Independent Investigation Assurance Review
NHS England North West Boroughs

STEIS 2016/28277

Final Report v1.6

Private and confidential

August 2021

Niche Investigation Assurance Framework

insight integrity impact

Niche Health and Social Care Consulting
4th Floor, Trafford House
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Manchester
M32 0RS

24th August 2021

Dear Sir / Madam,

Independent Quality Assurance Review, NHS England North West Boroughs

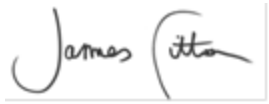
Please find attached our report in relation to an independent quality assurance review concerning North West Boroughs Healthcare NHS Foundation Trust, NHS Wigan Borough Clinical Commissioning Group and NHS Knowsley Clinical Commissioning Group.

This report 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. The scope of our work has been confined only to provide an assessment of the implementation of the organisations' resultant action plans against the Niche Investigation and Assurance Framework (NIAF) review. Equally, events which may occur outside of the timescale of this review will render our report out of date.

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

This is a confidential report and is for the sole attention of the project sponsor and stakeholders. No other party may place any reliability whatsoever on this report as this report has not been written for their purpose. The Trust must seek our prior written approval before this report can be shared or released. Different versions of this report may exist in both hard copy and electronic formats and therefore only the final signed version of this report should be regarded as definitive.

Yours sincerely,



James Fitton

Niche Health and Social Care Consulting Ltd

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

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1. Method

1.1 Background and context for this review

NHS England North commissioned Niche Health and Social Care Consulting Ltd (Niche) to undertake an assurance review against the Niche Investigation and Assurance Framework (NIAF), to provide an assessment of the implementation of the action plan developed in response to recommendations from the Niche independent investigation, following the tragic death of a young man (referred to as DEG in this report) on 29 October 2016, into the care and treatment provided by North West Boroughs Healthcare NHS Foundation Trust (NWB). This is a high-level report on process to NHS England North West, undertaken on the basis of a desktop review only, without site visits or interviews.

1.2 Implementation of recommendations

This review was focussed on the implementation of the action plan by NWB and the implementation of recommendations pertaining to Wigan Borough and Knowsley Clinical Commissioning Groups (CCGs). The recommendations and actions are focused on the borough of Wigan only. The provider of mental health services for Wigan Borough residents transferred from North West Boroughs Health Care Foundation Trust to Greater Manchester Mental Health NHS Foundation Trust on 1st April 2021**.** Knowsley CCG no longer has co-ordinating commissioner oversight of Wigan Borough MH & LD Services, as it did when Wigan Borough CCG commissioned services from NWB with Knowsley CCG being the co-ordinating commissioner of NWB.

Based on the Niche independent investigation into the care and treatment provided by NWB into the tragic death of DEG, there were nine recommendations for NWB, with two of the recommendations involving Wigan and Knowsley CCGs, with four overarching themes:

- Care plan and risk assessments.
- Child and Adolescent Mental Health Services (CAMHS) pathways.
- Partnership working.
- Serious incident and complaint processes.

Each theme identified specific recommendations and highlighted the desired outcome, along with individual actions, completion dates and a Blue, Red, Green, Amber (RAG) rating to enable clarity of achievement. Blue indicated all actions were delivered and transformational change achieved, green indicated that actions were on track for completion but would require a quality assurance process to indicate level of embeddedness and transformation, amber indicated delayed but managed, and red indicated not likely to be delivered within the time frame.

The action plan structure converted the theme into recommendations and then into manageable tasks with evidence of collective responsibility and division of workload. In addition, a clear narrative picture was provided of the progress of each recommendation with associated historical and current supporting evidence. For clarity of process, this assurance review lists the recommendations by overarching theme.

1.3 Review method

Our work comprised a desktop review of documents provided by NWB and the CCGs. These included documents provided for assurance purposes in February 2021, and, where necessary, we have reviewed additional and previous assurance documentation from September 2020, including policies, procedures, action plans, minutes and communications. The assurance review focusses on the actions that have been progressed and implemented in response to the recommendations made in the independent investigation report. We set out our summary of findings in relation to the progress of each agency. We have not reviewed any health care records because there was no requirement to re-investigate in the review's terms of reference. The information provided to us has not been audited or otherwise verified for accuracy.

2. Assurance overview

The Niche Investigation Assurance Framework

The assessment is meant to be useful and evaluative, and we adopt a numerical grading system to help our clients focus on the steps they need to take to move between the stages of completed, embedded, impactful and sustained – with an improvement which has been 'sustained' as the best available outcome and response to the original recommendation.

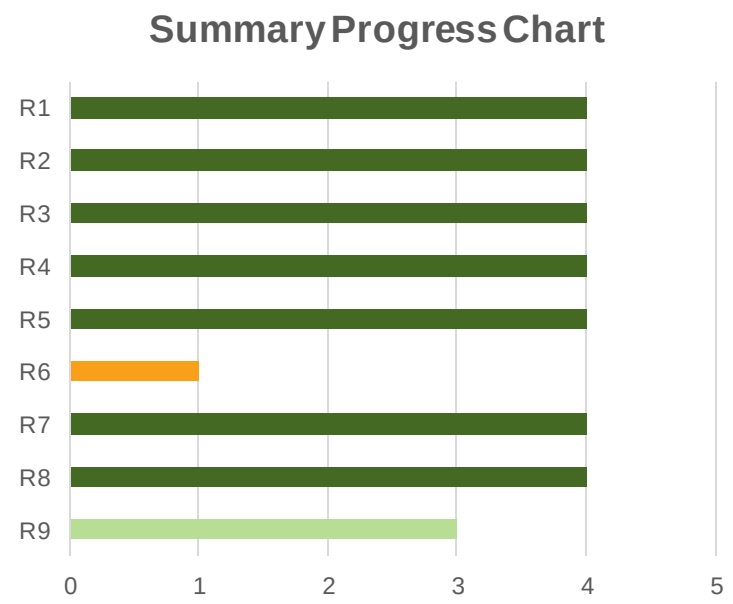
Our framework is:

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

There were 9 recommendations in total, two of which also include actions for NHS Wigan and Knowsley CCGs, in cooperation with NWB.

Implementation of recommendations

We have rated the progress of the actions which were agreed from the nine recommendations made. Our findings are summarised below:



Summary

Significant progress has been made in relation to all actions apart from recommendation 6, where action has commenced but not progressed substantially. We have provided examples of further assurance required to demonstrate action is complete, tested, embedded and/or sustained as appropriate. We recognise that progress has been affected by system pressures due to Covid-19.

Assurance overview

Recommendation		NICHE rating	Further assurance required to demonstrate action is complete, tested, embedded and sustained
1	All patients must have risk assessments and care plans which comply with Trust and national standards, and the Trust should develop an assurance framework that evidences compliance.	4	• Full roll out and implementation of the CPA QAF as part of the quarter 2 work under Mersey Care NHS Foundation Trust.
2	The Trust should develop an approach to the quality assurance of care plans that addresses communication with other agencies for patients with complex needs. This must include assurance that appropriate communication plans are in place.	4	• Finalise plans for CPA compliance and quality monitoring.
3	The Trust must demonstrate that the CAMHS pathway has identified and implemented the requirements of the NICE guidance into the 'iThrive' pathways, and that this is monitored.	4	• NWB THRIVE steering group minutes, an updated THRIVE service specification, and 10 case studies to demonstrate the NICE guidance has been embedded and sustained.
4	All patients should have a risk assessment which addresses triggers and relapse indicators, and includes assessment and management plans if there is an escalation in risk, covering risk and coping strategies.	4	• A NWB QAF structure able to provide data on safety planning, together with safety plan case studies and feedback from staff, children, families and partners to demonstrate further risk escalation embeddedness. • Negotiation with the CCG regarding the 100% training target and further NWB QAF audits to demonstrate compliance of staff attending the CAMHS training.

Assurance overview

Recommendation		NICHE rating	Further assurance required to demonstrate action is complete, tested, embedded and sustained
5	All young people under the care of CAMHS must have a named practitioner with responsibility and oversight of their care in line with the Trust care coordination and lead professional policy, and this must be included in the implementation of the i - Thrive model in Wigan.	4	To demonstrate sustained improvement the Trust should provide assurance as follows: • CAMHS CPA data indicating the 95% target for the service user seeing their care coordinator within the last 6 or 12 months is met consistently. • Case studies providing feedback from young people and their carers to indicate they know how to contact their care coordinator.
6	All young people who are under the care of CAMHS who have an Education Health Care Plan (EHCP) must have their EHCP referenced in the CPA care plan. The care coordinator must liaise with the EHCP coordinator.	1	• A system for checking updated information is documented in RiO. • Staff focus groups and CPA training delivered to include roles and responsibilities for contributing to EHCPs • Audit cycles of EHCP in care plans • A revised CPA QAF able to provide the assurance specific to the EHCP.

Assurance overview

Recommendation		NICHE rating	Further assurance required to demonstrate action is complete, tested, embedded and sustained
7	The Trust and NHS Wigan CCG must ensure that all investigations and serious incident reports meet national quality requirements, to include particular reference to engaging with and listening to families.	4	To demonstrate sustained improvement the Trust should provide assurance as follows: • Feedback to families following initial investigation of incidents. • Quarterly 2020/21 quality priority Duty of Candour audits demonstrating improvement and compliance within the national timescales. • Training rolled out Trust wide to ensure staff are aware of the requirements for meaningful engagement with families.
8	NHS Wigan Borough CCG and NHS Knowsley CCG must ensure that all systems for sign-off of Trust SI reports provide quality assurance that the requirements of the NHS England SIF are met.	4	The CCGs should supplement the assurance provided by ensuring the Trust provides: • An updated serious incident and learning SOP, including the use of an assurance tool for use within local and corporate safety panels, with examples to indicate that these are in use and impacting positively on the quality of the RCA, which reflects the closure checklist being used in serious incident sign-off meetings between the Trust and CCGs. To demonstrate sustained improvement the CCGs should provide assurance that demonstrates: • Improvements in quality measured and audited.

Assurance overview

Recommendation		NICHE rating	Further assurance required to demonstrate action is complete, tested, embedded and sustained
9	The Trust must complete the review of the complaint handling process and implement the recommendations from the review, incorporating particular reference to engaging with and listening to families.	3	To demonstrate the action (with specific reference to engaging with and listening to families) is embedded and sustained the Trust should provide assurance as follows: • Audit of patient feedback on the handling of the complaints process. • Staff feedback on case supervision to support engagement with service users and families.

Assurance review findings

3. Assurance review of the action plan

Based on the Niche independent investigation following the tragic death of DEG into the care and treatment provided by NWB, there were nine recommendations for NWB, including two that involved Wigan Borough and Knowsley Clinical Commissioning Groups (CCGs), with four overarching themes:

- Care plans and risk assessments
- Child and Adolescent Mental Health Services (CAMHS) care pathway
- Partnership working
- Serious incident and complaints processes

Each theme identified specific recommendations and highlighted the desired outcome, along with individual actions, completion dates and a Blue, Red, Green, Amber (RAG) rating to enable clarity of achievement. Blue indicated all actions were delivered and transformational change achieved, green indicated that actions were on track for completion but would require a quality assurance process to indicate the level of embeddedness and transformation, amber indicated delayed but managed and red indicated not likely to be delivered within the time frame.

The action plan structure converted the themes into recommendations and then into manageable tasks with evidence of a collective responsibility and division of workload.

In addition, a clear narrative picture of the progress of each recommendation with associated historical and current supporting evidence was provided.

For clarity of process, this assurance review lists the recommendations by overarching theme.

Agency	No. recommendations
NWB	7
NWB & NHS Wigan Borough and Knowsley CCGs	2

3. Assurance review findings

Recommendation 1: All patients must have risk assessments and care plans which comply with Trust and national standards, and the Trust should develop an assurance framework that evidences compliance.			
Theme – Care plans and risk assessments			
Desired outcome	**NWB action plan**	**NWB evidence submitted**	**Niche comments and gaps on assurance**
An assurance framework is developed and implemented which sets out the timetable for monitoring of the Care Programme Approach (CPA) risk assessments and care plans in line with Trust and national standards.	Develop and approve an assurance framework.	Trust standard operating procedure (SOP) for the use of the CPA quality assurance framework (QAF) first draft presented at the Trust quality, safety, safeguarding and governance group (QSSG) 19 September 2020.	The Trust SOP was approved for use as a Wigan pilot September 2020. The SOP references national standards and has clear standards and a section on monitoring compliance with the procedure. The action is met and there are no gaps in assurance.
An assurance framework is developed and implemented which sets out the timetable for monitoring of the CPA risk assessments and care plans in line with Trust and national standards.	Develop an implementation plan commencing in Wigan initially, then roll out across the rest of the Trust CAMHS.	Trust SOP for the use of the CPA QAF. Borough QSSG minutes September 2020 - January 2021. CPA presentation quarter 4 2020 and March 2021 with details of CPA governance, training compliance figures, staff feedback evaluation indicating the greatest area of growth in knowledge and the impact on practice. CPA infographic year end 2020/21. Trust quality account 2020/21.	The SOP was approved for use in the Wigan pilot September 2020. Although an implementation plan was not submitted for assurance, the September, November, December 2020 and January 2021 Borough QSSG minutes evidence the progress with the implementation of this in Wigan but not specifically across the Trust CAMHS. The CPA presentation and infographic provides assurance that there has been an implementation plan rollout. However, we note that an agreement is awaited that the CAMHS collaborative will roll out and implement the CPA QAF as part of the quarter 2 work under Mersey Care NHS Foundation Trust.

Recommendation 1: continued			
Desired outcome	NWB action plan	NWB evidence submitted	Niche comments and gaps on assurance
An assurance framework is developed and implemented which sets out the timetable for monitoring of the CPA risk assessments and care plans in line with Trust and national standards.	The SOP for the CAMHS service will be updated to reflect the expected care planning, risk assessment and safety planning standards.	SOP for the use of the CPA QAF.	The QAF has sections on care planning, risk assessment and safety planning to reflect the expected standards. The action is met and there are no gaps in assurance.
An assurance framework is developed and implemented which sets out the timetable for monitoring of the CPA risk assessments and care plans in line with Trust and national standards.	The assurance framework will have been approved via the Trust QSSG, reporting to the Trust quality committee.	SOP for the use of the CPA QAF.	First draft presented at the Trust QSSG 19 September 2020. Approved for use for Wigan pilot September 2020. The action is met and there are no gaps in assurance.
The Trust will achieve the agreed target of 100% of staff having completed the training and can demonstrate the agreed level of competence to undertake the clinical activity in practice.	Develop and approve an updated face-to-face/other media training curriculum and identified competencies for all identified staff within CAMHS services including the key components of: • risk assessment, formulation and management; • effective, collaborative safety planning; and • person-centred care planning.	SOP for the use of the CPA QAF. CPA presentation quarter 4 2020 and March 2021 with details of CPA governance, training compliance figures, staff feedback evaluation indicating the greatest area of growth in knowledge and the impact on practice. CPA training workbook.	The CPA presentation details the whole systems approach and associated mandatory training delivered by a workbook with supervision on completion, compliance monitoring and supplementary training to enhance staff skills. Compliance training percentages provided indicate 81% for the Trust overall and 76% for Wigan, with the caveat that capacity to release staff was affected by the Covid-19 pandemic. The action is met and there are no gaps in assurance.

Recommendation 1: continued			
Desired outcome	NWB action plan	NWB evidence submitted	Niche comments and gaps on assurance
Quality performance data indicates 100% of care records sample have achieved compliance with Trust and national standards for CPA, risk assessments and care plans for young people cared for under the CPA framework. An audit will be completed bi-monthly in this respect.	Develop and implement a quality performance reporting system. Bi-monthly monitoring of compliance completed by Borough QSSG which demonstrates actions being taken to address identified gaps in compliance.	Borough QSSG minutes September 2020. Wigan Borough Matron QAF report November 2020. Wigan CPA QAF audit tool and audit December 2020/January 2021 with summary report. CPA QAF audit tool revised January 2021. Correspondence indicating the Trust has taken a decision to move from bi-monthly to quarterly audits.	The CPA QAF revised January 2021 audit tool is comprehensive and improved. The September, November, December 2020 and January 2021 Borough QSSG minutes evidence the progress with the development and implementation of a quality performance reporting system. September 2020 Borough QSSG minutes record low return of the QAF audit. November 2020 report indicates improvement in returns. The December 2020/January 2021 Wigan CPA QAF audit summary indicates significant improvements with 100% compliance with risk assessment and safety planning and 90% compliance with care plan standards. However further assurance to demonstrate sustained improvement is required. Email correspondence indicates sharing of lessons in Borough and Trust-wide meetings to identify which actions should be implemented and tracked for improvement impact. The action has been met.

NIAF rating: A comprehensive assurance framework has been developed with a whole systems approach to CPA transformation and delivery, together with an SOP and associated training together with evidence indicating staff were able to demonstrate the impact on their practice. We note the improvement in the delivery of the QAF and the summary of work remaining to year-end report on the Wigan Borough (including CAMHS) quarter 4 CPA QAF results and the progress of CPA, CAMHS and THRIVE training. There is a gap in assurance that the assurance framework has been rolled out across the rest of the Trust CAMHS, however we note that the work is ongoing as part of the CPA collaborative work reporting under the quality strategy. We note that the CPA work-stream meeting of 5 July 2021 was to agree that the CAMHS collaborative will roll out and implement the CPA QAF as part of the quarter 2 work under Mersey Care NHS Foundation Trust. Given this, although the action is complete, tested and embedded, further assurance is required to demonstrate sustained improvement.

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

Recommendation 4: All patients should have a risk assessment which addresses triggers and relapse indicators, and includes assessment and management plans if there is an escalation in risk, covering risk and coping strategies.			
Theme – Care plans and risk assessments			
Desired outcome	**NWB action plan**	**NWB evidence submitted**	**Niche comments and gaps on assurance**
The Trust will achieve the agreed targets of 100% of staff having completed the training and can demonstrate the agreed level of competence. Staff are able to articulate what actions to take in the event of an escalation of risk.	The CAMHS training curriculum to be reviewed and include: • Risk assessment skills, awareness of relapse indicators and triggers. • Safety planning and how to collaboratively safety plan in order to ensure that both the young person and their family is aware of how the interventions offered will increase based on an identified increase in clinical risk. • Opportunity for families to increase their knowledge and understanding of risk via online training/carers sessions. • Training evaluation to include feedback from staff on level of learning.	CPA presentation quarter 4 2020 and March 2021. NWB CPA training workbook 2018 – 2021.	A CAMHS training curriculum was not provided for assurance. However, the CPA presentation demonstrates it includes the requirements and details the whole systems approach and associated mandatory training delivered by a workbook with supervision on completion, compliance monitoring and supplementary training to enhance staff skills. Compliance training percentages provided indicate 81% for the Trust overall and 76% for Wigan, with the caveat that capacity to release staff was affected by the Covid-19 pandemic.
Quality data indicates 100% of records sampled showed that children and their carers have a safety plan on entry to the service.	Develop and implement quality performance audit reporting and system to include patient feedback.	SOP CPA QAF. Example of a child safety plan 2020/2021.	The QAF is structured to be able to provide data on safety planning. However, there is a gap in assurance in that no examples of safety plans were submitted for assurance purposes. It is noted that case studies were to be presented at the quality assurance visit April 2021, although these have not been provided and the action is therefore partially met.

Recommendation 4: continued			
Desired outcome	NWB action plan	NWB evidence submitted	Niche comments and gaps on assurance
Quality data indicates 100% of records sampled show that children and their carers have a safety plan on entry to the service.	Monthly monitoring of compliance completed by Borough QSSG, which demonstrates actions being taken to address any identified gaps.	Borough QSSG minutes September 2020. Wigan Borough Matron QAF report November 2020.	September 2020 Borough QSSG minutes record low return of the QAF audit. November 2020 report indicates improvement in returns. The December 2020/January 2021 Wigan CPA QAF audit summary indicates significant improvements with 100% compliance with risk assessment and safety planning and 90% compliance with care plan standards. The action has been met. However assurance to demonstrate sustained improvement is required.
Quality performance data indicates 100% of sample care records have achieved compliance with risk assessment, formulation and planning, and safety plans are in place to identify the agreed change in intervention when a young person's clinical risk increases.	A safety plan will be developed so that all children, young people and their carers receiving intervention from the CAMHS service will receive this safety plan at the point of entry to the service, this will be updated in response to any changes in their risk profile.	Example of a child safety plan 2020/21. December 2020/January 2021 Wigan CPA QAF audit summary.	It is noted that case studies were to be available April 2021 although these were not provided. The December 2020/January 2021 Wigan CPA QAF audit summary indicates significant improvements with 100% compliance with risk assessment and safety planning and 90% compliance with care plan standards. No examples of safety plans were provide and the action is therefore partially met.

Recommendation 4: continued			
Desired outcome	NWB action plan	NWB evidence submitted	Niche comments and gaps on assurance
Quality performance data indicates 100% of sample care records have achieved compliance with risk assessment, formulation and planning, and safety plans are in place to identify the agreed changing intervention when a young person's clinical risk increases.	Identify 10 case studies which demonstrate appropriate action taken following escalation of concerns and risks; to include patient feedback.	Anonymised example of a case escalated to the multidisci0linary team (MDT) 9 December 2020. Children and young people mental health services (CYPMHS) Wigan MDT meeting 9 December 2020. Summary of caseload supervision for CAMHS practitioners September 2020.	One specific anonymised example provided of clinical concerns being escalated to the MDT, the outcome of which is recorded in the clinical notes. The records include feedback from the mother. There is a gap in assurance in that no evidence of patient feedback was submitted. It is noted that case studies were to be presented at the April 2021 quality assurance visit. The summary of caseload supervision (184 cases) evidences the number of cases (18) which were escalated to the MDT and/or risk quadrant meetings due to concerns and risks. The action is partially met.

NIAF rating: There is evidence of the development and implementation of a quality performance reporting system and of changing interventions when a young person's clinical risk increases, which is able to demonstrate that all patients have a risk assessment which addresses triggers and relapse indicators and includes assessment and management plans if there is an escalation in risk, covering risk and coping strategies. Only one case study of risk escalation was provided, and not the 10 required including feedback from staff, children, families and partners. Further assurance is required to demonstrate the embeddedness of risk escalation. The Trust did not achieve the agreed target of 100% of staff having completed the CAMHS training curriculum due to the impact of the Covid 19 pandemic. However, despite this the December 2020/January 2021 Wigan CPA QAF audit summary indicates 100% compliance with risk assessment and safety planning and 90% compliance with care plan standards. The 100% training target may not be realistic, as new staff come into post, and may require negotiations with the CCG as part of the ongoing quality and safety monitoring. Further QAF audit will provide the assurance to provide a rating that demonstrates a sustained improvement.

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

Recommendation 3: The Trust must demonstrate that the CAMHS pathway has identified and implemented the requirements of the NICE guidance into the 'iThrive' pathways, and that this is monitored.			
Theme – CAMHS care pathway			
Desired outcome	NWB action plan	NWB evidence submitted	Niche comments and gaps on assurance
Children and their carers are offered a CAMHS service which is compliant with NICE guidance. THRIVE being the identified model of care in place.	Undertake benchmarking of the existing CAMHS provision to confirm that the service is compliant with the Thrive framework.	Summary of Wigan CAMHS THRIVE benchmarking outcomes 2019 – 2021. CAMHS THRIVE and MindEd training email 23 September 2020. Wigan THRIVE model PowerPoint presentation (undated). Embedding THRIVE in CAMHS teams: What would it look like? PowerPoint presentation (undated). CAMHS THRIVE model 8 March 2019. THRIVE training PowerPoint presentation (undated). THRIVE training records 2019 – 2020. MindEd training compliance as of February 2021 for Wigan CAMHS.	Staff were encouraged to undertake the MindEd training modules prior to post-training discussions in 2021 to consolidate the learning and discuss local practices, care plans and risk assessments from a THRIVE framework perspective. The presentations ask the question (supported by data) as to whether the services are already working in this way and indicate the next steps, the mechanisms for embedding the THRIVE model and how to redefine the CAMHS offer to support the THRIVE hub model. THRIVE training records indicate low numbers of attendees, increasing as the training is delivered online in 2020 as a result of the Covid-19 pandemic. In summary, February 2021 records indicate 15 of 40 staff (38%) have completed this course over the past year. Summary annual benchmark data confirms that the service is compliant with the THRIVE model and the action is met.

Recommendation 3: continued			
Desired outcome	NWB action plan	NWB evidence submitted	Niche comments and gaps on assurance
Children and their carers are offered a CAMHS service which is compliant with NICE guidance, THRIVE being the identified model of care in place.	The outcomes of the benchmarking exercise to be presented to the Borough operational group and CAMHS collaborative group to inform any actions which are required.	Summary of Wigan CAMHS THRIVE benchmarking outcomes 2019 – 2021.	Summary annual benchmark data confirms that the service is compliant with the THRIVE model and the action is met, however no assurance was provided to indicate that this was presented to the Borough operational group and CAMHS collaborative group to inform any actions which are required. The action is therefore partially met.
Children and their carers are offered a CAMHS service which is compliant with NICE guidance, THRIVE being the identified model of care in place.	Three and six-monthly monitoring to be undertaken and the outcomes presented to Borough QSSG and CAMHS collaborative group.	Warrington and Halton THRIVE engagement evaluation September 2018. Lessons learned case study PowerPoint presentation November 2020. Lessons learned framework January 2021. Wigan QSSG minutes 8 September and 11 November 2020.	The Warrington and Halton evaluation states that they went live with the THRIVE service transformation in April 2018, includes staff feedback and recommended that the THRIVE transformation continued to be rolled out across the remaining Boroughs. However no assurance was provided to indicate that this was presented to the Borough operational group and CAMHS collaborative group to inform any actions which are required. The action is therefore partially met. The lessons learned framework provides a structure and process with templates and guides including a staff internet dedicated page, although the accompanying policy and procedure was not included and noted as being in draft. The lessons learned presentation indicates that information on the plan for bi-monthly quality assurance audits to be completed is to be provided in the February 2021 update report.

Recommendation 3: continued			
Desired outcome	NWB action plan	NWB evidence submitted	Niche comments and gaps on assurance
… continued	… continued	… continued	The Wigan November 2020 QSSG minutes indicate a session on lessons learned from this case was undertaken. QSSG reports to the operations and integration committee (OIC) and clinical leadership group (CLG) and includes updates on the delivery of the i -THRIVE implementation plan. Task and finish groups drive the implementation of the model. However, the terms of reference are undated and there is no review date and no minutes of the steering group or task and finish reports were submitted for assurance purposes.
Children and their carers are offered a CAMHS service which is compliant with NICE guidance, THRIVE being the identified model of care in place.	Identify 10 cases across each of the five needs-based groups (two in each) and develop case studies which demonstrate i -Thrive-compliant care. Lessons learned to be shared across the Borough and Trust.	To be led by CAMHS clinical psychologist in a clinical lead role by 31 January 2021. Learning lessons from DEG cascade email 19 January 2021 for Borough- and Trust-wide meetings.	We note the identification of 10 cases is to be led by a CAMHS clinical psychologist in a clinical lead role with a timescale of 31 January 2021. No assurance provided at this point and this part of he action has not been met. The email had a learning lessons from DEG as a PowerPoint presentation attached and indicated this was to be shared across the Borough and Trust.

Recommendation 3: continued			
Desired outcome	NWB action plan	NWB evidence submitted	Niche comments and gaps on assurance
Children and their carers are offered a CAMHS service which is compliant with NICE guidance, THRIVE being the identified model of care in place.	Confirm how the Trust monitors the delivery of the pathway in line with NICE guidance.	NICE CG 158 combined assessment tool February 2018, with other examples of scheduled NICE audits. Warrington and Halton THRIVE engagement evaluation. THRIVE steering group terms of reference and agenda 27 February 2019. THRIVE service specification.	The NICE CG 158 combined assessment tool February 2018 is provided as an example of how CAMHS implement NICE guidance. The example provided is concerned with antisocial behaviour and conduct disorders. It appears to have been updated to November 2020 with text relating to the implementation of the THRIVE framework, and although specific actions in respect of this are not detailed, leads are assigned with revised completion dates of January 2021. The purpose of the THRIVE steering group is defined as being to oversee the implementation of the THRIVE model, provide oversight and track and report on progress of the implementation plan. The agenda indicates that the group met on 27 February and was due to meet again on 27 March 2019. However, no minutes were submitted as assurance. Although the service specification has been updated in some parts to reflect the THRIVE model, in other parts it is out of date, with an overall review date of March 2019.

Recommendation 3: continued			
Desired outcome	NWB action plan	NWB evidence submitted	Niche comments and gaps on assurance
… continued	… continued	… continued	Although the service specification has been updated in some parts to reflect the THRIVE model, in other parts it is out of date, with an overall review date of March 2019.

Recommendation 3:

NIAF Rating: The Trust can demonstrate that they have undertaken a benchmark of the existing CAMHS provision to assess whether the service is compliant with the THRIVE framework and that they have developed a system to monitor the delivery of the pathway in line with NICE guidance. It is noted that annual THRIVE benchmarking 2019 and 2020 undertaken with commissioners and partner agencies indicated that the Trust was achieving THRIVE-like practice, that the transformation work continues as part of the collaborative CAMHS THRIVE work with partner agencies and that the benchmarking exercise is due again in 2021 to identify the strength of assurance that these new ways of working are embedded. Further assurance is also required in associated with the governance of the implementation of the THRIVE framework , i.e. THRIVE steering group minutes and an updated service specification.

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

Recommendation 5: All young people under the care of the CAMHS service must have a named practitioner with responsibility and oversight of their care in line with the Trust Care Coordination Policy and Lead Professional Policy, and this must be included in the implementation of the i - Thrive model in Wigan.			
Theme – CAMHS care pathway			
Desired outcome	**NWB action plan**	**NWB evidence submitted**	**Niche comments and gaps on assurance**
Children and their carers receive care in line with Trust CPA policy and procedures.	Confirm that the CAMHS pathway operational guidance contains this requirement. The review of the Trust CPA policy and procedures is completed and approved to include the CAMHS requirements.	Trust CPA policy and procedures issued June 2018, review June 2021. Email 19 January 2021 from Warrington head of quality to leadership team. January 2021 SOP for early intervention in psychosis. To be reviewed no less than every three years. SOP for referral management issued August 2018, review August 2021.	The CPA policy revision update states that where a child/young person has a serious mental health problem they will be subject to CPA, referring primarily, though not exclusively, to children and young people who are being managed within the 'Getting More Help' section of the THRIVE framework. The SOP for the first-episode psychosis pathway provided as assurance against this action states that it applies to people aged between 14 and 65 years, has a section on interface with children and young people's services, and states that a care coordinator must be allocated when the service user progresses onto the treatment pathway. The SOP for referral management provided as assurance against this action gives a THRIVE context in which the referral single point of access is being developed. Within this, the pathway has a point at which cases are allocated to a care coordinator or a lead professional stating that the allocation could be with another agency.
Children and their carers know who their care coordinator or lead professional is.	Obtain patient/carer feedback via carers groups.	None.	No evidence of patient/carer feedback was submitted as assurance that children and their carers know who their care coordinator or lead professional is. It is noted that case studies are still being identified for feedback from staff, children, families and partners.

Recommendation 5: continued			
Desired outcome	NWB action plan	NWB evidence submitted	Niche comments and gaps on assurance
Clinical staff are able to articulate what their roles and responsibilities are as a care coordinator and lead professional. Personal development reviews include competence in this role and provide learning opportunities for individual staff where appropriate.	Update of Trust CPA policy is implemented and staff awareness-raising/training is completed which includes the updated requirements.	MindEd training curriculum: extracts from an email to all CAMHS team members. Warrington THRIVE and CAMHS presentation. Trust CPA policy staff training feedback and evaluation December 2019; completed January 2020. Wigan Borough-wide CPA compliance December 2019 – December 2020. CPA training workbook April 2018, for review 2021 by the CPA collaborative. Warrington THRIVE model engagement report. CPA procedure: lead professional role authorities and lead responsibilities. CPA procedure: care coordinator roles and responsibilities.	The MindEd training curriculum provides modules for the staff to complete with a view to post-training discussions in 2021 to help consolidate the learning, and to discuss local practice. The THRIVE presentations do not reference the revised CPA Policy. Staff training evaluation showed that a small sample (30) of feedback forms were reviewed, although there was no specific indication that these included CAMHS staff. There is no assurance that the training included the specific CPA CAMHS policy amendments (issued after the training evaluation date). The Wigan Borough-wide CPA compliance report is aggregated and not CAMHS specific. The CPA training booklet is adult focussed and states the CPA mainly covers adults of working age, but the principles must be applied to any individual receiving these services regardless of their age. However, it does have a section on CAMHS and the THRIVE model, but this simply describes the model and states that some CAMHS services are proposing to replace the tiered model with a conceptualisation of a whole system approach.

Recommendation 5: continued

Desired outcome	NWB action plan	NWB evidence submitted	Niche comments and gaps on assurance
…continued	…continued	…continued	However the Wigan CAMHS CPA QAF monitoring check July 2020 and December 2020 – January 2021 indicates that all (10) cases had the care coordinator/lead professional recorded in RiO. The Trust CPA data indicates that reviews 'by any professional' as a stand in for the care coordinator to maintain the level of quality and safety during the Covid 19 pandemic, were consistently above the 95% target, and care coordinator completing reviews was above 90%. The action is met.
CAMHS performance data shows 100% compliance with recording who the care coordinator and lead professional is in RiO (an electronic clinical record system) care records. The young person's care plan records who this clinician is and how young people and their carers can contact them.	Review and update CPA reporting key performance indicators for CAMHS teams. Wigan Borough/Trust monthly monitoring to be undertaken as part of the Trust quality and performance report. Actions are in place to address identified gaps in compliance.	January 2021 CPA QAF audit tool. Wigan CAMHS CPA QAF monitoring check July 2020 and December 2020 – January 2021. CPA data May 2020 to May 2021.	The revised January 2021 CPA QAF audit tool demographic section has a space to record the care coordinator. However, the QAF could be improved further to include the expected practice of a care coordinator as set out in the roles and responsibilities document. The QAF does not appear to be able to audit how young people and their carers can contact them. The action is met.

Recommendation 5: continued			
Desired outcome	NWB action plan	NWB evidence submitted	Niche comments and gaps on assurance
NIAF Rating: The SOPs for early intervention and referral management need to refer to the amended CPA Policy. The CPA training workbook is adult focussed and requires review. We note that the CPA training evaluation indicated that 87% had learned more about the requirements of a care coordinator, although the records do not indicate CAMHS staff attendance or feedback, and the training and evaluation took place before the CAMHS CPA policy amendments. However, the Trust is able to demonstrate 100% CAMHS compliance with recording the care coordinator and lead professional in RiO care records from July 2020 to January 2021 in line with the Trust care coordination and lead professional Policy reviews 'by any professional' as a stand in for the care coordinator to maintain the level of quality and safety during the Covid 19 pandemic, were consistently above the 95% target, and care coordinator completing reviews was above 90%. **Overall rating for this recommendation: 4 (action completed, tested and embedded)**			

Recommendation 2: The Trust should develop an approach to the quality assurance of care plans that addresses communication with other agencies for patients with complex needs. This must include assurance that appropriate communication plans are in place.			
Theme – Partnership working			
Desired outcome	**NWB action plan**	**NWB evidence submitted**	**Niche comments and gaps on assurance**
Patient care plans will be co-produced with all agencies involved in the patient's care. The care plan will articulate how the agencies will communicate to ensure that outcomes are achieved.	Development of a CPA QAF will include the expected standards for communication with other agencies and the development of co-produced care plans. Development of an audit tool for the CPA QAF alongside audit frequency and reporting structure.	Summary of Wigan CAMHS THRIVE benchmarking outcomes 2019 – 2021. Partnership and collaboration 'One Voice' meeting minutes 16 November 2020. Multi-agency risk quadrant meeting terms of reference updated 19 December 2020. SOP for the CPA QAF approved September 2020 (no review date). December 2020 – January 2021 CPA QAF audit. CPA presentation to Wigan CCG March 2021. Quarter 4 CPA presentation to wider commissioners. Quality account 202/21.	The benchmarking summary indicates that patient care plans are co-produced with all agencies. The 'One Voice' monthly meeting minutes also indicate a level of partnership and collaboration, including young people. The multi-agency risk quadrant weekly meeting minutes describe part of its purpose as to promote multi-agency working and ownership of the children and young people that present in the risk quadrant of THRIVE. The SOP for the CPA QAF includes evidence of multi-agency working within the care plan, with names/titles/details of others who supporting the delivery of the care plan. The SOP for the CPA QAF includes the ability to evidence that all agencies involved in the patient's care have received and are in agreement with the patient's care plan. The December 2020 to January 2021 QAF audit indicates 100% compliance and evidence of partnership working with other agencies. At year end the Trust reported 96% evidence of detailed collaborative working. It is noted that Merseycare are awaiting feedback from GMMH on plans for 2021/22 in terms of CPA compliance and quality monitoring.

Recommendation 2: continued			
Desired outcome	NWB action plan	NWB evidence submitted	Niche comments and gaps on assurance
Staff are able to articulate their roles and responsibilities as care coordinators in ensuring that effective communication is key for the delivery of quality care.	Training sessions delivered to staff on the use and application of the CPA framework. Obtain feedback from staff via training evaluation and supervision.	CPA presentation quarter 4 2020 and March 2021. NWB CPA training workbook 2018 – 2021.	The CPA presentation details the whole systems approach and associated mandatory training delivered by a workbook with supervision on completion, compliance monitoring and supplementary training to enhance staff skills. Compliance training percentages provided indicates 81% for the Trust overall and 76% for Wigan, with the caveat that capacity to release staff was affected by the Covid-19 pandemic. A Trust-wide random sample of 30 staff on CPA training between December 2020 and January 2021 indicated that 70% had reflected specifically on the importance of working collaboratively with service users, family and other agencies and that there was 100% compliance with risk assessment and safety planning and 90% compliance with care plan standards.

NIAF Rating: The Trust has developed an approach to the quality assurance of care plans that addresses communication with other agencies for patients with complex needs with assurance that appropriate communication plans are in place. The Trust summary THRIVE benchmarking 2019 – 2020 indicates that they have improved and sustained THRIVE-like practice with reference to partnership and collaborative working, and minutes of meetings demonstrate partnership working between agencies and inclusion of young people. The SOP for the CPA QAF is able to provide evidence of partnership working and communication with the December 2020 – January 2021 audit indicating 100% compliance and evidence of partnership working, with a random sample of staff indicating 70% had reflected on the importance of collaborative working and the year end CPA information indicates 96% compliance and evidence of partnership working. This demonstrates sustained improvement through 2020, however due to the merger CPA compliance and quality monitoring plans for 2021/22 are yet to be finalised.

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

Recommendation 6: All young people who are under the care of CAMHS who have an Education Health Care Plan (EHCP) must have their EHCP referenced in the CPA care plan. The care coordinator must liaise with the EHCP coordinator.			
Theme – Partnership working			
Desired outcome	**NWB action plan**	**NWB evidence submitted**	**Niche comments and gaps on assurance**
CAMHS teams are aware of all children open to the service who have an Education Health Care Plan (EHCP) and engage appropriately with the EHCP coordinator about these children and young people.	Review frequency of receiving information from EHCP coordinator and the system for checking updated information is documented in RiO.	Referral to the education, health and care pathway in Wigan Borough (template document – August 2018). Special educational needs and disability (SEND) EHCP pathway published by Wigan Borough clinical commissioning group (CCG) and Wigan Council. Graduated response SEND flowchart.	It is noted that there is an EHCP referral template and a care pathway and that RiO is being updated with an adjusted timescale of 31 March 2021 to be able to check updated EHCP information. At this point assurance has not been received in respect of this and the action has not been met.
Staff are able to articulate their own role and responsibilities in order to competently contribute to the EHCP.	Training and awareness sessions completed with all relevant staff on their role and responsibilities in line with CPA policy and contributing to an EHCP.	No evidence submitted.	It is noted that the timescale for staff focus groups and CPA training delivered to include roles and responsibilities for contributing to EHCPs has been adjusted to 31 March 2021. At this point assurance has not been received in respect of this and the action has not been met.
100% of audited cases where an EHCP plan is in place evidences the EHCP in the care plan to ensure an integrated approach to care.	Wigan Borough/Trust monthly monitoring to be undertaken as part of Trust Quality and Performance Report, actions being taken to address areas of concern.	Care and Treatment Reviews (CTRs): Policy and Guidance, Including policy and guidance on Care, Education and Treatment Reviews (CETRs) for children and young people (March 2017) published by NHS England. CPA QAF audit tool updated January 2021.	It is noted that an audit of EHCP in care plans will be completed in quarter 4. The NHS England CETR policy refers to quality assurance evidence on adherence to the policy as follows: • The CETR standards are being met, with particular focus on legal issues such as consent, registration/DBS checks, etc.

Recommendation 6: continued

Desired outcome	NWB action plan	NWB evidence submitted	Niche comments and gaps on assurance
			• Immediate actions following CTRs (e.g. safeguarding referrals) are followed up. • CTR recommendations are being followed up and actioned. • There is feedback from external expert advisers that they are well supported and able to engage well with the CTR process. • There is feedback from people with learning disabilities and their families on the quality of the review and the subsequent outcomes. The CPA QAF does not specifically refer to EHCP in the qualitative sections on care plans and risk. With reference to the assurance required for CETRs, the QAF only refers to appropriate action being taken following a safeguarding referral. The action has therefore not been met.

NIAF Rating: The Trust is not currently able to demonstrate that all young people under the care of CAMHS who have an EHCP have this referenced in the CPA care plan indicating liaison between the care coordinator and the EHCP coordinator. The work being undertaken to 31 March 2021 to provide the assurance for this recommendation is noted. The CPA QAF should be reviewed to provide the assurance specific to the EHCP**.**

Overall rating for this recommendation: 1 (action commenced)

Recommendation 7: The Trust and NHS Wigan CCG must ensure that all investigations and SI reports meet national quality requirements, to include particular reference to engaging with and listening to families.			
Theme – Serious incident and complaints processes			
Desired outcome	NWB/CCG action plan	NWB evidence submitted	Niche comments and gaps on assurance
The Trust and NHS CCG must ensure that all investigations and SI reports meet national quality requirements, to include particular reference to engaging with and listening to families.	NHS Wigan Borough CCG in partnership with the Trust will review the serious incident process to ensure that all serious incident reports meet the national quality requirements and specifically reference how the Trust have engaged with and are listening to families.	Care Quality Commission (CQC) 'Learning from Deaths' review August 2020 and letter November 2020. NHS Wigan Borough CCG provider assurance serious incident framework final 31 December 2020. Trust Being Open (including contractual DoC) Policy (April 2018, minor changes 2020 – 2021). NWB feedback from commissioners. NHS Wigan Borough CCG improvement action plan April 2021.	The CQC 'Learning from Deaths' review letter November 2020 stated that the Trust serious incident reports considered the DoC and included concerns shared by families and patient safety panels, had recognised the impact of deaths on families and had established staff roles to support families and systems to allow families to contribute to incident investigations. The Trust Board received additional training and established further training programmes for staff to improve the experience for patients, families and carers who were involved in serious incidents. However, the CQC review letter stated that in August 2020, less than half of final investigation reports reflected the voice of patients or families and the Trust recognised that work was needed to improve feedback to families following initial investigation of incidents. The provider assurance framework contains sections on Being Open and DoC and the Trust quality committee is delegated to receive assurance of compliance with the Trust Being Open (including contractual DOC) Policy through scheduled patient safety reports. The April 2021 NHS Wigan Borough CCG improvement action plan demonstrates that the serious incident process has been reviewed with the Trust to meet national quality requirements with specific refence to the NHS England SIF section 4.2.1; involving patients, victims and their families. NHS Wigan Borough CCG acknowledged the positive work undertaken by the Trust since 2016. The action has been met.

Recommendation 7: continued.			
Desired outcome	NWB/CCG action plan	NWB evidence submitted	Niche comments and gaps on assurance
100% of investigation reports will reflect the voice of the family as an equal partner throughout the duration of the investigation process in line with the principles of national quality requirements. Where this is not possible, the reason for this will be clearly articulated in the report.	Duty of Candour (DoC) will be applied in a timely and compassionate way in response to 100% of serious incidents.	Trust Being Open (including contractual DoC) Policy (April 2018, minor changes 2020 – 2021). Kin-nect quarter 1 and quarter 2 reports 2020; year-end infographic. Trust quality accounts 2020/21. 72-hour review and concise/ comprehensive templates. Patient safety panels review of DoC as part of the approval process for completed reports. CQC 'Learning from Deaths' review August 2020 and letter November 2020. DoC audits and training package. Quality forum minutes (draft 7 August 2020).	The Trust Being Open (including contractual DoC) policy provides clarity on roles and responsibilities, including the Family Support Lead (FSL) and staff training. The policy details that the Trust quality committee is delegated to receive assurance of compliance with the Being Open policy and adherence to the DoC through scheduled patient safety reports. The quality forum minutes state that three one-day 'Making Families Count' training sessions were delivered throughout September and October 2019 with the benefits of having early and more effective engagement with families who experience complex and traumatic bereavement. The Kin-nect reports for quarters 1 and 2 of 2020 for the Trust quality strategy demonstrate the governance and oversight of DoC performance under Work-stream 4: Improving the application of DoC (Being Open). The report details that previous quarters' DoC audits identified areas for improvement and compliance within the national timescales and that an audit action plan is in place to address areas of concern, with audits repeated each quarter. The year end infographic indicates DoC improvements from 4% in quarter 4 2019/20 to 54% 2020/21, with further work planned for 2021/22 to to streamline processes, reporting processes and additional training for staff to support further improvement in compliance. Given this, the action is partially met.

Recommendation 7: continued			
Desired outcome	NWB/CCG action plan	NWB evidence submitted	Niche comments and gaps on assurance
Investigation leads have the skills and competence required to undertake complex investigations.	Investigation leads will be fully trained in Root Cause Analysis (RCA) and Applied Human Factors. Complex investigations will be led by corporate patient safety leads with support from specialist advisors.	Knowsley 'Introduction to human factors' master class and 'Train the trainers' presentations, 2019, sessions 1 to 3.	The Trust reported that there are currently 38 RCA-trained staff, comprising three full-time patient safety reviewers and 35 operational service clinicians, plus specialists to advise on clinical practice to inform the reviews. However, no assurance was submitted in respect of this information, although the presentations appeared comprehensive. The action is partially met.
Families will experience compassionate and meaningful engagement throughout the serious incident investigation process.	Family concerns and terms of reference will be clearly identifiable within the body of all investigations and developed with the family reports.	CQC 'Learning from Deaths' review August 2020. Examples of Wigan Borough CCG serious incident reviews, indicating that families have contributed to the terms of reference and the family voice is included.	The CQC 'Learning from Deaths' review August 2020 indicated that the Trust had recognised the impact of deaths on families and had established the FSL role to contribute to incident investigations. The 72-hour checklist has the views of the family captured as part of the action to be completed, with a section for a reason if this is not complied with. The 72-hour investigation (January 2020) has a section on service user and or family contribution, including notification, support offered, questions and feedback. Both would be helpful appendices to the serious incident policy. The action has been met.

Recommendation 7: continued			
Desired outcome	NWB action plan	NWB evidence submitted	Niche comments and gaps on assurance
Families will experience compassionate and meaningful engagement throughout the serious incident investigation process.	Quarterly DoC performance monitoring will extend to include the family's contribution within serious incident investigations.	FSL training slides. DoC audits. Targeted DoC training package.	FSL training slides address the application of the DoC in the context of improving the experiences of patients and families who are involved in a serious incident investigation and complaints process. The Kin-nect reports for quarters 1 and 2 of 2020 for the Trust quality strategy demonstrate the governance and oversight of DoC performance under Work-stream 4: Improving the application of DoC (Being Open). The report details that previous quarters' DoC audits identified areas for improvement and compliance within the national timescales and that an audit action plan is in place to address areas of concern, with audits repeated each quarter. Given this, the action is partially met.

Recommendation 7: continued			
Desired outcome	NWB action plan	NWB evidence submitted	Niche comments and gaps on assurance
Families will experience compassionate and meaningful engagement throughout the serious incident investigation process.	The role of the FSL within the serious incident and complaints process will be developed in line with the Kin-nect work streams.	Kin-nect reports for quarters 1 and 2 of 2020. FSL role in place (rebranded from Family Liaison) with guidance and role description (June 2020, review June 2022).	The Kin-nect reports for quarters 1 and 2 of 2020 for the Trust quality strategy demonstrate the governance and oversight of this development as part of the progress of the Trust quality strategy and reflects the development of the FSL role within Work-stream 2: Development of the FSL role within serious incident and complaints processes. The FSL guidance and role description states that the FSL is allocated by the Borough senior leadership team (SLT) within 72 hours of an incident and will continue to communicate, support and work with the family and patient safety lead during any ongoing investigation. The guidance does not specifically relate to complaints but states that the role of Family Liaison Officer may also be utilised in any situation where, as part of a service user's care, there is a need for support and a point of contact. The FSL training slides include a flowchart referring to both the serious incident process and the complaints process. The action has ben met.
Families will experience compassionate and meaningful engagement throughout the serious incident investigation process.	A clear role descriptor for the family liaison officer will inform procedure.	FSL role in place (rebranded from Family Liaison) with guidance and role description (June 2020, review June 2022). FSL training slides and feedback from cohorts 1 and 2 October 2020.	The action has been met.

Recommendation 7: continued

Desired outcome	NWB action plan	NWB evidence submitted	Niche comments and gaps on assurance
Families will experience compassionate and meaningful engagement throughout the serious incident investigation process.	Opportunities to strengthen the family's right to reply and contribute to panel sign-off will be developed in collaboration with the CCG due to existing 60-day timeframes.	NHS Wigan Borough CCG improvement action plan. FSL role in place (rebranded from Family Liaison) with guidance and role description (June 2020, review June 2022). NHSE and NHSI patient safety updates May 2020 and March 2021. Excel spreadsheet of NWB serious incidents average days open 2016 – 2020. NWB 60 day extension requests x3.	The NHS Wigan Borough CCG improvement action plan demonstrates that the serious incident process has been reviewed with the Trust to meet national quality requirements with specific refence to the NHS England SIF section 4.2.1; involving patients, victims and their families. NHS Wigan Borough CCG acknowledged the positive work undertaken by the Trust since 2016. The Trust indicated that families are now supported with their right to reply as part of the sign-off process for patient safety reviews. The FSL checklist does not provide detail of any specific family contribution to report sign-off but details the FSL role in providing the report and discussing the outcome of the serious incident investigation, checking if there are any concerns raised, seeking closure and agreeing outstanding issues for discussion with the Borough leadership team. We note the various reasons that open serious incident days may be in excess of 100 days and that currently Wigan open serious incidents are low (17). The NHSE and NHSI patient safety updates indicate that the 60 day timeframe was suspended in May 2020 (re-iterated in March 2021) noting that organisations should be pragmatic about the sign off and closure of investigations, and formal panel meetings were not required to close investigations. We also note that the commissioning support unit produce a monthly 100 day report which is shared with the Trust. We were provided with three examples of serious incident escalation requests, to understand whether these were associated with the family's right to reply and contribute to panel sign-off. One of these requests provided a very clear explanation of the efforts the Trust had made and continuing difficulties in engaging with a family.

[Assurance review findings … continued]

Recommendation 7: continued			
Desired outcome	NWB action plan	NWB evidence submitted	Niche comments and gaps on assurance
Families will experience compassionate and meaningful engagement throughout the serious incident investigation process.	A baseline for good family engagement will be identified.	FSL role in place (rebranded from Family Liaison) with guidance and role description (June 2020, review June 2022). Monthly FSL Peer Supervision purpose May 2020. Group supervision contract 2020.	The action has been met.
Families will experience compassionate and meaningful engagement throughout the serious incident investigation process.	Internal benchmarking will be completed in line with the Kin-nect work streams.	Trust quality accounts 2020/21.	The Trust recognises that further work is needed with more FSL training and supervision being offered to improve feedback to families. The DoC workstream within Mersey care will continue with further transformation work. The action is partially met.

Recommendation 7: continued			
Desired outcome	NWB action plan	NWB evidence submitted	Niche comments and gaps on assurance
Families will experience compassionate and meaningful engagement throughout the serious incident investigation process.	Family experiences will be surveyed and results utilised to improve practise.	The Trust Board retains oversight of thematic analysis from 'Learning from death' November 2020. The outcome reports are shared with commissioners via the Trust quality forum. FSL training slides.	The FSL training slides reference the Trust quality strategy 2020/21 priority to improve experiences of patients and families who are involved in a serious incident investigation and complaints process. The training slides refer to families that have shared their stories to support the work and the development of the training with a specific example. The action is met.
Families will experience compassionate and meaningful engagement throughout the serious incident investigation process.	All Trust staff will be aware of the requirements for meaningful engagement with families in line with Kin-nect work plans through a series of workshops and a targeted communications strategy.	Further training dates are scheduled up to March 2021. FSL peer group supervision established in September 2020. Further analysis is being collated. Kin-nect task and finish group-training plan September 2020. FSL training slides and feedback from cohorts 1 and 2, October 2020.	FSL training sessions include direct feedback and family experience and state that families should be supported to work in partnership with the Trusts in delivering training for staff in supporting family and carer involvement where they want to. Trust wide training has only been provided to 45 staff, although their feedback is that the training has improved their knowledge and confidence to undertake the role. The action is partially met.
The Trust receives feedback from commissioners that requirements have been met.	Method for measuring/ evaluating the quality of serious incident investigations to be developed in collaboration with all partner CCGs.	Trust anecdotal feedback that progress has been made, particularly with reference to thematic reviews. Wigan Borough CCG e mail example of feedback to NWB. Serious incident and never events (SINE) panel review of effectiveness meeting minutes April 2021. SINE closure checklist.	It is noted that work continues and that feedback is currently obtained via Borough and lead serious incident review groups (SIRGs). Serious incident investigation remains a standing agenda item within Borough QSSG's and the Trust quality forum, as the Trust agreed method of provider assurance. The requirement is that the CCG will aim to provide feedback to the provider within 10 working days wherever possible; assurance was provided that this is undertaken within three days.

Recommendation 7: continued			
Desired outcome	NWB action plan	NWB evidence submitted	Niche comments and gaps on assurance
…continued	…continued	NWBHFT SINE panel checklist examples x 2 2020/21.	The serious incident and never events panel review of effectiveness meeting agreed that a new closure form to include a checklist and capture narrative feedback from the panel would be piloted. The subsequent closure checklist Is includes seeking evidence that those affected(including, patients/staff/victims and families) were involved in the process and supported appropriately. The SINE closure checklist is a comprehensive template based on RCA process with a dated feedback and decision section. Two current examples provided assurance that the use of the new protocols are impacting positively on the quality of the RCAs. The action has been met.

NIAF Rating: The Trust and NHS Wigan CCG have developed a baseline for good family engagement, the Being Open (including contractual DoC) Policy providing clarity on roles and responsibilities, including the newly designated role of the FSL, and associated staff training to ensure that all investigations and SI reports meet national quality requirements, to include particular reference to engaging with and listening to families. Training has been provided to 45 staff, with feedback that the training has improved their knowledge and confidence to undertake the FSL role, however this needs to be rolled out Trust wide. The monthly quality Kin-nect reports for 2020 quarters 1 and 2 for the Trust quality strategy demonstrate the governance and oversight of DoC. However, it is noted that the quarter 4 report was suspended due to the impact of the Covid-19 pandemic and given this and the further work required needed on training and to improve feedback to families following initial investigation of incidents, sustained improvement cannot be demonstrated at this time.

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

Recommendation 8: NHS Wigan Borough CCG and NHS Knowsley CCG must ensure that all systems for sign-off of Trust SI reports provide quality assurance that the requirements of the NHS England SIF are met.

Theme – Serious incident and complaints processes

Desired outcome	NWB/CCGs action plan	NWB/CCG evidence submitted	Niche comments and gaps on assurance
NHS Wigan Borough CCG and NHS Knowsley CCG must ensure that all systems for sign-off of Trust reports provide quality assurance that the requirements of the NHS England SIF are met.	NHS Wigan Borough CCG is to make arrangements to review the current serious incident management process in partnership with NHS Knowsley CCG, with the aim of ensuring that all systems for sign-off of Trust serious incident reports provide quality assurance that the requirements of the NHS England SIF are met.	NHS Wigan Borough CCG improvement action plan April 2021. Wigan Borough CCG Serious Incident and Never Events (SINE) closure checklist 16 April 2021 and examples x 2 2020/21. NHS Wigan Borough CCG provider assurance serious incident framework final 31 December 2020. NWB action plan review meeting notes October 2020, February and April 2021. Wigan Borough CCG e mail example of feedback to NWB. Current excel spreadsheet of NWB serious incidents and average days open 2016 – 2020. Serious incident and learning SOP July 2019.	The April 2021 NHS Wigan Borough CCG improvement action plan, associated closure checklist, feedback to the Trust and action plan assurance meetings demonstrates that the serious incident process has been reviewed and embedded to meet national quality requirements. The requirement is that the CCG will aim to provide feedback to the provider within 10 working days wherever possible; assurance provided that this is undertaken within three days. The excel spreadsheet on average days open for Wigan indicates an improving timeline over four years. However, the data for 2020 indicates that days open were still in excess of 100. We note the various reasons provided as to why this may be the case. Currently, the numbers of open serious incidents in Wigan is low (17) and the expected submission dates are being met. NHSE and NHSI patient safety updates indicate that the 60 day timeframe was suspended in May 2020 (re-iterated in March 2021) noting that organisations should be pragmatic about the sign off and closure of investigations, and formal panel meetings were not required to close investigations

Recommendation 8: continued			
Desired outcome	NWB/CCGs action plan	NWB/CCG evidence submitted	Niche comments and gaps on assurance
The Trust receives feedback from commissioners that requirements have been met.	NWB internal quality assurance tool to be developed to ensure all SIF requirements are met at the point of sign-off.	Wigan Borough CCG SINE closure checklist 16 April 2021. SINE panel checklist examples x 2 2020/21. NWB serious incident management policy (reviewed 2017). NWB serious incident and learning SOP July 2019. Phase 2 of the patient safety improvement plan. May 2019 KPMG patient safety panel audit report.	The Wigan Borough CCG SINE closure checklist is a comprehensive template (part of the NHSE serious incident framework) based on RCA process with a dated feedback and decision section. Two current examples provided assurance that the use of the new protocols are impacting positively on the quality of the RCAs. The Trust serious incident policy refers to a serious incident sign-off panel without a template attached to the policy. We note that an assurance tool is to be created for use within local and corporate safety panels. The SOP was approved in July 2019 and includes a general section stating that reports will be written incorporating principles for effective investigation, rather than a comprehensive sign-off template based on RCA process. The phase 2 patient safety improvement plan is in draft and is undated. However, it has a desired outcome of improving the quality of investigations through the development of quality assurance processes included in the SOP and with a timeframe of March 2021. The action is therefore partially met. The KPMG patient safety panel audit report focussed on the design and operation of the patient safety panel and does not provide assurance that SIF requirements are met at the point of sign-off.

Recommendation 8: continued			
Desired outcome	NWB/CCGs action plan	NWB/CCG evidence submitted	Niche comments and gaps on assurance
The Trust receives feedback from commissioners that requirements have been met.	Trust contribution to locality and lead commissioner SIRG/SINE panels to be agreed in support of quality assurance processes.	NWB action plan review meeting notes October 2020 and February and April 2021.	The minutes of the meetings clearly indicate the Trust's participation in regular NWB and CCG RCA action planning meetings to provide assurance on delivery of actions. The action is met.
The Trust receives feedback from commissioners that requirements have been met.	Method for measuring/evaluating the quality of serious incident investigations to be developed in collaboration with all partner CCGs.	Wigan Borough CCG SINE closure checklist 16 April 2021. SINE panel checklist examples x 2 2020/21. Wigan Borough CCG e mail example of feedback to NWB.	The SINE closure checklist is a comprehensive template (part of the NHSE serious incident framework) based on the RCA process with a dated feedback and decision section. The two examples and e mail feedback to the Trust from Wigan Borough CCG within three days provided appropriate assurance. The action is met.

NIAF Rating: NHS Wigan Borough CCG and NHS Knowsley CCG are able to ensure that there are sign off systems in place and embedded for Trust SI reports providing quality assurance that the requirements of the NHS England SIF are met. Further NWB assurance should include evidence of the SOP being updated to include the use of an assurance tool for use within local and corporate safety panels with examples to indicate that these are in use and impacting positively on the quality of the RCA.

O**verall rating for this recommendation**: **4 (action completed, tested and embedded.)**

Recommendation 9: The Trust must complete the review of the complaint handling process and implement the recommendations from the review, incorporating particular reference to engaging with and listening to families.			
Theme – Serious incident and complaints processes			
Desired outcome	**NWB action plan**	**NWB evidence submitted**	**Niche comments and gaps on assurance**
The updated complaints handling system and process is operational with the recommendations implemented, which includes engaging and listening to families.	Reviewed complaints process which improves levels of engagement and responsiveness. Additional improvement activity to be undertaken as part of the Kin-nect Steering Group and identified work streams.	Complaints and concerns policy, ratified October 2020. Complaints case records closure checklist 26 January 2021. Flowchart – receiving patient feedback following a complaint (links with the above policy).	The complaints and concerns policy records a major change in November 2019 to include 'Making Families Count' training days, although we could not find further reference to this within the body of the policy. The policy was further reviewed to introduce the national complaints framework in July 2020 and references the principles of Being Open and the Duty of Candour. It includes how the role of the FSL will work with the complaints investigator as required. The complaints closure checklist includes a requirement to send a complaints feedback survey letter to the complainant with the complaint response letter and to record whether this has been sent or record reasons why not sent, such as 'inappropriate due to complaint regarding suicide'. The process to receive feedback on the handling of the complaints process, as an appendix to the complaints and concerns policy, supports this and additionally details an automated monthly report, responses reported quarterly and action drafted for common themes by the complaints manager. We have not been provided with assurance to support this being embedded in practice and th4 action is therefore partially met.

Recommendation 9: continued			
Desired outcome	NWB action plan	NWB evidence submitted	Niche comments and gaps on assurance
Performance data indicates 100% of complaints (where this is relevant) included engagement with and listening to families.	Local Borough and Trust monthly monitoring to be undertaken as part of Trust Quality and Performance Report. Quarterly reports to the Trust (QSSG) include level of compliance, lessons learned and actions being taken to address concerns. Complaints which have not been responded to within the timeframes will be escalated to this group for action.	Complaints improvement plan. Quarterly integrated governance complaints report to Trust QSSG. Revised NWB and Mid-Mersey complaint response and investigation templates. Anonymised examples of complaint escalation to the executive team. Complaints closure checklist. Audit of complaints evidencing engagement with the service user and family.	Progress against the full improvement plan is reviewed and updated by the Patient Experience Manager on a monthly basis. The plan indicated completion of ensuring clear lines of communication between the Complaints, Concerns, and PALs Team and the Boroughs. Assurance is provided on a weekly basis through the submission of Trust-wide and Borough complaints reports to Executive Directors and Borough Senior Leadership Teams. The data presented within this report also offers assurance of quality improvements being achieved and state that key learning themes and actions taken by Boroughs, will continue to be shared with the Quality Committee via the borough presentations. The complaint response and investigation templates include target response date, date agreed with complainant and date report completed. Anonymised examples escalated to the executive team provide information on numbers of complaints open longer than 6 months and those out of timeframe with actions taken, escalation and barriers identified. The case record check to confirm the Trust engaged with the service user and family during the complaints process is dated as being undertaken for the period January to December 2020. Out of 40 cases, two were excluded.

Recommendation 9: continued			
Desired outcome	NWB action plan	NWB evidence submitted	Niche comments and gaps on assurance
… continued	… continued	… continued	The audit concluded that for 100% (38) of the remaining complaints received, case records clearly evidenced that the service user/family had been contacted to discuss their complaint and to clarify what their concerns are, which informed the terms of reference for the complaints investigation. However, there is no assurance of an ongoing audit process. It is noted that the process to receive patient feedback on the handling of the complaints process was implemented November 2020 with outcomes to be reported quarterly to the Trust QSSG, although a report has not been submitted as assurance. We have not been provided with assurance that complaints not responded to within the timescale are escalated to this group. It is noted that Borough surgeries are regularly completed to provide case supervision to support engagement with service users and families, although no assurance was submitted to evidence this practice being embedded. The action is partially met.

Recommendation 9: continued

NIAF Rating: Further assurance to evidence action being embedded and demonstrating a sustained improvement should include implementing the recommendations from the review of the complaint handling process with particular particular reference to engaging with and listening to families, ongoing audit of patient feedback on the handling of the complaints process, staff feedback on case supervision to support engagement with service users and families.

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

Appendices

Appendix A: Glossary of terms

CAMHS	Child and adolescent mental health	OIC	Operations and integration committee
CETR	Care, education and treatment review	QAF	Quality assurance framework
CCG	Clinical commissioning group	QSSG	Quality, safety, safeguarding and governance group
CLG	Clinical leadership group	PSR	Professional standards review process
CPA	Care programme approach	RAG	Blue, red, green, amber rating
CQC	Care quality commission	RCA	Root cause analysis
DoC	Duty of candour	RiO	Electronic clinical record system
EHCP	Education and health support plan	SEND	Special educational needs and disabilities
FSL	Family support lead	SI	Serious incident
GMMH	Greater Manchester Mental Health NHS Foundation Trust	SIF	Serious incident framework
MH & LD	Mental Health & Learning Disability	SIRG	Serious incident review group
MDT	Multidisciplinary team	SINE	Serious Incidents and Never Events
MindEd	NHS England health education e learning modules	SLT	Senior leadership team
NIAF	Niche investigation and assurance framework	SOP	Standard operating procedure
NICE	National institute for health and care excellence	THRIVE	A framework for system change – an integrated, person-centred and needs-led approach delivering mental health services for children, young people and their families
NWB	North West Boroughs Healthcare NHS Foundation Trust	i -THRIVE	The implementation of the THRIVE framework for system change

Appendix B: Documents reviewed

NWB NHS Foundation Trust documents reviewed:	
Internal working action plan with progress 5 October 2020	Engagement with primary schools
Aggregated update report and table 15 of February 2021	Behaviours of concern school process
Various CPA presentations, data, infographics, training information, policy, documents and communications	CPA and CAMHS policy mapping December 2020
Historic evidence for the CCG updated 13 August 2020	Warrington and Halton domestic abuse pathway 2018
Various CPA documents, SOP, audit templates, audits, outcome, summary information	Mindworks consultation governance process
Various documents and communications – county lines	Primary schools link operational model March 2019
Wigan Borough QSSG matron QAF report November 2020	SOP for early intervention in psychosis
Wigan Borough QSSG minutes 11 December 2020	Phase 2 various versions documents
Various THRIVE and MindEd documents, presentations, training information, workshop, engagement, steering group, service specification, framework for system change	YJS health subgroup terms of reference May 2018
Caseload supervision Wigan CAMHS	CAMHS referral management SOP
CAMHS transformation report	SOP serious incident process and learning
MDT escalation	YJS CAMHS case study
Various learning lessons information, studies, cascades, presentations, Framework	Cascade criminal exploitation
Risk management and assessment procedure v3.1	Trapped for frontline staff
Lead professional role authority and responsibilities procedure v3.1	Cuckooing presentation
Warrington and Halton schools link	Wigan partnership one voice minutes 16 December 2020
Care coordinator roles and responsibilities v3.1	Mindworks consultation governance process

[Appendix B: Documents reviewed … continued]

NWB NHS Foundation Trust documents reviewed … continued:	
Terms of reference multi-agency risk quadrant 9 December 2020	Being Open policy and procedure v3.2
EHC referral form Wigan template	Complaint and concerns policy v12, closure checklist v2, process for patient feedback following raising complaints, case audit check 2021
Transition CQUIN presentation quarter 4 2019	CCG learning from incidents 2019
EHC pathway guidance Wigan Borough CCG and council	Human factors masterclass × 3 and case study
Transition audit report quarter 3 and quarter 4	Wigan CAMHS example child safety plans × 2
CQUIN project plan indicators quarter 4	Low mood advice to parents 2021
NHSE CTR policy March 2017	Out-of-hours support information 2021
CQC learning from deaths letter November 2020	Anxiety Covid resource
Drop-in clinic evaluation December to February 2019	Train the Trainers presentation
72-hour review template, checklist, training information	External inspections feedback 2019 – 2020
Wigan GP leaflet June 2019	Phase 2 patient safety improvement action plan
Family voice within terms of reference for Wigan serious incident reviews	Incident management policy v10.1
Wigan responding to GPs June 2019	AAR HH methodology
Wigan multi-agency referral hub leaflet	MOU documents × 2
Family support lead guidance, checklist, training evaluation, peer supervision, supervision contract, interview template, letter to family 2020	KPMG Patient Safety Panel report
Wigan case study multi-agency referral hub	WSCB case review minutes 12 March 2019
Family support – the training slides and evaluation summary 2020	CEC cases
Local Patient Safety Panel terms of reference, implementation of update December 2018	Letter STEIS 2016 28277 December 2020
Various Kin-nect documents and reports 2020	Meeting notes and actions for 2016 28277 review February 2021

[Appendix B: Documents reviewed … continued]

NWB NHS Foundation Trust documents reviewed:	
Meeting to review traffic action plans agenda February 2021	Trust quality account and presentation 2020/21
Navigation of and timeline of action plan updates 2020 – 2021	ID 604: Re-audit national clinical audit of psychosis 2019/20
NWB guide to investigations	Kin-nect quality improvement infographic year end 2020/21
Original phase 2 patient safety plan	Kin-nect task and finish group – training plan September 2020
Trust quarterly complaints reporting to QSSG	Trust complaints improvement plan
Two anonymised examples of complaints weekly escalation to the executive team	Revised NB and now Mersey Care (Mid- Mersey) complaints response and investigation template
Wigan and Knowsley CCG documents reviewed:	
2016-28277 independent investigation NWB serious incidents and average days open 2016 – 2020	SINE panel checklist; and 2 examples of use
2020 24015 and 2020 11874 final pdfs	Feedback from WBCCG SINE panel to NWB
Meeting to review Trust action plans agenda 24 February 2021	NHSE and NHSU patient safety updates May 2020 and March 2021
Niche investigation – Wigan Borough CCG implementation plan 16 April 2021	Extension requests e mails: 3 examples.
NWB serious incident 2016 28227 action plan review meeting agenda and notes 9 October 2020	WBCCG action plan
Review of NWB action plans 2016 28227 and 2016 22949 meeting notes 24 February 2021	SINE panel effectiveness review April 2021
Wigan Borough CCG provider serious incident assurance framework final 31 December 2020	
Wigan Borough CCG SINE closure checklist 16 April 2021	

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