Independent Quality Assurance Review

NHS Manchester CCG, Greater Manchester Mental Health NHS FT and Pennine Care NHS FT

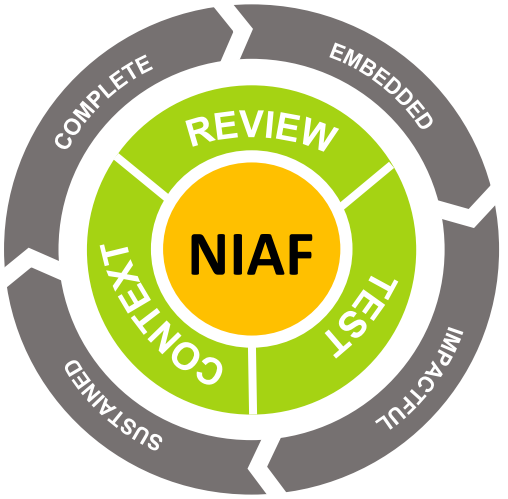
Ref: 2016/3780

Highly private and confidential

October 2019

insight integrity impact

Niche Investigation Assurance Kitemark



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

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1. Executive Summary

Background and context for this review

In February 2017, NHS England North commissioned Niche Health & Social Care Consulting Ltd (Niche) to carry out an independent investigation into the care and treatment of a mental health service user (L) by (the legacy) Manchester Mental Health and Social Care NHS Trust (MHSCT), Pennine Care NHS Foundation Trust (PCFT) and associated agencies following the homicide of a man (W) in February 2016. At the time of the investigation it was noted that MHSCT ceased to provide care as a registered mental health trust in January 2017. The organisation has now been integrated into Greater Manchester Mental Health NHS Foundation Trust (GMMH).

The investigation interviews commenced in November 2017 with the publication of the final report in November 2018. This included six recommendations which were intended to support the Trusts and NHS Manchester Clinical Commissioning Group (Manchester CCG) in learning and improving services and practices.

The terms of reference for the independent investigation required Niche to undertake an assurance follow up review after report completion. This is in order to provide an assessment of the implementation of the organisations' resultant action plans against the Niche Investigation and Assurance Framework (NIAF). This is a high-level report on progress to NHS England North undertaken on the basis of desktop review only, without further site visits or interviews.

Implementation of recommendations

Recommendations were used as the basis for action planning for each of the organisations rather than conversion into outcome focused action plans which would help support delivery and implementation. Action owners were, however, assigned in most cases and our review has found that two actions have been completed and tested with another three completed but not tested. A joint recommendation (R1) has been progressed by Greater Manchester Mental Health FT, however, evidence for Pennine Care FT is lacking. We also note an absence of collaboration by the two organisations to ensure that approaches to implementation are aligned.

Review method and quality control

Our work has comprised a review of documents. 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 from Pennine Care FT, Greater Manchester Mental Health and Manchester CCG to complete this review.

At Niche we have a rigorous approach to quality standards. We are an ISO 9001:2015 certified organisation and have developed our own internal single operating process for undertaking independent investigations. Our final reports are quality assured through a Professional Standards Review process (PSR) and approved by an additional senior team member to ensure that they have fully met the terms of reference for review.

2. Summary assessment on progress

The Niche Investigation Assurance Framework

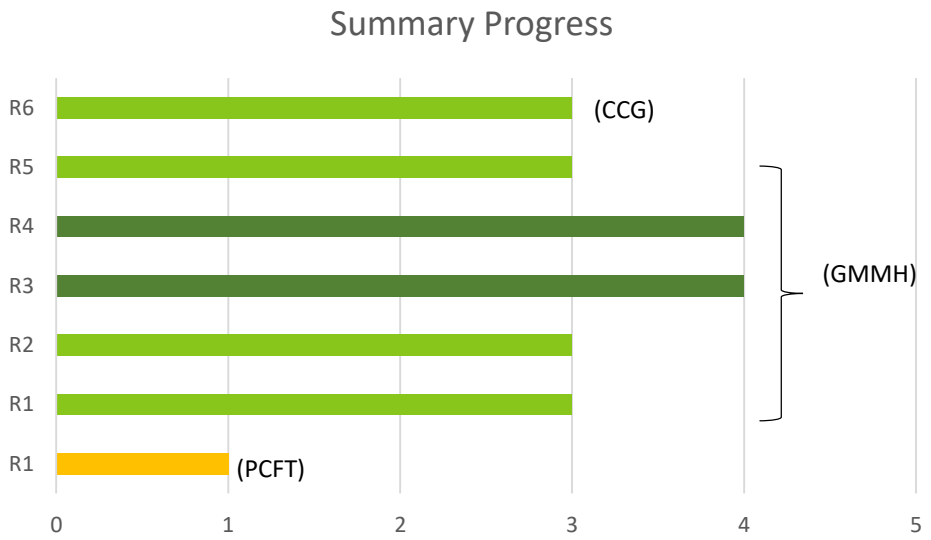
Assessing the success of learning and improvement can be a very nuanced process. Importantly, the assessment is meant to be useful and evaluative, rather than punitive and judgemental. We adopt a useful numerical grading system to support the representation of 'progress data'. We deliberately avoid using traditional RAG ratings, instead preferring to help our clients to focus upon the steps they need to take to move between the stages of completed, embedded, impactful and sustained – with an improvement which has been 'sustained' as the best available outcome and response to the original recommendation.

Our measurement criteria includes:

Score	Assessment category
0	Insufficient evidence to support action progress / action incomplete / not yet commenced
1	Action commenced
2	Action significantly progressed
3	Action completed but not yet tested
4	Action complete, tested and embedded
5	Can demonstrate a sustained improvement

Our assurance review has focussed on the subsequent actions that have been progressed and implemented in response to the recommendations made in the independent investigation report.

In relation to progression of actions which have been agreed from the six recommendations made from the internal investigation report. We have rated the findings which are summarised below:



Summary

There has been good progress in relation to some of the recommendations, however, we have received limited information from PCFT about the actions that have been implemented in order to progress Recommendation 1.

Assurance review findings

3. Assurance review of the Trust's action plan

The terms of reference for this current assurance review require an assessment of the implementation of the recommendations which resulted from the independent investigation into the care and treatment of a mental health service user (L) by (the legacy) Manchester Mental Health and Social Care NHS Trust following the homicide of W in February 2016.

The investigation report made six recommendations which were intended to support the Trusts and Manchester CCG in learning and improving services and practices. Recommendation 1 was assigned to PCFT and GMMH, recommendations 2-5 to GMMH, and recommendation 6 was for Manchester CCG.

We have been provided with updates from PCFT and Manchester CCG but have not seen an outcome focussed action plan to support delivery of these actions.

GMMH have incorporated their recommendations into a plan. Action owners have been assigned to each recommendation, the plan is RAG rated to allow an at a glance understanding of the status of each recommendation, and there is an evidence base of actions that have been taken. The Trust should be commended on the overall progress they have made in ensuring that learning and improvements take place.

There are some areas, however, where further improvements could be made. The recommendations themselves have not been broken into smaller discrete tasks and it is not clear what the methods of implementation were or the process for communicating changes to staff (including a description of the staff groups that communications are intended for), the frequency of audit or testing, and how results will be fed back and acted on.

Due dates were assigned to all but one of the GMMH recommendations (R4) which is marked as 'ongoing'. Recognising that obtaining assurance may be an 'ongoing' task, the Trust should instead have assigned a due date for delivery of the processes which would allow ongoing assurance to be provided.

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

Recommendation 1: Both PCFT and GMMH should clarify the MAPPA status at the point of transfer to other services for patients with forensic histories. This should also include identification and involvement of probation/NOMS for appropriate patients.	
Trust response and evidence submitted	Niche comments and gaps on assurance
GMMH • Edenfield Medium secure service has confirmed that at the point of transfer to other services it is the responsibility of the service social workers for identifying the involvement of probation and National Offenders Management Service for Patients. • Edenfield Social Workers are also responsible for notifying MAPPA of admissions, leave status and discharge and will attend all MAPPA meetings. • In order to raise awareness to staff of the role of MAPPA the Trust has developed guidance which has been approved by the Risk Management Group. This has been cascaded across services via the divisional Associate Directors. • To further raise awareness in relation to service users under MAPPA arrangements the Trust has enhanced the alert process within its PARIS electronic records system so that service users under MAPPA will be visible through staff accessing the alert.	• A number of actions have been progressed in order to implement this recommendation, and we have been provided with additional evidence of MAPPA communications via '7 minute briefings' and 'Splash Screens'. • The MAPPA guidance has gone back for wider consultation via Divisional Hubs after initial feedback from some clinicians. Once feedback has been reviewed the guidance will be cross-referenced with the Trust CPA Policy. • The Trust has proposed incorporation of an audit of the MAPPA guidance into the Trusts 2020/21 audit programme in order to provide evidence of implementation and compliance. 8
NIAF rating: GMMH has progressed a number of actions to meet this recommendation, however, there are some residual gaps in assurance given that the outturn audit has yet to be undertaken. Overall rating for this recommendation for GMMH: 3	

Recommendation 1: Both PCFT and GMMH should clarify the MAPPA status at the point of transfer to other services for patients with forensic histories. This should also include identification and involvement of probation/NOMS for appropriate patients.	
Trust response and evidence submitted	Niche comments and gaps on assurance
PCFT • No evidence of action implementation provided.	• The Trust is proposing to include a paragraph relating to the MAPPA status of patients at the point of transfer to other services within the CPA Policy; however, the Community Mental Health Teams (CMHTs) are under review. The Trust has recognised that this may have a direct relationship on the content of policy so revisions will be made once complete. Interim arrangements (e.g. through safeguarding adults training) have not been stated. • In the absence of a revised CPA Policy incorporating MAPPA guidance, the Trust will need to determine the timelines for the changes proposed to the policy, immediate contingency plans, and how these will be communicated to relevant staff and tested to ensure compliance. • The Trust will need to clarify how the actions referenced are aligned to those of GMMH.
NIAF rating: PCFT have provided some reassurances on actions to be taken but there is limited evidence of implementation. Further, the action developed to address the recommendation may be insufficient to promote sustainable change. Further work is required. Overall rating for this recommendation for PCFT: 1	

Recommendation 2: a. The Trust must provide clear guidelines for risk assessment and care planning for the titration of Clozapine in the community. b. The Trust and NHS Manchester CCG must develop and agree guidance for GPs on the administration of Clozapine and the limited function of blood tests for titration.	
Trust response and evidence submitted	Niche comments and gaps on assurance
2a) • In December 2018 The Trust developed a Task and Finish Group between senior pharmacy leads, operational staff, and senior clinicians from all divisions within the organisation to consider an interim process for Clozapine initiation across the Trust. GMMH now has a harmonised Clozapine Policy for the Trust which includes community prescribing. The new Policy has been supported with the development of inpatient and community guidance for the use of Clozapine. • A business case is also currently being developed for a Trust wide team with specialist knowledge to manage clozapine initiations. In preparation for the business case approval, the home initiation and intramuscular administration Standard Operating Procedures for Clozapine have been refreshed in order to provide further clarity on the process for prioritising and escalating concerns to managers about patients waiting to start on Clozapine.	• The Trust has a Clozapine Steering Group and a number of actions have been progressed in order to implement this recommendation. • New guidance documents are available and have been communicated to the Trust Medicines Management Group and Trust Clozapine Steering group. These should be audited regularly to ensure compliance Trust-wide.
2b) • GMMH have developed GP Clozapine Information guidance letters. These have incorporated learning from the homicide in relation to a list of the tests to be included.	• This recommendation has been fully implemented.
NIAF rating: GMMH has progressed a number of actions to meet this recommendation, however, there are some residual gaps in assurance. Overall rating for this recommendation: 3	

Recommendation 3: The Trust AWOL policy should be amended to ensure that any decision to discharge an AWOL patient in their absence is explicitly risk assessed, supported by a detailed decision making tool, and reported on centrally to ensure practice is monitored.

Trust response and evidence submitted	Niche comments and gaps on assurance
• The Trust AWOL Policy has been harmonised and strengthened to ensure that service users who are informal and return from leave have their MHA status reviewed on return from AWOL. Although it would not be deemed best practice to discharge service users in their absence, the GMMH AWOL Policy highlights that any decisions made by a team in relation to this should be supported by a detailed risk assessment and recorded within the service users records'. The Policy has provided flow charts for staff to provide at a glance guidance and assist in the decision making of teams in these instances. • Further review of compliance against the Policy has been carried out via a Trust wide audit. This audit took place over a 12-month period, included 277 service user records and was completed by the Strategic Lead for Patient Flow. The aim of the audit was to review if staff were fully implementing the policy and also decision making by MDTs following an individual going AWOL. The outcome of this audit demonstrated that overall staff were implementing the Policy correctly and MDTs were recording decisions where service users were discharged in their absence. A repeat of this audit has been scheduled in the Trust 19/20 audit programme in Quarter 3.	• The audit that is referenced confirmed good practice in many aspects of the AWOL Policy. In relation to this recommendation it also identified 12 patients who were discharged in their absence. The 48 hour / 7 day follow-up was completed in all but two cases. • The scheduling of a repeat audit is good practice to confirm whether compliance is being sustained. 8

NIAF rating: This recommendation has been completed and testing has evidenced that it is largely embedded in practice. Further testing is planned to ensure changes in practice have been sustained. In order to fully meet this recommendation the Trust should demonstrate sustained improvements to practice.

Overall rating for this recommendation: 4

Recommendation 4: The Trust should assure themselves and commissioners that arrangements are in place to provide appropriate medical cover on the acute adult in-patient wards to ensure medical oversight and continuity of care.	
Trust response and evidence submitted	Niche comments and gaps on assurance
• The Trust has implemented a proactive recruitment strategy and have reviewed job plans and support for consultant posts within Park House. They have been successful in the recruitment of good calibre substantive consultant posts into vacancies. All acute in-patient wards across Bolton, Salford, Trafford and South Manchester areas now have full Consultant establishments. • The Trust recognise that this position is an ongoing risk for the organisation and this is being closely monitored by the Workforce Development Strategy Group and the Medical Workforce Sub-Group. A further recruitment campaign is ongoing with enhanced consultant support and sessional allocation for adult in-patient consultants. In the interim, Lead Consultants have worked proactively with Human Resource colleagues and any vacancies have been successfully recruited into by locum cover. The locum consultants appointed have been of a high calibre and have been providing a consistent service to Park House. • A key role also being introduced as part of the recruitment strategy includes the role of Advanced Practitioner (AP) posts to support multi-disciplinary teams. A lead AP commenced in post in June 2019 with other substantive posts being considered. The aim is to have an AP on each ward.	• A number of actions have been progressed in order to implement this recommendation and there is ongoing reporting as described. The Board is also sighted on areas of risk through, for example, quarterly safe working hours reports for doctors in training. 8

NIAF rating: This recommendation has been completed and on-going compliance is being monitored at Board and Committee levels. This is an area of on-going risk which is recognised by the Trust.

Overall rating for this recommendation: 4

Recommendation 5: The Trust must ensure that discharge planning arrangements on the adult acute in-patient wards comply with Trust policy, and that arrangements are made to appropriately grade those patients with complex needs and often forensic and/or substance misuse histories who are at high risk of disengagement from mental health services, and who should receive assertive and proactive care to prevent them being lost to services, even if discharged whilst AWOL.

Trust response and evidence submitted	Niche comments and gaps on assurance
• A 'special notes system' was developed within AMIGOS prior to the acquisition of MHSC and GMW Trust. This system assisted staff in identifying critical information in relation to a service user and highlighted where a forensic assessment had been completed for an individual. Community and in-patient services were audited against use of the special notes criteria and these audits have demonstrated positive results around how staff implemented this system. • In December 2018, all GMMH Manchester services ceased to use AMIGOS and moved onto PARIS in line with the rest of the organisation. PARIS enables staff to raise individual service user alerts and capture a service users risk information, particularly those with forensic histories who may be in contact with MAPPA. • Since development of the new organisation, Manchester adult acute wards have a dedicated substance misuse practitioner specifically working with the teams and patients to improve awareness, knowledge and skills in relation to complex patients with serious mental health and substance misuse problems. The Trust has also introduced a dedicated Strategic Lead for Patient Flow role. This role is key in ensuring continuity of care for service users and to ensure service users are placed back with the same consultant and clinical teams as far as possible. • Adult acute wards have improved pathways for referral for forensic assessments and gateways to beds, and ward managers have an awareness of implementing referrals for forensic assessments. • Continued overleaf.	• A number of actions have been progressed in order to implement this recommendation and the audit referenced overleaf identified good practice in many aspects of discharge planning. However, it has also highlighted some gaps: – 52% of the patients had no mental state examination documented in the electronic records in the 7 days prior to discharge; – 20 out of the 50 patients were identified as having substance misuse difficulties. 8 (40%) of these patients were not referred or signposted to appropriate services during their in-patient admission; and – 28 patients were identified as having a care coordinator who were under the community mental health team during their admission. The care coordinator for 9 (32%) patients had not been involved in the discharge planning process.

Recommendation 5: continued	
Trust response and evidence submitted	Niche comments and gaps on assurance
• There have been examples recently where joint working and referral has meant a smoother and safer transition for the service users requiring medium secure services. Referral pathways have also been highlighted within the Adult Acute Inpatient Ward Managers meeting and recorded within the minutes. • Wards have been completing audits of the ward discharge checklists that are now in place and results have been positive in relation to how staff are implementing discharge meetings. An audit was recently completed by a senior clinician looking at a sample of 50 patients records where service users have been discharged from wards and whether risk assessments had been completed by staff and the decision making by the team prior to the service users discharge. The audit has revealed good practice with regards to the discharge planning process. The majority of the patients had a discharge CPA meeting and follow-up arrangements at the time of discharge. For patients discharged in their absence, there is clear documentation and discussion of risk management and follow-up arrangements. • The discharge planning audit results have been presented to the Consultant Senior Leadership Team meeting and is due to be presented to the October In-patient Consultant Forum meeting and to the Trust Clinical and Quality Audit Committee.	• The discharge planning elements of the CPA Policy and learning from the audits has been communicated to senior medical staff and the Clinical Quality and Audit Committee. The Trust will need to ensure that key findings are cascaded to other staff groups with repeat audits to test compliance with Trust policy.
8	

NIAF rating: GMMH has progressed a number of actions to meet this recommendation, however, there are some residual gaps in assurance.

Overall rating for this recommendation: 3

Recommendation 6: NHS Manchester CCG should assure themselves that the Trust is identifying the cohort of patients at most risk of disengagement from services, who have complex needs and often forensic histories with a background of drug abuse. This identification should then lead to the Trust being able to provide an assertive care pathway for this group with escalation routes into appropriate inpatient beds and access to appropriate clinical and forensic support and advice when needed.

Manchester CCG response and evidence submitted	Niche comments and gaps on assurance
• GMMH have a detailed SOP for the CMHT which has been shared with NHS Manchester CCG. This document describes the daily MDT zoning meetings which are a whole team approach to care enabling a targeted clinical response that can adapt quickly to changes in service users' needs and risk. It encompasses a traffic light system with service users placed in different zones dependant on their level of need and risk; this determines the type of interventions offered. The zoning process allows for daily reviews of care and is inclusive of the whole staff team so enhances a targeting of resources and allows for enhanced communication of service users at risk. The approach provides structured intensive case management of identified service users, safeguarding issues and where vulnerable adults are highlighted. The Trust has a number of services they can utilise depending on service users needs as identified through the zoning meeting. • The Trust is currently working towards a seven day CMHT service across the GM footprint. Teams are now co-located across central, south and north Manchester sites. With Consultant cover for the MDT to be in place by November 2019 and extensive staff side engagement, this extended service will provide better coverage to patients within Manchester. • The CCG will be visiting the CMHT on a quality walk-round and sitting in on a zoning meeting to fully understand how the zoning meetings are working.	• CMHTs and associated processes are well established in GMMH and NHS Manchester CCG has provided some information on the CMHT SOP. However, there is no evidence to support appropriate implementation of this procedure by the Trust i.e. that patients with complex needs are escalated into appropriate inpatient beds, and can access clinical and forensic support and advice when needed. 8

NIAF rating: GMMH has progressed a number of actions to meet this recommendation, however, there are some residual gaps in assurance that Manchester CCG will need to pursue.

Overall rating for this recommendation: 3

Appendices

Documents reviewed

GMMH	
7 Minute Briefing on MAPPA	GMMH MAPPA Guidelines (July 2019)
MAPPA alert communications	MAPPA Splash Screen
Community Clozapine Guidelines	Clozapine GP Letter
Trust MMG Minutes 24th January 2019	Clozapine Inpatient Guidelines July 2018
Trust MMG Minutes 19th July 2018	AWOL Policy Audit
Medical Leadership Structure – March 2019	Medical Workforce Group Meeting – Minutes 6th December 2018
Medical Workforce Group Meeting – Minutes – 16 May 2019	Medical Workforce on In-Patient Units – June 2019
Operations Directorate Structure – V12 – June 2019	Quarterly Report 01.11.18 to 05.02.19 Final
Discharge planning Audit May 2019	Escalation 7 Bullet Briefing v3 final
Manchester CCG	
CMHT SOP V44 28.02.19	

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