Independent Quality Assurance Review of Mr A and Mr O Independent Investigation

Action plan implementation

Rotherham, Doncaster and South Humber NHS Foundation Trust
NHS North Lincolnshire Clinical Commissioning Group
NHS England and NHS Improvement (North East and Yorkshire & North West)

Ref: 2017-1375

Private and confidential

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Niche Investigation Assurance Framework

insight integrity impact

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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.

Our Final Report has been written in line with the terms of reference for our Independent Investigation into the Care and Treatment of two Mental Health Service Users (Mr A and Mr O). 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Events which may occur outside of the timescale of this review will render our report out-of-date.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 is a confidential Report and has been written for NHS England and NHS Improvement 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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1. Executive Summary

Background and context for this review

On the morning of 16 January 2017 Mr A, who was an inpatient in a mental health acute inpatient provided by Rotherham Doncaster and South Humber NHS Foundation Trust ("the Trust" hereafter), entered the bedroom of another patient Mr O and attacked him. Mr O sadly died later that day.

Following this incident the Trust undertook an internal investigation using a Legal Director from Capsticks LLP, the specialist health care lawyers, as the lead reviewer. After this, NHS England (North) commissioned Niche Health and Social Care Consulting (Niche) to carry out an independent investigation into the care and treatment of both mental health service users (Mr A and Mr O).

Our investigation found that the recommendations made in the internal report did not adequately address the practice issues identified. We therefore made eight recommendations intended to support the Trust, their commissioners and NHS England in learning and improving services and practices.

The terms of reference for the independent investigation required Niche to undertake an assurance follow up review (this report) after completion of the independent investigation. This was in order to provide an assessment of the implementation of the organisations' resultant action plans against the Niche Investigation and Assurance Framework (NIAF), with issue of a brief written report on progress to NHS England (North). This is a high level assurance review and does not include further site visits or interviews.

Review method and quality control

Our work has comprised a desktop review of documents including policies, procedures, action-plans, minutes and communications. It is important to note that we have not reviewed any health care records because there is no element of re-investigation contained within the review terms of reference. We used information provided by the Trust, NHS North Lincolnshire Clinical Commissioning Group (CCG) and NHS England. This information has not been audited or otherwise verified for accuracy.

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.

The Niche Investigation Assurance Framework (NIAF)

Assessing the success of learning and improvement can be a very nuanced process. Importantly, the assessment is meant to be useful and evaluative, rather than punitive and judgemental. We adopt a numerical grading system to support the representation of 'progress data'.

We deliberately avoid using traditional RAG ratings, instead preferring to help our clients to focus upon the steps they need to take to move between the stages of completed, embedded, impactful and sustained – with an improvement which has been 'sustained' as the best available outcome and response to the original recommendation.

1. Executive Summary (cntd)

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.

We are asked to complete assurance reviews within six to 12 months of publication of the investigation. Therefore, for most, if not all, recommendations, evidence of completion of actions within this timescale would be the intended outcome. For organisations to be able to provide evidence of embedded improvement within this period is an excellent achievement.

We made five recommendations related to the incident and subsequent management of the incident, and three recommendations that related to incidental findings.

Recommendations related to the incident and its management

Recommendation 1:

NHS England must clarify the responsibilities of a Trust in relation to Duty of Candour and Being Open when the incident relates to a criminal offence.

Recommendation 2:

The Trust and their commissioners must ensure that serious incident investigation reports make clear the links between the issues identified and the recommendations being made.

Recommendation 3:

The Trust must assure itself and its commissioners that front line staff receive appropriate support from managers both in hours and out of hours, when dealing with serious incidents.

Recommendation 6:

The Trust must ensure that observations form part of a patient's electronic record.

Recommendation 7:

The Clinical Commissioning Group must ensure that the revised serious incident management policy provides clarity about the assurance and monitoring processes and how these are to be evidenced.

Recommendations related to incidental findings

Recommendation 4:

The Trust must ensure that clinical staff have the skills and knowledge to be able to provide appropriate physical healthcare (in particular acute alcohol withdrawal), or be able to access appropriate physical healthcare from other organisations (in particular community dental services) in a timely fashion.

Recommendation 5a:

The Trust must ensure that staff are fully aware of and execute their responsibilities for safeguarding when there are concerns about the vulnerability of patients.

Recommendation 5b:

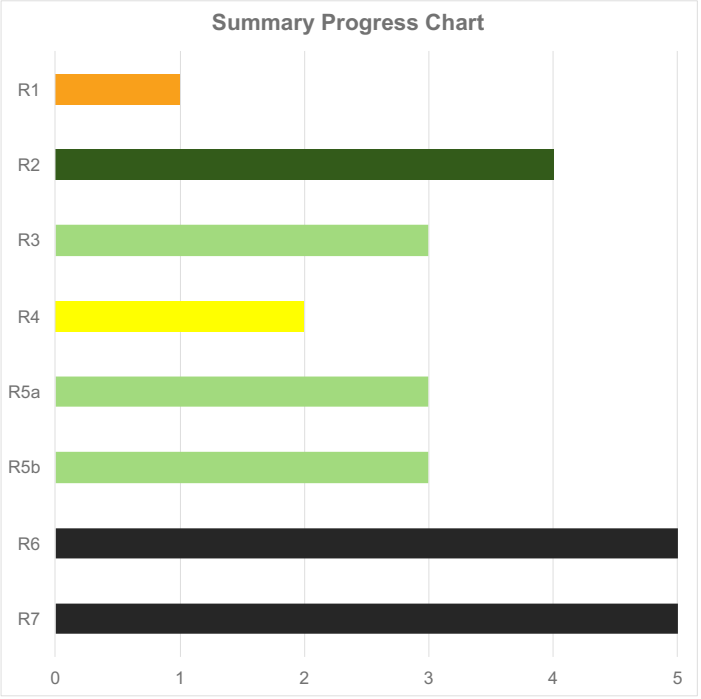
The Trust and the Clinical Commissioning Group must work with the Local Adult Safeguarding Board and its members to develop a robust process for escalation, oversight and follow up both immediately and after a serious incident (where Safeguarding concerns are identified), and in the longer term, to ensure that learning from such events is fully captured and shared.

2. Summary assessment on progress

Implementation of recommendations

In relation to progression of actions which have been agreed from the eight recommendations made from our investigation report, we have rated the findings which are summarised below:

- **R1** – NHS England has made little progress on their action and has advised that this was due to an administrative error that resulted in the action not being placed on the national action tracker. The oversight was not identified until this assurance review was being arranged. **Overall rating: 1**
- **R2** – The Trust and CCG have embedded the learning in relation to the quality of serious incident investigation reports. A further six months of evidence would demonstrate sustained improvement. **Overall rating: 4**
- **R3** – The Trust has implemented changes to ensure support is available to staff when dealing with serious incidents, but has not yet tested the impact of those changes. **Overall rating: 3**
- **R4** – The Trust has made emergency contact numbers available to staff and has assessed that the existing physical health policy is fit for purpose. But we have not seen evidence that they have addressed the concerns identified in relation to acute alcohol withdrawal. **Overall rating: 2**
- **R5a** – The Trust has provided safeguarding training to large numbers of staff, strengthened the support to front line staff and provided two case studies, but they have not assessed the impact of the training more widely. **Overall rating: 3**
- **R5b** – The Trust and CCG have made significant progress in implementing a process for escalation, oversight and follow up when a serious incident has an associated adult safeguarding concern. However that process has not yet been assessed. **Overall rating: 3**
- **R6** – The Trust has made progress in identifying a strategic solution to ensuring observations form part of a patient's electronic record, but we have not seen any evidence that the short-term solution is effective. **Overall rating: 5**
- **R7** – The CCG takes a robust approach to monitoring the progress of serious incident investigations and quality assuring serious incident investigation reports submitted. **Overall rating: 5**



Assurance review findings

Recommendation 1 NHS England must clarify the responsibilities of a Trust in relation to Duty of Candour and Being Open when the incident relates to a criminal offence.	
NHS England response and evidence submitted	**Niche comments and gaps on assurance**
• The independent investigation report was discussed at the North Yorkshire and Humber Quality Surveillance Group (QSG) on 22 November 2019. The record of the meeting states that the action for NHS England was approved and accepted at the National Independent Investigations Governance Committee (IIGC) on 6 June 2019. • Recommendations requiring national action are escalated through the Regional Independent Investigations Review Group (IIRG) (in this case the North) to the National IIGC. This meeting meets quarterly and we have seen evidence that the intention was to take the national recommendation to National IIGC on 6 June 2019. However there is no evidence that the item was discussed, and neither does the recommendation appear on the national action tracker. • The recommendation was discussed at the National IIGC on 9 October 2020. The discussion noted that there was ongoing work in reinforcing the wider application of Duty of Candour and application to mental health homicide cases. There was also discussion regarding the CQC definition and how that is interpreted in mental health homicide situations. The recommendation was accepted as a national action and will now feature on the national recommendations action log. • The North Regional IIRG has undertaken a check to ensure that all NHS England national recommendations made within other investigations commissioned by NHS England North have been escalated appropriately, and have confirmed this is the case.	We have seen evidence of the recommendation being discussed at QSG meetings in the North. We can also see that a report to the North Yorkshire and Humber QSG meeting held on 22 November 2019 states that the action for NHS England was “approved and accepted at the national Independent Investigations Governance Committee (IIGC) on 6 June 2019”. However NHS England later identified that the action was not then included on the national recommendations action log. The delay in the recommendation being escalated to the National IIGC was significant and the omission only identified when evidence for this review was being collated. As a consequence of the delay work has only recently started on implementing the required actions.

Recommendation 1 NHS England must clarify the responsibilities of a Trust in relation to Duty of Candour and Being Open when the incident relates to a criminal offence.	
NHS England response and evidence submitted	Niche comments and gaps on assurance
• Correspondence has been shared between the Regional Investigations Team and the National Patient Safety Team regarding the inclusion of clarity about Duty of Candour within the Patient Safety Incident Response Framework which will replace the NHS Serious Incident Framework (2015) in due course.	

NIAF rating:

The evidence provided indicates that this action has commenced, but has not yet significantly progressed.

Overall rating for this recommendation: **1 (action commenced)**

Recommendation 2:

The Trust and their commissioners must ensure that serious incident investigation reports make clear the links between the issues identified and the recommendations being made.

Trust response and evidence submitted	Niche comments and gaps on assurance
• The Trust has established a Serious Incident Meeting whose function is to review all Serious Incident investigation reports to ensure that they make clear links with the issues identified and the recommendation and to undertake a confirm and challenge process. The group is made up of a number of senior clinicians and subject matter experts. Once reports have gone through this process there is a final 'confirm and challenge' with the Care Group Triumvirates before sign off and submission. The first meeting was held on 17 April 2020. • The quality of serious incident reports has improved and the Trust is assured that there are clear links between issues raised and the recommendations being made. Terms of reference are agreed prior to the start of each investigation by the independent inspector assigned and the Care Group Triumvirate. The outcome of each serious incident review and the recommendations are discussed with service leads in the care group via an Organisational Learning meeting each month. • The Head of Patient Safety attends a monthly Serious Incident Review Meeting held by North Lincolnshire Clinical Commissioning Group (CCG). The focus of this meeting is to review the learning from serious incidents and ensure that all actions are undertaken. Where required, a member of the Care Group Triumvirate will also attend the meeting. • Notes of the organisational learning meeting held on 16 July 2020 show detailed discussion about a serious incident report. Discussion identifies care delivery problems, service delivery problems and root cause.	We have seen the Serious Incident Assurance Framework Flowchart, the Incident Review Process and the Terms of Reference for the North Lincolnshire Care Group Organisational Learning Meeting that the Trust has developed. We have reviewed the minutes of the Organisational Learning Meeting held on 16 July 2020. These show evidence of discussion about a serious incident, identifying care and service delivery problems, root cause and identification of a further recommendation. We have also seen the Terms of Reference for the Serious Incident Group. This group will review all incidents graded as "serious" as defined in the Trust Incident Reporting Policy. The Trust has made good progress in evidencing that serious incident reports are reviewed for quality and content prior to submission to the CCG for sign off. We have seen that the Trust uses a formal checklist to help to ensure that all standards set out in the NHS England Serious Incident Framework have been addressed prior to submission to the CCG.

Recommendation 2: The Trust and their commissioners must ensure that serious incident investigation reports make clear the links between the issues identified and the recommendations being made.	
NHS North Lincolnshire CCG response and evidence submitted	Niche comments and gaps on assurance
• Notes of the Serious Incident Group Meetings held between NHS North Lincolnshire CCG provided for 28 August 2019, 2 October 2019, 27 November 2019, 11 March 2020 and 29 July 2020. • CCG assessments of serious incident reports have been provided showing a detailed checklist, indication of whether the CCG is assured or further information is required, and themes in the report and action plan.	We have seen the evidence of regular formal discussion between the Trust and the CCG about serious incident reports and their findings. The meetings follow a consistent format ensuring that key aspects of serious incident investigations are considered, including reports pending, received reports that have been quality assured, or where further work is required, extension requests and items for escalation to the Quality Assurance and Improvement meeting. Where the CCG has required further information there is evidence that they have considered the link between the findings, lessons learned and recommendations, and learning not highlighted but evident in the narrative.

NIAF rating:

The evidence reviewed clearly demonstrates that there is assessment by the Trust and their commissioners to ensure that serious incident investigation reports are making clear links between issues identified and recommendations being made. Twelve months' evidence of the meeting of the Trust Serious Incident Group would demonstrate a sustained improvement.

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

Recommendation 3:

The Trust must assure itself and its commissioners that front line staff receive appropriate support from managers both in hours and out of hours, when dealing with serious incidents.

Trust response and evidence submitted	Niche comments and gaps on assurance
• The Trust has reviewed the On Call Policy to ensure that it clearly articulates the process for providing front line clinicians with appropriate support from managers when dealing with serious incidents. • The Trust operated a Seven Day Management Model during the COVID-19 pandemic in order to ensure that front line clinicians have appropriate support from managers seven days per week during that ongoing incident. • All managers on out of hours on call rotas participated in the Joint Decision Model training to establish clear expectations of what is required of them. • Training is delivered by Yorkshire Ambulance Service and is routinely organised when new on call managers start in the Trust. • 100% of staff from Gold Command have been trained; 17 people trained despite only eight on the rota. • 100% of staff from Silver and Bronze Command have been trained; 57 people trained despite only 51 on the the rota.	We have seen that the Trust On Call Policy is now more robust and the Trust has told us that training has been delivered to all staff who participate on the rota. The Trust has provided us with numbers of staff trained and the source data. The Trust told us that all managers on the out of hours on call rota have participated in the Joint Decision model training, and we have seen the source data. The Trust has not provided an assessment of the impact of the revised policy and training. Therefore it is not possible for us to comment upon the effectiveness of the policy and training on front line staff.

NIAF rating:

The Trust has implemented the recommendation but we have not seen evidence that the Trust has tested the impact of the changes.

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

Recommendation 4:

The Trust must ensure that clinical staff have the skills and knowledge to be able to provide appropriate physical healthcare (in particular acute alcohol withdrawal), or be able to access appropriate physical healthcare from other organisations (in particular community dental services) in a timely fashion.

Trust response and evidence submitted	Niche comments and gaps on assurance
• The Trust has reviewed the existing Physical Health Policy to clarify whether it has the mechanism to ensure that staff have the skills and knowledge to be able to provide appropriate physical healthcare or be able to access appropriate physical healthcare from other organisations. This confirmed that existing processes were in place. • To support this the Trust provides a range of clinical skills training sessions that staff are supported to attend. There has also been a change in the skill mix of doctors who are available on the ward to respond to physical health concerns. • The Trust has developed practice guides for staff to detail the response to be taken when physical healthcare needs are identified and the services that are available. The guides are on display on the ward with key contact details for appropriate physical health teams. • CQUIN report for Q3 2018/19. • Contact details for unscheduled care practitioners and a summary of when to contact them. • Contact details for emergency dental services and podiatry services.	We have reviewed the Physical Health Policy and note that it specifies that on admission “every patient, with consent, must have a physical assessment” in accordance with the standards set out in the Trust Physical Assessment, Examination and Ongoing Care of Inpatients Policy. The Policy also states that patients who develop physical health needs during an inpatient stay or who are identified as having a possible physical health problem must undergo a physical health examination within a reasonable time governed by the severity of the problem reported. If after examination a referral to a primary care provider is required, an appointment should be made, and the patient supported to attend. The Physical Healthcare CQUIN Report for Q3 2018/19 provides an update on CQUIN references: • 3a: Improving physical healthcare to reduce premature mortality in people with serious mental illness – Cardio metabolic assessment and treatment for patients with psychoses. • 3b: improving physical healthcare to reduce premature mortality in people with serious mental illness – Collaborating with primary care clinicians. The narrative indicates that the Trust’s RAG is green for the areas assessed and we have seen the source data.

Recommendation 4: The Trust must ensure that clinical staff have the skills and knowledge to be able to provide appropriate physical healthcare (in particular acute alcohol withdrawal), or be able to access appropriate physical healthcare from other organisations (in particular community dental services) in a timely fashion.	
Trust response and evidence submitted	Niche comments and gaps on assurance
	We have seen the contact numbers for unscheduled care practitioners and emergency dentists and podiatrists. None of the evidence provided addresses the issue of acute alcohol withdrawal that we specifically referenced in our original recommendation. We were told that the Trust has set up training, but this was not in place at the time of our review.

NIAF rating:

The evidence reviewed found that the Trust has made very good progress in ensuring that staff have access to training and support to provide or access good quality physical healthcare. However none of the evidence provided addressed the specific issue of acute alcohol withdrawal.

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

Recommendation 5a:

The Trust must ensure that staff are fully aware of and execute their responsibilities for safeguarding when there are concerns about the vulnerability of patients.

Trust response and evidence submitted	Niche comments and gaps on assurance

• The Trust has a target of 90% of staff being compliant with their safeguarding training. A compliance audit for safeguarding training for Mulberry Ward showed the following:
  • Level 1 – 97.05%
  • Level 2 – 92.96%
  • Level 3 – 100%
• Safeguarding lead professionals are an active part of the ward clinical team and participate on a regular basis in multi-disciplinary team discussions.
• A Band 6 ward-based safeguarding lead has been identified.
• A ward safety plan has been developed by ward staff in conjunction with the safeguarding lead professionals. This safety plan recognises the vulnerability of all patients.
• Two safeguarding case studies.
• Letter from North Lincolnshire Children's Multi-Agency Resilience and Safeguarding Board regarding the Assurance Event on 18 October 2019 at Great Oaks that also considered aspects of adult safeguarding.
	As at 31 August 2020 the Trust had a high level of compliance with the safeguarding training requirements across the three different levels. Safeguarding adults: Level 1 – 97.14%; Level 2 – 100%; Level 3 – 90.91%; Safeguarding children Level 1 – 97.14%; Level 2 86.96%; Level 3 – 81.82%.
	
	12 areas of positive practice were identified by the Assurance Event undertaken by representatives of the North Lincolnshire Children's Multi-Agency Resilience and Safeguarding Board.
	
	We have seen two case studies that provide evidence of:
	• A patient story being used to develop a recording about a patient's experience of safeguarding. The recording has been shared during Safeguarding Adult Boards events and in staff training and awareness raising.
	• Inpatient staff providing support to a patient who had raised safeguarding concerns in respect to himself from another patient. Staff made the appropriate safeguarding alert, provided support to the patient to decide on the action to take and supported the patient in achieving the desired outcome.

NIAF rating:

The evidence reviewed shows that the Trust has ensured that the appropriate training and support is in place for staff to be able to execute their safeguarding responsibilities effectively. However the Trust did not provide source data evidence for the audit (the input) nor evidence that they have assessed the impact of the training (the output).

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

Recommendation 5b:

The Trust and the Clinical Commissioning Group must work with the Local Adult Safeguarding Board and its members to develop a robust process for escalation, oversight and follow up both immediately and after a serious incident, and in the longer term, to ensure that learning from such events is fully captured and shared.

Trust and Clinical Commissioning Group response and evidence submitted	Niche comments and gaps on assurance

• The Associate Nurse Director for the Care Group attends the Safeguarding Adult Board as the Trust's delegated Safeguarding Adult Board member.
• A three-part proposal has been developed in partnership between the CCG and Trust, for presentation to the Local Adult Safeguarding Board (LSAB) on 26 June 2020 (suspended until this date due to COVID-19). This includes:
  • Notification of Serious Incidents (SI) to the LSAB within 5 working days of identification of an SI.
  • A quarterly report to the Safeguarding Adult Board Executive Group on all relevant SIs, which include progress and learning identified.
  • Learning from SIs will be shared with and considered by the Prevention and Proportionality subgroup of the Safeguarding Adult Board as the lead forum.
	We have seen a copy of the presentation given to the Safeguarding Adult Board with a briefing on the NHS England Serious Incident Framework.
	
	The process of formal notification to the SAB of serious incidents within five working days where safeguarding adult concerns are identified has been included within the North Lincolnshire Safeguarding Adult Board Multi-Agency Procedures. The revised Procedures have been published on the the North Lincolnshire Safeguarding Adult Board website and we have seen a copy of this.
	
	The first quarterly report from NHS organisations was presented at the meeting held on 27 November 2020 (delayed from August 2020 due to other commitments and no open serious incidents with associated safeguarding adult issues) but we have not seen a copy of this.

NIAF rating:

The evidence reviewed showed that there has been significant progress in implementing a process for escalation, oversight and follow up when a serious incident has an associated adult safeguarding concern. However we have not seen evidence that the impact of the new processes have been assessed or used in practice. We have seen no evidence that learning from serious incidents has been shared and considered by the Prevention and Proportionality sub group.

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

Recommendation 6

The Trust must ensure that observations form part of a patient's electronic record.

Trust response and evidence submitted	Niche comments and gaps on assurance
• The Trust is working with the Electronic Patient Record (EPR) provider to create an observation record that is part of the EPR. The EPR provider is piloting an observation component of the EPR. • Simultaneously to this, the Trust has commenced a strategic technologies programme that incorporates a number of technological solutions to improving patient care and it has been agreed that electronic observations (E-Obs) will be incorporated into this. The Trust is therefore in the process of reviewing a number of options to ensure that the one selected is the best fit for the organisation. • The existing paper systems linked to the Purposeful Inpatient Admission (PIPA) model mitigate risk whilst the developmental work referred to above is progressed. • Staff are supported to record and monitor observations by the clinical system and patient records are comprehensive. Observations are recorded within the Early Warning Score and the paper copy scanned in to the electronic patients notes. This is discussed within the PIPA meetings daily and recorded within the PIPA template with details of actions, responsibilities and completed activity recorded in the daily record electronic notes. • An unannounced night visit conducted by the Interim Care Group Director on 6 August 2019 showed that observations were being undertaken in a staggered fashion and not on the quarter hour, observation record sheets reflected a variety of times. Observation records for the previous week also reflected a variety of times. • The CQC report published in February 2020 relating to the inspection in October 2019 stated "staff on all wards were undertaking observations as per the prescribed levels".	The Trust told us about the actions it is taking to implement a strategic solution to the incorporation of observations into a patient's electronic record. The Trust has told us that the existing paper systems linked to the PIPA model mitigate the risks whilst the strategic solution is being implemented. We can see that the PIPA template includes a discussion about the patient's observation levels but we cannot see how the template would provide the opportunity for observations to form part of a patient's electronic record. The Trust provided evidence of an audit to demonstrate that observation records were being scanned and uploaded to electronic patient records. This is evidence of sustained practice. The independent investigation identified concerns about: • use of rigid 15 minute observations; • observations not forming a core component of a patient's EPR; • lack of evidenced decision making when observation levels are reviewed. The file note of an unannounced visit undertaken by a senior nurse on 6 August 2019 states that she found evidence that observations were being conducted in a "staggered fashion and not on the quarter hour".

Recommendation 6	
The Trust must ensure that observations form part of a patient's electronic record.	
Trust response and evidence submitted	Niche comments and gaps on assurance
NIAF rating: The Trust has made progress in identifying a strategic solution to ensuring observations form part of a patient's electronic record. We have seen evidence of an audit that demonstrates sustained improvement in ensuring that paper observations are scanned into patients' electronic records. **Overall rating for this recommendation: 5 (evidence of sustained improvement)**	

Recommendation 7:

The Clinical Commissioning Group must ensure that the revised serious incident management policy provides clarity about the assurance and monitoring processes and how these are to be evidenced.

Trust response and evidence submitted	Niche comments and gaps on assurance

• NHS North Lincolnshire Clinical Commissioning Group has revised the Policy for the Management of Serious Incidents. The revised Policy was approved by the CCG Executive Team on 25 April 2019.
• The intention was to:
  • Ensure the policy is robust in the CCG's role and responsibility for the management and monitoring of serious incidents within commissioned services;
  • Ensure the policy is robust in the CCG's role and responsibility for the management and monitoring of serious incidents in relation to where NHS England take the [lead] or where external investigations are undertaken;
  • Weekly review of the action tracker in place to monitor all serious incidents reported by providers;
  • Review of both the serious incident meeting agenda and minutes template to provide assurance of monitoring of individual serious incidents.
	We have seen that the Policy clearly describes the process for management and oversight of serious incidents that involve a homicide by a patient in receipt of mental health care.
	We have seen that there is evidence of regular formal discussion (minutes of meetings) between the Trust and the CCG about serious incident reports and their findings. The meetings follow a consistent format ensuring that key aspects of serious incident investigations are considered, including reports pending, received reports that have been quality assured, or where further work is required, extension requests and items for escalation to the Quality Assurance and Improvement meeting.
	Where the CCG has required further information there is evidence that they have considered the link between the findings, lessons learned and recommendations, and learning not highlighted but evident in the narrative.

NIAF rating: The evidence reviewed demonstrates the CCG has a robust approach to monitoring the progress of serious incident investigations and quality assuring serious incident investigation reports submitted.

Overall rating for this recommendation: 5 (can demonstrate a sustained improvement)

Appendix

Appendix A: Documents reviewed

NHS England documents reviewed: Recommendation 1
Email from Business Coordinator – Independent Investigations Team dated 8 September 2020
South Yorkshire and Bassetlaw Quality Surveillance Group Master Forward Plan 2020/21
North Yorkshire and Humber Quality Surveillance Group Master Forward Plan 2020/21
West Yorkshire Quality Surveillance Group Master Forward Plan 2020/21
North Yorkshire and Humber Quality Surveillance Group Minutes 22 November 2019
West Yorkshire and Harrogate Quality Surveillance Group Minutes 20 September 2019
South Yorkshire and Bassetlaw Quality Surveillance Group Minutes 29 November 2019
North Yorkshire and Humber Quality Surveillance Group Sharing Learning Report 22 November 2019
Email from Business Coordinator – Independent Investigations Team dated 13 October 20
Trust documents reviewed: Recommendation 2
Serious Incident Assurance Framework Flowchart
Incident Review Process, North Lincolnshire Clinical Commissioning Group
Organisational Learning Meeting Terms of Reference
Organisational Learning Meeting Minutes 16 July 2020

Clinical Commissioning Group documents reviewed: Recommendation 2
RDaSH Serious Incident Group Meeting Agenda and Minutes 2 October 2019
RDaSH Serious Incident Group Meeting Agenda and Minutes 27 November 2019
RDaSH Serious Incident Group Meeting Agenda and Minutes 26 August 2020
Collaborative Serious Incident Meeting Agenda and Minutes 29 July 2020
Serious Incident Meeting Minutes 28 August 2019
Serious Incident Meeting Minutes 11 March 2020
Serious Incident Meeting Minutes 29 July 2020
Assessment of Level 2 comprehensive serious incident investigation report and action plan 12 July 2019
Assessment of Level 2 comprehensive serious incident investigation report and action plan 21 August 2019
Assessment of Level 2 comprehensive serious incident investigation report and action plan 11 March 2020
Trust documents reviewed: Recommendation 3
Managers on Call (Non-Medical Staff) Policy 18 April 2019
Response to the NHS England Debrief Paper June 2020
Trust documents reviewed: Recommendation 4
Physical Health Policy 1 May 2020
Practice Guides
Physical Health Guide
North Lincolnshire CQUIN Report Q3 2018/19

Trust documents reviewed: Recommendation 5a
Letter from North Lincolnshire Children's Multi-Agency Resilience and Safeguarding Board to RDaSH 31 October 2019
Safeguarding Case Studies
Trust and Clinical Commissioning Group documents reviewed: Recommendation 5b
North Lincolnshire Safeguarding Adults Board Executive Group Minutes 4 May 2020
North Lincolnshire Safeguarding Adults Board Minutes 20 June 2020
Summary of actions taken by the Trust and Clinical Commissioning Group in response to Recommendation 5b
Safeguarding Adults Board Briefing on Recommendation 5b
North Lincolnshire Safeguarding Adults Board Executive Group Report 4 May 2020: Proposal to address Recommendation 5b
Serious Incident Overview Presentation for North Lincolnshire Safeguarding Adults Board June 2020
Trust documents reviewed: Recommendation 6
File note of night visit 6 August 2019
PIPA template
Clinical Commissioning Group documents reviewed: Recommendation 7
Extract of minutes of Executive Team Meeting 7 May 2019
North Lincolnshire Clinical Commissioning Group recommendation 7 action tracker
North Lincolnshire Clinical Commissioning Group Policy for the management of serious incidents in services commissioned by North Lincolnshire Clinical Commissioning Group
Serious incident policy front sheet

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