Independent Investigation Assurance Review Joint Safeguarding Adult and Mental Health homicide review – Greenwich

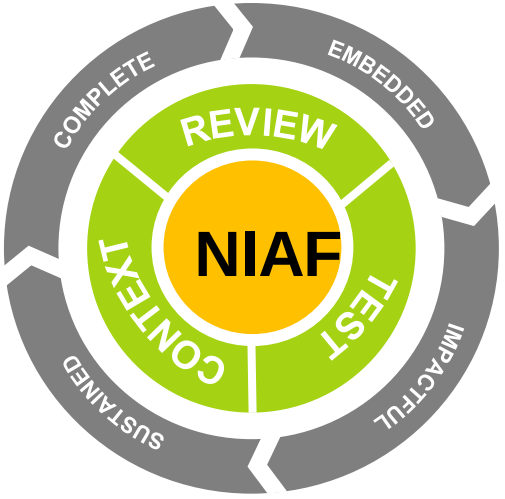
Mrs A and Ms B

STEIS 2016/5083

Private and confidential

October 2021

Niche Investigation Assurance Framework



insight integrity impact

October 2021

Niche Health and Social Care Consulting
Trafford House
Chester Road
Old Trafford
Manchester
M32 0RS

Dear Sir or Madam

Independent Quality Assurance Review, Royal Borough of Greenwich

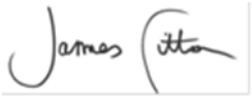
Please find attached our report of September 2021 regarding our independent quality assurance review concerning several care providers (Oxleas NHS Foundation Trust, NHS Greenwich Clinical Commissioning Group (CCG), Bridge Support, Royal Borough of Greenwich (RBG), Lewisham and Greenwich NHS Trust) in Greenwich. This report follows on from our earlier independent quality assurance review report dated June 2021. Following the publication of this report it was agreed with NHS England (London) and the Royal Borough of Greenwich that the care providers involved in this assurance review would have further time to submit evidence of progress made against their action plans. Our draft report dated June 2021 and this subsequent report were written in line with the terms of reference for the joint Independent Mental Health Homicide Investigation and Safeguarding Adult Review into the care and treatment of Mrs A and Ms B, published in July 2019.

This report is a limited scope review and has been drafted for the purposes as set out in those terms of reference alone and is not to be relied upon for any other purpose. The scope of our work has been confined only to provide an assessment of the implementation of the organisations' resultant action plans against the Niche Investigation and Assurance Framework (NIAF review). Equally, events which may occur outside of the timescale of this review will render our report out-of-date.

Our report has not been written in line with any UK or other auditing standards; we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability; or accuracy of that data or information.

This is a confidential report and is for the sole attention of the project sponsor NHS England (London) and the Royal Borough of Greenwich. No other party may place any reliability whatsoever on this report as this report has not been written for their purpose. Different versions of this report may exist in both hard copy and electronic formats and therefore only the final signed version of this report should be regarded as definitive.

Yours sincerely,



James Fitton
Niche Health and Social Care Consulting

insight integrity impact

Authors: Carol Rooney and Sue Salas

Lead Partner: James Fitton

First published: October 2021

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
Trafford House
Chester Road
Old Trafford
Manchester
M32 0RS

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

insight integrity impact

Contents

Contact
Carol Rooney
Associate Director

1. Summary

1.1 Background and context for this review

NHS England (NHSE) London and Royal Borough of Greenwich (RBG) Safeguarding Adults Board commissioned Niche Health & Social Care Consulting Ltd (Niche) and Andy Nash Ltd in February 2017 to carry out a joint safeguarding adult review and independent mental health homicide investigation. The joint review was into the care and treatment of two mental health service users (Mrs A and Ms B) in South London following the homicide of Mrs A by Ms B in February 2016.

The joint report reviewed care provided by: Oxleas NHS Foundation Trust, NHS Greenwich Clinical Commissioning Group (CCG)*, Bridge Support, RBG, Lewisham and Greenwich NHS Trust and London Ambulance Service.

The final report was published in July 2019. The report included 17 recommendations which were intended to support the agencies, NHSE and RBG Safeguarding Adults Board in learning and improving services and practice.

The terms of reference of the joint review required Niche to undertake a follow up assurance review 12 months after publication of the joint review and investigation report. This was to provide an assessment of the implementation of the resultant action plan against the Niche Investigation and Assurance Framework (NIAF). Niche were delayed in undertaking this NIAF due to the pandemic and its associated pressures.

This is a high-level report on progress to NHS England (London) and Royal Borough of Greenwich Safeguarding Adults Board, undertaken on the basis of a desktop review only, without site visits or interviews.

*Since the joint report was published, NHS Greenwich CCG has become part of NHS South East London CCG (SEL CCG).

1.2 Implementation of recommendations

This comprised a review of the implementation of action plans by Oxleas NHS Foundation Trust, NHS SEL CCG, Bridge Support, Royal Borough of Greenwich, and Lewisham and Greenwich NHS Trust.

1.3 Review of method and quality control

Our work comprised a desktop review of documents provided by the agencies. These included policies, procedures, action plans, minutes and communications.

We have not reviewed any health care records because there was no element of re-investigation in the review's terms of reference. The information provided to us has not been audited or otherwise verified for accuracy.

Niche circulated the draft findings of the NIAF in June 2021. However, it was subsequently agreed with NHS England (London) and RBG that the organisations would be given more time to provide evidence of having addressed the issues raised in the recommendations arising from our Homicide Inquiry and their subsequent action plan. This report dated "September 2021" is the updated version of our initial NIAF after we reviewed additional documentation submitted to us by RBG.

2. Summary assessment on progress

The Niche Investigation Assurance Framework

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 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.

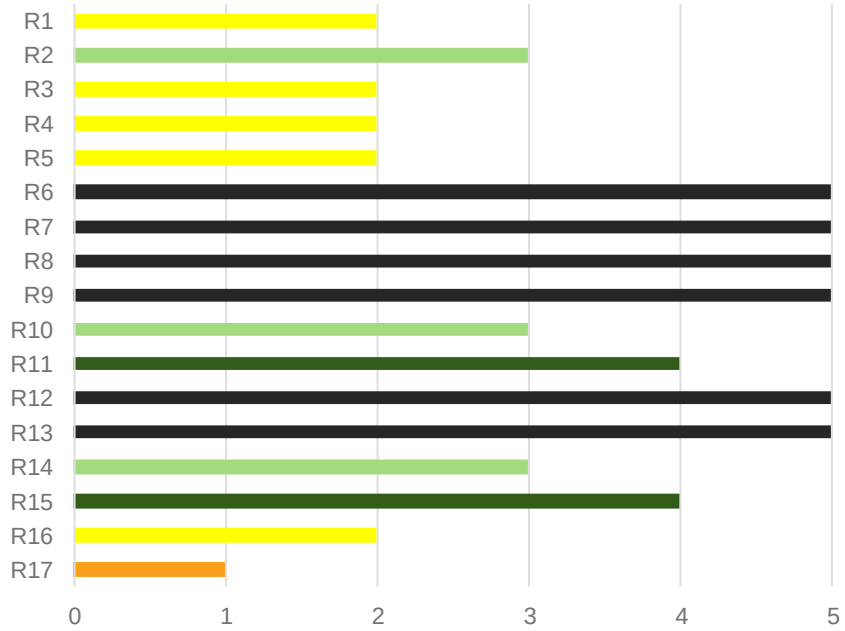
Our measurement criteria are:

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 focussed on the actions that have been progressed and implemented in response to the recommendations made in the independent investigation report. We set out our summary of findings in relation to the progress of each agency.

Implementation of recommendations

We have rated the progress of the actions which were agreed from the 17 recommendations made. Our findings are summarised below:



Summary

There has been good progress made in relation to many actions, but there are still areas where actions have been started but not progressed substantially.

Our suggestions should prove useful for the agencies concerned in developing these actions; sufficient engagement and governance is key to the delivery of the entirety of the action plan.

Assurance review findings

3. Assurance review of the action plan

We made 17 recommendations based on our joint review and investigation into the care and treatment of Mrs A and Ms B.

The recommendations pertaining to agencies/providers are in the table (right).

The agency action plans, in most cases, set out more than one action to address the recommendations. Leads and completion dates were assigned to each action. It was helpful that actions were assigned to individuals as opposed to blanket responsibility going to one individual e.g. the head of division. By separating out tasks, there was evidence of a collective responsibility and division of workload, converting the recommendations into manageable tasks.

The evidence provided by Oxleas NHS Foundation Trust was structured into sections:

- protocols or policies;
- development process and governance arrangement including dissemination to cascade and implement the process;
- information sharing protocols to support;
- local audit;
- other evidence including more recent and on-going improvements;
- other evidence including screen shots of RiO records.

This structure provided a clear picture of the progress of each recommendation, with associated supporting evidence.

Agency	Recommendations
Oxleas NHS Foundation Trust	7,8,9,10,11,12,13,14,15
NHS Greenwich CCG	1,5
Bridge Support	6 (and joint 7 with Oxleas NHS Foundation Trust)
Royal Borough of Greenwich	2,3,16,17
Lewisham and Greenwich NHS Trust	4

3. Assurance review findings

Recommendation 1: NHS Greenwich CCG should ensure that GPs are fully involved in information sharing with respect to information about individuals with long term mental health issues.		
CCG action plan	Response and evidence submitted	Niche comments and gaps on assurance
1. GP Mental Health Lead, GP Clinical Practice Lead for mental health and an Oxleas NHS Foundation Trust representative to present this report as a case study and raise awareness at the GP Protected Learning Time.	GP Mental Health Lead, GP Clinical Practice Lead for mental health and an Oxleas NHS Foundation Trust representative to present this report as a case study and raise awareness at the GP Protected Learning Time.	No evidence submitted that this took place.
2. Designated Nurse for Adult Safeguarding to incorporate learning from this report and the Safeguarding Adult Review (SAR) report into training provided for primary care staff from April 2019	Designated Nurse for Adult Safeguarding to incorporate learning from this report and the SAR report into training provided for primary care staff from April 2019.	The learning has been incorporated into the adult safeguarding training package (training pack provided), which we have reviewed. The slides are supported during the face-to-face training by a brief verbal outline of the case and further discussions - training material seen, but no evidence of delivery/implementation was submitted.

Recommendation 1: continued		
CCG action plan	Response and evidence submitted	Niche comments and gaps on assurance
3. DocMan (IT delivery system) delivers patient care updates/correspondence from Oxleas NHS Foundation Trust clinicians (RiO system) to Greenwich GP records directly electronically.	Both systems have been embedded since introduction in 2016. Primary care commissioning leads continue to work closely with the Clinical Transformation lead at Oxleas NHS Foundation Trust. Completed: • Connect Care scope and datasets • Connect Care 'Health Information Exchange' pathway document shows how information can be accessed by these organisations: • Lewisham and Greenwich NHS Trust and, Oxleas NHS Foundation Trust, GP Practices (Bexley, Greenwich, Lewisham), Out of Hours / Urgent Care, and Social Care (Web Portal). The document shows the areas that can be reviewed/accessed: • Problems, Diagnoses, Procedures • Medications • Allergies • Radiology and Laboratory results • Clinical summary documents • Referrals, past/planned appointments and admissions, Out of Hours (OOH).	Two documents provided (Connect Care scope and datasets) confirm that anyone who accesses the system can see a useful dataset relating to mental health service users. The Oxleas NHS Foundation Trust data set supplied shows the comprehensive range of information that can be viewed/provided.
4. Connect Care (IT system) in place and hosted by LGT (Cerner), whereby Greenwich GPs can review patients under care of other service providers, including Oxleas NHS Foundation Trust, in south-east London and vice versa.	Embedded and in use since 2016 - accepted. Usage of the Connect Care system has increased significantly since access to it has been improved and simplified; previously users had to log on to a separate portal with their own unique username and password and hence uptake was limited.	Documents provided demonstrating what information is available across Connect Care. No information provided about uptake or usage.

Recommendation 1: continued		
CCG action plan	Response and evidence submitted	Niche comments and gaps on assurance
5. Greenwich GPs to receive a briefing in 'Greenwich Meantime', a CCG monthly newsletter, reminding them about information sharing protocols, in particular General Medical Council (GMC) protocol: Confidentiality: good practice in handling patient information. Briefing to make particular reference to people with mental health issues.	Domestic Homicide Review/Safeguarding Adult Review in Greenwich: One of the 17 recommendations states that GPs should be fully involved in information sharing with respect to information about individuals with long term mental health issues. The context behind this is that the GP was diligent in his care of Mrs A, but operated in isolation from the rest of the care system and was not given the opportunity of either sharing information or participating in care planning. Some potentially significant information was held by the GP and not shared, and the GP was not routinely invited to Care Programme Approach (CPA) meetings.	The briefing went out via email in the CCG newsletter, Greenwich Meantime, in May 2019.
6. NHS Greenwich CCG to explore further opportunities to improve routine information sharing between GPs and other non-NHS agencies involved in a patient's care through maximising functionality of existing IT systems where Information Governance policies permit this.		No evidence provided.

N**IAF rating:**

- Greenwich CCG have demonstrated that the information sharing system across health systems has been established.
- It would be helpful to see information about how it has been used, what uptake there has been, and/or any benefits noted.
- The safeguarding training has been updated, and the 'lessons learned' paper shared with GPs.
- More information about the delivery of the training, what the targets were and who attended would help to show implementation .

Overall rating for this recommendation: 2 (action significantly progressed).

Recommendation 2: Royal Borough of Greenwich should assure itself that its statutory duties in respect of carers of people with mental health problems are being discharged.

RBG action plan	Response and evidence submitted	Niche comments and gaps on assurance
1. Royal Borough of Greenwich will work with Oxleas NHS Foundation Trust as part of a wider Royal Borough of Greenwich review of the Carers offer and processes within mental health that will ensure that Oxleas NHS Foundation Trust are delivering the requirement for carers.	Quarter 3 Audit of carer assessments to include: 1.Number of young carers identified and how many are referred for assessment. 2.Number of carers identified and how many carers' assessments have been undertaken. The completed audit included a review of following seven items: 1. Was a carers' registration form completed and uploaded in RiO? 2. Has the service user's consent been sought (Support Network Engagement Tool)? 3. Is the carer's voice and views evident throughout the assessment? 4. Has a 6-month review taken place? 5. Was the carer offered a copy of the assessment? 6. Has a Care Act assessment been completed with the service user? 7. Was the carer given information about support/resources and advocacy in Greenwich?	The response indicated that between May and August 2020: • an average of 74.9% of carers received an assessment, and • of 8 assessments reviewed, 75% had evidence of carer involvement.

NIAF Rating:

- The audit confirms that carer assessments are being completed and a significant number can evidence the involvement of carers.
- We suggest a repeat of this audit to take place to evidence improvements in this area and highlight where further work is required.

Overall rating for this recommendation: 3 (action completed but not yet tested).

Recommendation 3: Royal Borough of Greenwich should update its 2015 Carers Policy to cover mental health and children in transition.

RBG action plan	Response and evidence submitted	Niche comments and gaps on assurance
1. Policy to be updated as part of the Carers Offer review undertaken by Royal Borough of Greenwich.	A project to review the carers offer was started in 2019, and a proposal was presented to the Health and Adults Services Directorate Management Team. It set out an action plan for redefining the carers offer, which included mental health and transitions for young carers. RBG has recently started up a Carers Stakeholder group which is anticipated will to identify priorities for carers and looking to re-specify the services provided by the carers centre. A 'Carers Customer Journey' project was started in May 2019. The project scope included: • overhaul of the carers assessment process; • development and roll out of staff training; • development of a new process for personal budget to carers; • identification and formalisation of the carers offer across the borough; • borough wide carers engagement to identify areas for service improvements.	The Carers policy has not been updated. We were informed that work is underway. A draft carers action plan has been presented to the Directorate Management Team which we have reviewed. The draft action plan and minutes indicate that the Carers policy and plan are being reviewed and underway, but further action has been stalled by Covid-19.

NIAF Rating:

- The recommendation required the policy to be updated, which has not been achieved.
- There is a draft carers action plan which includes this and other actions, and there is evidence management have some oversight of the plans.

Overall rating for this recommendation: 2 (action significantly progressed).

Recommendation 4: Lewisham and Greenwich NHS Trust should provide assurance that where there is a question of vulnerability and capacity, a capacity assessment is always carried out and documented.		
Trust action plan	Response and evidence submitted	Niche comments and gaps on assurance
• Mental Capacity Act (MCA) training undertaken as part of the mandatory safeguarding training for all clinical staff. • Regular audit of Mental Capacity Act record keeping. • Staff awareness and knowledge of Mental Capacity Act to be included on peer reviews of all clinical areas.	**Lewisham and Greenwich NHS Trust identified 4 actions to meet this overarching recommendation, please see below:**	
1. Action: Mental Capacity Act training undertaken as part of the mandatory safeguarding training for all clinical staff.	Compliance (as of 23/7/2020) Mental Capacity Act and Consent to Treatment – 90.21% of staff are compliant. Safeguarding level 2 training – 91.61% of staff are compliant.	We received copies of the training pack which is comprehensive and detailed. We were provided with summary figures for staff trained, rather than the details of numbers attended and dates. We received copies of policies relevant to MCA and safeguarding and best interest meetings.
2. Action: Regular audit of Mental Capacity Act record keeping.	Lewisham and Greenwich NHS Trust indicated that the audit was carried out in April 2019, and results presented in September 2019. This was due to be repeated in April 2020 but postponed due to the Covid outbreak. Methodology for audit: The Trust receives on average 50 completed forms (form 1) every month across both of the sites. For the purposes of the audit all Deprivation of Liberty Safeguards (DoLS) activity was encompassed, including DoLS which have already been authorised by the Supervisory body and form 1 requests for urgent and standard authorisations. Information was collected regarding 39 patients who were known to be under DoLS during a 1 week period.	We were provided with a copy of this audit. This audit was carried out for people already under a DoLS - all of these cases should have full assessments recorded regarding capacity; documented evidence of regular review of capacity / consultation with relatives and clear documentation about; where the patient is at any time i.e. on ward / left / deceased etc. Points 1 & 2 of the actions described appear to be related to the stroke ward (although this is unclear) where they expected to find a higher proportion of forms, but in this period only one was received.

Recommendation 4: continued		
Trust action plan	Response and evidence submitted	Niche comments and gaps on assurance
	The MCA audit found five areas for improvement: 1. There has been inconsistency in identification of when a patient may be at risk of having their liberty deprived and when a DoLS should be considered. 2. There appears to be a poor understanding of DoLS and when they are required. 3. Inconsistency in formal Mental Capacity Assessments being completed for patients where there are questions surrounding their capacity. 4. Differing opinions on what constitutes continuous supervision and control. 5. Poor communication between ward teams and Safeguarding Adult team regarding when patients are transferred/been discharged/passed away.	The audit results suggest that only doctors are completing the forms. The audit also stated that they identified some improvements in staff identifying restrictions at time of requesting a DoLS but no further detail was given. Point 3 - the results state that 67% of the cases referred did not have a completed assessment form – often the notes just stated 'lacks capacity' – this is not decision specific and not properly assessed – although it is not possible to discern how many patients this relates to. We consider that 67% is more than 'inconsistent'. Point 4 - staff identified need for DoLS only when the patient tries to leave the ward. Point 5 - it appears that there was poor communication between wards and the safeguarding adult team. The audit identified that in 59% of cases, the patient's representative had not been contacted. The audit document was not signed / author or dated, and there was no review date given. In summary, the audit focused on completion of form 1 (request for DoLS). The areas audited related to making a DoLS request and what happened once this had been completed. This audit only considered applications for DoLS. If / when repeated it would still only give assurance that people subject to DoLS had capacity assessments recorded. The SAR recommendation asks for assurance that 'where there is a question of vulnerability and capacity, a capacity assessment is always carried out and documented'. This recommendation was not intended to apply exclusively to inpatients under DoLS.

Recommendation 4: continued		
Trust action plan	Response and evidence submitted	Niche comments and gaps on assurance
		As the SAR related to a community setting, we would have expected to see more evidence that staff are considering capacity when working with people in different situations – i.e. in community settings / supported living accommodation and not just people on wards subject to DoLS. We would also expect evidence that when someone is identified as vulnerable and there are concerns about decision-making, capacity is considered, and if appropriate assessed and recorded. Given the above we find this action limited in assurance. In particular, there is limited assurance that capacity is being considered / assessed and documented even for people subject to DoLS.
3. Action 3: Staff awareness and knowledge of Mental Capacity Act to be included on peer reviews of all clinical areas	These are the Trust Improving Together audits (iTAP) as part of the ward accreditation. We launched this programme in October 2019 and we are just completing our baseline audits of all inpatient areas. This was delayed due to Covid. The audit is undertaken on the software 'Perfect Ward', no paper copies. Any area highlighted as red is re-audited after 3mths, amber after 6mths and green after 9mths. Staff are asked specifically: • Can staff explain when a Mental Capacity Act Assessment can be undertaken? • Can staff explain who can undertake a Mental Capacity Act Assessment?	This is a significant action within the overall recommendation and as such impacts on the overall rating. Evidence should be obtained by audit that staff in all areas are considering capacity for those identified as vulnerable before moving the overall rating for this recommendation. It appears this was an audit process due to start but postponed because of the organisation responding to the Covid-19 pandemic.

Recommendation 4: continued		
Trust action plan	Response and evidence submitted	Niche comments and gaps on assurance
4. Additional action: improvements to capacity assessment form on IT system to allow recording of rationale / decision - making etc.	The capacity assessment has been added to the Trust's electronic patient record (iCare) so that it is easily accessible for staff to complete. However, there are no free text boxes in the assessment and the Trust safeguarding team have raised this to the iCare build team to have this amended. The assessment form was sent and is an appendix within the training document – there is also an exemplar on the intranet (not available to Niche). Improvement in the completion of MCAs is on the Trust safeguarding risk register.	Whilst the form is available online the staff are unable to record free text as noted. This means detail of the assessment is recorded separately in patient notes. The Trust plan to amend the IT system but this may be delayed for three months. In terms of assurance, we suggest the specific IT issue should be placed on the Trust risk register, so that the Board are sighted on the importance of this, and the possible three-month delay. The results of the audit show staff were not routinely recording capacity assessments in April 2019 for those people subject to DoLS.

NIAF Rating:

- Part of the action was to audit Mental Capacity Act record keeping. The audit supplied focused only on referrals for inpatients who were already subject to DoLS, who should have existing MCA paperwork in place.
- An audit of referrals for capacity assessments would provide information on whether staff were making appropriate referrals and meet the expected action.
- The evidence does show, however, that there remains inconsistency in formal Mental Capacity Assessments being completed for patients where there are questions surrounding their capacity- which suggests the need for further understanding of the barriers. We acknowledge that Covid-19 has had an impact on these plans.

Overall rating for this recommendation: 2 (action significantly progressed).

Recommendation 5 : NHS Greenwich CCG must assure themselves that there are systems in primary care to monitor the treatment of patients under secondary mental health care.

CCG action plan	Response and evidence submitted	Niche comments and gaps on assurance
1. DocMan (IT delivery system) delivers patient care updates from Oxleas NHS Foundation Trust medical records (RiO system) directly to Greenwich GPs electronically. 2. Connect Care (IT system) in place and hosted by LGT (Cerner), whereby Greenwich GPs can review patients under care of other service providers in South East London.	Both systems have been embedded since introduction in 2016. Primary care commissioning leads continue to work closely with the Clinical Transformation lead at Oxleas NHS Foundation Trust. Connect Care 'Health Information Exchange' pathway document shows how information can be accessed by these organisations: Lewisham and Greenwich NHS Trust and Oxleas NHS Foundation Trust, GP Practices (Bexley, Greenwich, Lewisham), OOH / Urgent Care, and Social Care (Web Portal). The document shows the areas that can be reviewed/accessed: • Problems, Diagnoses, Procedures • Medications • Allergies • Radiology and Laboratory results • Clinical summary documents • Referrals, past/planned appointments and admissions, Out of Hours.	Information provided for evidence of action for recommendation 1 shows that the information is accessible but does not refer to how care might be monitored.

NIAF Rating:

- The CCG has demonstrated that the IT structures for information sharing are in place and accessible to the partner agencies.
- To show evidence of implementation it would be helpful to have an audit demonstrating application, some feedback from the age ncies involved, and/or some case evidence of usage.

Overall rating for this recommendation: 2 (action significantly progressed).

Recommendation 6 : Bridge Support should develop a quality monitoring process that provides assurance that risk assessments and wellbeing plans are completed accurately.

Bridge action plan	Response and evidence submitted	Niche comments and gaps on assurance
Bridge Support implemented a Quality Management System (QMS) across the whole organisation to ensure quality is maintained throughout all its services. The QMS and its implementation relates solely to Bridge Support and not the other organisations.	Audits of the Bridge Support QMS are conducted to ensure that processes are being followed and are effective with emphasis on Flexible Support. Support Plan training is now provided by Service Managers as part of Support Workers induction. Bridge Support will provide Oxleas NHS Foundation Trust with a spreadsheet list of patients who receive Flexible Community support from their service and for whom Oxleas NHS Foundation Trust offer secondary care services to. The list is updated bi-monthly to reflect changes in level of care. Bridge Support checks to see if an employee has attended Care Programme Approach (CPA) Meeting or has the documentation from the meeting as part of the QMS process which describes the delivery of service PR006. Task Force meetings were specifically put in place as a result of the joint review. Bridge Support are in the process of formalising the format of these meetings. The preceding Task Force meetings were helpful in improving communications and resulted in the suggestion of a joint QI project.	Dedicated posts (a Quality Manager and a Learning and Development Manager) are intended to focus on: • improving quality and training and in particular improvements in processes, reporting, analysis and lessons learned (Quality); and • skills development, communication and effective delivery of online as well as face-to-face training. Staff training is recorded in individual HR records, and a skills audit is completed. PR006 delivery of service procedures shows clear steps, with senior oversight and auditable standards. The ongoing monitoring and maintenance of these is embedded into the QMS, and we have seen examples of this being followed. There is evidence of monitoring and maintenance.

NIAF Rating:

- Bridge Support can demonstrate a robust new quality management system that has implemented and monitored the new processes and standards.
- We have seen evidence of monitoring via audit

Overall rating for this recommendation: 5 (action complete, tested and embedded and shows evidence of sustainable improvement).

Recommendation 7: Oxleas NHS Foundation Trust should agree with Bridge Support what routine patient care information will be provided about patients under the care of secondary mental health services, and develop systems to ensure that the agreed information is received and processed in a timely way.

Trust action plan	Response and evidence submitted	Niche comments and gaps on assurance
Oxleas NHS Foundation Trust have an information sharing policy which was reviewed in May 2018. This policy sets out the legal and ethical framework for the sharing of personal identifiable information with other public sector and voluntary organisations. Support plan training is now provided by service managers as part of support workers induction. Bridge Support will provide Oxleas NHS Foundation Trust with a spreadsheet list of patients who receive flexible community support from their service and to whom Oxleas NHS Foundation Trust offer secondary care services. The list is updated bi-monthly to reflect changes in level of care. Bridge Support and Oxleas NHS Foundation Trust will hold a half day workshop in April 2019 for Bridge Support Mental Health and community teams to review information flows using case studies as working examples for improvement. Bridge Support will now check to see if an employee has attended Care Programme Approach (CPA) Meeting or has the documentation from the meeting as part of the quality management system (QMS) process which describes the delivery of service (Bridge Support policy PR006).	Oxleas NHS Foundation Trust will review with Bridge Support what patient information is included in the lists which are shared and check that the information is being shared in a timely manner and a regular frequency. There is an expectation that Bridge Support mental health support workers are invited to all CPA meetings and receive copies of documentation from CPA meetings. The half day workshop will review how effectively this is working and revise systems and processes to ensure that the support workers are always invited to CPA meetings and receive documentation of the meetings The Trust Performance and Quality Assurance Committee (PQAC) had a presentation on 15 January 2020 on the Community Mental Health Team action plan update. It was reported that work had now progressed into the next stage, the focus of which was to embed and sustain the agreed protocols. The fortnightly taskforce meetings with internal stakeholders and partner agencies were due to lead into quarterly forums where action plans would be reviewed and the sharing of ideas and initiatives across organisations would continue. For example, a quality improvement (QI) project in collaboration with partner providers around supporting service users in a crisis.	The workshop was held in April 2019 and resulted in an information-sharing protocol (rather than a report) between Bridge Support and Oxleas NHS Foundation Trust. A joint summary report detailing the agreed routine information was shared between Bridge Support and Oxleas NHS Foundation Trust. Quarterly provider meetings are held, attended by team managers from Oxleas NHS Foundation Trust and Bridge Support as well as the other two providers in the Greenwich Mental Health Pathway. Bridge Support attend weekly bed management meetings with Oxleas NHS Foundation Trust. January 2020 audit shows that the standards set for flexible community support were met – with only one action,–that service users were sometimes reluctant to sign to agree their goals, and not all the goals listed were SMART.

Recommendation 7: continued

Trust action plan	Response and evidence submitted	Niche comments and gaps on assurance
	The relationships with floating support providers such as Bridge Support remain part of the on-going actions and work, relationships and working together is stronger. The information sharing agreement is embedded and routine regular sharing of placement lists ensuring that they are up to date. The support workers are invited to CPA meetings and this is regularly audited.	Oxleas NHS Foundation Trust have stressed to staff the importance of giving Bridge Support staff adequate notice to attend CPA meetings, whether they are being held face to face or virtually, and the need to share documentation arising from CPA meetings. The CPA review audit was due to be completed by June 2019. This should show that Bridge Support colleagues have been invited to CPA meetings. This audit relates to CPA reviews undertaken within the previous month. Using the list from Bridge Support of all CPAs due in June and July 2019, RiO records were examined for the detail and there were nine patients that had a CPA during the past month. Of these nine, the Bridge Support worker attended seven CPA reviews, with evidence that a Bridge Support worker was invited by email / telephone to the other two reviews but did not attend. Audit dated June 2020 showed CPA dates, invitations to Bridge Support to attend, attendance and any non-attendance and reasons if not attended. Audit dated June 2020 shows the Bridge Support were invited to all relevant CPA reviews (n = 14) and attended (n = 10). Of these two had explanations, and two had no apologies received.

NIAF Rating:

- The Trust has carried out a number of actions in conjunction with Bridge Support to meet this recommendation and have demonstrated clear and sustained improvements.
- Bridge Support have incorporated these aspects into their QMS and are able to demonstrate new systems that have been effective.
- The work has been reported to the Trust Quality Committee and Board, which shows that there is senior oversight and monitoring of progress.

Overall rating for this recommendation: 5 (action completed, tested and embedded and shows evidence of sustained improvement – Oxleas NHS Foundation Trust and Bridge Support).

Recommendation 8: Oxleas NHS Foundation Trust must ensure that risk assessments are updated at the time of care or service transitions.

Trust action plan	Response and evidence submitted	Niche comments and gaps on assurance
Transfer of care policy, updated in April 2018, which aims to ensure a high and consistent standard of care for all people within our services who are being transferred within Oxleas NHS Foundation Trust or externally. Section 1.3 states pre-transfer: that in the weekly caseload zoning meeting multidisciplinary team (MDT) including the consultant put client into green zone and agrees transfer timescale. Section 2.3 states that within a month of referral the risk assessment is completed, and this should also include any risks to children including dependants.	Clinical risk assessment and management policy was updated January 2016, outlines individual responsibilities in respect of assessment and management of risk. Section 7 stipulates when to assess risk. The nature of the clinical risk assessment will depend on the context in which it is made. The use of DIALOG+ (a structured communication tool to improve engagement) has been adopted to improve the engagement of patients in care planning and ensure the care plans are firmly centred around patient needs. This was initially presented at PQAC in July 2019. Pilots were undertaken by one of the Greenwich Intensive Community Management for Psychosis (ICMP) teams and all three Early Intervention in Psychosis teams. In addition, training on risk assessment (DICES) was delivered to teams and discussions held on how the learning can be embedded at zoning meetings. Updates provided at PQAC in July 2020 (Minutes not yet available).	Care planning and risk assessment audit results up to 20 October 2019 show sustained improvement since March 2019. The overall quality target of 75% was reached in June 2019 and has consistently been above this up to October 2019. The section concerning risk assessment shows that the expected target of 90% of risk assessments completed has been above 90% since May 2019. There are quality standards monitored by the bimonthly Performance Improvement Committee, who report to the bimonthly Trust Board. A protocol with checklist is in place for transfer of patients between Oxleas NHS Foundation Trust inpatient units and other provider inpatient units, or from one Oxleas NHS Foundation Trust ward to another. There are monthly care plan audits, and improvements are shown in the question 'does the care plan address increased risk identified since the last risk assessment?', and 'has the service user been involved in the development of their care plan?'

Recommendation 8: continued		
Trust action plan	Response and evidence submitted	Niche comments and gaps on assurance
The Transfer of Care Policy was updated to include an explicit addition made to state that all risk assessments must be updated at the time of care or service transitions by the transferring team to complement the requirement for the receiving team to update the risk assessments within four weeks.		

NIAF Rating:

- The Trust have updated both the Transfer of Care and Risk Assessment policies and provided focussed risk assessment training.
- New processes have been introduced and piloted, and the implementation has been monitored by quality groups.
- Audits demonstrate an improvement in risk assessments, links to care plans, and service user involvement in plans.

Overall rating for this recommendation: 5 (action completed, tested and embedded and shows evidence of sustained improvement).

Recommendation 9: Oxleas NHS Foundation Trust Safeguarding policy should be amended to include consideration of whether the service user may present a risk to other vulnerable adults or children.

Trust action plan	Response and evidence submitted	Niche comments and gaps on assurance
We have introduced a new flow chart to guide clinicians in all teams in making safeguarding referrals. The first question is "Is the adult at risk an Oxleas NHS Foundation Trust service user?" If the answer is 'no' the action is to contact the Local Authority on the numbers listed to report concerns. If the answer is' yes' the guidance triggers the safeguarding adult referral process. This has been done to ensure that consideration is given to include whether a service user may present a risk to other vulnerable adults who may or may not be service users themselves of Oxleas NHS Foundation Trust .	A flow chart for information sharing and management for Multi Agency Public Protection Arrangements (MAPPA) or High-Risk People (HRP) is in place. This was supported by a training session in March 2020 to managers and seniors in CMHTs. Care programme approach (CPA) policy reviewed June 2018, section 9.5.3 states that the assessment will also address any risks including any Safeguarding (Adults or Children) issues and any concerns must be recorded on SG1 for Adults (as per Multi-agency Safeguarding Adults policy, Protocols and Guidance for Oxleas NHS Foundation Trust) and Children's Social Services Child in Need and Child Protection Form for Children (as per Safeguarding & Protecting Children & Young People policy). Person centred care planning is a Trust key priority. We have a care plan policy updated in March 2018 to enable high standards of person-centred care. It incorporates 13 principles including effective risk management and discharge planning. Care plans must outline clear risk management plans for all identified risks and discharge plans must be discussed with patients, their family and support networks. To further improve our practice in general, last year, we have raised awareness around High-Risk panels and MAPPA.	We have seen the ToR and flowchart for Greenwich HRP, which shows referral, process and outcomes of HRP discussions. Comprehensive evidence shows the Safeguarding policy has been amended, with a new flowchart guide for staff, with evidence of implementation. Adult and children's safeguarding teams have been amalgamated, and a safeguarding hub has been set up in the 3 boroughs, offering discussion slots monthly for complex cases.

NIAF Rating

- The Safeguarding policy has been amended, the flowchart has been updated, and there is evidence that it is in use.
- The CPA policy has been amended to reflect this change.
- Safeguarding hubs have been set up in the 3 boroughs, for staff to bring complex cases for discussion.

Overall rating for this recommendation: **5 (action complete, tested and embedded and shows evidence of sustained improvement).**

Recommendation 10: Oxleas NHS Foundation Trust should assure itself that race and ethnicity, gender and religious issues are routinely addressed in CPA needs assessment and care planning as per the Trust's policy.		
Trust action plan	Response and evidence submitted	Niche comments and gaps on assurance
Our care programme approach (CPA) policy, updated February 2018, demonstrates that in Oxleas NHS Foundation Trust, the principles of CPA are adopted for all services users who require assessment, planning, review and co-ordination of the range of treatment, care and support they receive from our mental health services. The approach to individuals' treatment, care and support puts them at the centre. Family and support network input forms a vital part of the support required to aid a person's recovery from mental health problems. In addition, appendix 1 of this policy states other factors which may need to be taken into consideration including ethnicity/immigration issues and sexuality/gender issues in respect of child and adolescent mental health needs. Our digital patient information system, RiO, contains the service user's care plan called My Care Plan. It contains a specific section for equality with its own drop-down menu for protected characteristics of age, belief, civil / partnership / marriage, disability, gender, pregnancy / maternity, race / ethnicity, sexual orientation and transgender. This ensures that these issues are routinely addressed in care planning and assessments and reviews. This information is routinely collected and recorded on RiO as part of the core assessment for all service users.	CPA Policy section 4.9. Equality and Human Rights policy sections 5 & 9. Audits of CPA to show equality reviewed in needs assessment Feb & July 2020. Screen shot of RiO, my care plan, showing equality drop down menu. Audits of CPA to check that needs assessments address race, ethnicity, gender and religious issues has been added to the improvement programme and will be undertaken on a monthly basis going forward.	The Trust has provided policy and guidance changes, followed by adjustments to RiO which will enable equality information to be gathered. The inclusion of this in care planning has yet to be tested, although it is to be added to the improvement and audit programme.

Recommendation 10: continued		
Trust action plan	Response and evidence submitted	Niche comments and gaps on assurance
We have a care planning policy which was reviewed in March 2018. This policy aims to ensure a high and consistent standard of person-centred care for all people using our services wherever in the Trust they seek help. Personalising care planning is a Trust priority that seeks to give the service user the opportunities to plan and make decisions in managing their care and treatment. The underlying key principles support staff in putting service users at the centre of the process and include everyone involved in their care. We have an equality and human rights policy, reviewed October 2017. This policy sets out our commitment to the principles of equality, diversity and human rights. It provides a framework within which the Trust will ensure that it fully meets legislative and regulatory requirements and works toward excellent practice. It also outlines how the Trust will ensure compliance with staff and patient rights and aspirations laid out in the NHS Constitution and in the Equality Act (2010). We monitor the completion of mandatory equality and human rights training through learning and development reports, discussed at the Workforce Learning and Development Group. Access to continuing professional development is monitored through the workforce report, which is discussed at the Equality and Human Rights Governance Group.		The Trust notes that spot checks of CPA needs assessments and care plans will be conducted to check that race, ethnicity, gender and religious issues are routinely addressed in the CPA needs assessment and care planning. The equality and human rights policy sets out principles, and training is provided and monitored, although no results or outcomes were submitted.

NIAF Rating:

- The inclusion of the change in care planning has not yet been tested.
- Audit/spot checks are planned to demonstrate that the addition of race/ethnicity gender/religion are routinely addressed in CPA.
- Evidence of the implementation and outcomes of these changes is needed to demonstrate that actions are embedded.

Overall rating for this recommendation: 3 (action complete but not yet tested).

Recommendation 11: Oxleas NHS Foundation Trust Board must provide assurance that the actions identified in the internal action plan have been completed.		
Trust action plan	Response and evidence submitted	Niche comments and gaps on assurance
Recommendation 1: There was an immediate review of all community cases open to teams to check they had follow-up appointments. Ongoing monitoring of appointments is available via ifox clinical information system. This action is completed. Recommendation 2: There are regular ongoing reviews of consultant caseload sizes. Consultants are motivated to look into reducing case load numbers and foster greater and stronger relationships with primary care colleagues to ensure smooth transitions. In addition, the primary care lead is now developing and finalising the shared care protocol which will allow depot stable patients to move to primary care for treatment. This action will remain ongoing and will not be completed as it now constitutes part of regular ongoing oversight of caseload sizes. Whilst we are satisfied that there are regular caseload reviews, we remain concerned that caseload sizes remain large and the potential risks that this may create, and these will continue to be monitored and raised with commissioners.	In 2018 an internal review of serious incident processes was conducted by the Trust's internal auditors. Areas of good practice were identified including that the Trust has a thorough process for investigating and reviewing level 5 Serious Incidents, with a comprehensive composition of panel members.	We have seen evidence of the Trust incident management policy, which is in line with the NHS England's Serious Incidents Framework. The Trust holds a series of learning events throughout the year which share learning and changes to practices from the outcomes of incident investigations. The Patient Safety Serious Incident Group (PSIG) reviews any actions due for completion and reports to the Performance and Quality Assurance Committee of the Trust Board. PSIG reviews all completed serious investigation reports and receives an update from each directorate on the progress of actions with evidence. The Trust Board reviews all Board level inquiry reports and action plans upon completion. The Board reviews the findings, learning, best practice and recommendations as well as consideration of root cause and avoidability. The action plan is agreed and updated in light of any feedback. The action plan and progress of implementation with evidence are presented to the Board via the PQAC six months later. All action plans are to be reported to the PQAC and then to the Board with a list of evidence before sign off.

Recommendation 11: continued

Trust action plan	Response and evidence submitted	Niche comments and gaps on assurance
Recommendation 3: Forensic supervision and input into forensic risk assessments should be available to adult mental health consultants where there are patients with a forensic history on their caseload. Recommendation 4: Cross directorate work to establish case-based discussions and guidelines for how decisions are made in respect of how patients moving through recovery adult mental health services receive support in risk management and other forms of assessment from forensic services. The actions changed following the further borough reconfiguration in April 2017 – although reflective practice sessions can be accessed it was considered by clinical directors to require a different approach after the borough reconfiguration. The revised practice implemented in 2018 by clinical directors is: consultants can refer any patient to forensics for advice as well as assessment, and forensics will review at their MDT and provide feedback, AMH/OP consultants have immediate access to on-call forensic consultants at any time day or night where more urgent opinions or advice are required.	The forensic directorate receives requests for risk assessments from in-patient wards and the community. Forensic colleagues have also attended professionals' meetings and individual cases have had joint working with the forensic community team. There is also a forensic on call consultant who is available at all hours for discussion/advice. Reflections from clinical directors is that discussing patients within quarterly reflective practice meetings are two-fold, one there would not be robust documentation regarding the discussion and any action plan, secondly it would not be sufficiently timely and could cause a delay in accessing forensic supervision/support. Board paper confirming actions completed (at time that the publication of report went to board). CHMT forum minutes CMHT action plan and minutes	The Trust has demonstrated a formal structure which provides robust review and scrutiny of action plans, reporting up to the Board. This action plan for the investigation has been formally signed off as complete.

Recommendation 11: continued		
Trust action plan	Response and evidence submitted	Niche comments and gaps on assurance
Recommendation 5: Focused clinical leadership to shape the expectations and culture of risk assessments so that all are clear of their responsibilities of who should be carrying these out, when and how they document decisions, thinking processes and reflections about dynamic and static risks.	Zoning meeting and schedules are fully established and embedded in teams. These multidisciplinary meetings happen three times a week with regular documentation of thinking processes and decision making as well as details of risk plans. Periodic audits have been conducted to examine whether the zoning meetings done weekly at Intensive case Management and Psychosis (ICMP) West are concordant with Trust protocol in terms of a) risk documentation b) linking to risk history c) care plan documentation d) client contacts (depending on zone). The audit study was carried out as a pilot study to assess the value of weekly zoning meetings and identify areas of improvement. Zoning meetings take place three times per week in all community teams. Trice weekly huddles are in place along with bed management to ensure that cases with high risk of relapse or relapsing are picked up and reviewed promptly.	Board paper confirming actions completed (at time that the publication of report went to board). CHMT forum minutes. CMHT action plan and minutes. The Trust has demonstrated that zoning meetings are embedded in the ICMP teams. Standards are in place of the conduct of these meetings, and there are periodic audits which show compliance.

NIAF Rating:

- The Trust has demonstrated that the internal actions have been completed.
- There is a formal structure which provides review and scrutiny of action plans, reporting up to the Board.

Overall rating for this recommendation: 4 (action complete, tested and embedded)

Recommendation 12: Oxleas NHS Foundation Trust Board must ensure that action plans have an appropriate level of evidence-based assurance before sign off.

Trust and CCG action plan	Response and evidence submitted	Niche comments and gaps on assurance
The actions in the Oxleas NHS Foundation Trust internal serious incident investigation report action plan were ongoing and subject to changes following the new model of borough based services in 2016. These were subsequently reviewed by the medical director, nursing director, service director, clinical directors, service directors and deputy chief executive in 2017. The completion of the actions is outlined for each recommendation below.	Incident Management policy (Sections: 3.7, 3.9, 3.13-3.15, 8.9-8.10). Agenda and Minutes of Serious Incident Meeting. Performance & Assurance Meeting July 2019. Agenda and Minutes of Serious Incident Meeting. Performance & Assurance Meeting Sept 2019. Example of action plan update to Exec & PQAC Jan 2020. Agenda and Minutes of Serious Incident Meeting. Performance & Assurance Meeting Jan 2020. Email regarding monitoring of actions 19.7.2019.	We have seen evidence of the structured approach the Trust has introduced to review the quality of Serious Incident (SI) reports and agree any recommendations. Tracking of due dates and action plans is done through the Serious Incident Performance & Assurance Group which is chaired by the Executive Director of Nursing. We have seen evidence that there is reporting up to the Executive Team and PQAC. Evidence for action plan implementation is agreed, and there is a system of spot checks on actions in place.

NIAF Rating:

- We have seen evidence of a Trust structure which provides senior oversight of SI reports.
- The quality of reports, recommendations and action plans is scrutinised, and there is evidence of check and challenge in the system.
- Implementation of recommendations and action plans has senior oversight, with reporting to the Executive Team.

Overall rating for this recommendation: 5 (action completed, tested and embedded and shows evidence of sustained improvement).

Recommendation 13: Oxleas NHS Foundation Trust and NHS Greenwich CCG should agree standards for outcome focussed recommendations following a serious incident, and standards for the level of evidence required for assurance before action plans are closed.

Trust and CCG action plan	Response and evidence submitted	Niche comments and gaps on assurance
The Clinical Commissioning Group reviews all serious incident investigations and action plans upon completion and monitor this through the Clinical and Quality Review Group and by seeking assurances and evidence of completion through attendance at Patient Safety Serious Incident Group.	Agenda and Minutes Serious Incident Performance & Assurance Meeting July 2019. PQAC redacted minutes with SI action plan reporting July 2019. Agendas and Minutes Serious Incident Performance & Assurance Meetings Sept 2019 – July 2020. SI Performance & Assurance Group Terms of Reference.	The spot checks in relation to actions from serious incidents that are noted in the SI Performance & Assurance Group meetings are chosen at random by the CCG members. These are not shared with the Trust in advance of the meetings. We have seen evidence of how these spot checks have been implemented, and examples of a thematic review. The minutes show examples of embedded learning which have been presented at the SI Performance and Monitoring Group.

NIAF Rating:

- New standards have been agreed with the CCG and monitored through SI quality meetings.
- The CCG has implemented a system of checking that Trust actions have been completed.
- The Trust and CCG can demonstrate that a system is in place and provides robust monitoring of the quality and the implementation of recommendations.

Overall rating for this recommendation: 5 (action completed, tested and embedded and shows evidence of sustained improvement).

Recommendation 14: Oxleas NHS Foundation Trust Board must ensure that any large service re-design has been assessed for impact and risk to quality of clinical care, and that detailed milestones are tracked on an appropriate risk register.

Trust action plan	Response and evidence submitted	Niche comments and gaps on assurance
The Board and executive committee have a track record of successfully implementing large service configuration changes which are always assessed for risk and impact and include detailed milestones which are tracked and a risk register. These are overseen by the chief executive and Chair. The most recent example is reconfiguring three directorates into boroughs and establishing Bexley Care as well as establishing new models of care as the South London Partnership. Service changes are monitored through the performance and quality assurance committee. Significantly large changes in service provision are always agreed and signed off with local authorities, clinical commissioning groups and / or specialist commissioning bodies with additional oversight from the local Health Scrutiny Committee.	Cash Release Efficiencies (CRE) and Quality Impact Assessment (QIA) process v1.2. Bluebell House QIA – May 2018. Bromley CAMHS QIA – Feb 2019. QIA and CQC registration COVID-19 flow chart. ECB and MV Service change. QIA COVID-19 ECB and MV. QIA COVID-19 CAMHS. QIA COVID-19 MH In-patients. Exec front sheet – service redesign – HMP Medway. Exec front sheet – service redesign – CAMHS. Copy of the Oxleas NHS Foundation QIA template and the QIA and Non-Executive Policy Reviews was submitted.	There have not been any large-scale service redesigns in the past two years. We have seen examples of risk assessments used when a service redesign is planned. Oxleas NHS Foundation Trust has developed a new QIA template and policy which it plans to use. For large service redesigns an 'Executive task force' is arranged, and situation/background/assessment, recommendation (SBAR) document completed – example 'SBAR for Changes to service provision for CAMHS in ED'- which contains analysis and risk mitigation plans, which are then discussed and agreed as appropriate.

NIAF Rating:

- The Trust has described the systems which are in place for service redesign but note there has not been a large-scale redesign since this recommendation was made.
- There are clear structures in place to plan and implement service re-design. The supporting structures have been developed but not yet fully tested.
- **Overall rating for this recommendation: 3 (action completed but not yet tested).**

Recommendation 15: Oxleas NHS Foundation Trust and Local Authority should ensure that staff are aware of when they can, and must, share information about individuals whose care they are responsible for.

Trust action plan	Response and evidence submitted	Niche comments and gaps on assurance
Oxleas NHS Foundation Trust have an information sharing policy, reviewed in May 2018. The policy sets out the legal and ethical framework for the sharing of personal identifiable information with other public sector and voluntary organisations. Oxleas NHS Foundation Trust safeguarding adult guidance and safeguarding children' policies and procedures make it explicitly clear when staff can and must share information about whose care, they are responsible for. This is included in statutory and mandatory training. All staff have access to the Head of Safeguarding Adults and Prevent and Head of Safeguarding Children for additional advice and to discuss any concerns about information sharing and their responsibilities and how to do so. Level 3 safeguarding adult face to face training commences on the 17 April 2019. The training days will be made available at a frequency of a minimum of 2 sessions a month and will be role specific.	Information Sharing policy. Safeguarding Guidance. Confidentiality and Carers policy. Level 3 Safeguarding Adults training overview. PQAC redacted Minutes – July 2019. Trust-wide CEG Agenda – Jan 2020. CEG Front Sheet – Jan 2020. CEG redacted Minutes Jan 2020. Trust PEG Agenda – Jan 2020. Trust PEG redacted Minutes – Jan 2020. Acute Care Forum redacted Minutes – Feb 2020.	The Trust can demonstrate that confidentiality in relation to carers has been the focus of ongoing action, following on from the recommendation made.

Recommendation 15: continued		
Trust action plan	Trust response and evidence submitted	Niche comments and gaps on assurance
The content of the safeguarding adult role specific face to face training will be reviewed by the Learning and Development Group of the Greenwich Safeguarding Adult Board. Further joint training will be facilitated by the Learning and Development Group of the Greenwich Safeguarding Adult Board. The Greenwich Service Director will develop new case studies to share with teams to remind them of when they can, and must, share information about individuals whose care they are responsible for to further support the embedding of learning from this review. The Medical Director will run a series of workshops including inviting feedback from families and producing films. The planning for the workshops will be scoped out with senior clinicians and a story board designed for the films. The filming will be undertaken including senior clinicians and family members. The workshops and film will be launched.	Case Studies for discussion with staff – workshop April 2019. 'Hundred Families' Charity Board presentation. The Confidentiality and Carers policy was revised and published in February 2020. It was due to be discussed at the Safeguarding Adults Board Learning and Development Meeting in March 2020, but this meeting was deferred due to Covid-19. It will be discussed when the meeting reconvenes. The policy was on the agenda for discussion at the Community Mental Health Forum in July 2020. The Trust has produced an initial film to be used for staff training on how to discuss the issues of confidentiality with patients and families. However, due to Covid-19, this has been put on hold.	We note that the Trust arranged the following workshops with staff; • April 2019 using case studies discussed at the PQAC July 2019, 13 attenders • Acute Care Forum in February 2020, 17 attenders • Patient Experience Group Jan 2020, 13 attenders • Clinical Effectiveness Group Jan 2020 presentation from Hundred Families on family and carer involvement and impact in mental health homicides, 25 attenders.

NIAF Rating:

- The Trust can demonstrate a range of actions that reinforce staff awareness of confidentiality and information sharing.
- There is work planned to further embed awareness, including how clinicians engage with families.

Overall rating for this recommendation: 4 (action complete, tested and embedded).

Recommendation 16: Where a major service change is proposed in mental health services, and the local authority is in a Section arrangement with an NHS body, the redesign should be negotiated, led and implemented jointly by the local authority and NHS.

RBG action plan	Response and evidence submitted	Niche comments and gaps on assurance
RBG will write formally to Oxleas NHS Foundation Trust to confirm that because of the Section 75 arrangements being in place, if there is any proposed change to community Mental Health Services that they need to be shared and agreed with RBG before being implemented. Any major service change proposed by mental health services must include a Quality Impact Assessment and an Equality Impact Assessment to assess and mitigate against any potential risk to service users.	A copy of the letter from Assistant Director, RBG to, Greenwich Service Director, Oxleas NHS Foundation Trust dated 13/10/2020 regarding Section 75 requirements in relation to service changes and service redesign was submitted. A copy of a letter from Greenwich Service Director, Oxleas NHS Foundation Trust dated 17/06/2021 to Senior Assistant Director, RBG was submitted to provide an update on Recommendations 16 and 17. It confirms that they are involving RBG with plans around mental health models of care and QIAs are planned. A copy of Oxleas NHS Foundation Trust's "Quality Impact Assessments and Non- Executive Directors led reviews Policy" dated June 2021 and a copy of the Quality Impact Assessment template was submitted.	There was no evidence of action until October 2020. Oxleas NHS Foundation Trust have jointly commissioned work to inform and enable the development of a Greenwich Mental Health Alliance and possible wider service changes. They are working with RBG via the Community Mental Health Transformation Board in designing new mental models of care. Impact assessments are planned. There are plans to move to operational service lines from Borough based services. Oxleas NHS Foundation Trust stated that these plans do not directly impact on the current Section 75 arrangements. They state, "*any potential risks and impact to users of mental health services will be shared and mitigated if they arise during the change programme and implementation phase.*" No minutes of follow up or discussion at SAB were submitted. No evidence of completion of the training sessions regarding undertaking QIAs is available as yet.

NIAF Rating:

- RBG formally wrote to Oxleas NHS Foundation Trust to confirm that under Section 75 any proposed service changes should be shared and agreed with RBG. Oxleas NHS Foundation Trust submitted a copy of the Quality Impact Assessment excel template sheet and policy that may be used when a major service change is proposed.
- Oxleas NHS Foundation Trust confirmed that there is a structure and process in place which is utilised when mental health service redesign is proposed. RBG did not confirm the structure and process in place. No minutes from discussions at SAB were used as evidence of the process.

Overall rating for this recommendation: 2 (action significantly commenced).

Recommendation 17: Where a major service re-design in mental health services is being proposed and implemented the Trust must ensure that it complies with the Regulations when considering a substantial development of the health service and consults the Local Authority. This should be subject to regular scrutiny by relevant Local Authority council committees.

RBG action plan	Response and evidence submitted	Niche comments and gaps on assurance
Royal Borough of Greenwich to share with Oxleas NHS Foundation Trust the details of the committees who it is appropriate to consult with in the event of a proposed service change e.g. Health and Adult Scrutiny and the Health and Wellbeing Board.	There was no evidence of action until a communication was sent in October 2020. Greenwich Service Director, Oxleas NHS Foundation Trust submitted a letter to Senior Assistant Director, RGB dated 17/06/2021 stating that Oxleas NHS Foundation Trust staff are key members of a range of committees including: • Safeguarding Board • Safer Communities Committee • Healthy Greenwich Alliance • Mental Health Alliance Board • Safer Neighbourhood Board • Health and Wellbeing Board. It was confirmed that the Trust would "*inform relevant committees about changes and provide information and seek contributions, as necessary*".	No minutes available but email confirmation received to state this was discussed at the SAB and that relevant committees will be informed if changes are planned. Oxleas NHS Foundation Trust confirmed which relevant committees would be consulted in the event of future planned changes.

NIAF Rating:

- There has been minimal action against this recommendation.
- Oxleas NHS Foundation Trust confirmed to us which committees will be consulted in the event of future planned changes.
- RBG should share with the Trust which committees should be consulted in event of future planned changes, so that they are able to evidence full completion of this action.
- **Overall rating for this recommendation: 1 (action commenced).**

Appendices

Appendix A: Glossary of terms

CAMHs	Children's and Adolescent Mental Health Services	QMS	Quality Management System
CCG	Clinical Commissioning Group	RBG	Royal Borough Greenwich
CEG	Clinical Effectiveness Group	RIO	Clinical Record System
CMHT	Community Mental Health Team	Section 75	Partnership agreements under Section 75 of the National Health Service Act 2006
CPA	Care Programme Approach	SAB	Safeguarding Adults Board
ED	Emergency department	SAR	Safeguarding Adult Review
DocMan	Clinical Record System	SBAR	Situation, background, assessment, recommendation
DoLS	Deprivation of Liberty Safeguards	SI	Serious Incident
HRP	High Risk People	SMART	Specific, measurable, attainable, relevant and time-based
iCare	Electronic record system		
ICMP	Intensive Care Management in Psychosis		
ITAP	Trust "Improving Together" audit		
MCA	Mental Capacity Act		
NHSE	NHS England		
NIAF	Niche Investigation and Assurance Framework		
PQAC	Performance and Quality Assurance Committee		
PQAG	Performance and Quality Assurance Group		
QIA	Quality Impact Assessment		

Niche Health & Social Care Consulting 4th Floor
Trafford House
Chester Road
Stretford
Manchester
M32 0RS

Tel: 0161 785 1000

www.nicheconsult.co.uk

Niche Health and Social Care Consulting Ltd is a company registered in England and Wales with company number 08133492.