Independent Quality Assurance Review

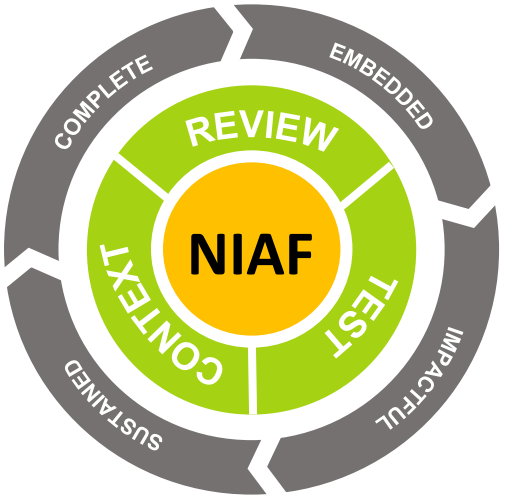
Derby and Derbyshire CCG, Derbyshire Healthcare NHS Foundation Trust, Nottinghamshire Healthcare NHS Foundation Trust and NHS England Specialised Commissioning

Ref: 2016 18856

Final Report

December 2021

Niche Investigation Assurance Kitemark



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

Our Final Report has been written in line with the Terms of Reference for our Independent Investigation into the Care and Treatment of a Mental Health Service User (Mr N). This 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.

Events which may occur outside of the timescale of this review will render our report out-of-date.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 (overseas) 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. However, where there is evidence that the information is not accurate, this has been made clear in the report and in relation to all other information received from organisations and individuals, a factual approach has been adopted with discrepancies and variances in accounts highlighted where known.

This Report and has been written for the purposes of Derbyshire Healthcare NHS FT, NHS Derby & Derbyshire CCG, Nottinghamshire Healthcare NHS FT and NHS England Specialised Commissioning alone under agreed contractual terms. 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, approved version of this Report, the 'Final Report' should be regarded as definitive.

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insight integrity impact

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1. Executive Summary

Background and context for this review

NHS England (Midlands & East) commissioned Niche Health & Social Care Consulting Ltd (Niche) to carry out an independent investigation into the care and treatment of a mental health service user (Mr N) in Derbyshire following a 'near miss' event.

Mr N had a history of mental illness and substance misuse and was on remand in HMP Nottingham in February 2016 when he became psychotic and made threats to harm. Mr N was assessed on 11 February 2016 and recommendations for treatment under Section 2 of the Mental Health Act , 1983 (MHA) were made. A psychiatric intensive care unit (PICU) bed was sought but admission was refused by several independent providers due to his risk history. Mr N was released on 12 February 2016, and on 13 February he approached a policeman in Derby saying he was hearing voices and wanted to harm someone with a weapon. He went voluntarily to the Emergency Department (ED) in Derby with the police officer.

Mr N spent 2 days in an acute hospital emergency department while further referrals and assessments were made, and he was admitted under Section 2 of the MHA on 15 February 2016 to the Enhanced Care Ward (ECW), Radbourne Unit, Derby. He was physically aggressive and very challenging and spent all of his time in seclusion. He remained there until transfer to Rampton Hospital on 10 March 2016.

Following publication of our investigation, a multi-agency action plan was developed that contained ten recommendations intended to support Derbyshire Healthcare NHS Foundation Trust (DHCFT), Nottinghamshire Healthcare NHS Foundation Trust (NHCFT), Derby and Derbyshire CCG (DDCCG) and NHS England Specialised Commissioning (NHSESC) with learning and improving services and practices.

The terms of reference for the Niche independent investigation required Niche to undertake an assurance review follow-up after report completion.

This is in order to provide an assessment of the implementation of the organisations' resultant action plans against the Niche Investigation and Assurance Framework (NIAF).

This is a high-level report on progress to NHS England (Midlands & East) based on a desktop review and two telephone interviews with DHCFT and DDCCG, without site visits.

Implementation of recommendations

Recommendations were incorporated into a multi-agency action plan. Action owners were assigned, and all actions were reported as completed upon finalisation of our assurance review.

We saw that providers had worked collaboratively, particularly when implementing large scale strategic changes in the sourcing of PICU beds. Given the scale of these system wide changes, there has been limited opportunity to test the impact of and how these changes have been embedded into practice. We have therefore suggested that future pieces of work are undertaken to strengthen assurance.

Review method and quality control

It is important to note that we have not reviewed any healthcare records because there is no element of re-investigation contained within the review terms of reference. We used documentation provided by DHCFT, NHCFT, DDCCG and NHSESC to complete this review and information received from telephone interviews with DHCFT and DDCCG.

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.

2. Summary assessment on progress

The Niche Investigation Assurance Framework

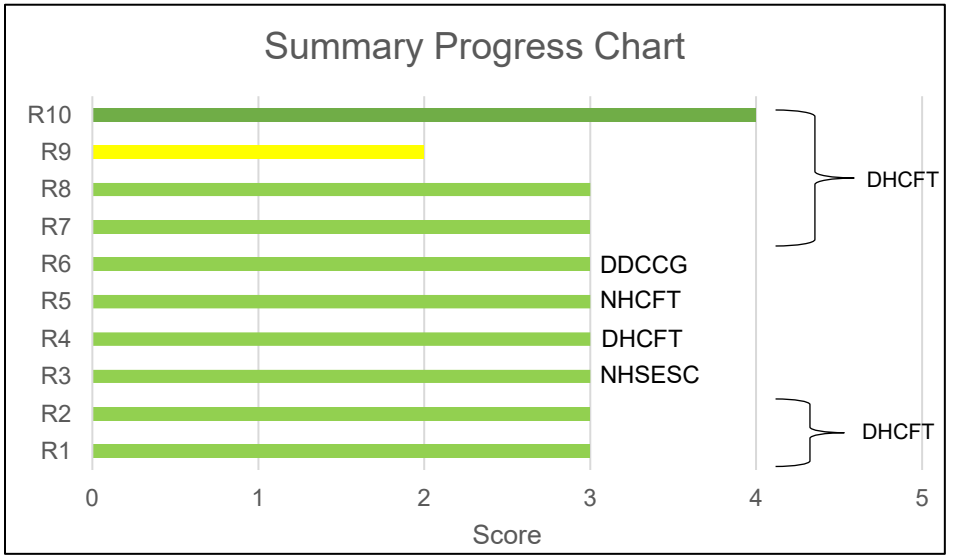
Assessing the success of learning and improvement can be a very nuanced process. Importantly, the assessment is meant to be useful and evaluative, rather than punitive and judgemental. We adopt a useful numerical grading system to support the representation of 'progress data', as shown in the NIAF ratings 'Summary Progress Chart'. 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 actions that have been progressed and implemented in response to the recommendations made in the independent investigation report.

In relation to progression of the agreed actions from the six recommendations made in the internal investigation report, we have rated progress as shown in the table below:



Summary

There has been good progress in relation to most of the recommendations. However, there are some residual gaps in assurance for recommendation 9.

Assurance review findings

3. Assurance review of the multi-agency action plan

The terms of reference set by NHS England (Midlands & East) for this assurance review require an assessment of the implementation of the recommendations which resulted from the Niche independent investigation into the care and treatment of Mr N following his release from HMP Nottingham on 12 February 2016.

It was felt that the risks presented by Mr N on release from HMP Nottingham were of sufficient concern to regard this as a 'near miss' event, and that learning should be drawn out that could be shared across systems. The investigation report made 10 recommendations which were intended to support all the providers in learning and improving services and practices.

As shown on 'Summary Progress Chart' table, recommendations one, two, four, seven, eight, nine and ten were assigned to Derbyshire Healthcare NHS FT (DHCFT). Recommendation six was assigned to Derby and Derbyshire CCG (DDCCG), recommendation five to Nottingham Healthcare Foundation Trust (NHCFT) and recommendation three to NHS England (NHSESC).

These recommendations were developed into a multi-agency action plan. The action plan was last updated on 3 December 2020 and used a 'RAG rating', identifying all actions as green and therefore completed. We have received updates from all providers and undertaken telephone interviews with DHCFT and DDCCG.

We found evidence of good partnership working between the providers, particularly in respect of the new processes for sourcing PICU beds and the monitoring of the use of out-of-area PICU beds. We saw the inclusion of a clear escalation protocol to senior members of staff within DHCFT, both within and out of usual hours of working, to ensure secure and PICU beds are available for internal and external referrers. All providers should be commended for the efforts made to work collaboratively on the completion of the multi-agency action plan.

We did assess that further work is required by DHCFT to strengthen assurance for recommendation nine. For this recommendation, we found a lack of systems to identify episodes of longer-term segregation.

We have recommended that the Trust strengthens policy to ensure that there is clearer guidance to staff in the identification and management of any episodes of long-term segregation.

Our detailed assessment of the progress each of the organisations has made in implementing and embedding change can be found on the following pages.

Recommendation 1:DHCFT must ensure that a risk management plan is developed and implemented when risks are identified, incorporating the review and use of recent and past records, using clinical risk assessment tools.		
Multi-agency action plan	DHCFT response and evidence submitted	Niche comments and gaps on assurance
'DHCFT has now replaced the FACE risk assessment tool with Safety Assessment. The new Safety Assessment tool has been undergoing additional updates during the last 12 months and pilots rolled out in relation to more area specific tools. Safety assessments and audits of up-take and use are in place. Live reporting systems in inpatient settings. Reports of compliance'.	Discussions were held by the Trust's Safety Planning Group and resulted in the development of the Safety Risk Assessment tool. The Safety Risk Assessment tool included the requirement for practitioners to review current and historical risk information and include this within the assessment. The Trust's 'Care Programme Approach [CPA] Policy and Procedure' (February 2020) guided staff to include longer term and longitudinal risk factors based upon the 'Patient Safety Model'. Staff were advised to read the 'Assessment and Management of Safety Needs Policy' for further guidance. A Care, Capacity and Safety Assessment Dashboard for 2020- 2021 was developed and included the compliance rates for the completion of Safety Assessment Tools for: Adult acute services (97%) Adult community services (87%) and Forensic and Mental Health Rehabilitation services (49%). The Trust's Quality and Safeguarding Committee has overall monitoring responsibility for the Trust's compliance rate for the completion of Safety Risk Assessments. The Quality and Safeguarding Committee has a senior independent Chair and has executive and non-executive representation including the Trust's Medical Director. We saw that a Quality Performance Dashboard was presented to the Quality and Safeguarding Committee in September and November 2020. September 2020's data evidenced that 60% of patients had a Safety Risk Assessment tool in place and 90% of staff had completed e-learning for clinical safety planning. November 2020's data evidenced that just over 50% of patients had a Safety Risk Assessment' tool in place and 90% of staff had completed the clinical safety planning e-learning.	We were not provided with the 'Assessment and Management of Safety Needs Policy'.

Recommendation 1: continued		
Multi-agency action plan	DHCFT response and evidence submitted	Niche comments and gaps on assurance
	We note that the Trust explained that the data reflected in the Quality Performance Dashboards did not take into account those patients where a 'safety box' (the previous process) had been completed instead of a safety plan, in keeping with current policy. The Trust are also currently in the process of transferring to a new electronic record system. The Trust described that the new electronic record system will include a new process for the safety plan which will not include the use of a 'safety box'. A new three stepped process for completing the safety plan will include an initial risk screen, risk assessment and safety plan linked to the care plan. Therefore, Safety Risk Assessment tool data in future audits should more accurately represent the Trust's compliance rates. The Trust have described that they are currently piloting the use of more specific risk assessment tools for Older Adult and Learning Disability specialist services.	We have not been provided with a 'going live' date for the new electronic patient care record. We have not seen any outcomes to the pilots that have been completed.

NIAF rating:

The Trust have made some progress with the implementation of this action and have made pro-active efforts to ensure that staff have completed relevant training in order to implement the Safety Risk Assessment tool. As the Trust are moving to a new electronic record system, the overall performance figures have been skewed due to the current system being unable to pull through all the meaningful data to fully represent the percentage of patients who had completed risk assessments.

We have not been provided with a date that the new system will go live. Following the introduction of the new electronic record system and amendments to policy, the Trust should complete further audits to assure itself that changes to practice have been fully embedded.

Overall rating for this recommendation: 3

[Assurance review of the multi-agency action plan, continued]

Recommendation 2: DHCFT should ensure that all safeguarding referrals are actioned appropriately, and outcomes recorded		
Multi-agency action plan	DHCFT response and evidence submitted	Niche comments and gaps on assurance
'This is an existing standard and the annual audit programme will continue to audit this practice and ensure current practice remains at the expected standard. CQC Good rated- good governance in Safeguarding, See 2020 Safeguarding Annual reports and CQC independent scrutiny and section 12 audit'.	Safeguarding Children and Adults operational groups report on a quarterly basis to the Quality and Safeguarding Committee which reports directly to the Trust Board. The Quality and Safeguarding Committee minutes (September 2020) included the review of the Safeguarding Children and Adults quarterly assurance reports and reported that the Trust were assured that the CQC statutory requirements (Regulation 13, Safeguarding people who use services from abuse) continued to be met by the Trust. DHCFT described that they are committed to partnership working to discharge its statutory duties with Derby City & Derbyshire Safeguarding Children and Adults Boards. In respect of safeguarding children, the DDCCG discharge their duties under Section 11 of the Children's Act 2004, through the completion and review of a Section 11 audit. The Trust's 'Safeguarding Children and Adults at Risk Annual Report' (2019-2020) described that the Safeguarding Children Team undertook the Section 11 self-assessment on the 13 December 2019, as part of a quality visit led by DDCCG and Derby and Derbyshire Safeguarding Children Partnership (DDSCP). The report described that the outcome of the audit indicated that the Trust was fully compliant against all five standards within the audit. In respect of safeguarding adults, the Trust's Safeguarding Children and Adults at Risk Annual Report (2019-2020) described that DDCCG had completed a Safeguarding Adults Assurance Framework (SAAF) follow-up visit on 30 September 2019. DDCCG described that the Trust had implemented a comprehensive action plan. This included their progress in implementing priorities identified within the SAAF document (completed during 2018-19). DDCG described that they were assured on the progress and development of the Trust's adult safeguarding work.	The 'Safeguarding Children and Adults at Risk Annual Report 2019-20 evidenced that there were no Trust breaches of the CQC's Regulation 13, (Safeguarding people who use services from abuse).

Recommendation 2: continued		
Multi-agency action plan	DHCFT response and evidence submitted	Niche comments and gaps on assurance
	The 'Safeguarding Children and Adults at Risk Annual Report' (2019-2020) described that the Trust's Safeguarding Unit prepare a monthly report that is issued to all Clinical Operational Assurance Team (COAT) meetings for the Trust which include Specialist, Children's, Neighbourhood, Forensic and Campus divisions. The report also notes that the safeguarding leads provide organisational scrutiny, guidance and learning and includes points for action for the divisional representatives as well as points for information. It is reported that safeguarding operational groups can escalate matters that require executive or committee consideration and/or inclusion in the Trust Risk Register but, equally, can escalate good news stories and lessons learned to share across the organisation. A care planning audit undertaken in the Neighbourhoods division evidenced that >60% of community service users with 'recognised safeguarding concerns' had had their concerns adequately acted upon.	The Neighbourhood division care planning audit did not include a date of completion and did not include a date for a future scheduled audit. We did not see any inpatient audits in respect of 'staff recognising concerns' and if they were adequately acted upon.

NIAF rating:

The Trust provided good evidence of meeting contractual arrangements in respect of safeguarding adults and young people under their care. However further work is needed to complete this recommendation, specifically in respect to understanding if staff members recognise safeguarding concerns appropriately and if concerns are reported and recorded appropriately.

Overall rating for this recommendation: 3

Recommendation 3: The NHS England secure services specification should ensure that: a standard operating procedure is in place for all referrals, with clear timelines and accountability for decision making, which addresses how to negotiate the pathway between CCG and NHSE commissioned services; provision of a single point of access, with a written response to referrals with a jointly agreed contingency plan if there is no suitable bed available; there is a dispute resolution protocol with named partners; a pathway for urgent referrals is in place, with agreed escalation on urgency or level of security; there is a process for responding to an urgent referral, with the opportunity to have multi-professional urgent case management discussions to problem-solve and source a shared solution.		
Multi-agency action plan	NHSESC response and evidence submitted	Niche comments and gaps on assurance
'A standard operating procedure (SOP) is in place, with clear timelines and accountability'.	IMPACT is the provider collaborative for adult medium and low secure inpatient services across the East Midlands. Provider collaboratives, or 'new care models' as they were previously referred to, is an approach set out in the NHS Five Year Forward View for Mental Health in 2016. IMPACT established an 'Improved Admissions Task and Finish Group that included representation from the IMPACT project team, all nine inpatient providers, community teams and case managers from NHS England. Consultation was described as having also taken place with the Ministry of Justice and representatives from the local prisons within the East Midlands. The aim of this was to review processes in situ at that time and to develop a SOP. The group worked over a seven-month period to look at improving the process. The group reported that at each stage, the work had been taken back to services for comments from patients within those settings as well as from the larger co-production events.	We found evidence that a SOP was collaboratively developed for the pilot and included clear timelines and accountability at each stage of the referral, assessment and admission process.
	The SOP developed by the Task and Finish Group includes information pertaining to: • the rationale for changing the process; • referral criteria; • the referral process; • the assessment process and report; • admissions of restricted patients from community settings; • monitoring of the referral and admission process; and • dispute resolution.	We have not had sight of a ratified SOP following the completion of the pilot.

Recommendation 3: continued		
Multi-agency action plan	NHSESC response and evidence submitted	Niche comments and gaps on assurance
	The SOP was launched as part of an NHS England and IMPACT Pilot of the Single Point of Access Admissions Process on the 1 October 2019. Full implementation commenced on the 1 April 2020. Oversight throughout the pilot was facilitated by the IMPACT Clinical Reference Group. Once fully implemented, the plan was for the IMPACT Improved Admissions Task and Finish Group to continue to meet monthly and monitor the outcomes and data from the changes in the process. The IMPACT CoRE (Coproduction, Research and Evaluation) Group produced a paper evaluating the pilot in February 2020. This paper described that there was *"a statistically significant reduction in both the number of assessments experienced by each person referred, the length of the assessment process since the introduction of the Single Point of Access (SPA) and a significant increase in the number of patients admitted within 28 days of referral. Referrers and assessors had found the process clearer, quicker and more efficient."* Limitations to the pilot were described. It only focused on admissions and the improvements in admission assessments and priority given to new admissions, might have led to delays in transitions between services (with more people put on waiting lists). A further evaluation was recommended to explore the process and impact of the SPA on patients transitioning between secure services. The IMPACT Referrals to Adult Secure Inpatient Service: Guidance for Referrers was updated to include service users already admitted to a secure bed and in transitions between services to a different level of security and for those patients subject to recall under Section 41 (MHA).	We found evidence that the validity and efficacy of the SOP was reviewed prior to the completion of the pilot, with recommendations for further consideration to include patients who did not require emergency admission. Although we have seen evidence that the guidance had been updated to include all patients, this did not include a date when these changes were made. In the absence of reviewing the ratified SOP, we are unable to confirm whether these changes had been transferred into practice.

Recommendation 3: continued		
Multi-agency action plan	NHSESC response and evidence submitted	Niche comments and gaps on assurance
'The IMPACT Hub is a single point of access'.	The IMPACT Hub was established to support new referrals, assessment and admission processes as well as the development of the provider collaborative. It acts as a SPA. The Hub is a central clinical service made up of a team of professionals and includes Mental Health Case Managers, who have previously worked within NHS England. In addition to the co-ordination and oversight of all referrals and assessments, the Case Managers are also responsible for the admissions and transition of service users within IMPACT. All referrals are made on the IMPACT Referrals Form for Adult Secure Inpatient Services and sent to the IMPACT referral email address.	The East Midlands provider collaborative went live on 1 October 2020 and consists of all secure providers in the East Midlands led by NHCFT. We saw evidence that the IMPACT Hub acted as a SPA throughout the pilot.
'A system for urgent referrals is in place'.	The referral form requires the referrer to indicate the urgency of the referral, in line with the service specification. However, the level of urgency is ultimately determined by the assessing provider. Once the hub receives a referral, they are required to review and action this on the same day (or the following day if the referral is made out-of-hours). Timescales for the assessments are in one of two categories, Urgent and Non-Urgent. Urgent referrals are required to receive an assessment within two days compared to non urgent referrals, where an assessment must take place within 21 days.	We did not see guidance for those situations where there is a disparity between the referrer and the assessing team in respect of the urgency of the assessment required. The SOP only states that the ultimate decision will be made by the assessing team, who would not have a working knowledge of the patient requiring assessment.

Recommendation 3: continued		
Multi-agency action plan	NHSESC response and evidence submitted	Niche comments and gaps on assurance
There is a process for responding to an urgent referral, with the opportunity to have multi-professional urgent case management discussions to problem-solve and source a shared solution.	Should the referring clinical team disagree on the outcome and recommendations made by the assessing team, staff are directed to follow the dispute resolution guide within the SOP which states that: • The assessing team must instigate a clinician-to-clinician discussion regarding any difference of opinion. • If the respective clinicians are unable to agree an outcome, the referral, clinical information and recommendations made by the assessing team, these are reviewed by the Mental Health Case Manager to establish the reasons for the dispute. • The Mental Health Case Manager should attend any professionals' meetings to assist with the decision-making process with a view to resolving the dispute. • Where resolution of the dispute is still not achieved then the case will be taken to the IMPACT Panel.	We did not see the inclusion of a designated timeframe for dispute resolution. This could delay the admission or transfer process.

NIAF Rating:

A number of actions have been taken to complete this recommendation. However, there are some residual gaps in assurance that could be addressed by assessing the efficacy and validity of the SOP, following the completion of the pilot in April 2020. We note the extent of the implementation challenges involved in the new structures would understandably take significant time to bed in before any future testing takes place.

Overall rating for this recommendation: 3

Recommendation 4. DHCFT must ensure that the management of requests for inpatient admission in DHCFT should incorporate escalation actions to take place in cases where there is the likelihood of a patient requiring detention under the MHA and is in need of a Derbyshire placement urgently.		
Multi-agency action plan	DHCFT response and evidence submitted	Niche comments and gaps on assurance
'Revision to PICU and out of area protocol and flowchart to include the NHS England secure service specification protocol, and agreed new practice is in place. *Local management team, operating procedure. Ready to receive the revision and up-date operating procedure. This will be included in on-call and business continuity procedures.* *This is in practice. No near miss incidents have occurred since, of this nature, from DHCFT perspective. Nov 2020'.*	The Trust's Psychiatric Intensive Care Protocol includes processes for sourcing an inpatient psychiatric PICU bed within and out-of-hours. It includes a specific escalation protocol for when a bed cannot be located nationally due to presenting risks. The process mandates that this must be followed *'…when access to a PICU bed has been exhausted and declined due to providers stating they believe it is clinically unsafe to admit and all reasonable escalation to access a bed has been exhausted'*. The escalation protocol states as follows: '*A specific timescale cannot be set but if a patient is unable to access the care that they need within a period of five days, then an inter-organisation planning strategy meeting should be called taking into account the best interests and safety of patients and staff.'* *'Prior to the inter-organisational meeting a referral for an assessment to IMPACT must be made.'* *'Where a patient's presenting needs remain unresolved, then inter-agency planning should come into practice to explore the safest solutions and least restrictive environment.'* *'A least restrictive option may be immediate step up to low or medium secure service provision.'* *Triggering a multi-organisation review and a multi-disciplinary strategy meeting should be undertaken by the Director of Nursing or Medical Director of the organisation where the patient is currently residing. This can occur in-hours or out-of-hours as required, to maintain the safety of patients and staff.'*	The Trust's Psychiatric Intensive Care Protocol did not include a date of ratification and implementation. We have not seen any evidence of communications to staff to advise of the escalation protocol.

Recommendation 4: continued		
Multi-agency action plan	DHCFT response and evidence submitted	Niche comments and gaps on assurance
	'No PICU will accept the patient due to clinical presenting needs / despite bed being available. Refer to IMPACT and escalate for an interagency planning call within 5 days.' 'IMPACT's 'Standard Operating Procedure for the Management of Referrals, Assessments and Admissions to Secure Inpatient Services within the East Midlands' includes a dispute process for occasions when the referring clinical team is not in agreement with the outcome and recommendations made by the assessing team, including the requirement for an inpatient bed. Should the dispute resolution process fail to resolve a difference of opinion in relation to an admission, an arbitration process must commence within five working days. Should the outcome of the arbitration process include a recommendation to admit a patient, the IMPACT Panel will direct the service to admit the patient.	

NIAF rating:

The Trust has progressed this action but have been unable to test how embedded the process is in practice, due to a lack of 'near miss incidents' following the completion of the action plan. The Trust could assure itself further by reviewing examples of admissions requested outside of usual working hours and review the processes followed after a request for a bed has been made and up until the point of admission. The Trust plan to incorporate the NHS England secure service specification protocol and agreed new practice within the local management team and operating procedures. This will include on-call and business continuity procedures. For assurance purposes, the Trust should consider future audits to assess compliance with the escalation processes and to test their effectiveness.

Overall rating for this recommendation: 3

Recommendation 5: All relevant providers must ensure that when external referrals for a mental health bed are made by prison healthcare psychiatrists; the process designed to achieve this should be locally agreed between the commissioners and providers, and relevant clinicians should be apprised of the situation in good time.		
Multi-agency action plan	NHCFT response and evidence submitted	Niche comments and gaps on assurance
This has been agreed and NHCFT have agreed to the protocol.	Since October 2019 access to secure placements in the East Midlands has followed the as part of the moving into 'provider collaboratives'. NHSE and the providers in the East Midlands developed a provider collaborative. All nine providers are represented within the development of the provider collaborative which has taken the name IMPACT, following a co-production event with service users, carers, and regional stakeholders. The East Midlands provider collaborative went live on 1st October 2020 consists of all secure providers in the East Midlands, led by NHCFT. We were told that NHCFT implemented the IMPACT protocol in agreement with local commissioners and other local healthcare providers. The IMPACT protocol included processes for locating low secure and medium secure inpatient beds for the transfer of prisoners. Also, prisoners who present as a grave and immediate risk or serious risk to the public, and who must be managed in high security, can be referred but any referral must be supported by an access assessment by a medium secure service provider. For urgent referrals, assessment should take place within two days and the outcome shared with the referring clinician verbally with the submission of a brief report within 24 hours of the assessment taking place. A final report is then shared with the referring clinician within five days of the assessment taking place. Non-urgent assessments are completed within 21 days and a final report is shared with the referring clinician within seven days of the referral taking place We were told that a similar protocol for those being released from prison or being admitted to non-secure beds in the Derbyshire community is not yet in place but is underway.	

NIAF rating:

The providers have collaboratively agreed with and implemented the IMPACT protocol for referrals for secure beds. Further assurance could be sought through audits to test how well the protocol works for prisoners being transferred or directly admitted to secure service inpatient beds and to test that referring clinicians are updated within the Impact Protocol timeframes. **Overall rating for this recommendation: 3**

[Assurance review of the multi-agency action plan, continued]

Recommendation 6: NHS Derby & Derbyshire CCG must provide assurance that there are arrangements in place to access PICU beds in urgent situations, including an escalation protocol with timescales and stepping-up process agreed.		
Multi-agency action plan	DDCCG response and evidence submitted	Niche comments and gaps on assurance
'The Derby & Derbyshire CCG commission PICU beds from a selection of NHS (non-Derbyshire) and private providers. PICU beds are accessible and work has been undertaken to support this work through a PICU manager There are some residual risks that a PICU provider could refuse admission due to clinical grounds. Therefore, in cases of this nature an escalation protocol has been drafted. The protocol/ escalation meeting was co-designed on the 8th November 2019, a draft has been proposed for urgent access to PICU and a PICU contract is in place. The Trust has written an expression of interest to the CCG. The Trust has written a clinical case for change based upon PICU need now, and emerging population need. Bid to build a PICU in place with treasury'.	DDCCG advised that they are aware of an existing escalation protocol designed by the 'IMPACT provider collaborative' that included escalation processes for allocating PICU beds through to the Directors of Nursing at Derbyshire Healthcare and Nottinghamshire Healthcare NHS FTs. The Psychiatric Intensive Care Protocol include the processes for allocating a PICU bed for service users already within Trust and new referrals into the Trust. The procedure covers admissions both within and outside of usual working hours. For those service users who are already inpatients under Trust services, the protocol describes the requirement for the service user's team to have implemented the '72-hour protocol'. This describes the use of DHCFT's rapid tranquilisation policy, consideration of enhanced nursing observations and additional staffing before assessment for a PICU bed is completed. The service user must have undergone an assessment by the inpatient clinical team, ideally including the inpatient psychiatrist, within 3 hours of referral as part of the 72-hour protocol. Where the risks are clinically assessed as immediate and imminent harm to self or others or actual harm has been caused, the guidance directs staff that the '72-hour protocol' should not be followed. The procedure states that all potential referrals for PICU placement should be discussed with the PICU Case Manager or in their absence Enhanced Care Ward. Manager, or the Bleep Holder in order to ascertain the need for PICU and ensure the 72-hour protocol has been implemented. When a referral is made outside of usual working hours, a PICU placement should be sought from the first on-call manager. If the Trust receives a direct referral from the community, the protocol states that a clear rationale for direct referral and admission should be given.	

Recommendation 6: continued		
Multi-agency action plan	DDCCG response and evidence submitted	Niche comments and gaps on assurance
	If a PICU bed is declined (based on a provider stating they believe it is clinically unsafe to admit) and when all reasonable escalation had been exhausted, the Psychiatric Intensive Care Protocol sets out the processes to be followed: *'A specific timescale cannot be set but if a patient is unable to access the care that they need within a period of five days, then an inter-organisation planning strategy meeting should be called taking into account the best interests and safety of patients and staff.'* *'Prior to the inter-organisational meeting a referral for an assessment to IMPACT must be made.'* *'Where a patient's presenting needs remain unresolved, then inter-agency planning should come into practice to explore the safest solutions and least restrictive environment.'* *'A least restrictive option may be immediate step-up to low or medium secure service provision.'* *Triggering of a multi-organisation review and multi-disciplinary strategy meeting should be undertaken by the Director of Nursing or Medical Director of the organisation where the patient is currently residing.'* DDCCG described that Derbyshire is currently an outlier nationally as it is one of the few CCG areas that have no locally commissioned male or female PICU beds. Consequently, the DDCCG outsource beds from other providers via block contracts and spot purchase arrangements. Presently DDCCG have contracts for male and female PICU beds in Northamptonshire and Manchester. We saw evidence that oversight of the use of out-of-area beds (including PICU beds) is monitored by the Out of Area Placement meetings that are attended by representatives from the Trust and DDCCG.	We are unable to confirm the frequency of these meetings.

Recommendation 6: continued		
Multi-agency action plan	DDCCG response and evidence submitted	Niche comments and gaps on assurance
	'DDCCG described that pre-procurement work is currently underway to ensure that PICU beds are available to patients within 45 minutes of Derby to ensure that patients are admitted to PICU beds closer to their home. We saw evidence that these plans are overseen by the DDCG Clinical Committee'. We were told that DHCFT will have their own PICU by 2024 and have made a submission for capital funding for male PICU beds in Derby.	

NIAF rating:

We found evidence that the Trust and DDCCG have been working in collaboration to ensure that there are sufficient arrangements in place to facilitate access to PICU beds in urgent situations. We found evidence of an escalation protocol with timescales and a stepping-up process agreed with senior members of staff within DHCFT. The Trust described that there have been no further instances of being unable to admit a service user to a PICU bed following the incident and therefore, are currently unable to evidence how this action has been tested and embedded.

Overall rating for this recommendation: 3

Recommendation 7: DHCFT should ensure that the Trust emergency management/business continuity plans include serious interruption of services and that there is a structure to ensure such occurrences are managed with appropriate leadership and senior oversight.		
Multi-agency action plan	DHCFT response and evidence submitted	Niche comments and gaps on assurance
'The Trust has an Emergency Incident Response Plan and Procedures in place (on Connect). On call rotas ensure Manager (1st on call) and Senior Manager (2nd on call) availability across the Trust and the rota is managed by the Emergency Planning team? We have a Business Continuity policy. In a case example of closing the 136 suite for more than 5 days and prolonger high level staffing. Emergency planning principles and practice will be adopted. DHCFT has had no further incidence of an incident of this nature, to be able to evidence this recommendation'.	The Trust's 'Emergency Incident Response Plan and Procedures Policy'(2018) was ratified by the Trust's Quality Group and superseded the 'Emergency Preparedness, Resilience and Response Plan Policy. The policy defines roles and responsibilities within DHCFT for responding to a major incident or a disruption to business continuity. We saw examples of incidents and of disruptions to services that may require implementation of the Emergency Plan. We found that staff within the Trust or external agencies are instructed to initially notify the Trust switchboard to report a major incident or disruption of service, who then notify the Chief Operating Officer within hours or the first on-call manager out-of-hours. If a major incident or interruption of service has been assessed, they are required to implement the Emergency Plan. On implementing the Emergency Plan, the Chief Operating Officer or second on-call manager will assemble the Incident Control Team (ICT) in the designated Incident Control Centre. The role of the ICT is to formulate and implement the overall response to a major incident or disruption to business continuity. They are also responsible for co-ordinating the Trust's response with that of other agencies. Core representatives of the ICT include senior Trust members, for example the Trust's Director of Nursing and Patient Experience, Director of Corporate & Legal Affairs and Deputy and Assistant Director(s). Within normal working hours the Chief Operating Officer is responsible for taking control of the ICT and is the designated Incident Director. In their absence, the responsibility falls to the Deputy Director of Operations. During out-of-hours, the second on-call manager fulfils the role of Incident Director.	

Recommendation 7: continued		
Multi-agency action plan	DHCFT response and evidence submitted	Niche comments and gaps on assurance
	The response may consist of three phases: • Incident Response (within minutes to hours)– responding to the major Incident and/or the immediate disruption to service provision; • Service Continuity (within minutes to days) –implementation of measures to commence recovery of critical services; and • Recovery (within days to months) – implementation of medium to longer-term recovery measures. For example, in the event of damage to or loss of a building. Within the policy, we saw the inclusion of 'Action Cards' that referenced specific roles and actions that must be taken by all key players involved in the implementation of the 'Emergency Plan'. We saw that the Emergency Planning Lead is responsible for ensuring that a review of the Incident Response Plan and the Business Continuity Management System is undertaken on an annual basis to take account of organisational changes, post incident reviews, near misses or exercises.	

Recommendation 7: continued

NIAF rating:

The Trust have significantly progressed this action. We found that the Emergency Incident Response Plan and Procedures Policy (2018) included contingency plans in the event of serious interruptions to services, which are implemented and overseen by senior Trust leaders. The Trust have reported that to date, they have not been able to test the validity and efficacy of the plan because there have not been any further episodes of serious interruptions to services. The Trust could consider testing emergency management/business continuity plans at set intervals with planned exercises for example a 'pretend fire' to test and strengthen assurances.

Overall rating for this recommendation: **3**

Recommendation 8: DHCFT should ensure that seclusion practice is monitored to provide assurance that policy requirements for reviews are met and adhered to.		
Multi-agency action plan	DHCFT response and evidence submitted	Niche comments and gaps on assurance
'The policy has been reviewed and advice from the CQC national team on definition of an independent review. DHCFT will ensure record keeping defines independent team and includes how are they are independent from the team that recommended seclusion. Nov 2020 MHA committee reviews seclusion and seclusion use. No further incidence of seclusion or long - term segregation of this nature'	The Trust's Seclusion and Long Term Segregation – Psychiatric Emergency Policy and Procedure (2019) states that mandatory reviews should be completed as part of the seclusion pathway (Code of Practice (CoP, 1983) as follows: *'Nursing reviews - should take place at least every two hours by two registered staff, one of whom was not directly involved in the decision to seclude [CoP Ch 26.134].'* *'Medical reviews - unless seclusion was authorised by a psychiatrist, a seclusion review will be undertaken by a duty doctor within the first hour of seclusion commencing, or without delay if the patient is newly admitted, not well known, or if there is a significant change in their usual presentation. [CoP Ch 26.116].'* *'Medical reviews will take place every four hours from the commencement of seclusion until the first Internal Multi-disciplinary Team review takes place [CoP Ch 26.131].'* *'Following this first Internal Multi-Disciplinary Team review further medical reviews should continue at least twice in every 24hr period [CoP Ch 26.132].'* *'At least one of these twice daily reviews should be by the patient's Responsible Clinician, or other consultant out-of-hours [CoP Ch 26.132].'* *'Internal MDT reviews -The Internal Multi-Disciplinary Team should review the patient as soon as is practicable [Chapter 26.137]. This should be within 24 hours of seclusion commencing.'* *'Internal MDT reviews will take place within every 24hrs throughout the seclusion episode [Chapter 26.139].'*	We have not seen evidence of samples of completed reviews to determine if these had been completed in keeping with the policy requirements.

Recommendation 8: continued		
Multi-agency action plan	DHCFT response and evidence submitted	Niche comments and gaps on assurance
	'Independent MDT reviews- If the period of seclusion continues for longer than 8hrs consecutively or 12hrs intermittently during a 48hr period then an independent MDT review should be undertaken [Chapter 26.141].' The Policy also described that it is the responsibility of the clinicians involved in seclusion practice to ensure that this policy is followed. The Trust's Mental Health Act (MHA) Committee reviews the use of seclusion. At the committee meeting held in March 2020, an action was recorded for the forward plan to include ~~r~~estrictive practice, restraint and seclusion and that this be reported to the committee on a six-monthly basis.	We did not see evidence of a review of seclusion practice and have not had sight of more recent committee minutes to determine if the use of seclusion is reported every six months.

NIAF rating:

The Trust have made efforts to implement this recommendation and have improved the monitoring of seclusion practice via the Trust's MHA Committee. However further work is needed to ensure that seclusion practice is monitored and executed in keeping with local policy and the MHA Code of Practice (1983).

Overall rating for this recommendation:3

Recommendation 9: DHCFT should align the definition of long term segregation in their policy with that of the MHA code of practice, develop a system to identify any cases of long term segregation, and any instances of long term segregation should be reported and monitored formally through quality structures.		
Multi-agency action plan	DHCFT response and evidence submitted	Niche comments and gaps on assurance
'Process in place for the review of all incidents of patients being placed long term segregation. Policy reviewed DHCFT does not have the clinical environment necessary to care for people in long term segregation and we do not carry out this practice. As the Trust does not have a full long-term segregation or high support area we cannot meet the minimum MR required standards of the required facilities. The Trust can also confirm that any use of restricted movement in Trust facilities is the equivalent of seclusion/ the seclusion pathway is commenced. Nov 2020 MHA committee reviews seclusion and seclusion use. No further incidence of seclusion or long-term segregation of this nature'.	The Trust's 'Seclusion and Long Term Segregation – Psychiatric Emergency Policy and Procedure' (2019) states: *'The Code of Practice 2015 defines long-term segregation as a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determines that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis.'* In respect of the use of long-term segregation, the policy mandates that: • A multi-disciplinary team (MDT) review should be convened to discuss the implementation of long-term segregation and should include a representative from the CCG, Safeguarding team, Carer, Independent Mental Health Advocacy (IMHA), care team and service user where possible. • Once approved a specific care plan should be produced to outline the approach, intervention and treatment strategy and milestones review triggers. • The patient should be reviewed every 24hrs by an approved clinician and weekly by the full MDT.	We did not find any detail pertaining to what timeframe would be considered as 'long-term' and therefore the interpretation of 'long-term' may be a subjective assessment by secluding practitioners. We did not find evidence of a system to identify any cases of long-term segregation. We have not had sight of the MHA Committee' meeting minutes to determine how incidents of long-term segregation are monitored. We are unable to confirm how incidents of long-term segregation are reported by practitioners, for example through a Trust's incident reporting system.

Recommendation 9: continued		
Multi-agency action plan	DHCFT response and evidence submitted	Niche comments and gaps on assurance
	The policy describes that practitioners should routinely review incidents of seclusion and long-term segregation and includes a review of access to appropriate facilities to manage these incidents. The Trust's Quality and Safeguarding Committee and MHA Committee are responsible for monitoring and overseeing the use of seclusion across the Trust footprint and convene quarterly throughout the year. We saw that the use of seclusion is reported into the Quality and Safeguarding Committee via the submission of the Quality Performance Dashboard and that any actions required are agreed within this meeting.	The guidance to staff is too vague in respect of who should complete the reviews and the frequency with which these reviews should take place.

NIAF rating:

The Trust described good governance arrangements in respect of the use of seclusion in inpatient settings. However current policy is vague in respect of defining the duration of time before an episode of seclusion is considered as 'long-term segregation'. We are unaware of any systems that have been developed to identify the use of long-term segregation and recommend that the policy is updated with clearer guidance and instruction to staff about the review and management of long-term segregation incidents.

Overall rating for this recommendation: 2

Recommendation 10: Recommendation 10: DHCFT should ensure that the exclusion criterion regarding admission under Section 2 MHA be removed from the Kedleston Unit operational policy.		
Multi-agency action plan	DHCFT response and evidence submitted	Niche comments and gaps on assurance
'For the service to review admission process in relation to Section 2 MHA patients into the Kedleston Unit. *In addition, the NHSE admission protocol has been considered and does not use Section 2 as an exclusion criteria. This is confirmed and in place'.*	We reviewed the Kedleston Unit Operational Policy and Procedure (2018) and it describes how care and treatment are provided to patients with mental health problems, who are detained under the Mental Health Act (1983). The policy did not include Section 2 of the MHA as an exclusion criterion for psychiatric inpatient admissions.	

NIAF rating:

This action had been fully completed. Moving forward, the Trust could review admissions to the Kedleston Unit to determine if service users subject to Section 2 are admitted to an inpatient bed following referral.

Overall rating for this recommendation: **4**

Appendices

Appendix A: Glossary of terms

CCG	Clinical Commissioning Group
COAT	Clinical Operational Assurance Team
CoP	Code of Practice
CQC	Care Quality Commission
DHCFT	Derbyshire Healthcare NHS FT
DDCCG	Derby and Derbyshire CCG
DDSCP	Derby and Derbyshire Safeguarding Children Partnership
ECW	Enhanced Care Ward
ED	Emergency Department
ICT	Incident Control Team
MDT	Multi-Disciplinary Team
MHA	Mental Health Act
NHSCFT	Nottinghamshire Healthcare NHS Foundation Trust
NHSESC	NHS England Specialised Commissioning
NIAF	Niche Investigation and Assurance Framework
PICU	Psychiatric Intensive Care Unit
SOP	Standard Operating Procedure
SPA	Single Point of Access

Appendix B: Documents reviewed

DHCFT documents reviewed:	
‘Neighbourhoods Clinical Record Audit Tool, 12/11/2018.	Minutes of the Mental Health Act Committee Meeting, 6/03/2020.
Quality Performance Dashboard, September and November 2020.	Seclusion and Long Term Segregation – Psychiatric Emergency Policy and Procedure, 2019.
Quality and Safeguarding Committee minutes, 11/02/2020 and 8/9/2020.	
Safety Planning Meeting minutes, 8/1/2018 and 9/7/2018.	
‘Adults revised safety plan with no comments’.	
‘Capacity, Care and Safety Assessments- Dashboard’ 2020.	
‘SystmOne User Guide Risk Screen Assessment’.	
Safeguarding Children and Adults at Risk Annual Report 2019-2020.	
‘PICU Referral Pathway Flow Chart’.	
Business Continuity Policy, 2020.	
Emergency Incident Response Plan and Procedures, 2019.	
‘First On-Call Calendar Sample’	
‘Second On-Call Calendar Sample’	
Kedleston Unit Operational Policy and Procedure, 2018.	

Appendix B: Documents reviewed

DDCCG documents reviewed:
Executive Team Meeting minutes, 26/10/2020.
Out Of Area Placement Meeting, 19/10/2020.

NHSESC documents reviewed:
IMPACT ‘Referrals to Adult Secure Inpatient Service: Guidance for Referrers’ (undated).
Paper for the Midlands Mental Health, Learning Disability and Autism Group 29th August 2019 NHS England and IMPACT Pilot of Single Point of Access Admissions Process into Secure Care for the East Midlands
IMPACT ‘Standard Operating Procedure for the Management of Referrals, Assessments and Admissions to Secure Inpatient Services within the East Midlands’ (undated).

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