Independent Quality Assurance Review

Cumbria, Northumberland, Tyne and Wear NHS FT
NHS South Tyneside Clinical Commissioning Group

Service User A

Final Report

May 2022

insight integrity impact

Niche Health and Social Care Consulting
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30 May 2022

Dear Karen,

Independent Quality Assurance Review, Cumbria, Northumberland, Tyne and Wear NHS FT and NHS South Tyneside Clinical Commissioning Group

Please find attached our final report of 30 May 2022 in relation to an independent quality assurance review of the implementation of recommendations resulting from the investigation into the homicide committed by a mental health service user, A, in 2018.

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 Events which may occur outside of the timescale of this review will render our report out of date.

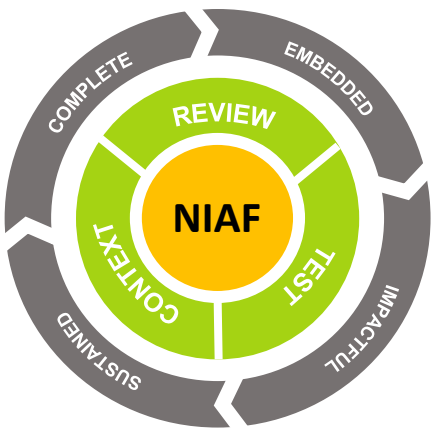
Our report has not been written in line with any UK or other auditing standards; we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information.

This report is for the attention of the project sponsor and stakeholders. No other party may place any reliance whatsoever on this report as it has not been written for their purpose. Different versions of this report may exist in both hard copy and electronic formats and therefore only the final signed version of this report should be regarded as definitive.

Yours sincerely,

James Fitton

Niche Health and Social Care Consulting Ltd



Niche Investigation Assurance

insight integrity impact

Contents

	Page
1. Method	4
2. Assurance summary	6
Appendices	
1: Evidence review	16
Recommendation A1	17
Recommendation A2	18
Recommendation A3	19
Recommendation A4	22
Recommendation A5	23
Recommendation A6	24
Recommendation A7	25
Recommendation A8	27
Recommendation B1	28
Recommendation B2	28
Recommendation B3	29
2: Glossary of terms	30

1. Method

1.1 Background and context for this review

Niche undertook an independent assurance review following Northumberland, Tyne and Wear (NTW) NHS Foundation Trust's internal investigation into the care and treatment of mental health service user A. This report was finalised in April 2021 (referred to as 'our April 2021 report') . Niche have now been commissioned by NHS England and NHS Improvement to undertake a follow-up review of progress made, both:

- against the eight original recommendations made within the Trust's internal investigation report in March 2019; and
- against the three recommendations which Niche made in our April 2021 report.

1.2 Review method

This is a high-level report on progress to NHS England and NHS Improvement, undertaken through desktop review only, without site visits or interviews.

Our work comprised a review of documents provided by Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust ('CNTW' or 'the Trust'). (Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust was formed in 2019 when the mental health and learning disability services in North Cumbria were transferred to NTW). These included policies, procedures, audits, meeting minutes and staff communications.

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

1.3 Implementation of recommendations

The Trust's internal investigation in 2019 made eight recommendations (A1-A8) and the Niche independent assurance review in April 2021 made three recommendations (B1-B3).

These recommendations are listed opposite and on the next page.

A. Recommendations made in the Trust's internal investigation report (March 2019)	
A1	The EIP (Early Intervention in Psychosis) service should, with immediate effect, ensure and evidence that all staff are aware of and comply with the requirements of the 'Promoting Engagement with Service Users Policy'. Bring back learning to CBU (Community Business Unit) South Quality Standards Group.
A2	The EIP service should, with immediate effect, ensure that all staff fully utilise the evidence-based FACE (Functional Analysis of Care Environment) risk assessment tool at points where changes of risk warrant this, using supervision and the IT audit report.
A3	The EIP service should review within three months, how to ensure that a carers' needs assessment is offered and facilitated and include an audit of the 'Getting to Know You' documentation.
A4	The revised arrangements for transition between CAMHS (Children and Adolescent Mental Health Services) and ADHD (Attention Deficit Hyperactivity Disorder) Services should be audited within three months to ensure they are timely and effective.
A5	Referral between forensic CAMHS and adult forensic services needs to be streamlined. To be taken to the Business Delivery Group, Safety, for further discussion. Quality improvement meeting planned for 17.04.19.
A6	*[Name]* Ward should ensure through management supervision, that all registered nursing staff with responsibility for student nurses validate entries made in clinical records in order to discharge their professional accountability for the actions of the student.

1. Method (cont.)

A7	The EIP team should utilise this report within a learning event in order to ensure that the lessons learnt are discussed and integrated into the Care Coordination process. To be discussed within Trust wide EIP away day and the strategy group. Individual team members should have the opportunity to reflect on their contribution to the care process through both clinical and management supervision. Update required on the Trust wide implementation of the Trust supervision process and policy.
A8	Senior Trust officers should discuss and agree future Trust Policy in relation to involvement / information sharing with the family of a victim, when the victim is not known to mental health services in these circumstances. In relation to this case, legal advice should be sought regarding the level of information from this investigation report that can be shared with the victim's family. A meeting is offered to the victim's family to provide feedback regarding the investigation. In order to minimise distress, the process relating to the NHS England Independent Investigation should also be explained to the family by a representative being present from NHS England at the meeting. The Trust should write to service user A's mother and offer a further opportunity to meet and receive feedback on the outcome of the investigation. Medical advice should be sought from service user A's RC (Responsible Clinician) regarding any feedback or otherwise to the patient regarding the review of his care and treatment.

B. Recommendations made in the Niche April 2021 report	
B1	Trust Serious Incident (SI) Panel meetings should be formally recorded.
B2	The Trust should ensure that SI action plan evidence is rigorously tested and recorded in advance of action plan sign off.
B3	The Trust should assure itself within three months of receipt of the final report that it can evidence the implementation and completion of each recommendation, all of which were signed off at the South Locality Quality Standards Group meeting in September 2019.

2. Assurance summary

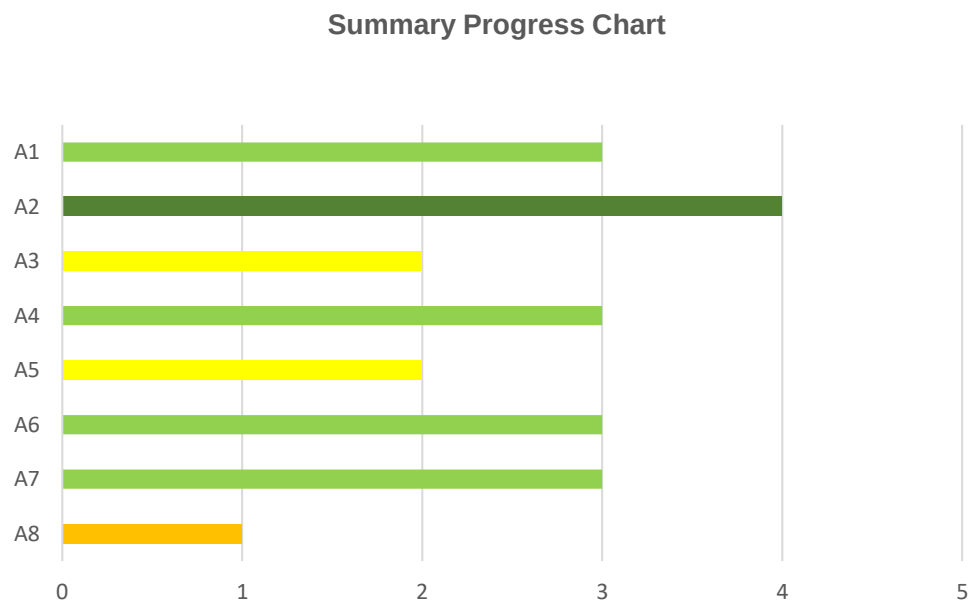
Scoring criteria key

The assessment is meant to be useful and evaluative. We use a numerical grading system to support the representation of 'progress data', which is intended to help organisations focus on the steps they need to take to move between the stages of completed, embedded, impactful and sustained.

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, but not embedded
5	Can demonstrate a sustained improvement

Recap of progress position as at April 2021

In our April 2021 report, we reported that the progress made in implementing recommendations made in the internal SI report was as follows.

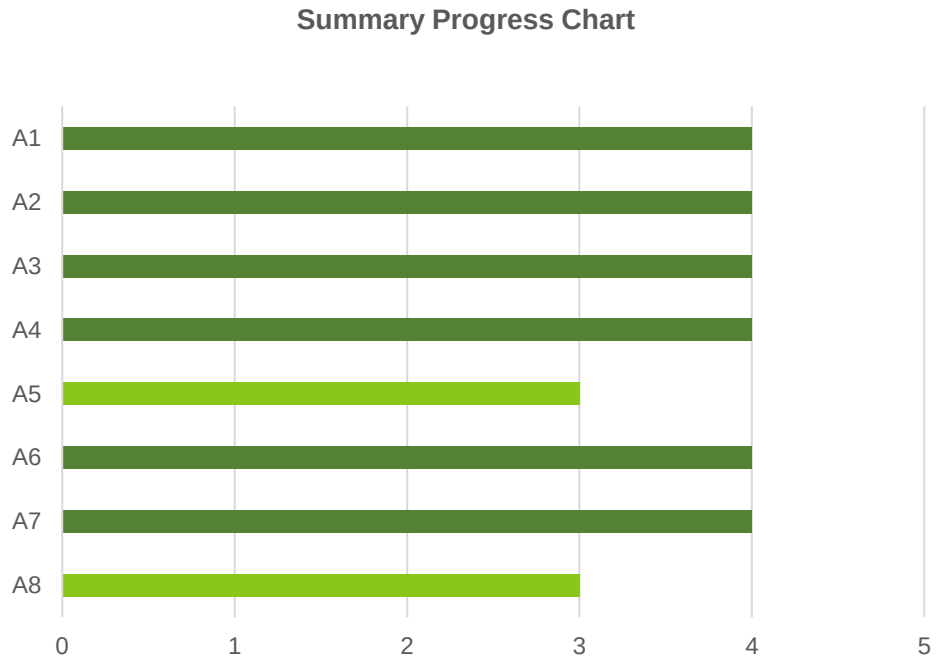


Actions had been completed in most cases, although there were areas in which further evidence of assurance was required, particularly in relation to recommendations A3, A5 and A8.

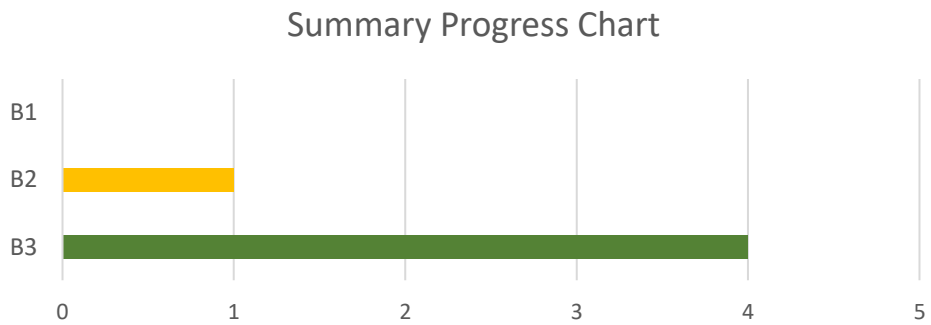
2. Assurance summary (cont.)

Position as at May 2022

Having reviewed the evidence provided by the Trust, we summarise the current progress position against the Trust's internal investigation recommendations as follows:



Against the three recommendations from the Niche independent assurance review (B1-3), the progress has been rated as follows:



Assurance Summary

Progress has been made since our last assurance review in 2021, although in some cases there needs to be continued testing to ensure compliance with the changes made and to demonstrate that sustained improvements are being achieved. There has, however, been more limited progress against two of the three recommendations in our report of April 2021. We have offered examples of further assurance which may demonstrate actions are complete, tested, embedded and/or sustained as appropriate for the Trust and Clinical Commissioning Group (CCG) to consider.

Some headline commentary to support these ratings has been provided in the following pages and Appendix 1 (evidence review) provides details of the individual examples and evidence submitted to Niche used to assess action taken, progress made and impact achieved.

2. Assurance summary (cont.)

A. Recommendations made in the Trust's internal investigation report (March 2019)

Recommendation A1

The EIP service should, with immediate effect, ensure and evidence that all staff are aware of and comply with the requirements of the 'Promoting Engagement with Service Users Policy'. Bring back learning to CBU (Community Business Unit) South Quality Standards Group.

Niche assurance rating for this recommendation (April 2021)	**3**

The Trust provided evidence that action had been taken to raise the profile of the Promoting Engagement with Service Users Policy and it had been shared across community teams.

Audit results from April 2020 showed staff were aware of the policy, but further audits would be required to evidence that the requirements of the policy had been embedded into practice.

Niche assurance rating for this recommendation (May 2022)	**4**

Key findings: The Trust provided a supporting statement to describe the current practice in the Early Intervention in Psychosis (EIP) Service from October 2021 and an updated position from March 2022. This included the use of a 'Longest Waiters Report' that shows how many weeks have passed since a client's last appointment with the service and, where booked, their next appointment date. However, in the example given, there were clients who had not been seen in four or five weeks with some not having an entry for the next appointment date.

The monitoring of this process, through clinical supervision or within team meetings, was described in the statement, although the Trust has not provided any evidence of monitoring or standards for the procedures used by the EIP team to be able to assess their impact during this review.

The Trust did not provide any evidence that re-audits or other monitoring mechanisms have been completed, using the same standards as the audit in April 2020, to ensure continued awareness of the Promoting Engagement with Service Users Policy or embedding into practice.

Residual recommendations:

- Ongoing monitoring (through, for example, key metrics, quality assurance impact statements and where appropriate the use of audit data) to confirm continued awareness of the Promoting Engagement with Service Users Policy and embedding into practice.

2. Assurance summary (cont.)

Recommendation A2

The EIP service should, with immediate effect, ensure that all staff fully utilise the evidence-based Functional Analysis of Care Environments (FACE) risk assessment tool at points where changes of risk warrant this, using supervision and the IT audit report.

Niche assurance rating for this recommendation (April 2021) **4**

The Trust had taken steps to promote the use of the FACE risk assessment and provided evidence of monitoring via performance dashboards. Further evidence was required to demonstrate practice has become fully embedded.

Niche assurance rating for this recommendation (May 2022) **4**

Key findings: The Trust provided a supporting statement to describe the current practice in the Early Intervention in Psychosis (EIP) Service from October 2021 and an updated position from March 2022. This included a description of the team producing weekly reports to identify clients who have not had their FACE review completed in the last 12 months. This is reviewed by the EIP Pathway Coordinator who identifies any outstanding actions and updates the dashboard. An insufficient sample of these weekly reports have been submitted to determine whether there is an improving trend.

The Trust provided anonymised examples of the individual caseload audits completed as part of monthly clinical supervision. This involves one case, selected at random, from each clinician's caseload to be audited in depth. There is a standard supervision template to support this.

The FACE risk assessment is included in the individual reviews with clinicians and supervisors, ensuring current and historical risks are accurately reflected in the scoring, and risk formulation details with a risk management plan are included. The statement provided in March 2022, included an expectation that any actions would be identified in red, and reviewed seven days later by the Clinical Lead, to ensure that they have been completed.

While this evidence from the local team offers some assurance that local team practice and action to improve has continued since our last review in 2021, we have not been able to assess a performance trend or sustained improvement by a review of the evidence in the statements and individual files alone.

Residual recommendations:

- The Trust should complete an audit to provide evidence of FACE risk assessment practice, supervision reviews and actions taken. There should be a commitment to a cycle of re-audits or monitoring through other mechanisms to continue to measure the changes made and impacts of improvements for the team and individual clients.

2. Assurance summary (cont.)

Recommendation A3

The EIP service should review within three months, how to ensure that a carers' needs assessment is offered and facilitated and include an audit of the 'Getting to Know You' documentation.

Niche assurance rating for this recommendation (April 2021)	**2**

The Trust has evidence that the incident had been discussed with staff, but provided limited evidence of whether it had reviewed how carers' assessments are offered and facilitated.

Niche assurance rating for this recommendation (May 2022)	**4**

Key findings: The Trust completed an audit of the Getting to Know You documentation for all teams across the Community CBU South Locality, in September 2021. The audit looked at the uptake and quality of the Getting to Know You process across the community team, using five standards related to identifying carers and offering support to carers. This did not include a review of whether the cases audited had carers' assessments offered or facilitated.

The total number of cases and records reviewed is not specified but the report states that: "five records for each qualified member of staff for each team" were reviewed and that records between 12-16 July 2021 were examined. The results found four areas were non-compliant with expected targets and partial compliance in the fifth area across the teams reviewed.

As the audit was across all teams in Community CBU South Locality, the Trust provided a separate email from the Clinical Lead which included only the EIP results. This showed a higher compliance rate for EIP, with four of five areas compliant (over 80% compliant) and one area ("Has a carer relative been identified and recorded on RiO during the initial assessment?") not meeting the standard with 78% compliance reported. While this is positive, additional audits would be needed to evidence sustained improvement or a performance trend.

In relation to carer's needs assessments, the Trust told us that processes have changed through amendments to clinical supervision reviews, a new 'opt-out' process for family intervention, and through regular welcome days and carers' forums (remotely due to COVID-19).

The Trust provided copies of the training slides for the Carer Awareness Training: Core Principles. This includes guidance and support for staff to understand the importance of engaging and supporting carers, with specific reference to Statutory Carers Assessments. There is no Trust-wide process or resource for facilitating and monitoring the training, so each locality is asked to support delivery for their teams. We have not been provided with registers or evidence of uptake across the EIP team at the time of this review.

The Trust are planning further improvement work in 2022/23 through their delivery of Quality Priority 3: Patient Care – increasing time staff are able to spend with service users and carers. This will include engagement with stakeholders and reviews to measure the use of the Getting to Know You documentation. This work has been delayed due to the pandemic.

Residual recommendations:

- Complete the audit cycle and seek further assurance that carers' assessments are being offered and facilitated in line with Trust policy.

2. Assurance summary (cont.)

Recommendation A4

The revised arrangements for transition between CAMHS and ADHD Services should be audited within three months to ensure they are timely and effective.

Niche assurance rating for this recommendation (April 2021)	3

The Trust provided details of revised transition arrangements and completed an audit of the revised arrangements in 2019. However, the audit results indicated that there were still gaps in practice. This included the key worker and new worker being present (65% of cases), contact details being shared (70% of cases) and family or carers involvement (84% of cases).

Niche assurance rating for this recommendation (May 2022)	4

Key findings: An audit in June 2021 used 20 randomly selected cases to assess the quality of the referrals for transition appointments via the Children and Young Peoples Service (CYPS) which was previously the CAMHS service. This included reviewing standards that had been agreed across the localities and focused on information included across seven domains (assessment, developmental history, physical health, mental health, substance misuse, risk assessment and medication).

The two audits offer evidence that the Trust continues to take action to monitor the transitions, and the original audit met the recommendation requirements although continued to identify gaps in practice. The 2021 audit results also show gaps and areas for improvement across the domains with compliance results ranging from 42% to 88% in the cases audited. Action to respond to the results of both audits will be needed to demonstrate sustained improvements in this area.

Residual recommendations:

- Ongoing monitoring (through, for example, key metrics, quality assurance impact statements and where appropriate the use of audit data) to test compliance with revised arrangements.

Recommendation A5

Referral between forensic CAMHS and adult forensic services needs to be streamlined. To be taken to the Business Delivery Group, Safety, for further discussion. Quality improvement meeting planned for 17.04.19

Niche assurance rating for this recommendation (April 2021)	2

The Trust had not provided evidence of its review of the referral process between CAMHS and Forensic services but had developed a flowchart designed to improve the referral process. In April 2021, we said testing would be required to assess the effectiveness of the revised process.

Niche assurance rating for this recommendation (May 2022)	3

Key findings: The Trust provided bulletins (dated July 2021) shared with staff across the Trust in October 2021. The bulletins included links to the revised referral forms for the Forensic Community Team, which would also be used by the CAMHS teams.

Further monitoring or information on planned audits to measure impact and action would be needed to support embedding in practice or sustained improvements.

Residual recommendations:

- The Trust should monitor and test the impact of the new referral form (through, for example, key metrics, quality assurance impact statements and where appropriate the use of audit data).

2. Assurance summary (cont.)

Recommendation A6

[Name] Ward should ensure through management supervision, that all registered nursing staff with responsibility for student nurses validate entries made in clinical records in order to discharge their professional accountability for the actions of the student.

Niche assurance rating for this recommendation (April 2021) **3**

The Trust had taken steps to ensure clinical notes were appropriately validated and had communicated this message to students and their mentors. We were not provided with evidence of ongoing monitoring of student nurse entries in clinical notes and whether this has led to improved practice.

Niche assurance rating for this recommendation (May 2022) **4**

Key findings: The Trust shared emails referencing audits completed in December 2021. The results show continued gaps in practice and areas for improvement in the validation of entries in clinical records by students or non-registered staff. Following this audit, the Trust are developing an audit tool for weekly use by Ward Managers to address the improvement needed and monitor progress.

Residual recommendations:

- The new weekly audit tool should be finalised, tested and reviewed to ensure it is effectively measuring progress and informing improvements

Recommendation A7

The EIP team should utilise this report within a learning event in order to ensure that the lessons learnt are discussed and integrated into the Care Coordination process. To be discussed within Trust wide EIP away day and the strategy group. Individual team members should have the opportunity to reflect on their contribution to the care process through both clinical and management supervision. Update required on the Trust wide implementation of the Trust supervision process and policy.

Niche assurance rating for this recommendation (April 2021) **3**

The Trust provided evidence that the internal investigation report and resultant learning was shared at team meetings and a Lessons Learned event. The Trust did not provide an update on implementation of the Trust supervision process or detail any resultant impact from the shared learning.

Niche assurance rating for this recommendation (May 2022) **4**

Key findings: There are a range of tools and monitoring systems now in place to support this recommendation. This includes a new Supervision Policy, Modern Matron leadership in embedding supervision, a new electronic recording system and audits being recorded in clinical systems.

There are various arrangements for the Clinical Lead, Nurse Consultant and EIP Pathway Manager to support operational supervision. Dashboards are being used to monitor this, although we have not seen these or had evidence of follow-up actions to assess their impact. The team meet weekly (using a standard agenda). There are also twice weekly mini multi-disciplinary team (MDT) meetings to discuss clients of concern and a fortnightly complex case forum, where one client is discussed in depth.

We have not been provided with minutes of these meetings, the supporting process or had access to audit or monitoring tools that would evidence performance trends or impacts of the changes for the Team.

Residual recommendations:

- Audits and ongoing monitoring (through, for example, key metrics and quality assurance impact statements) to demonstrate the impact of shared learning and that this has been embedded into practice.

2. Assurance summary (cont.)

Recommendation A8	
Senior Trust officers should discuss and agree future Trust Policy in relation to involvement/information sharing with the family of a victim, when the victim is not known to mental health services in these circumstances. In relation to this case, legal advice should be sought regarding the level of information from this investigation report that can be shared with the victim's family. A meeting is offered to the victim's family to provide feedback regarding the investigation. In order to minimise distress, the process relating to the NHS England Independent Investigation should also be explained to the family by a representative being present from NHS England at the meeting. The Trust should write to service user A's mother and offer a further opportunity to meet and receive feedback on the outcome of the investigation. Medical advice should be sought from service user A's RC (Responsible Clinician) regarding any feedback or otherwise to the patient regarding the review of his care and treatment.	
Niche assurance rating for this recommendation (April 2021)	**1**
The Trust had not provided evidence that it had developed/reviewed its policy for sharing reports with families, that the report was shared with the victim's family, or if a meeting was offered to service user A's mother to discuss the report findings.	
Niche assurance rating for this recommendation (May 2022)	**3**
Key findings: The Trust have produced a Practice Guidance Note to support independent investigations. This includes the process for sharing information with families following discussion between the Caldicott Lead and the police. The Practice Guidance Note was approved in January 2022 and includes information to support governance and a monitoring framework that will support future assurance. The Trust also provided documents that provide information on the meetings that took place with Service User A's mother in April 2019 and March 2021.	
Residual recommendations:	
• The Trust should ensure that the governance and monitoring framework set out in the new Practice Guidance Note is followed to provide them with evidence of sustained improvements to practice.	

2. Assurance summary (cont.)

B. Recommendations made in the Niche April 2021 report

Recommendation B1

Trust Serious Incident (SI) Panel meetings should be formally recorded.

Niche assurance rating for this recommendation	0

Key findings: The Trust advised that they were reviewing the terms of reference for Serious Incident Panels and would be sharing a revised version with Serious Incident Panel Chairs for comment in February 2022. A draft of the new terms of reference has not been provided and we are unable to review against this recommendation.

The Trust also stated that the SI Panels will not be minuted as *'They are clinical discussions and an Multi-Disciplinary Team panel chaired by a Director will finalise and agree reports.'* As the Trust position remains unchanged, this means we cannot offer an assurance rating for action or progress against this recommendation.

Residual recommendations:

- The Trust and commissioners should review the expectations for recording serious incident panels and make sure this is clearly reflected in policy and meets national guidance (new guidance is due for release in summer 2022).

Recommendation B2

The Trust should ensure that SI action plan evidence is rigorously tested and recorded in advance of action plan sign off.

Niche assurance rating for this recommendation	1

Key findings: In November 2021, the Trust completed a risk-based audit of their action planning following serious incident investigations. This reviewed a sample of 12 action plans, produced between April 2020 and June 2021. The audit identified seven actions to be taken by the Trust to address issues which included a lack of Trust guidance on the management of action plans and inconsistencies in investigations producing SMART (Specific, Measurable, Achievable, Realistic and Timely) actions.

The audit identifies a control framework for the production of SI action plans but also acknowledges the lack of any Trust guidance on the management of SI action plans. The audit action plan recommends that a Practice Guidance Note, outlining roles and responsibilities, should be produced and the target date for completion was February 2022. We have not been provided with a copy of this new Practice Guidance Note or informed of any amendments to existing Trust guidance that would support this.

The completion of the audit does align with our recommendation and offers evidence that the Trust has continued to explore the issues relevant to SI action plans and to identify improvements needed to support the SI action plan process. However, this does not demonstrate sufficient progress to resolve the issues found by our report or the Trust audit.

Residual recommendations:

- The recommendation remains unchanged

2. Assurance summary (cont.)

B. Recommendations made in the Niche report (April 2021)

Recommendation B3	
The Trust should assure itself within three months of receipt of the final report that it can evidence the implementation and completion of each recommendation, all of which were signed off at the South Locality Quality Standards Group meeting in September 2019.	
Niche assurance rating for this recommendation	**4**

Key findings: The evidence shared for individual recommendations demonstrates progress since our last review, with all recommendations from the original investigation now complete.

Our report has provided assurance in relation to this, however, further testing is required across all recommendations to be assured that changes made have had the required impact or are being sustained in practice.

Residual recommendations:

- There needs to be continued testing to ensure compliance with the changes made and to demonstrate that sustained improvements are being achieved for all recommendations.

Appendix 1: Evidence review

Appendix 1: Full evidence review

Recommendation A1
The EIP service should, with immediate effect, ensure and evidence that all staff are aware of and comply with the requirements of the 'Promoting Engagement with Service Users Policy'. Bring back learning to CBU (Community Business Unit) South Quality Standards Group.

Key evidence submitted	Niche review
Impact Statement from the EIP Service, 14 October 2021	This impact statement provides an update on the quality indicators and review completed by the Trust in October 2021 against the actions in the internal investigation. The whole EIP team, Community Clinical Manager and Group Nurse Director are recorded as being involved in the reviews of practice and development of the impact statements. Internal assurance against this action is recorded through the management team monthly report on 'Longest Waiters'. This is a new monthly report which was not in place at the time of the incident. The statement includes reference to client contacts being checked regularly during supervision. It is not clear if the supervision approach is captured in policy or procedure for the team or Trust. .
Assurance Evidence Document from the EIP Service, 23 March 2022 Example Longest Waiters Report (embedded file), 6 March 2022 Examples of the Clinical Supervision Peer Reviews between 2 February-11 March 2022 (embedded file)	This document provides an updated position on the actions being taken and included an example of the Longest Waiters Report from 6 March 2022. The Trust told us that this report will be used by the Clinical Lead and Pathway Manager to identify any clients whose last contact with the service was three weeks or more ago. This would be reviewed to ascertain the reason and action taken to explore the appropriateness of this, for example, some clients may be preparing for discharge from EIP and will be seen monthly instead of three-weekly. An email would also be sent to the clinician if the last contact or next appointment date is not clear. In the example Longest Waiters Report, there were 11 clients who had not been seen in four or five weeks. Six of these did not have an entry for the next appointment date. With only one example of the report, it is not possible to offer any further assurance or comment on the effectiveness of the process or action taken by the team. The document also provides detailed information and examples of in-depth case reviews used as part of supervision for clinicians in the team. It was unclear whether this is a formal process, supported by amendments to the Trust's Clinical Supervision/Peer Review Policy since the investigation and recommendations in 2019 and 2021, or if there are monitoring processes in place to identify how often supervision is taking place.

Appendix 1: Full evidence review (cont.)

Recommendation A2	
The EIP service should, with immediate effect, ensure that all staff fully utilise the evidence-based FACE risk assessment tool at points where changes of risk warrant this using supervision and the IT audit report.	
Key evidence submitted	**Niche review**
Impact Statement [Service User A],14 October 2021	This Impact Statement prepared by the EIP team in October 2021 references weekly reports to identify clients who have not had their FACE review completed in the last 12 months and that this is checked by the Pathway Manager/Clinical Lead. The Impact Statement also references a random audit that would allow issues to be flagged during supervision to support clinicians and help reach Trust standards in completing and updating FACE in practice. While the information and tools discussed in the Impact Statement are likely to provide evidence that this has been progressed since our last report in April 2021, we cannot offer assurance of progress and embedding of the actions based only on the statement.
Assurance Evidence Document from the EIP Service, 23 March 2022 Examples of the Clinical Supervision Peer Reviews completed on 25 February and 11 March 2022 (embedded files)	The updated impact assessment includes references to the clinical supervision approach within the team. The Trust told us they expect one case from each clinician's caseload to be audited in depth and shared two examples of the template used. This does include FACE risk assessment. The reviewer (Clinical Lead) will consider whether this meets Trust standards and cross reference to alerts and other plans for the client. The statement also references the dashboard that the EIP Pathway coordinator reviews on a weekly basis to identify any outstanding dashboard measures which include FACE risk assessments being completed within the last 12 months.

Appendix 1: Full evidence review (cont.)

Recommendation A3

The EIP service should review within three months, how to ensure that a carers needs assessment is offered and facilitated and include an audit of the Getting to Know You documentation.

Key evidence submitted	Niche review
Clinical Audit Report: CA-21-0021: Getting to Know You Community CBU, South Locality *(embedded within impact statement dated 14 October 2021)*	The final report is dated 30 September 2021. This records that the draft had been disseminated and approved at the Clinical Standards Group, Community CBU, South Locality on 14 September 2021. There is no date included for the Final Report sign-off at the Trust's Clinical Effectiveness Committee. The audit records minor areas of concern with a low risk rating assigned. There is a table included to show the report distribution including clinical managers and Directors in the Trust. The audit had been undertaken to show if the Getting to Know You documentation in Rio is being routinely completed and demonstrate if this is now embedded into service. Data was reviewed from the period 12–16 July 2021. With 5 records per qualified member of staff (band 5 and above). It is unclear how many records or staff members this included. <u>Results</u>
Impact Statement [Service User A],14 October 2021	This records the team's quality indicators review and notes: • Review of one case per month in clinical supervision including the Getting to Know You document. • Creation of a spreadsheet with the date identified that the Getting to Know You form is due for review, and which is reviewed at monthly supervision. • An opt-out process has been developed for family intervention. • The service are offering regular welcome days and carers' forums to ensure carers are receiving support (currently remote due to COVID-19).

Action Plan Point	Standard	Compliance Attained
4.1	Has a carer /relative been identified and recorded on Rio during the initial assessment?	73%
4.2	Is there evidence the Getting to Know You (GTKY) process has commenced?	58%
4.3	Is there evidence the carer/relative person has been offered a carer support appointment?	58%
4.4	If the carer /relative initially declined carer support is there evidence this has been re-visited at a later point (within a 3 month time scale)?	29%
4.5	Is there evidence the team have maintained regular contact with the carer/relative supporter throughout the episode of care?	84%

Appendix 1: Full evidence review (cont.)

Recommendation A3 (cont.)

Key evidence submitted	Niche review
Email from the EIP Team to Community Clinical Manager, 21 December 2021	In an email dated 21 December 2021, the Clinical Lead in the EIP Service referenced the audit (above) and the team's plans to review each month during supervision, supporting staff to remember to keep this under review as per the policy. We have not seen evidence of supervision records to assess if this has been done in the months following the September 2021 audit. The results shared in this email are different to those recorded in the audit (see table above): **Getting to Know you (1173)** **EIP – S Tyneside Sunderland** **No. / Assessment of Evidence Held** 1. Has a carer relative been identified and recorded on Rio during the initial assessment? — 78% 2. Is there evidence the Getting to Know You (GTKY) process has commenced? — 100% 3. Is there evidence the carer / nearest person has been offered a carer support appointment? — 100% 4. If the carer / relative initially declined carer support is there evidence this has been re-visited at a later point (within a 3-month time scale)? — 91% 5. Is there evidence the team have maintained regular contact with the carer relative supporter throughout the episode of care? — 97%
Quality Priority Update Report - Q3 2021-22	This report is an update on the Trust's Quality Priorities for quarter 3 of 2021/22. It includes an update on the Quality Priority 3: Patient Care – increasing time staff are able to spend with service users and carers and plans for further work in 2022/23 that would support the carers' needs assessments and Getting to Know You processes and practices at the Trust.
Carers Awareness Training Core Principles Slides, February 2021	Slides created and shared by the Patient and Carer Involvement team. These include specific references to carers' support including statutory carers' assessments.

Appendix 1: Full evidence review (cont.)

Recommendation A3 (cont.)	
Key evidence submitted	**Niche review**
Carers Awareness Training Summary Guide V01, July 2021	This is a supporting guide for staff that explains the purpose and aims of the Trust-wide Carers Awareness training. This includes the expectation that the training is co-delivered with carer representation. There is a requirement for the respective localities to ensure that facilitators use the Carers Awareness Training Attendance Record to capture how many people have attended. It also states that responsibility for evaluating the carers' sessions is with the locality and that this should consider delivery and content in addition to the longer term impact on staff members' practice.
Email from Nurse Consultant – Community CBU, South Locality, 1 March 2022 *Embedded documents* • *Carers Awareness Training Core Principles (February 2021);* • *Carers Awareness Training Plan (5 November 2021);* • *Register for use in the planned carers' training; and* • *Evaluation form for use by attendees (delivery and content).*	This email includes an update from the locality that plans to roll out the Carers Training had been agreed in November 2021. However, this had been delayed due to operational pressures and Opel 3 *(NHS England identify different levels of operational pressure with Opel 3 reflecting that the service is experiencing major pressures that are compromising patient flow and this continues to increase).* The email does say dates have been booked in March and April. Documents embedded within the email included: • Carers Awareness Training Core Principles (February 2021); • Carers Awareness Training Plan (5 November 2021); • An example register for use in the planned carers' training; and • An example evaluation form for use by participants (delivery and content). We have not seen specific evidence of the expected method for evaluating the longer term impact on individual staff members' practice once they have completed the training.

Appendix 1: Full evidence review (cont.)

Recommendation A4	
The revised arrangements for transition between CAMHS and adult ADHD Services should be audited within three months to ensure they are timely and effective.	
Key evidence submitted	**Niche review**
Transition referrals to the adult ADHD team via CYPS Report, 16 July 2021 CA-20-0027 (v5)	This is an audit report reviewing the quality of information in referrals for transitions across the localities. The conclusion of the report stated "Based on the work undertaken, the Trust is performing at a level showing areas of concern. It is noted that across all cases audited, only 15% of referrals contained all the information requested." The rates of compliance varied across the localities and the 7 domains in the audit of 20 cases randomly selected. Seven actions are identified to support improvement with a target date for completion by November 2021. We have not seen additional evidence to be able to assess whether this action has been taken or if a further audit to measure impact is planned (although we note the update provided in the email below).
Email from the Trust, 21 December 2021	The Manager for the Adult ADHD team provided an email update that stated *"In south we have met and are working with clinical leads in CYPS to manage the issues that arise as work not being completed as requested by the medics in adult services. We have recommenced face to face transitions but with Covid we are also supporting a one off mop up session with CYPs completing and presentation transitions of those ready to move over We have a team meeting (now via teams) to review with the medics the information they are requesting from CYPS and to arrange feedback to CYPS via the medics from that point"*
Supplementary information received	Additional emails have been provided by the Trust that relate to actions from the audits to introduce a client tracker process within ADHD. The emails acknowledge that the embedding of the tracker may take several months and, as of February 2022, the tracker had not been built by the Rio team. While this may support practice in future, it cannot be used as evidence in this review.

Appendix 1: Full evidence review (cont.)

Recommendation A5
Referral between forensic CAMHS and adult forensic services needs to be streamlined. To be taken to the Business Delivery Group, Safety, for further discussion. Quality improvement meeting planned for 17.04.19.

Key evidence submitted	Niche review
Bulletin, October 2021	Trust Bulletin dated 5 October 202 includes (page 12 of 18) an overview of the Forensic Community Team and support available. There is an external web link to the up-to-date referral form (see below).
Safer Care Bulletin – October 2021	Content as above. Shared in 6-page Safer Care Bulletin issued in October 2021 by the Patient Safety Specialist Team.
Email from Associate Director for Secure Services, 9 December 2021	The Associate Director for Secure Services provided an email update that stated: • *"Information about the FCT's work and referral process was added to the Trust Bulletin and Safer Care Bulletin.* • *Referral documentation, and service information is now on the Trust Intranet.* • *Roll out of presentations to local teams/wards is ongoing (this includes to Cumbria) however impacted due to COVID, but the Team plan to continue the roll out of this into the New Year.* • *The Team are exploring options in relation to regular supervision slots for key areas – again plan to move this forward into the New Year."*
Forensic Community Team (North East and Cumbria) – Referral form, July 2021 Webpage (accessed via link in bulletin, 3 February 2022)	The referral form is Version 14 and dated July 2021. It is 6 pages with prompts and guidance for completion by referrers.

Appendix 1: Full evidence review (cont.)

Recommendation A6

[Name] Ward should ensure through management supervision, that all registered nursing staff with responsibility for student nurses validate entries made in clinical records in order to discharge their professional accountability for the actions of the student.

Key evidence submitted	Niche review
Email from Associate Nurse Director, 21 December 2021	The email from the Associate Nurse Director states that the Clinical Nurse Specialist has audited clinical notes in Rio on 14 December 2021. The audit had identified work is still needed to embed this across inpatient wards. Actions reported to be taken to improve validation processes include this being a task in the Night Duty jobs checklist (completed by the Nurse in Charge every night) and being added to the shift co-ordination sheet as part of the morning handover. The email also states that an audit tool would be developed by the Clinical Nurse Specialist in December 2021. The tool would then be presented to ward managers on 5 January 2022 and ward managers would be asked to complete weekly audits and escalate any issues to the Registered Nurse responsible. Ward managers are also asked to include any notes completed by non-registered staff for completeness.
Email from Practice Education Team Manager, 21 December 2021	The email from the Practice Education Team Manager states; • *"Attended induction to ensure information on validation process was being passed to students and included in slides.* • *Also included at the induction for apprentices.* • *Shared in team meetings and via email with the Practice Education Team.*

Appendix 1: Full evidence review (cont.)

Recommendation A7	
The EIP team should utilise this report within a learning event in order to ensure that the lessons learnt are discussed and integrated into the Care Coordination process. To be discussed within Trust wide EIP away day and the strategy group. Individual team members should have the opportunity to reflect on their contribution to the care process through both clinical and management supervision. Update required on the Trust wide implementation of the Trust supervision process and policy.	
Key evidence submitted	**Niche review**
Impact Statement [Service User A],14 October 2021	The Impact Statement provided by the EIP team from October 2021 includes quality indicators and review against this recommendation. This identifies the: • New trust wide supervision policy in place following investigation. • Modern Matron has taken a lead in embedding supervision across South Clinical Business Unit (CBU). • Trust now has a new electronic recording/monitoring system for supervision. • When audits are completed, they are documented in the progress notes and in the 'comments' section in the referral page on RIO. This can be pulled off as a caseload to enable the clinical lead to see when the person was last discussed in supervision and ensure a different patient is audited each time. • Complex case meetings have been established within the service, to give clinicians the opportunity to discuss complex cases within a set forum. These are offered twice monthly. • Formulation meetings have been established within the service, to enable clinicians to discuss in depth, the psychological formulations of the clients with whom they are working. • All clinicians receive monthly clinical supervision and three-monthly management supervision. • Weekly MDT meetings, and twice weekly huddles, within the service, with all staff in attendance, which give clinicians the opportunity to raise concerns/discuss clients care and treatment. • Monthly business meetings with all staff in attendance, to disseminate information shared by the CBU.
EIP Clinical MDT Meeting Minutes, 17 March 2022	This document is an example of the MDT meeting minutes following the weekly MDT. It includes headings and areas for the team to capture any reviews of clients including risk, care and treatment.

Appendix 1: Full evidence review (cont.)

Recommendation A7 (cont)	
Key evidence submitted	**Niche review**
Assurance Evidence Document from the EIP Service, 23 March 2022	The document provides information on the Trust wide implementation of the supervision process for the EIP Team. This includes current practice statements as follows: • All supervision is captured within dashboard. • EIP clinicians being provided with three monthly operational supervision by the EIP Pathway Manager. • Monthly supervision is provided to Band 6 care coordinators and Band 5 lead professionals by the Clinical Lead. • Monthly clinical supervision is provided to Band 3 clinical support workers and band 4 peer supporters, by a qualified member of staff, either a band 6 or 5. • Specialist supervision such as psychology or non-medical prescribers is provided appropriately as required. Individual supervision is supported by opportunities for the team to reflect with others through: • Weekly MDT meetings, where the whole team are present, and clinicians are encouraged to discuss clients of concern, in order for the team to offer clinical support. • Two mini-MDTs per week where clinicians are encouraged to discuss clients of concern. • A monthly formulation forum exists within the service, which is facilitated by a psychologist and a family therapist. One client is discussed in depth each time, to support clinicians to develop the psychological formulation. • A two-weekly complex case forum within the service, which is facilitated by the Clinical Lead and Nurse Consultant. One client is discussed in depth each time, to support the team in the management of complex cases.

Appendix 1: Full evidence review (cont.)

Recommendation A8

Senior Trust officers should discuss and agree future Trust Policy in relation to involvement/information sharing with the family of a victim, when the victim is not known to mental health services in these circumstances.

In relation to this case, legal advice should be sought regarding the level of information from this investigation report that can be shared with the victim's family.

A meeting is offered to the victim's family to provide feedback regarding the investigation. In order to minimise distress, the process relating to the NHS England Independent Investigation should also be explained to the family by a representative being present from NHS England at the meeting.

The Trust should write to service user A's mother and offer a further opportunity to meet and receive feedback on the outcome of the investigation. Medical advice should be sought from service user A's RC regarding any feedback or otherwise to the patient regarding the review of his care and treatment.

Key evidence submitted	Niche review
Email from the Clinical Risk and Investigations Team to Niche, 27 January 2022	In the email, the Trust reported that the policy for sharing incidents with families is due to be shared for consultation. This follows amendments to highlight that sharing reports will always be considered and there will be a discussion between the Caldicott Lead and the police.
File note: meeting with service user A's mother, 15 April 2019	The file note records an in-person meeting with the independent report author and service user A's mother to feedback the outcome of the serious incident investigation.
Trust meetings with service user A's mother	This is an undated document that records two meetings with service user A's mother: • 19 April 2019 – Meeting with Independent Investigator and Trust Director for South Locality services • 25 March 2021 – Meeting with Group Nurse Director and Executive Director of Nursing.
Update from the Trust regarding communications with the victim's family.	• In May 2019, the police asked the family if they were happy for their contact details to be shared with CNTW so contact could be made and an apology offered. • The family responded in June 2019 and were appreciative of the Trust's offer to meet with them, but said they did not want to do so at this time if they could not see the full report. • Legal advice was taken regarding disclosure but this was not possible in the absence of consent from the perpetrator.
Practice Guidance Note, Managing Independent Investigations, January 2022	The Trust produced a Practice Guidance Note in January 2022 for managing independent investigations. This includes information to support Trust staff in engaging with investigations, supporting all stages of the process and a governance process for assurance against action plans. It also highlights that sharing reports will always be considered and discussions to support this will be led by the Caldicott Guardian and the police.

Appendix 1: Full evidence review (cont.)

Recommendation B1	
Trust Serious Incident Panel meetings should be formally recorded.	
Key evidence submitted	**Niche review**
Email from the Clinical Risk and Investigations Team to Niche, 27 January 2022	In the email, the Trust said they had reviewed the terms of reference for Serious Incident Panels and would be sharing a revised version with Serious Incident Chairs for comment. The email also stated that SI Panels will not be minuted in the Trust as "*They are clinical discussions and an Multi-Disciplinary Team panel chaired by a Director will finalise and agree reports".* A draft of the new terms of reference has not been shared by the Trust.

Recommendation B2	
The Trust should ensure that SI action plan evidence is rigorously tested and recorded in advance of action plan sign off.	
Key evidence submitted	**Niche review**
Internal Audit Report, Risk Based Audit: Serious Incident Action Planning, 11 November 2021	The Trust completed a risk-based audit of their action planning following serious incident investigations. This does align with the recommendation made in our April 2021 report and provided further evidence of improvements that the Trust need to action. The audit reviewed a sample of 12 action plans produced between April 2020 and June 2021. There are 7 recommendations identified in the action plan and six are accepted for action. Two of the actions are completed and one partially completed. The other three had expected completion dates of 28 February 2022; we have not been provided with any information to confirm this has been done. This includes the recommendation for the Trust to produce guidance to support the management of SI action plans, addressing the lack of any existing framework in Trust policy or procedures. Plans for re-audit to ensure continuous improvement have not been provided.
Email from the Clinical Risk and Investigations Team to Niche, 27 January 2022	This email references the Quality Standards Group that discusses and agrees action plans, challenging content where necessary. The attendance and quoracy of the Quality Standards Group had not been included in the scope of the internal audit (above). We have not been provided with any additional evidence related to the group or any changes made since our April 2021 report to be able to comment on the effectiveness of oversight for SI action plans.

Appendix 1: Full evidence review (cont.)

Recommendation B3
The Trust should assure itself within three months of receipt of the final report that it can evidence the implementation and completion of each recommendation, all of which were signed off at the South Locality Quality Standards Group meeting in September 2019.

Key evidence submitted	Niche review
Impact Statement [Service User A],14 October 2021	This document provides evidence that in October 2021 the EIP team reviewed their progress against the recommendations of the internal action plan and our internal investigation. This included recommendations A1, A2, A3 and A7. All other recommendations are recorded as “not applicable to EIP”. The whole EIP team, Clinical Manager and Group Nurse Director were involved in developing the impact statement. It notes that the EIP felt that the evidence reviewed demonstrated that actions had been taken and continue to be embedded within the team.
Assurance Evidence Document from the EIP Service, 23 March 2022	The updated impact assessment includes updates and evidence on progress made against three of the 11 recommendations.

Appendix 2: Glossary of terms

Appendix 2: Glossary of terms

ADHD	Attention Deficit Hyperactivity Disorder
CAMHS	Children and Adolescent Mental Health Services
CBU	Community Business Unit
CCG	Clinical Commissioning Group
CYPS	Children and Young Peoples Service
EIP	Early Intervention (in) Psychosis
FACE	Functional Analysis of Care Environments
IT	Information Technology
MDT	Multi-Disciplinary Team
NIAF	Niche Investigation Assurance Framework
RC	Responsible Clinician
SI	Serious Incident
SMART	Specific, Measurable, Achievable, Realistic and Timely

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