An independent external quality assurance review following an internal investigation into the care and treatment of mental health service user A in North West Boroughs Healthcare NHS Foundation Trust.

September 2020

CONFIDENTIAL

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First published: April 2021

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 draft report has been written in line with the terms of reference as set out in our Letter of Engagement for an independent external quality assurance review following an internal investigation into the care and treatment of mental health service user A in North West Boroughs Healthcare NHS Foundation Trust in 2017. 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Events which may occur outside of the timescale of this review will render our report out-of-date.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.

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1 EXECUTIVE SUMMARY

1.1 North West Boroughs Healthcare NHS Foundation Trust (NWB or the Trust) provide treatment, support and guidance for a range of health needs for people living in Greater Manchester, Halton, Knowsley, Sefton, St Helens, Warrington and Wigan. These include physical and mental health conditions and learning disabilities.

1.2 In July 2017 the deputy team manager of the NWB recovery team, received a telephone call from the criminal justice team to inform them that service user A (the perpetrator) had been arrested the previous evening, shortly after 10 pm, for the attempted murder of an unknown male. The male had been stabbed in the chest and subsequently died.

1.3 Information later emerged that the victim was another service user B (the victim) of the recovery team, who shared the same care coordinator (CCO). Both service users A and B had been good friends for some time and spent a lot of time together.

1.4 Service user A was remanded in custody and then later transferred to medium secure care. In May 2018 he was ordered by the court to be detained under Section 37/41 of the Mental Health Act (1983) to remain in the medium secure hospital.

1.5 The clinical records for service user A demonstrate a prolonged pattern of physical violence, a propensity to use and carry knives for protection or to threaten or use against other persons, detail 14 different convictions, including assaults on police, and driving whilst under the influence.

1.6 Following the incident, a 72-hour review report was presented to the NWB patient safety panel. Trust documents indicate that this was followed by a limited interim review (undated). An addendum was added later in the process.

1.7 The stated aim of the internal investigation was to establish what should have happened, using Trust policies and procedures, NICE[1] guidance and best practice guidance, and identify any gaps in service provision and, or policy and practice.

1.8 The internal investigation reviewer was advised that due to the nature of the incident and the ongoing police investigation, agreement from the police would be needed before any contact could be made with the service user, their family or any member of Trust staff or external agency involved in the care or support of the patient to discuss the circumstances of this case.

1.9 These restrictions, and a request from the family for more time, led to an extension agreement date for the completed internal investigation of 30 November 2017.

[1] https://www.nice.org.uk The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care.

1.10 An addendum to this initial internal review was made on 10 April 2018 which highlighted that the whilst the police had agreed for the Trust to be able to speak with involved staff, they were not permitted to have any contact with service user A, the family or other involved external agencies.

1.11 A final addendum was made to the report by 17 April 2018 with amendments completed by 5 October 2018. Due to the limitations posed by the Police, the internal investigation stated that the findings and analysis were based solely on a review of service user A's electronic care records.

1.12 The internal investigation identified that risk and care planning documentation was not completed in line with Trust guidance and one Trust action was subsequently identified to address this. The action was to audit a random sample of cases from each practitioner in the recovery team to establish whether the risk and care planning documentation complied with the Trust care programme approach[2] (CPA) and record keeping Policies.

1.13 Concerns were raised about the report by the St Helen's Clinical Commissioning Group (CCG) and the NHS England (Cheshire and Mersey) team that the internal investigation report did not provide assurance.

1.14 On the 18 December 2018, following the outcome of these discussions the Trust began the process of commissioning a comprehensive independent investigation with an external reviewer (the second Trust investigation). For the purposes of this report the term 'independent investigation' will be used to identify this second report. The Trust also commissioned an internal assurance review of the whole serious incident investigation process with identified areas for learning forming a Trust patient safety improvement plan.

1.15 The NHS England Regional Investigation Team (RIT), on receipt of the Trusts internal investigation in April 2019, noted that an independent investigation with an external reviewer had already been commissioned. Therefore, the RIT proposed to commission an external quality assurance review. Terms of reference for this were placed before the Regional Independent Investigation Review Group in June 2019 for consideration and sign off.

1.16 The independent investigation with an external reviewer was commissioned on 2 January 2019 by the NWB deputy director of nursing and governance with a submission date agreed between the Trust, NHS England and Knowsley CCG. The report was submitted on 31 January 2019 as required.

1.17 The independent investigation described collaborative working on the investigation with medical expertise provided by Trust staff including the deputy medical director, the assistant medical director of quality and safety and with nursing expertise provided by the assistant clinical director. The report identified 12 gaps and actions to address these were made.

1.18 Of the 12 actions identified, seven were to conduct a peer review of the function of the St Helen's local recovery team focusing on specific areas,

[2] https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/care-for-people-with-mental-health-problems-care-programme-approach/ The Care Programme Approach (CPA) is a package of care for people with mental health problems.

following which, the findings and implications were to be assessed for relevance to the broader Trust wide recovery teams and, or the organisation, and consequent actions agreed as required.

1.19 In August 2019 NHS England commissioned Niche Health & Social Care Consulting (Niche) to undertake an external quality assurance review, specifically to:

- undertake a desktop review to consider the internal and independently commissioned investigations by NWB into the care and treatment of service user A;
- ensure that the investigations key lines of enquiry have been adequately considered and explored and highlighting any areas requiring further examination; and
- conduct an assurance review of all recommendations from the NWB investigations.

1.20 Niche is a specialist safety and governance organisation undertaking investigations into serious incidents in healthcare. Sue Denby, Senior Consultant, Investigations and Reviews carried out the external quality assurance review, with expert advice and peer review provided by Dr Carol Rooney, Associate Director, Niche. The investigation team will subsequently be referred to in the third person in the report.

1.21 The external quality assurance review has focussed on the following key lines of enquiry:

- a desk top review of the care provided;
- assessment of the quality of the internal and independent investigations;
- implementation of the internal and independent investigation recommendations;
- governance and systems for oversight by the Trust and CCG; and
- evidence of the impact of the action plan recommendations.

1.22 The external quality assurance review commenced on receipt of the clinical records in October 2019 and was completed in June 2020.

1.23 We used the Niche Investigation Assurance Framework (NIAF), to provide a well evidenced and rigorous assurance process.

1.24 In order to complete the review, we carried out a range of tasks including reviewing clinical notes and the internal and independent investigations, staff interviews, reviewing policies and procedures, and minutes of meetings and various reports.

1.25 NHS England contacted the service user A directly to inform him of the review taking place to seek his engagement. Service user A did not respond

to the letter. Subsequent contact with the responsible clinician (RC) for service user A were made to ascertain whether he would like to receive feedback on the report, and this was provided 9 April 2021. There are no contact details available for other family members.

1.26 NHS England also contacted the victim's family through the Trust family liaison officer (FLO) who responded stating that they did not wish to have any involvement in the process.

1.27 The terms of reference for this external quality assurance review are given in full at Appendix A. Staff interviewed are referenced at Appendix B. Documents and policies reviewed are referenced at Appendix C, Appendix D provides details of the credibility, thoroughness and impact checklist and Appendix E lists the abbreviations used in the report.

Structure of the report

1.28 Section 2 describes the process of the review.

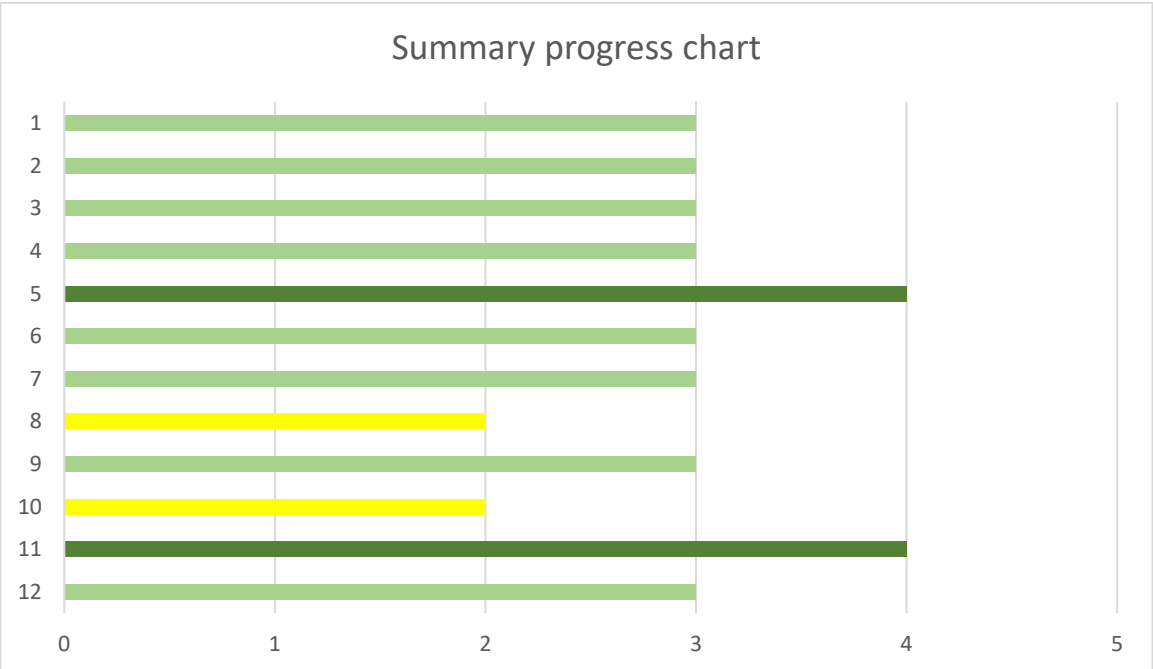
1.29 Section 3 focusses on the key lines of enquiry.

1.30 A summary is provided in section 4.

Assurance Summary

1.31 In relation to progression of actions we have rated the findings as summarised below.

1.32 On the basis of the information provided, of the 12 recommendations, we are assured two have actions significantly progressed, eight have actions completed but not yet tested and two have actions completed, tested and embedded.



2 ASSURANCE REVIEW

Approach to the review

2.1 The external quality assurance review has focussed on the implementation of both the Trust's internal and independent investigation action plans to identify progress made, to review processes in place to embed any lessons learnt and whether those changes have had a positive impact on the safety of Trust services.

2.2 The external quality assurance review commenced in October 2019, was completed in May 2020, and was carried out by:

- Sue Denby, Senior Consultant, Investigations and Reviews.

2.3 Expert advice and peer review were provided by Dr Carol Rooney, Associate Director, Niche. The investigation team will subsequently be referred to in the third person in the report.

2.4 This external review was comprised of a review of documentary evidence supplemented by an interview with the Trust independent investigation report author.

2.5 We have graded our findings using the following criteria:

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

2.6 The draft report was shared with NHS England and the Trust. This provided opportunities for those organisations that contributed significant pieces of information to review and comment upon the content

Review of the care provided

Chronology

2.7 We developed a high-level chronology based on a review of the clinical records and information contained within both the internal and independent investigations and examined whether these were accurate.

Internal Investigation

2.8 The internal investigation terms of reference did not include the scope required. The chronology utilises significant event information taken only from service user A's electronic care record only, between 15 December 2016 and 3 July 2017.

2.9 A background section of the internal investigation describes service user A's background from 2006 with details of his initial referral to secondary mental health services, his diagnosis of paranoid schizophrenia and his extensive forensic history.

2.10 For information relating to the limitations of the internal investigation we found that the reviewers were advised that due to the nature of the incident and the ongoing police investigation, agreement from the police would be needed before any contact could be made with the service user, their family or any member of Trust staff or external agency involved in the care or support of the patient to discuss the circumstances of this case.

2.11 The internal investigation chronology identified a number of outstanding questions that required further consideration, however it was stated that it was not possible at that time to explore these avenues due to the aforementioned limitations imposed on the Trust by the police.

2.12 An addendum to the internal investigation 17 April 2018 stated that the police granted the Trust permission to speak with those members of staff employed by the Trust who were involved in the care and support of service user A, to discuss the circumstances of the case. However, the police did not further confirm permission to speak with service user A, the family or any member of staff from any external agency outside of the Trust.

2.13 Due to this, although we found the scope of the internal investigation chronology was accurate, it was limited to the fact that information was taken only from the Trust electronic care record, and did not include information from 'Making Space'[3] or the GP.

2.14 The internal investigation chronology commences with clinical information relating to a CCO home visit to service user A to administer his depot (long acting) zuclopenthixol (antipsychotic) medication. The last entry of 3 July 2017 details the notification of service user A's arrest for attempted murder.

[3] https://makingspace.co.uk/about Making Space is a national charity and leading provider of adult health and social care services.

2.15 The internal investigation chronology predominately focusses on CCO visits to administer his depot antipsychotic medication, other home visits and details of consultant psychiatrist reviews.

2.16 The internal investigation chronology identified issues in the following areas:

- follow up after service user A did not attend for planned reviews;
- required medication review following reported physical health concerns;
- concerns about specialist assessment, and the involvement of a dual diagnosis worker, for substance misuse;
- missed depot medication; and
- no rationale for some home visits.

2.17 However, only one recommendation was made as a result in terms of risk and care planning documentation not completed in line with Trust guidance. This recommendation was to audit a random sample of cases from each practitioner in the recovery team to establish whether the risk and care planning documentation complied with the Trust CPA and record keeping Policy.

2.18 For the purposes of this report we have subsumed our analysis of the progress on this into recommendations 1 and 3 of the independent investigation.

Independent Investigation (the second Trust investigation)

2.19 In accordance with the terms of reference for the investigation, the independent investigation chronology commences 18 May 2004 and ends 3 July 2017.

2.20 The chronology starts with clinical information relating to service user A's first contact and admission to (unnamed) mental health services through being brought to an (unnamed) A&E department by the police for assessment, after he was seen to be behaving bizarrely, and ends 3 July 2017 detailing the notification of service user A's arrest for attempted murder.

2.21 The independent investigation chronology focusses on mental health admissions to hospital, risk, offences, contact and missed appointments, diagnosis, required medication review following reported physical health concerns, substance misuse; administration of depot medication, home visits and details of consultant psychiatrist reviews and disparities in the clinical records.

2.22 Forensic and 'adult life' sections of the independent investigation provide further narrative to support the chronology.

2.23 Gaps were identified and 12 recommendations were made as a result, seven of which were to conduct a peer review of the function of the recovery team focussing on specific areas, following which the findings and implications were to be assessed for relevance to the broader recovery teams and/or the organisation, and consequent actions agreed as required.

2.24 We found that the independent investigation chronology was accurate, comprehensive and met the terms of reference.

Care and service delivery problems

2.25 We considered the issues and care and service delivery problems identified in both investigations and assessed these against the high-level chronology.

Internal Investigation

2.26 The internal investigation chronology identified issues in the following areas:

- follow up after service user A did not attend for planned reviews;
- required medication review following reported physical health concerns;
- concerns about specialist assessment, and the involvement of a dual diagnosis worker, for substance misuse;
- missed depot medication; and
- no rationale for some home visits.

2.27 We found that although the internal investigation did not address the identified issues, by way of assigned recommendations to each, a gap was appropriately identified overall in risk and care planning documentation.

2.28 The associated Trust action was to audit a random sample of cases from each practitioner in the recovery team to establish whether the risk and care planning documentation complies with Trust CPA and record keeping Policies. We view the action identified as being appropriate at this point.

2.29 In a later addendum to the internal investigation, the CCO and a senior nurse practitioner in the recovery team were subsequently interviewed about issues relating to the quality of record keeping, including care planning, risk assessment and the role of the CCO.

2.30 There was an acknowledgment from the CCO that the record keeping in respect of care planning, risk assessment and issues related to the CCO role was not of an acceptable standard, however we found that the internal investigation did not explore whether there were associated human factors.

2.31 We found that the identified issue of the recovery team's rationale for visiting service user A at home to administer his depot medication rather than doing this through the depot clinic was explored with the CCO. The CCO indicated that service user A had full insight and understanding of his medical condition, and that the decision to continue home visits to administer the depot medication, rather than arrange for him to attend a depot clinic, was a 'follow on' from when he had been cared for by the assertive outreach team who had visited him at his home address.

2.32 We found that the internal investigation did not address the identified issue of the frequency for depot medication every two weeks, and consideration of extending the frequency to determine and, or maintain, medication at an appropriate minimum dose for maximum beneficial effect. This issue was later addressed in the external independent investigation.

2.33 We found that this was a gap and a reasonable issue to consider. On examination of the clinical records we found this had previously been discussed with service user A in November 2012. At that time, it was agreed that as he had a desire to visit his family more frequently, causing problems with the depot frequency, the doctor agreed to reduce the frequency to every two weeks, but to maintain the dose at the same level.

2.34 Although the police did not grant permission for the Trust to interview any external agency, we found that the identified issue of understanding the partnership working with 'Making Space' could have been explored with the CCO or the senior nurse practitioner. However, it was not.

2.35 We found that the internal investigation did not apply the Duty of Candour[4] (DoC) as required and did not believe the DoC applied to service user A. The was due to a lack of clarity relating to whether DOC applied to a perpetrator of a crime. This was an issue clarified with other Trusts and members of the national NHS England team who all concurred that the guidance could be clearer when it regards a perpetrator of a homicide. This was later addressed and actions agreed. The Trust acknowledged that DOC applied to the victim's family however this was delayed due to limitations imposed by the Police.

2.36 We note the appropriate guidance under the Care Quality Commission (CQC) Regulation 20 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20[5].

2.37 After a review in October 2018, service user A was contacted in writing. In January 2019, a letter of apology was sent on behalf of the Trust to both service user A, his mother and also the victim's family with a point of contact for service user A and the family members should they wish to receive any further support with regards to the incident and the investigations completed by the Trust.

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[4] https://www.professionalstandards.org.uk/what-we-do/improving-regulation/find-research/duty-of-candour Duty of candour means being honest when something goes wrong.

[5] https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour#full-regulation

Independent Investigation (the second Trust investigation)

2.38 We found that the independent investigation addressed the issues raised, though the chronology identified gaps and made appropriate recommendations in the following areas:

- risk assessment;
- clinical curiosity and understanding of influence bias;
- record keeping;
- management supervision;
- information sharing;
- application of the serious incident framework and DoC Policies;
- administration of depot medication;
- inappropriate action following a seizure;
- understanding of the nature of service user A's disorder;
- application of the did not attend (DNA) Policy;
- formal liaison with 'Making Space'; and
- the function of the recovery team.

2.39 We found that the independent investigation reviewed in detail the adequacy of risk assessments, risk management and care planning via the CPA, and did not find any issues relating to safeguarding. We found that gaps in these areas included record keeping, sharing of information and clinical curiosity.

2.40 The independent investigation did not make any findings in respect of the overall application of the CPA although the report stated that service user A was subject to CPA and had an allocated CCO.

2.41 However, various element of the CPA were identified as issues with recommendations against each. These included the lack of discussion with the care team, risk assessment, administration of depot medication, application of the DNA policy, inappropriate action following a seizure, and understanding of the nature of service user A's disorder.

2.42 We did not find it necessary to undertake further analysis of risk assessment, care planning or safeguarding as this was covered appropriately in the independent investigation.

2.43 We found that the independent investigation explored the human factors associated with the incident through interviewing the CCO and the 'Making Space' support worker. The human factors identified included supervision

skills gaps, and errors in thinking. The issue of capacity was explored in interviews but not identified as a problem by the staff.

2.44 We found that the independent investigation gave consideration to the role of 'Making Space', interviewed the support worker involved with service user A and made an appropriate recommendation in respect of liaison and communication with the service.

2.45 We found that the independent investigation approached service user A's mother and stepbrother to contribute to the review. The mother subsequently spoke to the reviewer at length on two occasions. The stepbrother did not want to contribute to the review.

2.46 The independent investigation also explored the application of the DoC in respect of his mother according to the terms of reference. Appropriate recommendations were made in respect of this.

2.47 The independent investigation states that the Trust will continue to make arrangements to contact other relevant family members as a matter of openness and transparency and is committed to meeting with service user A and the relevant families to share the findings of both the internal and independent investigations.

Summary

2.48 We reviewed whether both the investigations were robust, appropriate and complied with best practice and policy. We also reviewed the quality governance assurance processes sought by the Trust in this respect.

2.49 We assessed both of the investigation reports against the Niche 'credibility, thoroughness and impact' framework to objectively quantify (and score) how the investigations complied with best practice guidance (see Appendix B).

2.50 We found that the internal investigation chronology was adequate in terms of the issues identified against the timeframe. However, we found that not all issues raised were subsequently identified as gaps requiring a recommendation and associated Trust action.

2.51 Our view is that the internal investigation did not meet the terms of reference and was not of the quality required. However, the independent investigation subsequently commissioned identified all the problems which required resolution.

2.52 In addition, we found that the independent investigation adequately reviewed the lessons learnt from the original investigation of the critical incident and detailed the whole scale review the Trust were undertaking in respect of these.

2.53 We found both the internal and independent investigations referred to all the appropriate Trust policies. We found that according to their terms of reference the independent investigation also referred to NMC (Nursing and Midwifery Council) professional standards for nursing with regards to record keeping, NICE best practice and the Department of Health Risk Assessment Guidance (2007) whereas the internal investigation did not.

2.54 The independent investigation terms of reference did not require the independent investigation to consider carers assessments. We explored whether the people involved with, and caring for, service user A were adequately supported.

2.55 We found that the grandfather, uncle, mother, father and stepbrother were involved in the care of service user A at various times from 2005, with service user A living with his uncle, mother and father on separate occasions.

2.56 We found that records include their views, identified risk issues and indicate their involvement in his care however records do not indicate that their needs were separately assessed.

2.57 We found although the independent investigation made recommendations against various element of the CPA, that a gap could have been identified overall in terms of the role of the CCO and the coordinated partnership approach required for the application of the Trust CPA policy and the Local Authority formal needs assessment.

2.58 We found no requirement for further investigation regarding the role of, liaison and communication with 'Making Space'.

2.59 In addition to the information in both the internal and the independent investigation chronology, we found that records indicated service user A had a history of a 'couch syncope (fainting) years ago' that was not investigated further. A 2004 discharge summary detailed that service user A told the staff at the time that he was epileptic.

2.60 Service user A was seen in a neurology clinic for syncope 16 April 2017 accompanied by a support worker, having had a blackout on 18 January 2017, and referred to cardiology. We found that the omission of this information from the chronology did not impact on the outcome of either investigation.

Governance and systems for oversight

2.61 We found that the Trust completed a timeline of events and learning outcomes (undated) dated from 2 July 2017 when the incident occurred to 18 December 2018 when the Trust began the process of commissioning a comprehensive independent investigation with an external reviewer.

2.62 This included the range of serious incident activity relating to this case and the subsequent chronology of action planning, completion of improvement activities and actions, quality assurance processes and oversight of this case undertaken by the Trust.

2.63 The timeline informed us that the progress with this serious incident was subject to regular monitoring and oversight of progress by the quality committee and the Trust board.

2.64 We saw that the Trust board reviewed the organisation's assurance framework during 2019 and 2020 which resulted in the formal delegation of a detailed patient safety report to the quality committee from June 2019 with the quality committee providing a high-level monthly report on completed activity.

2.65 We found that the Trust has a lesson's learned forum, which is supported by lessons learned events taking place across each Borough. We viewed a March 2019 learning from incident presentation on how the Trust is learning for improvement. Actions to promote lessons learned across the organisation include:

- local learning via after action reflection and sessions delivered by matrons, heads of quality and assistant clinical directors;
- communications via theme of the week, patient safety alerts and lessons learned events;
- peer reviews;
- implementation of local patient safety panels;
- local processes supported through the corporate patient safety panel to ensure effective delivery;
- ensuring pan Borough learning is facilitated and ensuring delivery through appropriate collaborative groups, with central support and monitoring of effectiveness; and
- thematic reviews of serious incidents.

2.66 We also found that the independent investigation detailed overlapping lessons learnt from the internal investigation with specific Trust actions identified as:

- a timeline of events to assist in identifying the root causes of why the incident was not managed as well as it should have been;
- training to be provided to key staff with regard to the DoC;
- a review of the model of investigations currently in use;
- a need to increase engagement with the leadership team into the critical incident review process; and
- a review of how learning is shared across the Trust from one Borough to another.

2.67 Following the Trust lessons learnt review, thematic issues were identified and this work is now incorporated within phase two of a patient safety improvement plan which is reviewed quarterly in the Trust quality committee.

2.68 The phase two action plan addresses the following:

- quality of investigation report with the desired outcome of improvement in the quality of thorough, accurate and timely investigations delivered within the organisation;
- learning to improve and change practice with the desired outcome of themed improvement plans that address key priorities and emerging themes will be applied to all services in all Boroughs;
- being open and DoC with the desired outcome of compliance with the being open Policy framework;
- family and care involvement with the desired outcome of cultural shift regarding importance and value of learning from and with families; and
- patient safety culture with the desired outcome of evidence of continual improvement resulting in a reduction of the number of serious incident investigations required.

2.69 We investigated the structures in place to ensure the Trust investigation teams have appropriate skill and capacity; and examined the outcome measures used to assure the Trust board that investigations have been undertaken diligently.

2.70 We interviewed the NWB deputy director of nursing who told us that a new standard operating procedure (SOP) for serious incident investigations and learning (with templates) had been implemented. We viewed the SOP and found it to be comprehensive.

2.71 In terms of appropriate skills and capacity, we found that a new weekly initiation meeting following a serious incident (the corporate patient safety panel) allocates the most appropriate staff to undertake the review.

2.72 The Trust reports that 38 staff to date have completed training through two cohorts. Participants are being allocated as a second reviewer or lead investigator for serious incident investigations with support from designated serious incident leads to undertake their first investigation.

2.73 Although we have not viewed this specific training information, we have viewed patient safety panel minutes as appropriate assurance that local patient safety panel meetings are taking place weekly in each Borough to review all local 72-hour reviews, advise on next steps, post review learning, and review after action reviews and investigations to ensure local delivery of outcome focussed actions.

2.74 The local patient safety panel reports and/or escalates to the Trust patient safety panel for final agreement of investigation level for serious incident 72-hour reviews and for any concerns or delays with delivery of lessons learned locally.

2.75 A task group has been established to develop a resource toolkit to support consistent qualitative outcomes across all local patient safety panels. The

Trust quality committee continues to receive regular updates regarding the functioning and effectiveness of the local patient safety panels.

2.76 In terms of Trust board assurance, we viewed the serious incident report for April and November 2019 which reported that the weekly central patient safety sign-off panel for completed serious incident investigations was well established. In addition, the report stated that Borough local patient safety panels are in place and that work is ongoing to strengthen areas of positive practice.

2.77 In order to ensure that investigations have been undertaken diligently and being managed effectively we have viewed Trust board assurance in terms of a monthly report on serious incident cases and a quarterly generic patient safety report.

2.78 The November 2019 Trust board serious incident report received assurance from the Trust quality committee that the new format of an outcome-based action plan had been approved and the implementation of this model had commenced.

Implementation of the internal and independent investigation recommendations

2.79 We reviewed the evidence that recommendations have been implemented, the assurance that actions implemented will lead to positive change with impact on care, that they are tracked to the action plan outcomes and the qualitative and quantitive methods used to measure success.

2.80 The internal investigation identified that risk and care planning documentation was not completed in line with Trust guidance and one Trust action was subsequently identified to address this. We have analysed the progress on this by subsuming the action into recommendations 1 and 3 of the independent investigation.

2.81 This second investigation identified a series of 12 recommendations which were received by the Trust. An action plan was developed to address the identified areas of concern and improvement.

2.82 The report was approved by the Trust Patient Safety Panel on 29 January 2019. The final report was subsequently shared with the family. The approved report and developed action plan were submitted to NHS England.

2.83 The St Helens leadership team coordinated and implemented the action plan to support the local recovery team to complete the identified actions. Additionally, the Trust agreed that a series of quality assurance processes would be undertaken to consider the progress of actions, the embedding of changes in practice and the impact of change as a result of the improvement actions having been completed.

2.84 This included a recovery team peer review which was completed July 2019. The concept and use of peer reviews was in line with the Trust quality strategy 2019 to 2022.

3 ACTION PLAN PROGRESS

Recommendation 1: A review of the current clinical system to determine whether risk assessments correlate previous historical risks from historical risk assessments. A quality peer review team will review the function of the recovery team focussing on specific areas in relation to; multidisciplinary team (MDT) working, the role and function of the CCO, training needs and quality of clinical documentation, relevant NICE guidance compliance and treatments. The quality peer review team will consist of a range of disciplines within the organisation who can provide a multi-disciplinary review of the role and function of the recovery team.	
Trust response and evidence submitted	**Niche comments and gaps in assurance**
• Recommendation fully met. • Peer review completed July 2019. • Trust confirmed legacy risk information available. • There is an electronic system (named RiO) guide available for staff with information about accessing risk information within it. • All existing staff have completed RiO induction and training January 2020. • Staff observed using the system. Five referrals had been received and were processed covering the review of clinical history, risk assessment including historical risks and the use of alerts relating to risk on RiO. • A recovery team record keeping audit 1 December 2018 to 3 May 2019 identified 100% of the records had a completed risk assessment. • Safety huddles are in place and were identified by staff as a method for escalating risk. • A Trust wide infographic illustrating that at year end for 2019-20 the Trust completed a Trust-wide survey highlighted that safety huddles are adding value to improving the quality and safety of our services and to patient experience. A total of 238 teams across all boroughs and from 32 different services took part in the survey. • Copy of corporate induction June 2020 indicating that 23 recovery team staff were compliant.	• The peer review document examined systems, staff knowledge and capability. • Staff were able to verbalise how they escalate risk within the team systems. • However, the peer review identified that patients at risk had no documented record of actions to be taken and who would be responsible. There was no process to identify if the previous day's actions had been completed or if this process of escalation was captured on the patient record. • The RiO guide details that amendments took place in 2016 however does not have a formal sign off or issue and review/audit date. • The Trust stated that within the recovery team mandatory training is monitored monthly, which includes RIO training on entry to the system. • Terms of reference for safety huddles not provided. The Trust referenced the fact that further work to develop the safety huddles is required as a Trust wide action with recommendations and learning to be shared learning across the Trust during 2020-21. • The Trust referenced areas for improvement against the national clinical audit of psychosis July 2018 including the number of service users with no documented care plan, documented crisis plans and clinical plans.

NIAF rating: It is clear the Trust has demonstrated that staff within the recovery team are aware of the need for and process to identify, record and escalate risk and it is clear that the Trust has implemented this recommendation. However, the Trust has outlined that further work is required in terms of documenting actions for patients at risk and safety huddles generally. Assurance has not therefore been provided to demonstrate that identifying, recording and escalating risk is embedded at the current time.
Overall rating for this recommendation: 3

Recommendation 2: Lack of clinical curiosity and understanding of the influences bias has on clinical judgement and assessment. A quality peer review team will review the function of the recovery team (as above).	
Trust response and evidence submitted	**Niche comments and gaps in assurance**
• Recommendation partially met with the remainder of actions to be identified and included in the phase two action plan as part of the wider Trust transformation initiatives. • The Trust commissioned a wider review of services to support teams in transforming services towards the provision of place-based care and treatment including an internal review of model of care within recovery teams led by a nurse consultant within the organisation. • The recovery team were involved and undertook work to review the SOP's to address the actions identified in the serious incident review action plan, and to support early work towards the transition. • The SOP's are aimed at influencing and improving staff's clinical curiosity through use of improved access to information to inform clinical assessment and formulation. • All information was collated into the recovery team operational guidance (updated in January 2020) to ensure that the team have all the relevant information within one document locally. • Pathways developed provide some assurance that structured interventions are in operation which are designed in line with NICE guidelines and standards, to support practitioners in practice. • Work continues to develop these further as part of the adult mental health care collaborative as part of the CPA review	• The recovery team minutes refer to a SOP for referrals being developed and we viewed the completed SOP issued 1 May 2019. • The Trust has indicated that the recommendation is partially met, given the wider Trust work they are undertaking to develop the model. • Only one example was provided of clinical curiosity being used within a recovery team meeting. • The Trust phase two action plan has greater clinical curiosity as a theme with the aim of practitioners using a range of evidence-based assessment tools, clinical curiosity and information provided by patient and carers to make a sound clinical decision without bias. This theme has a timescale of March and December 2020. • It is therefore not clear from the current assurance provided that the recommendation has been embedded in practice within the recovery team. • However, it is expected that the wider Trust work will provide this assurance.

which is in progress for 2019 to 2020 and 2020 to 2021. • The peer review process observed the use of clinical curiosity and standard SOP's in a multidisciplinary meeting. • The peer review report indicates that staff were aware of these and were able to demonstrate their use in clinical practice. • The peer review witnessed evidence of clinical curiosity for a patient that had been assessed where the criteria was not clear and further assessment was required. • The minutes of the recovery team meetings of 18 March 2019 and 15 April 2019. • The recovery team have invested in psychosocial intervention training both within the team and across the wider organisation to support the provision of evidence-based interventions for people with psychosis. • In addition, the work to meet the other recommendations including the assessment of clinical risk through the reframed multidisciplinary team working and the improvements made with the model and provision of clinical and management supervision; to support consensus assessment and decision making in clinical practice and reduce the likelihood and risk of lack of clinical curiosity single practitioner bias on clinical decision making.	
NIAF rating: It is clear the Trust has implemented this recommendation. However, it must continue the developments in the phase two action plan as part of the wider Trust transformation initiatives. This theme has a timescale of March and December 2020. **Overall rating for this recommendation: 3**	

<table>
<tr><td colspan="2">Recommendation 3:
Record keeping gaps, delays, records created and amended after index offence, missed depot May/June, 28/30 June, risk assessment updated after index offence. Entries onto the electronic record at the time of booking psychiatric review appointments. A quality peer review team will review the function of the recovery team (as above).</td></tr>
<tr><th>Trust response and evidence submitted</th><th>Niche comments and gaps in assurance</th></tr>
<tr><td>Recommendations 3 and 4 are fully met however it is proposed that improvement work will continue for 2019 to 2020 and 2020 to 2021 as part of wider Trust transformation initiatives.
The peer review was completed in July 2019 and included record keeping audits on all service users from the period 1 December 2018 to 5 July 2019 and actions completed to address areas of concern and the relevant human resources actions having been fully completed with practitioners involved in this serious incident.
Robust monitoring of the individual practitioner and confirmation that the records audit schedule is in place.</td><td>The recovery team record keeping audit contains recommendations and an action plan with completion dates ranging from August 2019 to ongoing dates in 2020.
The audit does not contain information relating to the governance of the action plan however the QA review document indicates that all actions have been completed.
Monthly managerial and clinical supervision dates for the individual practitioner provided.</td></tr>
<tr><td colspan="2">NIAF rating: The recommendations have been implemented however the assurance provided does not provide evidence that the record keeping audit actions have been completed and closed. However, we note that the Trust will carry forward further actions to phase two, through 2020 and 2021, with the head of quality continuing to audit achieved standards of record keeping locally. We have not therefore been provided with assurance that this recommendation has been embedded at the current time.
Overall rating for this recommendation: 3</td></tr>
</table>

Recommendation 4: Records were created and amended after the index offence. The Trust will complete a forensic examination of records to determine what information was added or deleted after the index offence and consider requirement for inclusion in future audits. There should be a preliminary review with the care coordinator with regards to record keeping and to ascertain if there are any current issues with regards to their practice. Consideration should be given to whether or not this should involve a disciplinary process.	
Trust response and evidence submitted	**Niche comments and gaps in assurance**
• Recommendations 3 and 4 are fully met and closed within the action plan; however, it is proposed that improvement work will continue for 2019 to 2020 and 2020 to 2021 as part of wider Trust transformation initiatives. • Once the management supervision module is launched and records keeping audit results are known, it is recommended that this rating is revisited with a view to rating as fully met and closed. • The peer review was completed in July 2019 which included record keeping audits on all service users from the period 1 December 2018 to 5 July 2019 and actions completed to address areas of concern and the relevant human resources actions having been fully completed with practitioners involved in this serious incident. • Robust monitoring of the individual practitioner and confirmation that the records audit schedule is in place.	• As above.
NIAF rating: The recommendations have been implemented however the assurance provided does not provide evidence that the record keeping audit actions have been closed. **Overall rating for this recommendation: 3**	

Recommendation 5: Management supervision failed to identify record keeping failures and lack of essential professional curiosity. A quality peer review team will review the function of the recovery team (as above).	
Trust response and evidence submitted	**Niche comments and gaps in assurance**
• Recommendation 5 is partially met with the remainder of actions to be identified and included in the phase two action plan as part of the wider Trust transformation initiatives. • The Trust provided an e mail and a screenshot indicating that they launched the management supervision module on 1 July 2020 with a short video for staff to take them through the system, a FAQ section and an e mail contact point for unanswered questions. • Clinical supervision forms part of the Trust quality strategy (presentation provided) with key indicators. • The peer review was completed in July 2019, the new clinical supervision system is now being implemented and the plans now in place for management supervision to be electronically captured for monitoring compliance in the 2020 to 2021 work programme. • A revised supervision Policy was implemented in August 2019 and merged the two previous separate clinical supervision and management supervision Policies. • Underpinning this new policy are the clinical supervision and support procedure and the management supervision procedure. • Both the revised supervision Policy and the clinical supervision and support procedures were provided. • Templates provided to capture the content of supervision. • The Trust maintains oversight and compliance of delivery of clinical supervision as part of the quarterly monitoring of progress within the quality strategy quarterly reports to the quality committee. • Learning from this case has been integrated within the Trust's information governance core induction training on	• See comments pertaining to the record keeping recommendations 3 and 4. • The Trust launched the management supervision module on 1 July 2020. • The peer review process looked at recovery team management and compliance with provision of line management supervision of clinical cases and found that there was evidence of random caseload and documentation review. • The peer review process highlighted that there was evidence that the recovery team staff accessed a range of clinical supervision opportunities, good MDT working, shared decision making, and had processes in place to enable supervision and support for staff with difficult cases. • We saw recovery team minutes indicating that introducing the new system formed part of the Trust core briefing and that a support and supervision guide was available on a dedicated clinical supervision intranet page. • The format of the supervision templates was noted within the quality strategy presentation to the quality committee July 2019. These templates form part of the revised supervision Policy. • We viewed the operational and quality and performance meeting 7 May 2019 which detailed that My Supervision went live during March 2019 across all the Boroughs with over 650 staff accessing the system with over 400 supervision sessions being logged. • We viewed recovery team minutes July 2019 indicating an overview of both clinical and managerial supervision was taking place. • Good oversight and compliance structures noted.

record keeping and has since been delivered to all • members of staff within the recovery team. • In July 2019 staff reported that they had accessed a range of supervisions including clinical supervision and had received training in the current model and framework. • The provision of training was also noted in the St Helens Borough operational and quality performance meeting minutes held in May 2019. • Supervision compliance for the recovery team provided. • A positive example of supervision in practice was provided by the recovery team relating to a service user who was discharged from the inpatient ward into the community; and a case example was provided relating to escalating concerns addressed through supervision. • The supervision data for all CCO's was reviewed for the period June 2019 to February 2020.The information indicates that 12 out of the 16 practitioners (75%) had received management and/or clinical supervision within any three-month period. For the remaining four practitioners, their caseloads would have been subject to multidisciplinary review during the nine-month period. • The Trust plans to build a management supervision module to the My Supervision electronic system to be able to record and report compliance levels in the future. This is in line with the quality strategy 2019 to 2022 work-plan. • The Trust year-end position for the implementation of clinical supervision 2019-20 has been included in the Trust Quality Accounts Report for 2019-20, presented to the Quality Committee on 8 July 2020 and accepted, however the overall report is subject to final approval at the Quality Committee in August 2020. • The Trust provided evidence that the recovery team achieved the year-end quality priority target of 80% compliance	

for each staff member receiving clinical supervision, in line with Trust policy. • The St Helens Borough leadership team have been monitoring the recovery team compliance with clinical supervision during 2019-20 and through this year to-date for quarter one of 2020-21. The recovery team have achieved and sustained the Trust compliance target. • The Trust has plans to continue this work during 2020-21 with the integration of management supervision within the MySupervision system. Work will continue in the coming year; with a new quality priority being identified to build on this success with the development and implementation of coaching for safety.	
• **NIAF rating:** The Trust has implemented this recommendation and has assurance that clinical supervision is being received on a regular basis with examples of supervision in practice supporting staff with clinical decisions. The Trust has demonstrated that clinical supervision is embedded within the recovery team and have 'tested' that the team have sustained the level of delivery. This work is commendable. However, the overall rating reflects the fact that the recommendation refers to management supervision, not specifically clinical supervision, and the Trust plans to continue the work on this during 2020-21 with the integration of management supervision within the MySupervision system and with the development and implementation of coaching for safety being identified as a new quality priority. **Overall rating for this recommendation: 4**	

Recommendation 6: It is not known if the psychiatrist was ever told service user A's comments saying he would stab someone in the neck. A quality peer review team will review the function of the recovery team (as above).	
Trust response and evidence submitted	**Niche comments and gaps in assurance**
• Recommendation 6 is fully met and to be closed. • The serious incident action plan identifies that the actions have been completed and the outcome has been fully met. • This is based on the peer review having been completed in July 2019, the recovery model for MDT working is established, the new clinical supervision system now being implemented, management supervision being in place with local monitoring and oversight and the use of escalation processes for enabling complex care discussions based on sharing of information. • Given this recommendation was based on an unknown element, the Trust indicated that it was difficult to provide bespoke assurance regarding this case, and the assurance is taken from observations from other cases. • See assurance provided in respect of recommendation 5.	• We note the completed quality peer review. • We note the further work the Trust has undertaken on the recovery model (since 2017), risk, supervision and record keeping. • We note a December 2019 CPA presentation which indicates a full CPA review and that the Trust is standardising systems and processes ranging from clinical documentation, evidence-based practice and pathways in and out of services. • We note the practice of weekly safety huddle meetings in the recovery team although we were not provided safety huddle terms of reference for assurance. The Trust guidance (issued 2012) and local recovery services operational guidance (issued January 2020) refers to the practice of safety huddles only. • We note the peer review identified that although the safety huddle was identified by staff as the place to escalate concerns and risks, there was no assurance that there was a process to ensure actions identified had been completed. • We viewed an undated terms of reference, version 2 (annual review) for the recovery team MDT complex and/or high risk cases meeting.
NIAF rating: We concur that this recommendation is met. There are minor gaps in the assurance which can be resolved through dating the terms of reference for the MDT complex and, or high-risk cases meeting so that annual review can be undertaken. Additionally, assurance can be improved through including the terms of reference for the daily safety huddle and the use of escalation processes for enabling complex care discussions in the recovery services operational guidance and include assurance measures. The Trust has undertaken commendable work on clinical supervision demonstrating that these systems are embedded and sustained, however the Trust has further work to progress in terms of integrating management supervision. The Trust has not yet submitted evidence of safety huddle notes which demonstrates that identified actions have been completed for service users having escalated risks and complexity. **Overall rating for this recommendation: 3**	

Recommendation 7: The initial serious incident review was provided a significant period of time after the incident occurred and was not at the appropriate quality as expected. Confusion around the application of DoC. The Trust will continue with their serious incident improvement work, with a specific focus on DoC, role of FLO's and quality of serious incident investigation reports with a clear mechanism for the management of complex serious incidents with the support from the CCG's to ensure that all statutory obligations are met within a reasonable timeframe.	
Trust response and evidence submitted	**Niche comments and gaps in assurance**
• Recommendation 7 is fully met and the action closed; however further improvement work continues as part of the wider Trust transformation initiatives. • The incident management policy and incident reporting and investigation procedures provided both defining being open and duty of candour requirements and how to apply. • The Trust has made significant improvement to the quality and management of its serious incident investigations. This progress has been driven through both reflective learning from this case and a phased approach to improvement. • A serious incident framework outcome focussed action plan was created and approved in September 2018 in response to contract performance concerns issued in August 2018 forming the first phase of improvement. • 40 staff in key roles have been trained in advanced root cause analysis. • 72-hour review training was delivered across all local Boroughs within the organisation alongside the implementation of the local patient safety panel with the purpose of providing local oversight of learning from incidents and improvements required. • Local patient safety panels commenced in June 2018 to review all local 72-hour reviews and advise on next steps in relation to investigation and post review learning. • Each local patient safety panel is required to report and escalate to the corporate patient safety panel.	• The serious incident framework outcome focussed action plan has amber 'in progress' ratings for the development of a QA template, Trust-wide delivery of human factors training, and a process for reviewing similar incident findings. • However, it is noted that in November 2018 the quality safety safeguarding group received information on how the actions had been completed. • The phase two patient safety improvement plan has actions with timescales ranging from July 2019 to March 2021. Information was provided in an updated document to indicate which of the actions had been met. Oversight of the action plan is detailed. • Minutes of the Trust quality committee provided to assure the committee that there is good governance in place to manage patient safety across the organisation. • The MOU assurance provided was a sample rather than an established process, however the incident management SOP refers to a MOU being required if the investigation has led to a police investigation. • April 2019 Trust board minutes also refer to MOU's being put in place. • The SOP includes procedure details for the local patient safety panels undertaking 72-hour reviews and includes family involvement. • The incident management SOP does not refer to DoC, however the serious incident investigation report template has been updated to reflect how, when and to whom DoC was applied. • Further work will be progressed during quarter three 2019 and 2020 to ensure

• CCGs (including home and lead CCG's) are now routinely invited to contribute to terms of reference and proposed level of investigation for all serious incidents reported. • An externally commissioned audit of patient safety panels in quarter one of 2019 and 2020 indicated the Trust had achieved an improved rating of "significant overall assurance with minor improvements opportunities" in respect of the patient safety panels at corporate and borough level. Actions are in place to address the opportunities for minor improvements. • Direct learning from this case has informed an improved approach to complex investigations with an established process for formulating MOU's along with the use of collaborative investigation management plans. • A development day was held on 16 January 2019 which was delivered by the deputy director of nursing and governance and the organisational development team. The purpose of the day was to discuss and plan how new national guidance would influence how we learn from serious incidents and what the future vision is for patient safety within the organisation. Along with the broader findings from this review the work led to the development of the phase two of the patient safety improvement plan. • The phase two patient safety improvement plan includes themes relating to DoC, and family and carer involvement. • The 'Being Open' experience of service users and their families was a quality priority for 2019-20 leading to a new quality priority being identified for 2020-21. • A clear role descriptor for the FLO has been developed. • Oversight of the improvement plan is monitored via the Trust quality committee through the integrated governance safety report. • An update to the December 2019 quality committee concluded that the	that the understanding, application of and processes for DoC are robust, including a specific role for the FLO. • The separate serious incident management plan is useful and could form part of the incident management SOP at the next planned review.

serious incident investigation report template has been updated to reflect how, when and to whom DoC was applied. • Further work will be progressed during quarter three 2019 and 2020 via a work stream developed from the 'making families count' training to ensure that the understanding, application of and processes for DoC are as robust as possible with an aim of improving the experience and engagement of families post a serious or adverse incident occurring. • Two days of training from 'making families count' were delivered in October and November 2019. In total this reached 186 staff and initiated a drive from the majority of those attending to be involved in further work. A steering group has been established to deliver the project under the umbrella 'Kin-nect' - this is a quality priority for 2019 to 2020.	
NIAF rating: It is clear the Trust have met this recommendation and are continuing their work on serious incident improvement work, with a specific focus on DoC, the role of FLO's and the quality of serious incident investigation reports with a clear mechanism for the management of complex serious incidents. The Trust quality account reports that qualitative benchmarking is underway and is informing the plans for the consistent and meaningful application of DoC with families. A themed work-plan has been developed and this work will support compliance with the national requirements within learning from deaths guidance and the new national patient safety framework and is a dedicated work-stream for 2020-21. The new family liaison officer procedure, role description and guidance will form the basis of engagement events and for staff training. Work is planned to continue to implement this through a phased training programme in 2020-21 and through a series of engagement events. This ongoing work should develop the assurance required to evidence embeddedness of the work the Trust has undertaken. **Overall rating for this recommendation: 3**	

Recommendation 8: Prolonged intervals between depot medications. A missed depot medication in May/June 2017 was not identified. Inappropriate actions following a seizure in a patient on depot medication. A quality peer review team will review the function of the recovery team (as above).	
Trust response and evidence submitted	**Niche comments and gaps in assurance**
• Recommendations 8 and 10 are partially met with the remainder of actions to be identified and included in the phase two action plan as part of the wider Trust transformation initiatives. • This is due to the peer review having been completed in July 2019 the implementation of a localised depot clinic and depot administration standard operating procedures; and additional monitoring which indicates safe medicines management within depot clinics. • The assurance is limited regarding individual practitioner knowledge of the impact and potential of adverse effects of this; with the information not being available for inclusion in this report. However, there is evidence that this information is currently being collated, which is being supported by the medicine's management team. • As part of routine monitoring a depot clinic audit of 20 cases is currently underway in January 2020. Although the audit is due to be finalised, the matron was able to extract two examples identified mid-audit of actions being taken in the event of the service user not attending clinic to receive depot injection. The cases required an assertive outreach style of intervention to ensure the person received their treatment. • Further evaluation is required to identify the impact of new ways of working in reducing incidents of 'did not attends' within the depot injection clinic supported by the monthly monitoring of performance through the Trust quality and performance report for DNA rates and actions being taken to address areas of concern. • Remaining actions are transferred into the phase two action plan with the matron and head of quality as leads	• Depot clinic and depot administration Trust SOP provided (issued October 2018) which includes safe medicines management • Local recovery services operational guidance has a section on depot medication management and administration which also refers to the separate depot medication SOP for prescriptions. • We viewed recovery team minutes July 2019 indicating the operation of the depot clinics were being monitored. • January 2020 depot clinic audit not available. • We viewed the Trust DNA Policy. • Further work identified by the Trust on DNA's.

reporting to St Helens Borough leadership team. • The outcomes of local monitoring will inform the Trust's wider patient journey transformation project through the adult mental health collaborative as part of the 2020 to 2021 work plan and the continued monitoring of DNA's as part of monthly performance monitoring and oversight by the Trust.	
NIAF rating: The Trust has identified that they have put in place a localised depot clinic, depot administration standard operating procedures and additional monitoring which indicates safe medicines management within depot clinics. Assurance has not been provided in respect of this, and Niche have identified these further assurance requirements. However, the Trust has identified that assurance is limited and further work is required in terms of depot administration and DNA's. It is expected that phase two of the Trust development work, through 2020 and 2021, will address these gaps and the assurance requirements. **Overall rating for this recommendation: 2**	

Recommendation 9: There was a need for a greater understanding of the nature of service user A's disorder. A quality peer review team will review the function of the recovery team (as above).	
Trust response and evidence submitted	**Niche comments and gaps in assurance**
• The actions for recommendation 9 have been completed. The overall outcome has been partially met, due to the peer review having been completed in July 2019 the implementation of the clinical supervision systems, the development work with management supervision and framework and the new ways of working within the multidisciplinary recovery team. • The combination of these elements supports the open culture for learning, sharing of experience and lessons learned, information and guidance from senior clinicians for practitioners. Whilst the findings of the peer review were positive, it has been recommended that a more thorough evaluation of new ways of working is undertaken to be able to provide more robust assurance. • The findings of the serious incident review and the respective action plans have been shared with the team as part of a lessons learned offering practitioners the opportunity to reflect on the findings and how the new ways of working support improved multidisciplinary approaches to supporting service users with complex health needs. • The remaining actions are transferred into the phase two action plan; as described earlier in this report relating to supervision and in this action area to obtain further assurances around impact of learning in practice.	• No specific comments required. See NIAF rating.
NIAF rating: We concur that the combination of the implementation of the clinical supervision systems, the development work with management supervision and framework and the new ways of working within the recovery team supports the open culture for learning and sharing of experience and lessons learned, together with information and guidance from senior clinicians for practitioners. However, the Trust has stated that a more thorough evaluation of new ways of working will be undertaken to be able to provide more robust assurance and we are not therefore able to say that this recommendation has been embedded overall as yet. The Trust has however demonstrated that clinical supervision is embedded within the recovery team and have 'tested' that the team have sustained the level of delivery. This work is commendable.	

However, the overall rating reflects the fact that the recommendation refers to management supervision, not specifically clinical supervision, and the Trust plans to continue the work on this during 2020-21
Overall rating for this recommendation: 3

Recommendation 10: Failure in the application of the DNA policy. A quality peer review team will review the function of the recovery team (as above).	
Trust response and evidence submitted	**Niche comments and gaps in assurance**
• Recommendations 8 and 10 are partially met with the remainder of actions to be identified and included in the phase two action plan as part of the wider Trust transformation initiatives. • See further information relating to recommendation 8.	• See comments in respect of recommendation 8.
NIAF rating: See further information relating to recommendation 8. The Trust has identified that assurance is limited and further work is required in terms of depot administration and DNA's. It is expected that phase two of the Trust development work, through 2020 and 2021, will address these gaps and the assurance requirements. **Overall rating for this recommendation: 2**	

<table>
<tr><td colspan="2">Recommendation 11:
Lack of formal liaisons with ‘Making Space’. Together with ‘Making Space’, agree a process of formal meetings to review cases where they are jointly providing care. The meetings should have a clear agenda and be documented within records. The contents of the meeting are to be recorded within the clinical notes.</td></tr>
<tr><th>Trust response and evidence submitted</th><th>Niche comments and gaps in assurance</th></tr>
<tr><td>Recommendation 11 is fully met and to be closed as an action area.
Active working with ‘Making Space’ is ongoing in practice.
Work was undertaken with ‘Making Space’ and the minutes of a joint meeting on 29 March 2019 indicate that the “there are well-established good working relationships between each agency” and confirmation that staff employed within ‘Making Space’ are already invited to CPA reviews; there were no issues with receiving invitations to CPA or nurse-led reviews; and they do attend when service users give their permission”.
There was recognition from ‘Making Space’ that there had only been one occasion when a service user had declined this offer.
As part of the quality assurance check in January 2020, the matron reviewed the care records of five service users who were open to ‘Making Space’ and was able to confirm collaborative contribution to multidisciplinary meetings had taken place.</td><td>The 29 March 2019 meeting with ‘Making Space’ reviewed the current process regarding formal and informal reviews. Discussions took place regarding the current practice.
Assurance in terms of utilising the Trust CPA was provided in respect of there being formal documented meetings with a clear agenda.
A limited audit of cases was undertaken.</td></tr>
<tr><td colspan="2">NIAF rating: It is clear that the Trust has not needed to implement the specific requirements of this recommendation given that there is a Trust CPA policy in place which is working well between the two organisations. It is expected that ongoing Trust annual CPA audit would address any further issues in respect to collaborative working with other agencies.
Overall rating for this recommendation: 4</td></tr>
</table>

Recommendation 12: Significant changes occurred in the care delivered after the assertive outreach team was decommissioned. There was little recorded in records, and no discussions took place about service user A's presenting risk. A quality peer review team will review the function of the recovery team (as above).	
Trust response and evidence submitted	**Niche comments and gaps in assurance**
• Recommendation 12 is fully met and the action closed however further improvement work continues as part of the wider Trust transformation initiatives. • New ways of working by the multidisciplinary team are in place with related case studies provided. • This included complex case panels, multidisciplinary team meetings, safety huddles, and supports a more tailored approach to providing individualised care in line with personalised risk assessment and risk management plans. • The peer review in July 2019 noted examples of how practitioners now jointly work to provide coordinated plans of care for complex cases under the CPA framework. • The peer review noted that the recovery team skill mix includes a dual diagnosis trained practitioner who is able to provide specialised interventions in close liaison with the local substance misuse and alcohol service 'Change, Grow, Live' (CGL) with whom the Trust has a formalised information sharing agreement in place. • Joint working supports the provision of individualised care plans in support of substance misuse reduction and abstinence for those requiring secondary mental health service support and interventions. • There is recognition that the Trust continues to develop clinical pathways as part of the adult mental health collaborative patient journey transformation project and the CPA review as part of the work plan for 2019 to 2020 and 2020 to 2021. It is therefore proposed that this work is transferred into the phase two actions, with monitoring and reporting continuing via	• We viewed a recovery services clinical pathways document to offer structured, evidence-based treatment options to enhance the service user experience, improve the quality and efficiency of services transition through the service. • We also viewed a recovery services clinical pathways document to introduce a multi-service MDT meeting to improve the sharing of information and integrated working to ensure that the right people are being treated by the right team, at the right time. • We viewed psychological therapies, duty service contact and DNA pathways documents which clearly indicates that work is underway which may be the reason these pathway documents were undated

the quality strategy quarterly reports to the quality committee.	
NIAF rating: We understand that further Trust work is underway in phase two, through 2020 and 2021, to develop clinical pathways and we can see there are adequate mechanisms in place to monitor and report progress. As part of this it would be helpful to version control and date pathway documents. Given this work is transferred into the phase two actions we are not able to say this is embedded as yet. **Overall rating for this recommendation: 3**	

4 SUMMARY

4.1 The Trust has provided extensive evidence that learning from this incident has influenced the development of systemic changes through a wider Trust-wide transformation initiative with a phase two action plan taking this forward.

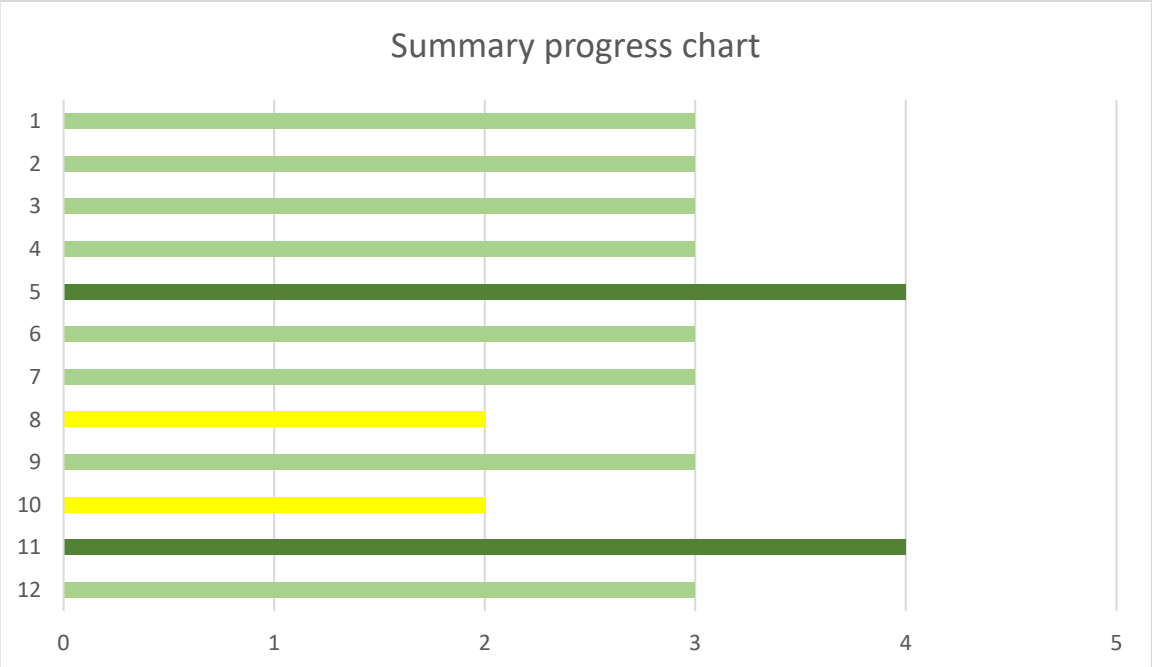
4.2 The Trust has demonstrated good progress with all the recommendations. It should now take steps to assure itself that all recommendations have been implemented fully, changes in practice have been successfully embedded, and where possible, can demonstrate improvements in practice.

4.3 In respect to recommendation 3 there are minor gaps in the assurance which can be resolved through dating the terms of reference for the MDT complex and, or high-risk cases meeting so that annual review can be undertaken. Additionally, assurance can be improved through including the terms of reference for the daily safety huddle and the use of escalation processes for enabling complex care discussions in the recovery services operational guidance and include assurance measures.

4.4 In relation to recommendations 8 and 10 the Trust has identified that assurance is limited, and further work is required in terms of depot administration and DNA's. It is expected that phase two of the Trust development work will address these gaps and the assurance requirements.

4.5 Of particular note is the assurance received for recommendation 5 where Trust has implemented the recommendation, has assurance that clinical supervision is being sustained and received on a regular basis and provided positive examples of supervision in practice supporting staff with clinical decisions.

4.6 On the basis of the information provided, of the 12 recommendations, we are assured two have actions significantly progressed, eight have actions completed but not yet tested and two have actions completed, tested and embedded.



Appendix A - Terms of reference

Purpose of the review

To undertake a desktop review to consider the investigations both internal and independent commissioned by NWB into the care and treatment of service user A.

Ensure that the investigations key lines of enquiry have been adequately considered and explored and highlighting any areas requiring further examination.

Conduct an assurance review of all recommendations from the earlier investigations including implementation of the learning outcomes from the review of the investigation process at NWB.

Involvement of the affected family members and service user A (the perpetrator)

Ensure that all affected families are informed of the review, the review process and are offered appropriate the opportunity to contribute including developing the terms of reference; agree how updates on progress will be communicated including timescales and format.

Offer service user A a minimum of two meetings, one to explain and contribute to the investigation process and the second to receive the report findings.

Scope of the desktop and assurance review

The desktop review will consider the internal and independent investigations commissioned by NWB.

The desktop review will include:

- The sourcing and review of relevant documents to develop a comprehensive chronology of events by which to review the investigations findings against.
- Interviews with key personnel, where necessary.
- The review and assessment of compliance with local policies, national guidance and where relevant statutory obligations.
- Assessment of the care and treatment received by service user A including the identification of any gaps or omissions in care not adequately addressed within the investigations commissioned by NWB.
- Review of the adequacy of risk assessments, risk management and care planning including carers assessment.

The multi-agency assurance review will;

- Assess and report on the progress made against the implementation of the recommendations from the internal and independent investigation and the learning outcomes document.

- Identify any notable areas of good practice or any new developments in services as a result of this issue

- Consider any partially implemented recommendations and identify possible organisational barriers to full implementation providing remedial recommendations as appropriate.

- Review and assess the CCG's assurance processes and oversight of Serious Incident management

Objectives

Provide a written report to NHS England that includes findings and measurable and sustainable recommendations for further action where necessary. The report should follow both the NHS England style and accessible information standards guide

The report should highlight any areas that require additional investigation.

Provide a concise case summary to share the learning opportunities.

Provide NHS England with a monthly update, template to be provided by NHS England, detailing actions taken, actions planned, family contact and any barriers to progressing the investigation.

Support an action planning and/or learning event to promote learning opportunities for the provider.

Within 12 months conduct a further assessment on the implementation of any associated action plans in conjunction with the CGG and Trust, if required. Provide a brief written report outlining the outcome of the assessment to NHS England, North.

Appendix B - Staff telephone interviews undertaken

Designation	Date
Independent investigation author	20 December 2019
NWB deputy director of nursing	9 January 2020

Appendix C - Documents reviewed

	Document	Date
1	Internal investigation	14 November 2017
2	Addendum to internal investigation	17 April 2018
3	Independent investigation	29 January 2019
4	Clinical records	April 1999 – 3 July 2017
5	Timeline of events and learning outcomes	undated
6	Serious incident investigations and learning	15 July 2019
7	Original and version 0.12 patient safety improvement action plan - phase two	December 2019
8	Quality assurance review document	Final draft 9 March 2020
9	Nursing and governance serious incident away day presentation	Undated
10	Serious incident management plan template	Undated
11	Serious incident working session plan	January 2019
12	Serious incident process and learning	3 July 2019
13	Service user A's CCO supervision dates	2019
14	RiO survival guide	Amendment date 24 November 2016. No issue date
15	Service user A's CCO caseload audit	2019
16	St Helens peer review	July 2019
17	St Helens record keeping audit	1 December 2018 – 5 July 2019
18	St Helens recovery team CCO's supervisions	2019 - 2020
19	St Helens DNA local procedure	Undated
20	Duty contact pathway document	Undated
21	St Helens team structure	Undated
22	St Helens psychological therapy pathway	Undated
23	St Helens local recovery team procedure	Undated
24	St Helens referrals SOP	May 2019
25	St Helens recovery team minutes	Various
26	St Helens lone working SOP	Undated
27	St Helens recovery team MDT PDSA document	Undated
28	St Helens recovery team information	July 2019
29	St Helens recovery team operational guidance	2012
30	Trust recovery operational guidance	2012
31	Combined St Helens recovery operational guidance	23 March 2020
32	St Helens depot medication SOP	October 2019
33	St Helens operational and quality minutes	7 May 2019
34	Key lines of enquiry findings	11 July 2019
35	Making Space meeting notes	24 April 2019
36	St Helens MDT structure SOP	Review date 24 November 2019
37	Serious incident action plan	September 2018
38	72-hour training power point presentation	9 September 2018
39	Sample MOU	N/A
40	Quality committee minutes	Various
41	Quality committee learning from incidents presentation	21 March 2019
42	Patient safety panel minutes	Various

43	Trust board patient safety report	April 2019
44	Trust board minutes	Various
45	Change grow live minutes	September and December 2017
46	Progress and outcomes report	Undated
47	CPA review presentation	December 2019
48	Psychological interventions training schedule	Undated
49	Care collaborative overview	10 January 2020
50	Recovery model update	11 December 2017
51	Recovery team provider visit report	17 December 2019

Appendix D - Credibility, Thoroughness and Impact checklist

Standard	Source	Internal investigation	independent investigation
Theme 1: Credibility			
1.1 The level of investigation is appropriate to the incident.	NPSA	Level of investigation not specified in NPSA terms. See below.	Yes.
1.2 The investigation has terms of reference that include what is to be investigated, the scope and type of investigation.	NPSA	Only one term of reference: To establish what should have happened using Trust policies and procedures, NICE guidance and/or best practice guidance and identify any gaps in service provision and/or policy and practice. The term of reference does not include the scope or type of investigation. However, the front sheet describes the investigation as limited and elsewhere as interim. The limited nature of the investigation is explained as being due to the Police requesting the Trust did not contact the service user, family, Trust staff or any external agency involved due to the nature of the incident. Essentially the investigation was a desk top review of the electronic care records.	Yes.
1.3 The person leading the investigation has skills and training in investigations.	NPSA; NHSE SIF	It is not possible to determine this as the report does not contain this information.	Yes. The person that undertook the independent investigation has a clinical background and undertakes work as an independent author for SCRs and is on the NW regional list for SCRs, DHRs and SCRs.
1.4 The investigations were completed within 60 working days.	NHSE SIF	No. 2.7.17 - incident. 3.7.17 - notified to the Trust. 14.11.2017 - panel approved. 142 days	2.7.17 - incident 3.7.17 - notified to the Trust. 2.1.2019 - independent investigation commissioned 29.1.2019 - patient safety panel approved the report.

Standard	Source	Internal investigation	independent investigation
			21 days
1.5 The report is a description of the investigation, written in plain English (without any typographical errors).	NPSA	Yes, there is a description of the incident. Some terms are used which are not in plain English, such as 'euthymic' but this is an internal report and the terms would be understood by those reading it. No typographical errors.	Yes
1.6 Staff have been supported following the incident.	NPSA	Staff were not interviewed. No information is available in the report about staff support.	No information is available in the report about staff support. The author stated that she was not party to this however she understood that the Trust supported the CCO.
Theme 2: Thoroughness			
2.1 A summary of the incident is included that details the outcome and severity of the incident.	NPSA	Yes	Yes
2.2 The terms of reference for the investigation should be included.	NHSE	Yes see 1.2.	Yes
2.3 The methodology for the investigation is described. This includes use of root cause analysis tools, review of all appropriate documentation and interviews with all relevant people.	NPSA	No. Relevant people were not interviewed (due to limitations imposed by the Police at this point). Chronology undertaken, gaps identified.	A methodology section is contained in the report and describes the formation of a chronology, staff interviewed, policies scrutinised but does not contain the root cause analysis tools used.
2.4 Bereaved/affected patients, families and carers are informed about the incident and of the investigation process.	NPSA, NQB	No, see 1.2.	The perpetrator's mother was contacted initially by letter to ask to contribute to the review; this was later completed via telephone conversation. His mother did not advise how she wished to receive the report during the telephone conversation to contribute to the review; however, this will be ascertained on completion of the

Standard	Source	Internal investigation	independent investigation
			investigation and the relevant steps will be made.
2.5 Bereaved/affected patients, families and carers have had input into the investigation by testimony and identify any concerns they have about care.	NPSA, NQB	No, see 1.2.	As above.
2.6 A summary of the patient's relevant history and the process of care should be included.	NPSA	Yes.	Yes.
2.7 A chronology or tabular timeline of the event is included.	NPSA	Yes.	Yes.
2.8 The report describes how RCA tools have been used to arrive at the findings.	NPSA	No.	No.
2.9 Care and service delivery problems are identified (including whether what were identified were actually CDPs or SDPs)	NPSA	No. Gaps are identified.	The report sets out findings rather than identifying SDPs or CDPs.
2.10 Contributory factors are identified (including whether they were contributory factors, use of classification frameworks, examination of human factors).	NPSA	No. Why the gaps occurred have been identified.	No
2.11 Root cause or root causes are described.	NPSA	No. The conclusion as that "it is likely that the care and treatment provided to service user A fell outside of that expected to be provided to a patient receiving care under the CPA." The reviewer was "unable to definitively identify any specific failings of	Yes. Follow up for non-attendance at medical reviews not identified through management supervision; the decommissioning of the assertive outreach team and a medical review

Standard	Source	Internal investigation	independent investigation
		the other identified areas until such time that authorisation and direction to proceed is received from the police allowing these additional lines of enquiry to be thoroughly investigated and explored."	of the perpetrator's breakthrough symptoms in March 2017.
2.12 Lessons learned are described.	NPSA	Lessons learnt are described as findings and analysis with a table looking at what should have happened against what did happen, gaps and reasons for the gaps.	Lessons learned are describes as gaps identified in a recommendations table. The report contains a section on arrangements for shared learning and lessons from the first internal investigation.
2.13 There should be no obvious areas of incongruence.	NPSA	Yes.	No.
2.14 The way the terms of reference have been met is described, including any areas that have not been explored.	NPSA	Practice was examined against the Trust CPA and record keeping policies. Best practice was not identified. NICE guidance was not reviewed. Gaps were identified. Areas not explored were identified.	Yes. In general terms the report identified a number of areas where practice has fallen short of the expected standards and the findings, gaps identified and expected outcomes all point to specific staff skill gaps.
Theme 3: Lead to a change in practice - impact			
3.1 The terms of reference covered the right issues,	NHSE SIF	See 1.2.	Yes
3.2 The report examined what happened, why it happened (including human factors) and how to prevent a reoccurrence,	NPSA, NHSE SIF, NQB	No. Human factors were not identified as the staff were not interviewed see 1.2.	The human factors identified in the body of the report include capacity, supervision, skills gaps. The report contains a section on 'psychological theories' which includes looking at errors in thinking. The author did not feel capacity was an issue; rather the issue was fundamental professional practice issues (concerned with the CCO). The author asked them to set the scene initially at interview and

Standard	Source	Internal investigation	independent investigation
			capacity was not identified as an issue.
3.3 Recommendations relate to the findings and those that led to a change in practice are set out.	NPSA	Yes, however the one recommendation is expressed as an action to address the gap identified.	Yes.
3.4 Recommendations are written in full, so they can be read alone.	NPSA	The action is written in full and can be read alone.	Recommendations are expressed as expected outcomes followed by actions identified.
3.5 Recommendations are measurable and outcome focussed.	NPSA	The action identified has an outcome included.	Yes.

Appendix E - List of abbreviations used in the report and appendices

‘A’	Service user referred to ‘A’ in this report
‘B’	The victim referred to as service user ‘B’ in this report
CCO	Care coordinator
CCG	Clinical commissioning group
CDP	Care delivery problem
CMHT	Community mental health team
CPA	Care programme approach
DoC	Duty of candour
DNA	Did not attend
FLO	Family liaison officer
NHSE SIF	National Health Service England serious incident framework
NIAF	Niche investigation assurance framework
NICE	National institute for Health and Care Excellence
NPSA	National patient safety agency
NQB	National quality board
NWB	North West Boroughs Healthcare NHS Foundation Trust
NHSE	National Health Service England
MAPPA	Multi agency public protection arrangements
MDT	Multidisciplinary team
MOU	Memorandum of understanding
RCA	Root cause analysis
SOP	Standard operating procedure
SDP	Service delivery problem
DHR	Domestic homicide review

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