons bulletins in January 2017, March 2018 and July 2018 show examples of good practice in family contact and following up family concerns. These learning lessons seminars are held quarterly. A clinical governance bulletin is issued monthly which highlights performance issues and feedback from service users and staff. • The views of 19 service users and 10 carers were collected and analysed as part of the recent review of the Assessment & Brief Treatment Team and Community Recovery Teams completed by Community Services Manager. Results showed room for improvement in service users and carers feeling listened to. • The Trust has engaged a new Patient Reported Experience Measures (PREMS) provider. A list of questions asked include whether they felt listened to, treated with kindness, knowing who to contact etc. and numbers of respondents were available. • There was a QI project in early 2018 focussing on increasing responses to the feedback surveys in Newham. • The Trust Quality Assurance Committee (QAC) minutes of December 2018 show service user engagement as active on the action log.

Recommendation 1: continued		
Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
There will be monthly Carers' group meetings in the inpatient unit. Care coordinators will have monthly contacts with carers in accordance with agreed key performance indicators.	• Quality dashboard July 2017 – CPA Audit. • Carer leads in each ELFT area, carer pack and are on ELFT website signposting to services and support. • Carers handbook, includes carers out of hours carers crisis line. • Monthly carer community health group and peer support structure in place. • Learning lessons bulletin September 2016 focusing on communicating with a family member. • Carers contacts are monitored monthly: Month % Carer Contacts • Sep-18 77.56% lowest • Nov-18 88.05% highest	• There is objective evidence that the Trust has systems in place to improve the communication with and experience of service users and carers.
The Borough Director Newham to discuss with Interim Head at London Borough of Newham (LBN) at a Joint Implementation Board Meeting (JIB) on 03.08.2017	• JIB workshop on mental health issues Nov 2018. • JIB meeting minutes May 2019.	• Minutes show communication and problem solving of issues where there is a social care and health concern, with decisions made about funding and resources.

NIAF review rating: **The Trust has implemented a number of actions to meet this recommendation and there has been some good progress. The Trust is able to show actions completed, tested and embedded.**

Overall review rating for this recommendation: **4 - Action complete, tested and embedded.**

Recommendation 2: The Trust must ensure that staff take responsibility for issuing formal invitations to all those they believe should be present at a Care Programme Approach meeting, or document discussions where this intention is changed.

Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
The Trust will ensure that care coordinators are responsible for drawing up an invitation list to CPA meetings and that all relevant people are invited including family members (subject to consent). The invite list will be reviewed by care coordinators at each CPA meeting to ensure they reflect the people currently supporting the patient.	• Revised CPA policy where care coordinator responsibilities are clearly defined (date/ref). • This includes discussion with service users prior to CPA meetings about who should attend. • Directorate Learning Lessons Bulletin. • Learning event material. • Arrangements for CPA meetings including attendance, timeliness and effectiveness are discussed in supervision. • The CPA policy states that service users must be involved and consulted about who they wish to attend. • The CPA policy is audited regularly and this audit reviews quality as well as adherence to policy.	The CPA policy states that service users must be involved and consulted about who they wish to attend. The CPA policy is audited regularly and this audit reviews quality as well as adherence to policy. The operational Managers have access to policy minutes, attendance sheets etc and will raise issues and questions with care coordinators in supervision. Operational Team Leads hold a 'drop in' session for any service user or carer who wishes to speak with them. There were no audit results available which showed whether actions had had any impact.

NIAF review rating : **The Trust has proposed a number of actions to meet this recommendation and there has been some progress and agreement from the CCG. However, there are still some key gaps in assurance in relation to the Trusts ability to demonstrate that these actions have effected an improvement in the area.**

Overall review rating for this recommendation: 3 - Action completed but not tested.

Recommendation 3: The Trust must ensure that appropriate support is given to clients wishing to apply for self-directed support funding, who are known to have gambling habits.

Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
• Applications for self-directed support funding (SDS) are no longer undertaken by Trust staff as the local authority now operates a separate system. • Trust staff would always provide relevant information to the local authority in relation to any applications, including any risks associated with the use of self-directed funds providing the service user gives consent.	• The Borough Director Newham to discuss with Interim Head at LBN at a Joint Implementation Board Meeting on 03.08.2017. • Copy of agenda and minutes of the Joint Implementation Board meetings. • The Borough Director has contacted the Interim Manager of the Adult Mental Health service in the London Borough of Newham to confirm that ELFT staff will share appropriate information about service users wishing to apply for Self Directed Support where they have permission from the service user to do so. • In addition, ELFT will support service users to make an application for SDS, again, if appropriate. Interface issues and concerns will be monitored and addressed through the regular Joint Implementation Board meetings.	• This recommendation is less relevant in the current system regarding applications for self-directed support funding. • The issue of support for gambling has been highlighted in learning lessons bulletins. • Gambling is included in the incident tracking system (Datix) as a safeguarding issue.

NIAF review rating: **The Trust has progressed the action to meet this recommendation, however, the recommendation is no longer entirely relevant in the current system.**

Overall review rating for this recommendation: 3 - Action completed but not tested.

Recommendation 4: The Trust must assure itself that risk assessments and risk management plans are reviewed when new information comes to light. The Trust must also implement an ongoing audit programme to provide assurance about organisational compliance with this requirement.

Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
• The risk assessment will be reviewed and updated at every CPA meeting and more frequently if required. This will be audited via a quarterly CPA and risk assessment audit.	• Revised CPA policy V1.2 August 2018. • Quarterly CPA & risk assessment quarterly audit which reviews completion and quality of the risk assessment, including current information. • Audit results are monitored via the performance monitoring in the directorate. • A Clinical Governance bulletin is issued monthly • Audit results are discussed in the Trust Quality Assurance meeting and are noted in the Directorate Management Team which meets monthly. • Learning Lessons seminars held quarterly.	• There are clear structures in place for reporting on and monitoring these issues. • Samples of the clinical governance bulletins and lessons learned bulletins were seen. • QAC Terms of Reference June 2018. • Minutes of the QAC Dec 2018, Feb & April 2019 were provided. • Agendas and Minutes of Newham Adult Mental Health Directorate meeting March 2019 were provided - the risk assessment was noted but audit results were not included. • Results for the quarterly CPA and risk assessment audits were not seen.

NIAF review rating: **The Trust has progressed the actions to meet this recommendation, however, these have not been tested**

Overall review rating for this recommendation: **3 - Action completed but not tested.**

Recommendation 5: The Trust must revise the Incident Policy or develop additional guidance, and provide appropriate training to ensure staff are clear about:
*the type of records to be created and stored when conducting an investigation; and
*storage and retrieval of clinical records & reporting of misplaced clinical records required for internal & external investigations.

Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
• The Incident policy will be revised to include guidance on the creation, storage and retention of records when conducting an investigation. • The incident policy will include direction on raising an incident when records cannot be located. • The incident policy will contain guidance on ensuring staff involved in an incident investigation are given support during and after the investigation including provision of clients' records.	• Updated Incident policy v8.4 November 2018. • Revised Datix reports screenshot showing. record incident recording parameters. • IG breaches report 1/4/18 to 28/1/19. • SI Review 10 day review meeting checklist. • SI review milestones & timeline checklist. • NHSE SI Review Checklist adapted for ELFT. • SI Review Committee Meeting 30/5/18 agenda & minutes.	• Corporate investigation teams structured supervision in place, process aligned to agreed quality standards but not documented. • Corporate investigation team training records. • Staff feedback forms on support given during & after an investigation – May 2018 SI review committee minutes suggest the funding not agreed for Trust wide trauma response service.

NIAF review rating: **The Trust has progressed the actions to meet this recommendation, however, these have not been tested.**
Overall review rating for this recommendation: **3 - Action completed but not tested.**

4. The CCG quality assurance processes

Responsibility for the quality assurance of action plans resulting from serious incidents at ELFT lies with NHS Newham CCG.

ELFT submitted evidence that the Mr L action plan had been implemented in February 2018.

Monitoring of issues that are identified as requiring ongoing monitoring has been absorbed into regular commissioning update and quality assurance visits.

Minutes of monthly Newham Mental Health Clinical Quality Review Meeting (CQRM) and Quarterly Clinical Quality Review Group for East London Foundation Trust (ELFT) with 'consortia' City and Hackney, Newham, and Tower Hamlets CCGs. An action tracker is kept to ensure follow through.

There is a local mental health CQRM (Newham every month - apart from months with Consortia meeting), this focusses on key issues, sometimes serious incidents (such as a sexual safety incident), issues with incidents, so family engagement in identification of risks was raised at the most recent CQRM in relation to one case.

There is a Consortia CQRM (quarterly - Tower Hamlets, Newham, City and Hackney) where Trust wide areas in mental health are reviewed, an example would be the CPA policy in July 2019 meeting. There is a forward planner for 2019/2020 to plan QA reviews.

A pathway review was completed in November 2018, monthly QA visits have been carried out in inpatient wards throughout 2018 with actions tracked. These include feedback from staff and patients.

QA visits – a number of assurance visits were carried out, attending internal meetings, events. Also visited sites such as Ruby ward and Ivory ward where recent serious incidents had occurred to look at any changes. Staff feedback and support is often looked at as part of the visits including awareness of incidents.

Currently reviewing the quality assurance visit framework at the moment - and will be looking at pathways and transfer between different services. The CCG is keen that some of the pathways are reviewed as multi agency to ensure that there is engagement from other organisations. Plans are to include carer/patient involvement with this process as well.

Action plans are monitored at the CCG's SI Panel meetings which are held every fortnight and chaired by the designated CCG Senior Quality Manager for that area. Appropriate representatives from the Trust are in attendance.

Monthly commissioner reports highlight areas identified as KPIs or lessons learned.

[The CCG quality assurance processes, continued]

Recommendations and action plans from serious investigation reports are signed off by the Trust at their SI Panel with review by the CCG (this process is described in their Serious Incidents Policy). There is a monthly ELFT - CCG consortium SI panel meeting.

The CCG rejects action plans if care or service delivery problems are not reflected in the recommendations or action plans, or if the action plan is not SMART.

All SI's are reviewed, and there is scrutiny of the quality & timeliness of reports and action plans, and tracking of action plans.

There is a monthly tracker of closed and open SIs, and detailed records kept of closures and non closures, with recommendations for action.

Serious Incidents are reviewed by NELCSU. The CCG receive real time alerts, and often request assurance at CQRM meetings or through CSU for 72 hour reports. Any serious incidents sent as a real time alert is reviewed not just by CSU specialists but also by CCG quality leads, and any safeguarding cases are reviewed by CCG safeguarding leads.

Occasionally the CCG will request further information or clarification on the serious incident and these are in form of a further information report (FIR). A CCG Serious Incident Panel meets with the ELFT Serious Incident leads and investigators every month. Key themes around risk assessments, staff support in handling incidents, risk assessments and carers/family involvement are key themes for CCG questions.

Themes are developed to look at during the quality assurance visits.

Embedded evidence is also requested in order to increase assurance of action implementation and CCG Senior Quality Managers recommend spot checks and audits where required.

We have seen evidence of this occurring with the homicide under review.

Action plans are monitored at the CCG's SI Panel meetings which are held every fortnight and chaired by the designated CCG Senior Quality Manager for that area. Appropriate representatives from the Trust are in attendance.

The action plan for the Mr L report was reviewed a the February 2018 CQRM with ELFT.

The Trust submitted extensive evidence and additional evidence around family and carer involvement. The CCG also ensured that carer involvement is included as a theme at future at QA visits.

The action plan was signed off as completed by NHS England in February 2018. This was agreed between NHS England & NHS Newham CCG.

Appendix A – documents reviewed

Documents reviewed	
ELFT documents	
Mr L updated action plan FINAL	Datix report parameters & screenshot
Revised Incident policy v8.4 2018.10	Risk & Governance report IG breaches 01/04/2018-28/01/2019
SI review 10 day checklist	SI review process milestone plan
NHSE SI review checklist adapted for ELFT	Mr L action plan summary information
Paper A – Agenda SI committee 30.5.18	Paper B – 2018 05 30 SUI draft minutes
ELFT/LBN Joint Implementation Board (JIB) minutes 7.5.19	Learning lessons presentations January 2017, March 2018 showing information sharing about family and carer contact
JIB workshop notes 11.11.18	CPA audit information up to July 2017
PREMS report since May 2018	PREMS/PROMS/FFT QI project
Carers contact performance report April 2018 to Oct 2018	Newham Carers Handbook
Datix report on gambling	CPA Policy v1.2 September 2018
Agenda Newham DMT meeting 22.11.18/28.3.19/24.1.19	Minutes Newham DMT 22.11.18/ 28.3.19
Quality Assurance Committee terms of reference June 2018	Quality Assurance Committee minutes 10.12.18
Quality Assurance Committee minutes 28.2.19	Quality Assurance Committee minutes 29.4.19
Newham Clinical Governance Newsletters issue 10, April 2017 & issue 21, July 2018	Care information quality dashboard Q2 2016/17
Newham CCG documents	
Newham CCG Annual Report 2017/2018	ELFT Month 5 (August 2019) Mental Health Service contract reports for 2019/20, with supporting appendices and papers
A2 Mental Health Quality Indicators report August 2019	ELFT - CCG Consortium Serious Incident Panel Agenda January 2018
Notes ELFT SI panel & actions 2019.09.16, & 12 November 2018	Attachment A minutes & action log
Attachment B ELFT not recommended for closure	Attachment C ELFT recommended for closure
Attachment D Monthly tracker	3 FIR examples March 2019
QA framework - MHCOP service pathway review visit November 2018	QA visits Newham Centre for Mental Health: February to November 2018
Ruby & Ivory Ward visit August 2019	MH Adults CQRM November 2019
Combined CQRM papers August, September and December 2019	ELFT Consortium CQRM papers April, July, October, December 2019
Forward planner 19-20 consortia	

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