An independent quality assurance review following the independent investigation into the care and treatment of a mental health service users (F and Maureen) in County Durham

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

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1. INTRODUCTION

The incident

1.1 F and Maureen were patients on Picktree Ward, a mental health service for older people (MHSOP) ward in the Bowes Lyon Unit at Lanchester Road Hospital, County Durham, provided by Tees Esk and Wear Valleys NHS Foundation Trust (TEWV, henceforth 'the Trust').

1.2 F was an 87-year-old man, who was initially admitted to Ceddesfeld Ward, Auckland Park Hospital on 7 April 2015 under Section 2 of the Mental Health Act (1983) (MHA) and then transferred to Picktree Ward on 10 April. He was admitted because the care home where he had been staying were unable to cope with his sudden and unpredictable aggressive behaviour.

1.3 Maureen was a 69-year-old lady who was an inpatient on Picktree ward, admitted on 17 April under Section 2 MHA. She had been receiving respite care in a care home in Peterlee, and had become unwell, with increasingly challenging and threatening behaviour which became unmanageable in the home.

1.4 By the time of the incident, both patients had become more settled, though both were regraded to Section 3 MHA.

1.5 Arrangements were being made for Maureen's discharge home. On 19 May 2015 she went on a home assessment with the Occupational Therapist. This had gone well.

1.6 After her return, whilst in the seating area outside the ward office Maureen approached F, who was sitting in a chair. She demanded he move from 'her seat'. F refused to move, and Maureen swiped at his face with her cardigan. The member of staff with her intervened to calm Maureen, but as Maureen turned to move away F impulsively jumped from the chair and pushed Maureen from behind.

1.7 Maureen was taken to University Hospital North Durham (UHND) and it was confirmed that she had a fractured neck of femur. Following surgery for the fractured neck of femur Maureen remained in the hospital. Her physical health deteriorated, and she subsequently died on the 25 May 2015.

The independent investigation

1.8 NHS England North 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 F and Maureen. Niche is a consultancy company specialising in patient safety investigations and reviews.

1.9 The independent investigation follows the NHS England Serious Incident

Framework[1] (March 2015) and Department of Health guidance[2] on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services.

1.10 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents occurring.

1.11 Most independent investigations review the care provided to the perpetrator up to the point of the incident. In this case, as both the victim and perpetrator were patients of the same service, we have reviewed the care provided during that episode of care for them both. We have limited our investigation to the care provided from the admission of both F and Maureen to Picktree ward up to the time of the incident on 19 May 2015.

1.12 The overall aim is to identify common risks and opportunities to improve patient safety and make recommendations about organisational and system learning.

1.13 The investigation was carried out by Nick Moor, Partner of Niche. Nick Moor is a former mental health nurse with more than 20 years clinical experience, most of which was in care of older people with mental health problems. He has also been leading investigator or responsible for the delivery of more than 50 serious incident investigations in healthcare.

1.14 Expert advice was provided by Andrea Ward, General Manager of the Mental Health Service for Older People, Nottinghamshire Healthcare NHS Foundation Trust. Andrea has worked in elderly care for over thirty years as a clinical practitioner, practice educator and senior manager.

Findings and recommendations of the independent investigation

F's care and treatment

1.15 F had received a comprehensive suite of multi-disciplinary assessments. However, not all were signed or completed correctly. We found inconsistencies in the completion of some assessments, with some having not followed the guidelines correctly. For example, the falls risk assessment did not fully consider all aspects of his medical history which pertinent factors in his risk of falls were, such as multiple prescribed medications and a heart condition which could cause fainting attacks.

1.16 The assessment of his risk of aggression was based on a robust formulation and thorough consideration of the factors that may increase the risk of

[1] *NHS England Serious Incident Framework March 2015. https://improvement.nhs.uk/documents/920/serious-incidnt-framwrk.pdf*
[2] *Department of Health Guidance ECHR Article 2: investigations into mental health incidentshttps://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents*

aggression. He was known to be predictably unpredictable. However, not all the incidents involving F were reported correctly, which potentially downplayed the consideration of his actual risk of aggression.

1.17 When he was on enhanced observations these were not recorded properly according the policy.

1.18 Also, although there were care plans to help prevent aggressive incidents, there was no robust plan to guide the management of F once he was involved in an incident. For example, he was known to be able to retaliate very quickly.

Maureen's care and treatment

1.19 Like F, Maureen had received a very comprehensive and wide-ranging suite of assessments. However, we again found gaps in the completion of these, especially some of the more routine assessments such as fluid balance charts and food intake recording. On some occasions, where the assessment indicated a need for intervention, this did not always follow. For example, there were occasions where her Early Warning Score indicated a need to contact medical staff (according to policy), but this did not happen.

1.20 The information concerning Maureen's rapid weight loss either does not seem to have been understood or acted upon. There was no care plan to address this rapid weight loss, although staff were monitoring her food intake and actually helping her to gain weight. Further to this, other assessments did not seem to acknowledge the weight loss or consider the risks this posed to Maureen's health.

1.21 Because of this there was no link made from a low BMI to the impact it had on her Waterlow, MUST and FRAX assessments and the potential for increased risk of harm. Consequently, there was no mitigation or intervention plan in place for reducing the risk of fracture or increasing Maureen's weight arising from this.

1.22 The risk of fracture and osteoporosis assessment known as the FRAX® tool[3] was completed incorrectly. This assessment gave her a score of a 12% probability of major osteoporosis and 4.6% probability of a hip fracture over the next ten years. This had failed to include her low BMI as a risk factor. When we completed the assessment again, we arrived at a higher risk of fracture (14% in ten years) and a 26% probability of major osteoporosis.

1.23 Like F, Maureen had a plan of care for her aggression, but also like F, this did not include guidance on how to actually manage an aggressive episode.

Was the death of Maureen predictable or preventable?

1.24 In considering this we have asked two key questions:

[3] *The FRAX® tool has been developed to evaluate fracture risk of patients at the metabolic diseases' unit, University of Sheffield. It is based on individual patient models that integrate the risks associated with clinical risk factors as well as bone mineral density (BMD) at the femoral neck.*

i. Was it reasonable to have expected those caring for F and Maureen to have taken more proactive steps to manage the risks presented by them?
ii. Did they take reasonable steps to manage these known risks?

1.25 We consider that F was known to be 'predictably unpredictable'. When he was placed on Enhanced Visual Observations (EVO)[4] there was a notable reduction in incidents, possibly because there were staff on hand to defuse any incidents before they escalated. We believe that it was premature to take him off EVO. We noted that the incident on 19 May was provoked by Maureen and F retaliated. Even though a member of staff was on hand they were unable to prevent him from pushing Maureen which led to her fall.

1.26 Although we believe it was predictable that F would be involved in an altercation with someone, it was not predictable that this would be Maureen, or lead to her death.

1.27 We have also considered the following points with regard to preventability:

- F was known to be predictably unpredictable and aggressive, particularly when retaliating;
- Maureen was inadequately assessed for risk of fragility fracture, and mitigation was not put in place soon enough; and
- After her fall, Maureen then spent an inappropriate amount of time lying on the floor whilst waiting for an ambulance. It is known that for people with COPD, lying flat reduces lung function and increases the risk of acquiring a chest infection.

1.28 Actions taken which may have lessened the risk of harm arising include:

i. More appropriate intervention planning to deal with F's retaliation when provoked (based on previous behaviours) may have prevented the retaliatory pushing over of Maureen;
ii. Earlier consideration of the risk of Maureen's osteoporosis and treatment of this whilst in the community may have lessened the likelihood of fracture;
iii. More rigorous assessment on admission for Maureen, with robust physical health interventions, based on accurate history taking and assessment might have improved her physical care; and
iv. Consideration of her risk of fragility fracture based on accurate assessment of BMI, and possible use of hip protectors may also have prevented Maureen fracturing her neck of femur.

1.29 Because of these issues, we believe that the death of Maureen was caused by several contributory factors all coalescing at the same time, and that it was preventable.

[4] The Trust Engagement and Observations procedure states that 'Enhanced Observation – within eyesight means the patient should be kept within eyesight and accessible at all times during the periods specified for this level of observation and if deemed necessary, any tools or instruments that could be used to harm themselves or others should be removed.'

Recommendations

1.30 The independent investigation made nine recommendations for the Trust.

Recommendation 1.
The Trust should assure itself that the findings and observations of patients when admitted to MHSOP wards leads to accurate care planning and appropriate interventions.

Recommendation 2.
The Trust should review management of aggression guidance and the clinical link pathway for Behaviours that Challenge in Mental Health Services for Older People wards to ensure that explicit guidance in how to manage an incident is an outcome of the assessment process and is included in intervention plans.

Recommendation 3.
The Trust should ensure that MHSOP wards fully comply with the policy on recording observations.

Recommendation 4.
The Trust should ensure that all relevant policies and procedures are updated whenever new guidance from NICE is issued.

Recommendation 5:
The Trust should develop a programme of increased awareness of the need to accurately report incidents with the MHSOP wards and assure itself that incidents are being accurately reported.

Recommendation 6.
The Trust should assure itself that MHSOP wards are now following its own best practice guidance with regards to Behaviours that Challenge in dementia.

Recommendation 7.
The Trust should assure itself that assessments of risks in elderly patients are completed thoroughly and accurately, incorporating all aspects of relevant medical history, and which then lead to appropriate interventions to mitigate these risks.

Recommendation 8.
NHS Durham Dales Easington & Sedgefield Clinical Commissioning Group and the Trust should work together to ensure that they fully implement the NICE Clinical guideline [CG146], Osteoporosis: assessing the risk of fragility fracture correctly identifying all patients at risk of fragile fracture on respective caseloads.

Recommendation 9.
NHS Durham Dales, Sedgefield and Easington CCG, NHS North Durham CCG, Tees, Esk & Wear Valleys NHS Foundation Trust, County Durham and Darlington NHS Foundation Trust and North East Ambulance Service should regularly and collectively review all deaths of patients transferred from MHSOP wards to A&E with suspected fragility fractures to fully identify opportunities for system improvements to reduce premature deaths.

Structure of the report

1.31 Section 2 describes the process of the review, and Section 3 reviews in detail the actions planned in response to the independent investigation, and the progress the organisation has made in implementing the recommendations and embedding change.

1.32 Section 4 sets out our overall analysis and conclusions.

Summary of findings of this assurance review

1.33 The external quality assurance review comprised of meetings and interviews with senior managerial staff from the above organisations and a review of documents and policies provided by responsible people in the organisations, as evidence of completion.

1.34 We have graded our findings using the following criteria:

Grade	Criteria
A	Evidence of completeness, embeddedness and impact.
B	Evidence of completeness and embeddedness.
C	Evidence of completeness.
D	Partially complete.
E	Not enough evidence to say complete.

1.35 We wish to acknowledge the significant efforts the Trust has made in implementing the actions primarily focussed on managing behaviours that challenge and mental health related risk in older people.

1.36 However, the overall conclusion of the review is that one third of the recommendations (i.e. three out of nine) are complete, embedded and with evidence of impact (Niche Grade ‘A’). Three are complete (Niche Grade ‘C’) and three lack sufficient evidence to say if complete (Niche Grade ‘D’).

1.37 One of the key themes of the independent investigation was the need to assess both mental and physical health risks properly and develop care plans to mitigate these risks and meet the needs. Despite the significant achievements of implementing the Behaviours that Challenge Clinical Link Pathway (CLiP), the Trust now needs to focus efforts on physical health assessments and the need to link these to appropriate plans of care, in particular, those frail elderly people at risk of osteoporosis and hip fracture. This latter aspect must be taken forward with the CCG.

1.38 Grading of implementation of actions

Recommendation 1	Niche Grade
The Trust should assure itself that the findings and observations of patients when admitted to MHSOP wards leads to accurate care planning and appropriate interventions.	D

Recommendation 2	Niche Grade
The Trust should review management of aggression guidance and the clinical link pathway for Behaviours that Challenge in Mental Health Services for Older People wards to ensure that explicit guidance in how to manage an incident is an outcome of the assessment process and is included in intervention plans.	A

Recommendation 3	Niche Grade
The Trust should ensure that MHSOP wards fully comply with the policy on recording observations.	C

Recommendation 4	Niche Grade
The Trust should ensure that all relevant policies and procedures are updated whenever new guidance from NICE is issued.	A

Recommendation 5	Niche Grade
The Trust should develop a programme of increased awareness of the need to accurately report incidents with the MHSOP wards and assure itself that incidents are being accurately reported.	C

Recommendation 6	Niche Grade
The Trust should assure itself that MHSOP wards are now following its own best practice guidance with regards to Behaviours that Challenge in dementia	A

Recommendation 7	Niche Grade
The Trust should assure itself that assessments of risks in elderly patients are completed thoroughly and accurately, incorporating all aspects of relevant medical history, and which then lead to appropriate interventions to mitigate these risks.	**D**

Recommendation 8	Niche Grade
NHS Durham Dales Easington & Sedgefield Clinical Commissioning Group and the Trust should work together to ensure that they fully implement the NICE Clinical guideline [CG146], Osteoporosis: assessing the risk of fragility fracture, correctly identifying all patients at risk of fragile fracture on respective caseloads.	**D**

Recommendation 9	Niche Grade
NHS Durham Dales, Sedgefield and Easington CCG, NHS North Durham CCG, Tees, Esk & Wear Valleys NHS Foundation Trust, County Durham and Darlington NHS Foundation Trust and North East Ambulance Service should regularly and collectively review all deaths of patients transferred from MHSOP wards to A&E with suspected fragility fractures to fully identify opportunities for system improvements to reduce premature deaths.	**C**

2. ACTION PLAN PROGRESS

2.1 The independent investigation was published in September 2017.

2.2 It was agreed that an assurance review of the implementation of the action plan would be carried out within 12 months of publication. The relevant section of the terms of reference is:

"Within 12 months conduct an assessment on the implementation of the Trusts action plans in conjunction with the CCG and Trust and feedback the outcome of the assessment to NHS England North."

2.3 We have been provided with a range of evidence to demonstrate assurance of the implementation of actions from this independent investigation.

2.4 It is acknowledged that this homicide has had far reaching effects on MHSOP in the Trust. The intention was that the learning from this tragic event should become embedded in everyday practice and improve the care of older people with complex dementia and challenging behaviour.

2.5 In the following section we review the implementation of actions by the Trust.

Recommendation progress

Recommendation 1	Niche Grade
The Trust should assure itself that the findings and observations of patients when admitted to MHSOP wards leads to accurate care planning and appropriate interventions.	**D**

2.6 The expected outcome was:

- "There are clear processes and procedures in place on MHSOP wards which ensure that findings from patients' assessments are clearly linked to planned care".

2.7 The expected evidence of this implementation was:

- Audit of observations and findings linking to care plans on MHSOP wards.
- Reports to Divisional governance.
- Copy of any new policies developed.

2.8 We made our recommendation because we were concerned to note in our independent investigation that much of the care planned in the intervention plan was not linked to findings from assessments for F.

2.9 Similarly, we found many of the assessment tools used to indicate risks for Maureen were not completed properly. For example, Early Warning Scores of above 5 should have required an urgent call to medical staff, hourly observations

and application of oxygen therapy if hypoxia present. But this did not happen. She also had a history of recent weight loss leading to increased frailty and low BMI. This should have increased the score on her Waterlow assessments to show she was at significant risk of pressure damage, but the Waterlow assessment was scored incorrectly. Similarly, the incorrect application of the FRAX tool did not identify the heightened risk of hip fracture for Maureen.

2.10 The action plan published by the Trust details the following actions:

a) 5 wards are piloting a refreshed Frailty CLiP (including falls). Full roll out is planned by the end of December 2017.
b) The Behaviours that Challenge CLiP is being implemented on all MHSOP wards.
c) Improved Multi-Disciplinary Team (MDT) care planning in the electronic record is being developed with IT support.
d) Dietitian colleagues to deliver training in use of SANSI tool (to replace MUST) across all wards – when the tool is incorporated into PARIS.
e) Specialty specific harm minimisation training e-learning module will be available to ward to ward staff.

2.11 We have been provided with the notes of the *"17 38 1 Clinical Audit Subgroup briefing for MHSOP SDG and all QuAGs; February 2017".* This was a briefing paper which shared the output of an audit into the assessment and management of challenging behaviour in MHSOP wards, the observations of nursing input into direct care and non-direct care, and the clinical re-audit for the treatment of constipation. The aim of the audit of the assessment and management of challenging behaviour across the Trust was to provide baseline measures against the key elements of practice relevant to the MHSOP Behaviours that Challenge CLiP as it was not fully rolled out to all wards.

2.12 This audit showed the following results for these audit questions as:

Question	**Overall Percentage answering yes for each question**
Q1 Is there a clearly stated description of the person's behaviours that challenge?	84% (38/45)
Q2 Is there evidence of an assessment of the behaviours that challenge using relevant techniques/ measures?	71% (25/35)
Q3 Is there evidence that a formulation process has taken place to understand the behaviours that challenge?	69% (31/45)
Q4a Are there care plans or intervention plans that address the person's challenging behaviours?	82% (37/45)
Q4b If there are care plans/ intervention plans that address the challenging behaviours: Are these plans linked to the formulation of behaviours that challenge? (n=29)	89% (25/28)

Q5 Is there evidence of a review of the person's behaviours that challenge after interventions of care plans/ intervention plans had been tried? (n=37)	86% (31/36)
Q6 Is there evidence of a re-assessment of the behaviours that challenge using relevant outcome measures? (n=25)	91% (21/23)

2.13 We have also seen the "*Clinical Audit of the Assessment and Management of Challenging Behaviour in MHSOP Organic Wards*" dated February 2017. A total of 45 records across the Trust were assessed for the purposes of this audit. This audit provided the following results:

Qu		YES	NO	NA
Q1	In PARIS/paper records is there a clearly stated description of the person's behaviours that challenge?	84% (38/45)	16% (7/45)	(0)
Q2	Is there evidence in PARIS/paper records of an assessment of the behaviours that challenge using relevant techniques / measures?	71% (25/35)	29% (10/35)	(10)
Q3	Is there evidence in PARIS/paper records that a formulation process has taken place to understand the behaviours that challenge?	69% (31/45)	31% (14/45)	(0)
Q4a	Are there care plans or intervention plans in PARIS care documents/ paper records that address the person's challenging behaviours?	82% (37/45)	18% (8/45)	(0)
Q4b	If there are care plans / intervention plans that address the challenging behaviours: Are these plans linked to the formulation of behaviours that challenge? (n=29)	89% (25/28)	11% (3/28)	(1)
Q5	Is there evidence in PARIS/paper records of a review of the person's behaviours that challenge after interventions of care plans / intervention plans had been tried? (n=37)	86% (31/36)	14% (5/36)	(1)
Q6	Is there evidence in PARIS/paper records of a re-assessment of the behaviours that challenge using relevant outcome measures? (n=25)	91% (21/23)	9% (2/23)	(2)
Q1	In PARIS/paper records is there a clearly stated description of the person's behaviours that challenge?	84% (38/45)	16% (7/45)	(0)

2.14 Although this audit evidenced good compliance with individual criteria, the data showed inconsistent implementation of the Behaviours that Challenge CLiP. However, the Trust reported that 51% (18/35) of records audited had a clearly stated description of behaviour that challenges with evidence of assessment using relevant techniques/measures, a formulation to understand identified challenging behaviour and a care/intervention plan to address it. Amber compliance was therefore assigned (compliance between 50 and 79% of sample audited).

2.15 The action plan arising from this audit includes the following as evidence of acting upon the findings:

RECOMMENDATION/ FINDING	INTENDED OUTCOME/ RESULT	ACTION (Indicating high, medium or low risk rating. Please also indicate the applicable QuAG/Specialty/Locality for each action as appropriate)	ACTION OWNER	TARGET DATE FOR ACTION COMPLETION
Para 7.2-7.5 There is inconsistency in the management of behaviours that challenge across MHSOP wards. MHSOP Quality Assurance Groups (QuAGs) will be managing and monitoring further roll out of the Behaviours that Challenge CLiP during 2017/18.	All wards will be able to demonstrate that they comply with the standards in the Behaviours that Challenge CLiP	Medium: Re-audit to assess progress made in embedding the Behaviours that Challenge CLiP	Sharon Tufnell, Graeme Flaherty-Jones	28/02/2018

2.16 We have not seen the re-audit to assess progress made in embedding the Behaviours that Challenge CLiP.

2.17 These two audits were particularly applicable for the findings in relation to care planning for F, and also provide assurance for the implementation of Recommendation 2 and 6 which we discuss later.

2.18 The "*Clinical Re-Audit of Harm Minimisation Trust Wide"* dated February 2018 assessed the following criteria:

All service users will have the clinical risks presented by them assessed, formulated and reviewed as often as deemed necessary.
The Safety Summary will consider the following for each service user: harm to self, harm to others, harm from others and other harms and risks.
The Safety Summary will consider the level of concern for each of the following: harm to self, harm to others, harm from others and other harms and risks.
The service user, families/carers and any other professional groups will be included in the formulation and management of clinical risks whenever appropriate and possible.
All service users will have evidence of a recovery oriented final plan.

2.19 The standard of compliance expected was 100%. This audit sampled 337 records from across all services in the Trust, including 70 records from in-patient wards and community teams for MHSOP.

2.20 This audit showed that:

"56 records did not have a completed Safety Summary, it was out of date, or it was not signed off. These were excluded from the Safety Summary analysis onwards. The audit reports that the Project Lead and Clinical Audit and Effectiveness Team

contacted Team Managers to advise them of the risk and requirement that staff must ensure each service user has an up to date and signed off Safety Summary. The Clinical Audit and Effectiveness Team followed up all of these cases with the teams and confirmed that all service users now have an up to date and fully completed Safety Summary recorded.

It was noted during the audit that there was significant use of bullet points rather than the safety summary being narrative based and were professionally focussed rather than being co-produced with the service user and/or their family/carer(s). There was little evidence that staff were capturing within the safety summary the harms that services can cause (Iatrogenic Harms) as part of a service users' recovery. Training on this is being rolled out as part of Harm Minimisation and Safety Summary training therefore this does not require an action at this time. An amber compliance rating was assigned to this clinical audit report. Safety summary compliance appears consistently high however there were 56 cases where assessment against the audit standards was not performed due to the safety summary not being in date, signed off, or completed. These cases were mitigated by escalation to team managers and ensuring this was put in place as soon as possible.

Areas of practice improvement relate to safety summaries consistently showing involvement of service users, family and carers where appropriate, considering patient consent for sharing information and including crisis/contingency plans as required."

2.21 This audit is comprehensive, and safety focussed and provides significant assurance for implementation of this recommendation and recommendations 2 and 6. The data is disaggregated for MHSOP in the appendix and shows near 100% achievement across the MHSOP sample audited for the criteria used. We therefore have a good understanding of how MHSOP services are assessing risk and whether this leads to appropriate and detailed care planning.

2.22 We have also seen the "MHSOP Speciality Development Group (SDG)" minutes of the meeting held on 17 February 2017. This was attended by 17 staff from across the service, and records notes of a range of actions to improve services in the directorate, including implementation of the Behaviours that Challenge CLiP. The Dementia Care Pathway and relevant NICE Guidance. However, there is no mention of auditing care plans to provide assurance that findings from patients' assessments are clearly linked to planned care.

2.23 We have also been told that "weekly spot checks by ward manager/ clinical leads now includes a review of Safety Summary and Intervention Plans. This includes a check that the intervention plan is appropriate. Any problems are corrected immediately and then discussed with the individual team member at the soonest opportunity. The process was formalised on Roseberry ward but has since been rolled out to all 4 "D&D" (Durham & Darlington) wards. These are also discussed at ward morning report-outs, where changes to observation levels for individual patients may be discussed. Individual patient records contain an entry regarding the report-out discussion, which is where the evidence would be found."

2.24 However, we have not been provided with the evidence that weekly spot checks take place and that the findings are acted upon to improve documentation and care planning.

2.25 We recognise that the Trust has focussed a great deal of effort on implementing the Behaviours that Challenge CLiP and it is to be commended for this.

2.26 Nonetheless the recommendation was made to address all health assessments, not just behavioural assessments or those linked to clinical risk in mental health. We have seen no evidence that physical health assessments in MHSOP clinical records (such as FRAX, MUST, Waterlow etc) have been audited to demonstrate that these are completed appropriately and lead to improved and relevant care plans.

2.27 For this reason, we have graded the assessment of completion of this recommendation as D, incomplete.

2.28 The Trust should now audit MHSOP records to demonstrate that physical health assessments are completed appropriately and lead to relevant care plans.

Recommendation 2	Niche Grade
The Trust should review management of aggression guidance and the clinical link pathway for Behaviours that Challenge in Mental Health Services for Older People wards to ensure that explicit guidance in how to manage an incident is an outcome of the assessment process and is included in intervention plans.	**A**

2.29 The expected outcome was:

- There are clear processes and procedures in place on MHSOP wards which ensure that findings from patients' assessments (in relation to aggression) are clearly linked to planned care.

2.30 The expected evidence of this implementation was:

- Evidence of review (meeting minutes, revised policy).
- Evidence that new policy is disseminated (training, meeting minutes, email communications).
- Evidence that policy is implemented, including audit of care plans.

2.31 In our independent investigation we identified that there had been a comprehensive formulation where it was identified that there were risks of aggression to others from F if he felt threatened or disrespected, and that he may respond aggressively to someone he perceives as interfering with him. However, although there was a general intervention plan to prevent aggressive and violent outbursts, a more specific plan based on experience and the outcome of the formulation meeting would have helped staff deal with F's retaliatory aggression.

2.32 We have been told that there has been a 'Quality Improvement' event to implement and embed the Behavioural that Challenge CLiP into Community Mental Health Teams (CMHT's) and Care Home Liaison teams (CHLT's). We have seen the output of this event which shows how these teams are working to implement the CLiP.

2.33 We have been provided with the following policies and procedures as evidence:

- "Verbal aggression – procedure for addressing verbal aggression towards staff by patients, carers and relatives." Last amended: 10 October 2018.
- "Person-centred behaviour support." Last amended: 05 April 2017
- "Person Centred Clinical Link Pathway for Behaviours That Challenge in community mental health and care home liaison Mental Health Services for Older People" Not dated.

2.34 We understand that the Behaviours that Challenge CLiP has been revised and much of the evidence provided would indicate this. However, we have not seen a copy of this revised CLiP.

2.35 We have seen the 'Target Progress Report' for implementation of the CLiP in Care Home Liaison teams and CMHT's. This report is a project management tool which evidences a baseline and improvement of implementation by recording the percentage of patients with appropriate documentation for managing challenging behaviours.

2.36 As discussed earlier, the "*Clinical Audit of the Assessment and Management of Challenging Behaviour in MHSOP Organic Wards*" dated January 2017 showed there was inconsistency in the management of behaviours that challenge across MHSOP wards. MHSOP Quality Assurance Groups (QuAGs) were to be managing and monitoring further roll out of the Behaviours that Challenge CLiP during 2017/18.

2.37 We have reviewed the "*Clinical Re-Audit of Harm Minimisation Trust Wide"* dated February 2018 .This audit is comprehensive and safety focussed, and provides significant assurance for implementation of this recommendation and recommendations 2 and 6. The data is disaggregated for MHSOP in the appendix and shows near 100% achievement across the MHSOP sample audited for the criteria used. These audit results are appended.

2.38 There is a specific audit criterion which asks: "Is there evidence that the Intervention/Care Plan was informed by the current Safety Summary?" This is directly related to our recommendation. The audit showed 100% compliance with this criterion.

2.39 We therefore have a good understanding of how MHSOP services are assessing risk and whether this leads to care planning.

2.40 We have seen evidence of Quality Improvement meetings for CMHT's and CHLT's, service improvement meetings involving a range of staff to discuss the

roll out of the CLiP, policies and procedures to provide guidance for staff on managing behaviours that challenge, and lastly we have seen audit and re-audit to demonstrate compliance with policy with detailed findings that show that "*explicit guidance in how to manage an incident is an outcome of the assessment process and is included in intervention plans"*. Because the audit results have significantly improved when re-audited this demonstrates impact.

2.41 For these reasons we have graded implementation of this recommendation as A, evidence of completion, embeddedness and impact.

Recommendation 3	Niche Grade
The Trust should ensure that MHSOP wards fully comply with the policy on recording observations.	C

2.42 The expected outcome was:

- MHSOP can demonstrate adherence to the Supportive Engagement and Observations Procedure

2.43 The expected evidence of this implementation was:

- Audit of MHSOP wards compliance with observation recording policy demonstrating compliance
- Feedback reports to divisional governance

2.44 Our independent investigation found that many of the days observations when F was on EVO went unrecorded. The policy stated:

"The staff who are allocated to deliver enhanced observation will record in the contemporaneous clinical record their involvement, time of their involvement, any evaluation based on the time spent with the patient and whom they handed responsibility over to. Those staff will ensure any pertinent information is handed over verbally when ending a period of enhanced observation."

2.45 We were unable to find records in the PARIS notes of such observations for when F was on EVO, other than statements such as 'remains on EVO'. Because it is not recorded, we are unable to comment on the grade and skill of staff undertaking the observations.

2.46 The policy also states:

"Engagement and observation practice will be reviewed at a minimum once every shift handover. Patients on enhanced observations should have their level reviewed and recorded on an ongoing basis but as a minimum every 72-hours."

2.47 We were unable to find any record that the EVO was reviewed at shift handover for our independent investigation.

2.48 The Trust action plan states that the action to implement this included:

a) SBARD[5] highlighting the recording requirements from the procedure to be circulated through MHSOP.
b) SBARD to include instructions regarding the need to give a rationale for rare circumstances where the procedure cannot be followed.
c) QuAGs have considered the use of zonal observation as per the procedure.

2.49 The Trust action was for "Modern matrons to randomly spot-check records of patients requiring Supportive engagement and provide reports to SDG in December 2017 and June 2018".

2.50 We were told that verbal assurance was received from the Modern matron and that part of her routine work is to visit each ward weekly and randomly check patient records, including those relating to observations. Problems are dealt with real-time and discussed with the staff involved. We have not seen evidence that this is happening.

2.51 However, we have been provided with three different audits (20 December 2017, *n=3*, 5 January 2018, *n=3,* and 18 February 2018, *n=3*) which could be evidence of these checks. The audit provided the following results:

Audit question	1	2	3	4	5	6	7	8	9	Total
Is there evidence within the Electronic Care Record that continuous supportive engagements have been agreed?	Y	Y	Y	Y	Y	Y	Y	Y	Y	9/9
Is there a documented intervention plan that relates to this decision?	Y	Y	Y	Y	Y	Y	Y	Y	Y	9/9
Is there evidence that the MDT were involved in this decision making?	Y	Y	Y	Y	Y	Y	Y	Y	Y	9/9
Do report out entries contain evidence of discussion surrounding clinical incidents that have taken place within the past 24 hours?	Y	Y	Y	NA	NA	NA	Y	Y	Y	6/6

2.52 We have seen evidence the Trust can demonstrate adherence to the Supportive Engagement and Observations Procedure, although the sample size presented was small. For these reasons we have graded implementation of this recommendation as C, evidence of completion.

2.53 To grade this as B (complete and embedded) or A (complete, embedded with evidence of impact) the Trust needs to provide a larger audit sample to show

[5] *Situation, Background, Assessment, Recommendation & Decision – a simple way of communicating the nature of a problem and its solution*

compliance, and re-audit this provide assurance on impact of change.

Recommendation 4	Niche Grade
The Trust should ensure that all relevant policies and procedures are updated whenever new guidance from NICE is issued.	**A**

2.54 The expected outcome was:

- All polices are updated according to Policy guidelines

2.55 The expected evidence of this implementation was:

- Trust NICE guidance implementation review process.
- Evidence that it works (suggested sample of last five NICE updates and relevant policies updated).

2.56 The Trust action plan records that "As part of the policy and procedure review process the Policy Lead is responsible for undertaking review of the evidence base which includes NICE Guidance where relevant. This process is documented within the Governance of Policies and Procedures Policy document CORP0001-v5: The Executive Management Team has delegated authority from the Trust Board to ratify all Trust policies and procedures."

2.57 We have not been able to access the "Governance of Policies and Procedures Policy" or provided with a copy of this. We do believe though that the Governance of policies and procedures policy mentioned above would only describe the Trusts intention that the Policy Lead was responsible for undertaking the review of the evidence base, including NICE guidance. It would not constitute evidence in itself that this actually happened in practice.

2.58 However, we were able to assess the evidence listed below from the Trust which provided assurance that policies and procedures have been updated in the light of new NICE guidance:

- **NICE Baseline Assessment Process** final from July 2018, (with January 2019 update) which provides clear guidance on how the Trust Clinical Audit and Effectiveness Team review all guidance published on the NICE website monthly and refers new/ updated guidelines to the Clinical Effectiveness Groups for a decision on implementation.
- **July 2018 SDG briefing for all QuAGs.** This includes an action plan for implementing NG54 "Mental Health needs in people with Learning Disability & QS142 Learning Disability; Identifying and Managing Mental Health Problems Action Plan".
- **Dementia Care Pathway: Guidance for prescribing acetylcholinesterase inhibitors and memantine**. PHARM-0046-v11 – Approved by Drug & Therapeutics Committee Sept 2018. This references "*NICE TA 217 Donepezil, galantamine, rivastigimine and memantine for*

the treatment of Alzheimer's disease. March 2011 (Updated May 2016)".

- Person Centred Clinical Link Pathway for in patient wards; Behaviours that Challenge in Mental Health Services for Older People This references NICE CG42 "*Dementia: supporting people with dementia and their carers in health and social care"* (2006). However, this guidance has now been superseded by *"Dementia: assessment, management and support for people living with dementia and their carers.*" NICE guideline [NG97] Published date: June 2018.
- **The Pharmacy Newsletter Issue 13 Dec 2018** also clearly references NICE guidelines, in particular the updated *"Dementia: assessment, management and support for people living with dementia and their carers.*" NICE guideline [NG97]

2.59 We have seen evidence that the Trust has a clear procedure for monitoring and implementing new NICE guidelines, and that these are translated into practice. For these reasons we have graded implementation of this recommendation as A, evidence of completion, embeddedness and impact.

Recommendation 5	Niche Grade
The Trust should develop a programme of increased awareness of the need to accurately report incidents with the MHSOP wards and assure itself that incidents are being accurately reported.	**C**

2.60 The Trust expected outcome was:

- MHSOP can demonstrate that clear communication regarding incident reporting has been shared with ward staff

2.61 The expected evidence of this implementation was:

- Evidence that MHSOP report incidents appropriately
- Would seek to understand benchmarking, and increase on DATIX against this, and also briefing sessions, meeting minutes etc and training

2.62 The Trust action plan records that:

a) SBARD to be written and circulated within MHSOP.
b) review of recorded incidents, trends including low reporting is a function of QuAGs.
c) ward report- outs include discussion of incidents that have occurred and confirm reporting has taken place.

2.63 We have seen the SBARD concerning '*Incident Reporting for MHSOP wards*' within the '*October 2017 Speciality Development Group (SDG) briefing for all QuAGs*'. This details clearly the independent investigation, its findings and a Trust plan to raise awareness of the need for enhanced incident reporting.

2.64 We were told that in Durham & Darlington, processes are as follows:

- A routine part of each ward report-out is to discuss any incidents occurring in past 24 hours and consider any changes to care plan indicated. Evidence that this happens is contained within patients' electronic record (We have seen a sample of these).
- Incidents are all discussed with the Directorate management team at the 1.pm DLM call. Checks that appropriate actions have been taken are given verbally by ward staff on this call and then followed up by modern matron/ locality manager as necessary (these calls are not recorded as they are a routine part of everyday business for us).
- A monthly - chair of QuAG reviews the IIC incident report to look for trends/ incidents of concern and drills into individual records if necessary, then reports to QuAG where any further actions are agreed.

2.65 We have seen evidence that this happens. We have seen minuted notes that Serious Incidents are reviewed in the monthly Specialty Development Group. We have seen evidence of a review of recorded incidents, trends including low reporting in the SDG.

2.66 We have seen evidence of ward report-outs including discussion of incidents that have occurred and confirm reporting has taken place.

2.67 The Trust has provided evidence of cascade of the SBARD and can demonstrate that this has reached staff within MHSOP. This is supported by a rigorous review of serious incidents in the SDG and includes an aggregated report to enable the service to understand better patterns of incidents and harms. This occurs suitable intervals when and is accompanied by analysis of trends.

2.68 We have seen some evidence that the Trust has made some attempts to increase awareness of the need to accurately report incidents with the MHSOP wards and assure itself that incidents are being accurately reported. For this reason, we have graded this as C, incomplete.

Recommendation 6	Niche Grade
The Trust should assure itself that MHSOP wards are now following its own best practice guidance with regards to Behaviours that Challenge in dementia	**A**

2.69 The expected outcome was:

- The Trust can provide evidence that the CLiP is implemented on all MHSOP wards.

2.70 The expected evidence of this implementation was:

- Audit of Behaviours that Challenge to assure this is in place. Training to embed practice

2.71 We have seen the Trust has a new approach called 'Positive Approach to Care'™ or PAC, developed by nationally recognised dementia educator and trainer Teep Snow. Trust information tells us that "*PAC is a concept to support people living with dementia by equipping both formal and informal carers with specific skills aimed at increasing understanding of what it is like to live with dementia. The approach is focused on care delivery, rather than theories. The evidence base for PAC™ is rooted in knowledge of neurology and brain change in people with dementia and how knowing about this means we adapt our approach and the environment to best support the individual".*

With regard to the Behaviours that Challenge CLiP "PAC™ can contribute detailed interventions to the primary preventative and secondary proactive strategies in Behaviour Support Plans either at single profession unmet needs assessment and intervention stage or following a psychological formulation. The level of detail and simple practical tips that PAC™ provides is essential to explain to and guide family carers and care homes to know exactly what to do/ say to support the person living with dementia. Knowledge of the GEMS™ allows them to also develop flexibility and begin to understand how to understand the person's level of functioning 'in the moment' and adapt their response accordingly".

2.72 We have seen evidence that the Trust has trained more than 100 staff between July 2018 and January 2019 in PAC.

2.73 We have discussed this extensively within the commentary concerning implementation of actions for Recommendation 2. We have seen evidence of Quality Improvement meetings for CMHT's and CHLT's, service improvement meetings involving a range of staff to discuss the roll out of the CLiP, policies and procedures to provide guidance for staff on managing behaviours that challenge, and lastly we have seen audit and re-audit to demonstrate compliance with policy with detailed findings that show that *"explicit guidance in how to manage an incident is an outcome of the assessment process and is included in intervention plans"*. Because the audit results have significantly improved when re-audited this demonstrates impact.

2.74 For these reasons we have graded implementation of this recommendation as A, evidence of completion, embeddedness and impact.

Recommendation 7	Niche Grade
The Trust should assure itself that assessments of risks in elderly patients are completed thoroughly and accurately, incorporating all aspects of relevant medical history, and which then lead to appropriate interventions to mitigate these risks.	**D**

2.75 The expected outcome was:

- MHSOP can demonstrate clear risk assessments which are linked to care

plans.

2.76 The expected evidence of this implementation was:

- Example of revised policy to ensure new referrals made clearly identify level of urgency.
- Training in risk for elderly people.
- If relevant revised policy.

2.77 We have seen evidence that the Trust has developed a new Clinical Speciality Guidance crib sheet called 'Safety Summary Compilation'. This guidance is aimed at helping staff identify the types of risk to be considered under a narrative risk assessment, that this should be person centred, identifies what the risk of this occurring is and what needs to be done to manage the risk of harm. We are not aware of when this was ratified and implemented but it appears comprehensive with a clear link to a risk-based formulation process.

2.78 We were told that there was verbal assurance from the modern matron that the role includes weekly visits to each ward and random spot check of patient records, including the safety summary. Problems identified are dealt with in real-time and staff involved are advised accordingly. Reports would be provided to QuAG by exception. We have not been provided with the evidence of these spot checks or reports provided to QuAG.

2.79 We have been provided with an email from the Clinical Audit and Effectiveness Team that outlines a Corporate Audit and scheduled for February 2019, to audit the Safety Summary. The data collection period will run for 5 weeks, with completion by the 8th March 2019.

2.80 As discussed at 2.18, the "*Clinical Re-Audit of Harm Minimisation Trust Wide"* dated February 2018 is a comprehensive and safety focussed audit and provides significant assurance for implementation of this recommendation. The data is disaggregated for MHSOP in the appendix and shows near 100% achievement across the MHSOP sample audited for the criteria used. This builds on the earlier audit also discussed in the review and demonstrates improvement in practice.

2.81 We have earlier commended the Trust for this action. However, as mentioned at 2.9, our concerns were not limited to mental health assessments of risk. In our independent investigation we found many of the assessment tools used to indicate risks for Maureen were not completed properly. For example, Early Warning Scores of above 5 should have required an urgent call to medical staff, hourly observations and application of oxygen therapy if hypoxia present. But this did not happen. She also had a history of recent weight loss leading to increased frailty and low BMI. This should have increased the score on her Waterlow assessments to show she was at significant risk of pressure damage, but the Waterlow assessment was scored incorrectly. Similarly, the incorrect application of the FRAX tool did not identify the heightened risk of hip fracture for Maureen.

2.82 We have not seen any evidence that the Trust can assure itself that this aspect of ensuring that assessments of risks in elderly patients are completed thoroughly

and accurately leading to appropriate interventions to mitigate these risks.

2.83 For these reasons we have graded implementation of this recommendation as D, partial completion.

2.84 As discussed at 2.28, the Trust should now audit MHSOP records to demonstrate that physical health assessments are completed appropriately and lead to relevant care plans.

Recommendation 8	Niche Grade
NHS Durham Dales Easington & Sedgefield Clinical Commissioning Group and the Trust should work together to ensure that they fully implement the NICE Clinical guideline [CG146], Osteoporosis: assessing the risk of fragility fracture, correctly identifying all patients at risk of fragile fracture on respective caseloads.	**D**

2.85 The expected outcome was:

- Assurance from the Trust and the CCG that the NICE Clinical guideline [CG146], Osteoporosis: assessing the risk of fragility fracture is fully implemented, correctly identifying all patients at risk of fragile fracture on respective caseloads.

2.86 The expected evidence of this implementation was:

- Evidence of joint working to implement the policy (meeting minutes, policy dissemination, training and guidance where appropriate).
- Evidence, through audit for example, to demonstrate full implementation.

2.87 We have been provided with evidence from the Trust that they have developed a 'Frailty CLiP', which is supported by an assessment question on the electronic record, PARIS.

2.88 The Frailty CLiP is a comprehensive guidance document that "provides assessment and treatment standards for managing frailty syndromes within MHSOP In- patient wards. It includes a post falls proforma. In addition, the frailty clip includes a falls algorithm for use by community services.

2.89 This document was approved at MHSOP SDG on 21 December 2018. It describes 'frailty syndromes' as defined by the British Geriatric Society (2014) as:

- Falls (e.g. collapse, legs gave way, 'found lying on floor').
- Immobility (e.g. sudden change in mobility, 'gone off legs' 'stuck in toilet').
- Delirium (e.g. acute confusion, 'muddledness', sudden worsening of confusion in someone with previous dementia or known memory loss).
- Incontinence (e.g. change in continence – new onset or worsening of urine or faecal incontinence).

- Susceptibility to side effects of medication (e.g. confusion with codeine, hypotension with antidepressants).

2.90 The CLiP references 14 NICE Guidelines, including multi-morbidity, falls, delirium. Lower urinary tract symptoms and incontinence in men and women, faecal incontinence and head injury. The CLiP provides much useful information on frailty, and in particular falls.

2.91 However, there is no mention at all of NICE Clinical guideline [CG146], Osteoporosis: assessing the risk of fragility fracture, (last updated February 2017).

2.92 The assessment question on PARIS is a 'yes/no' question asking if there is any suggestion the patient may have osteoporosis. Since the FRAX assessment was much more comprehensive, and yet still failed to identify Maureen's risk of hip fracture, it is difficult to see how this simple tick box question would do so.

2.93 The NICE Guideline[6] states for:

"Methods of risk assessment
1.3 Estimate absolute risk when assessing risk of fracture (for example, the predicted risk of major osteoporotic or hip fracture over 10 years, expressed as a percentage).
1.4 Use either FRAX[8] (without a bone mineral density [BMD] value if a dual-energy X-ray absorptiometry [DXA] scan has not previously been undertaken) or QFracture[9], within their allowed age ranges, to estimate 10-year predicted absolute fracture risk when assessing risk of fracture. Above the upper age limits defined by the tools, consider people to be at high risk.
1.5 Interpret the estimated absolute risk of fracture in people aged over 80 years with caution, because predicted 10-year fracture risk may underestimate their short-term fracture risk.
1.6 Do not routinely measure BMD to assess fracture risk without prior assessment using FRAX (without a BMD value) or QFracture.
1.7 Following risk assessment with FRAX (without a BMD value) or QFracture, consider measuring BMD with DXA in people whose fracture risk is in the region of an intervention threshold[10] for a proposed treatment, and recalculate absolute risk using FRAX with the BMD value.
1.8 Consider measuring BMD with DXA before starting treatments that may have a rapid adverse effect on bone density (for example, sex hormone deprivation for treatment for breast or prostate cancer).
1.9 Measure BMD to assess fracture risk in people aged under 40 years who have a major risk factor, such as history of multiple fragility fracture, major osteoporotic fracture, or current or recent use of high-dose oral or high-dose systemic glucocorticoids (more than 7.5 mg prednisolone or equivalent per day for 3 months or longer).
1.10 Consider recalculating fracture risk in the future:
- *if the original calculated risk was in the region of the intervention threshold for a proposed treatment and only after a minimum of 2 years,* ***or***

[6] https://www.nice.org.uk/guidance/CG146/chapter/1-Guidance#methods-of-risk-assessment

- *when there has been a change in the person's risk factors.*

1.11 Take into account that risk assessment tools may underestimate fracture risk in certain circumstances, for example if a person:

- *has a history of multiple fractures*
- *has had previous vertebral fracture(s)*
- *has a high alcohol intake*
- *is taking high-dose oral or high-dose systemic glucocorticoids (more than 7.5 mg prednisolone or equivalent per day for 3 months or longer)*
- *has other causes of secondary osteoporosis*

1.12 Take into account that fracture risk can be affected by factors that may not be included in the risk tool, for example living in a care home or taking drugs that may impair bone metabolism (such as anti-convulsants, selective serotonin reuptake inhibitors, thiazolidinediones, proton pump inhibitors and anti-retroviral drugs).

2.94 Our independent investigation identified that the assessment of risk of hip fracture for Maureen could have been picked up within primary care. It was not. We have seen no evidence that the CCG has been involved in the development of the 'Frailty CLiP'.

2.95 Whilst the 'Frailty CLiP' has much to commend it and appears highly useful for the assessment of frailty across the areas mentioned at 2.88, it does not address the key point of the recommendation, to assess the risk of hip fracture due to osteoporosis. Both the CCG and the Trust now need to work together to ensure that the NICE Clinical guideline [CG146], Osteoporosis: assessing the risk of fragility fracture implement is now fully implemented.

2.96 For these reasons we have graded implementation of this recommendation as D, partial completion.

Recommendation 9	Niche Grade
NHS Durham Dales, Sedgefield and Easington CCG, NHS North Durham CCG, Tees, Esk & Wear Valleys NHS Foundation Trust, County Durham and Darlington NHS Foundation Trust and North East Ambulance Service should regularly and collectively review all deaths of patients transferred from MHSOP wards to A&E with suspected fragility fractures to fully identify opportunities for system improvements to reduce premature deaths.	**C**

2.97 The expected outcome was:

- A regular, joint review of all deaths of patients transferred from MHSOP wards to A&E with suspected fragility fractures to fully identify opportunities for system improvements to reduce premature deaths.

2.98 The expected evidence of this implementation was:

- Evidence of multi-agency meeting (attendees, dates, outputs such as minutes, revised guidance) and review to consider improvements to reduce deaths.
- Evidence of actions taken, and where possible reduction in deaths.
- Evidence of audit for assessment to ensure implementation.

2.99 We have been provided with “Notes from Mental health Homicide Action Meeting held 16th July 2018” attended by NHS Durham Dales, Sedgefield and Easington CCG, NHS North Durham CCG, Tees, Esk & Wear Valleys NHS Foundation Trust, County Durham and Darlington NHS Foundation Trust and North East Ambulance Service.

2.100 It was agreed at this meeting that:

- TEWV would report any falls that result in a suspected fracture to CDDFT patient safety team.
- CDDFT will check if a fracture was confirmed and whether the patient died within their acute hospital stay.
- CDDFT will notify the CCG of the patient. If the patient was alive at the point, they were discharged from CDDFT MH will check with the GP system if they were still alive at 31 days.
- If the patient died within 31 days of the fall, the CCG will initiate a review of the case with all parties including NEAS.
- As a catch all, TEWV will report all falls to the quality review group meeting as a routine report.

2.101 We have been told that since our independent investigation, the process with some patient names has been tested, but there hasn’t been a death following fragility fracture since the incident was investigated.

2.102 For these reasons we can grade this action as ‘C’, complete, but cannot grade it as embedded or with impact.

3. OVERALL ANALYSIS OF ACTION PLAN

3.1 We wish to acknowledge the significant efforts the Trust has made in implementing the actions primarily focussed on managing behaviours that challenge and mental health related risk in older people.

3.2 However, the overall conclusion of the review is that one third of the recommendations (i.e. three out of nine) are complete, embedded and with evidence of impact (Niche Grade 'A'). Three are complete (Niche Grade 'C') and three lack sufficient evidence to say if complete (Niche Grade 'D').

3.3 One of the key themes of the independent investigation was the need to assess both mental and physical health risks properly and develop care plans to mitigate these risks and meet the needs. Despite the significant achievements of implementing the Behaviours that Challenge CLiP, the Trust now needs to focus efforts on physical health assessments and the need to link these to appropriate plans of care, in particular, those frail elderly people at risk of osteoporosis and hip fracture. This latter aspect must be taken forward with the CCG.

Appendix A – Terms of reference

Terms of Reference for Independent Investigations in accordance with NHS England's Serious Incident Framework 2015 Appendix 1.

The individual Terms of Reference for independent investigation 2015/30666 are set by NHS England North. These terms of reference will be developed further in collaboration with the offeror, and family members.

However, the following terms of reference will apply in the first instance:

Core Terms of Reference

- Review the Trust's internal investigation of the incident to include timeliness and methodology to identify:
    - If the internal investigation satisfied the terms of reference.
    - If all key issues and lessons were identified.
    - If recommendations are appropriate and comprehensive.
    - The implementation of the internal action plan through evidence.
    - If the affected families were appropriately engaged with.
- Following a desk top review of the internal report, identify gaps and additional key lines of enquiry required
- Assist the Trust to expand the internal report to consider the perpetrator as a patient where required, in doing so;
- Review the appropriateness of the treatment of the service user (victim) in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern including any areas of future risk.
- Review the adequacy of risk assessments and subsequent risk management, specifically the communication of risk information (including safeguarding) and plans for mitigation.
- Review and assess the Trusts compliance with local policies, national guidance and relevant statutory obligations.
- Establish contact with both the families of those affected as fully as is considered appropriate, in liaison with the Provider.
- Determine through reasoned argument the extent to which this incident was either predictable or preventable, providing a detailed rationale for the judgement.
- Provide a written investigative report to NHS England North that includes measurable and sustainable recommendations.
- Based on overall investigative findings, constructively review any gaps in service provision to both perpetrator and victim, identify opportunities for improvement.
- Assist NHS England in undertaking a brief post investigation evaluation.

Supplemental to Core Terms of Reference

- Conduct an evidence based review of internal report recommendations to confirm they have been fully implemented.
- Support the Trust to develop an outcome based action plan based on investigation findings and recommendations.

- Support the commissioners (North Durham CCG) to develop a structured plan to review implementation of the action plan. This should include a proposal for identifying measurable change and be comprehensible to service users, carers, victims and others with a legitimate interest.
- Within 12 months conduct an assessment on the implementation of the Trusts action plans in conjunction with the CCG and Trust and feedback the outcome of the assessment to NHS England North.

Appendix B – Clinical Re-Audit of Harm Minimisation Trust Wide, MHSOP results. Feb 2018

#	Question	MHSOP Hamsterley Ward	MHSOP Rowan Ward, Harrogate	MHSOP Springwood Malton	MHSOP Westerdale South	MHSOP Acomb Garth
SECTION 1 – CONSENT						
1	Is there evidence that staff have considered the service user's view to consent to:					
a	Share information with family/carers?	50% (2/4)	100% (3/3)	0% (0/1)	50% (1/2)	0% (0/3)
b	Make contact with family/carers?	50% (2/4)	100% (3/3)	0% (0/1)	50% (1/2)	0% (0/3)
SECTION 2 – SAFETY SUMMARY						
2	Does the Safety Summary consider the following:					
a	Harm from self to self?	100% (5/5)	100% (5/5)	100% (5/5)	100% (5/5)	100% (5/5)
b	Harm from self to self: level of concern?	100% (5/5)	100% (5/5)	100% (5/5)	100% (5/5)	100% (5/5)
c	Triggers?	100% (5/5)	100% (5/5)	100% (5/5)	100% (5/5)	80% (4/5)
d	Harm from others (including possible harms from services)?	100% (5/5)	100% (5/5)	100% (5/5)	100% (5/5)	100% (5/5)
e	Harm from others: level of concern?	100% (5/5)	100% (5/5)	100% (5/5)	100% (5/5)	100% (5/5)
f	Triggers?	100% (5/5)	100% (5/5)	100% (5/5)	100% (5/5)	100% (5/5)
g	Harm to others?	100% (5/5)	100% (5/5)	100% (5/5)	100% (5/5)	100% (5/5)
h	Harm to others: level of concern?	100% (5/5)	100% (5/5)	100% (5/5)	100% (5/5)	100% (5/5)
i	Triggers?	100% (5/5)	100% (5/5)	100% (5/5)	100% (5/5)	100% (5/5)
j	Other harms and risks (including possible harms from services)?	100% (5/5)	100% (5/5)	100% (5/5)	100% (5/5)	100% (5/5)
k	Other harms and risks: level of concern?	100% (5/5)	100% (5/5)	100% (5/5)	100% (5/5)	100% (5/5)
l	Triggers?	80% (4/5)	80% (4/5)	80% (4/5)	80% (4/5)	100% (5/5)
3	Is there evidence that current safety concerns were considered?	100% (5/5)	100% (5/5)	100% (5/5)	100% (5/5)	100% (5/5)
4	Is there evidence predisposing factors were considered?	100% (5/5)	100% (5/5)	100% (5/5)	100% (5/5)	100% (5/5)
5	Is there evidence that triggers were considered?	100% (5/5)	100% (5/5)	100% (5/5)	100% (5/5)	100% (5/5)
6	Is there evidence that protective factors were considered?	100% (5/5)	100% (5/5)	60% (3/5)	80% (4/5)	100% (5/5)
7	Were options considered to reduce harm?	80% (4/5)	100% (5/5)	80% (4/5)	100% (5/5)	100% (5/5)
8	Is there a final plan?	100% (5/5)	80% (4/5)	100% (5/5)	100% (5/5)	100% (5/5)
9	Does the final plan involve:					
a	The service user?	25% (1/4)	0% (0/2)	100% (1/1)	50% (1/2)	67% (2/3)
b	Where appropriate, service user's family?	40% (2/5)	0% (0/4)	60% (3/5)	33% (1/3)	50% (1/2)
c	Where appropriate, service user's carer?	40% (2/5)	0% (0/4)	75% (3/4)	67% (2/3)	-
d	Where appropriate, other professionals/agencies?	80% (4/5)	50% (2/4)	60% (3/5)	67% (2/3)	100% (4/4)
e	The ward/team?	100% (5/5)	100% (4/4)	80% (4/5)	100% (5/5)	100% (5/5)

#	Question	MHSOP Hamsterley Ward	MHSOP Rowan Ward, Harrogate	MHSOP Springwood Malton	MHSOP Westerdale South	MHSOP Acomb Garth
10	Does the final plan include a crisis and contingency plan?	0% (0/5)	0% (0/4)	20% (1/5)	0% (0/5)	80% (4/5)
11	Does Stage 1 of the Safety Summary consider historical risks?	20% (1/5)	60% (3/5)	100% (5/5)	100% (5/5)	100% (5/5)
12	Is there evidence that the Safety Summary was completed collaboratively with the service user and/or their family/carers?	0% (0/5)	80% (4/5)	60% (3/5)	100% (3/3)	80% (4/5)
SECTION 3 – OTHER HARM MINIMISATION ASSESSMENTS						
13	Has the “Incidents/Events” section been completed appropriately, including protective factors and risk events?	60% (3/5)	20% (1/5)	100% (5/5)	80% (4/5)	100% (5/5)
14	Is there evidence that the Intervention/Care Plan was informed by the current Safety Summary?	100% (5/5)	100% (5/5)	100% (5/5)	100% (5/5)	100% (5/5)
15	Is there evidence that there is ongoing assessment of risks within activity and/or case notes?	100% (5/5)	100% (5/5)	100% (5/5)	100% (5/5)	100% (5/5)