Independent Quality Assurance Review

Greater Manchester Mental Health NHS Foundation Trust and Salford CCG

StEIS 2017/10088

Final Report v1

Highly private and confidential

6 October 2021

insight integrity impact

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

6 October 2021

Dear Sir or Madam,

Independent Quality Assurance Review, Greater Manchester Mental Health NHS Foundation Trust and Salford CCG

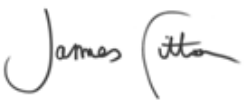
Please find attached our report of 6 October 2021 in relation to an independent quality assurance review of the implementation of recommendations resulting from the independent investigation into the internal investigation and action planning associated with that internal investigation, and a serious case review (SCR) into the care and treatment provided to a mental health and substance misuse service user (Mr M) in Manchester (report dated October 2019).

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). Equally, events which may occur outside of the timescale of this review will render our report out of date.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.

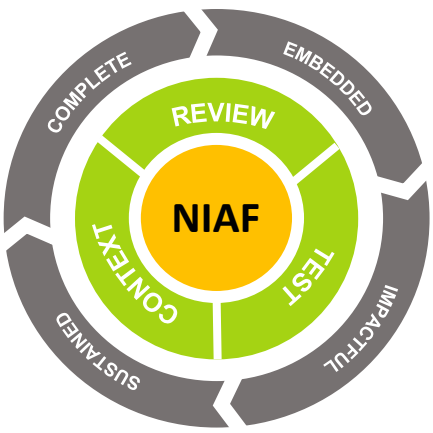
This report is for the attention of the project sponsor and stakeholders. No other party may place any reliability whatsoever on this report as it has not been written for their purpose. Different versions of this report may exist in both hard copy and electronic formats and therefore only the final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

Yours sincerely,



James Fitton

Niche Health and Social Care Consulting Ltd



Niche Investigation Assurance Kitemark

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Contents

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1. Method

1.1 Background and context for this review

NHS England and NHS Improvement commissioned Niche Health and Social Care Consulting Ltd (Niche) to undertake an assurance review using the Niche Investigation Assurance Framework (NIAF). This is intended to provide an assessment of the implementation of the actions developed in response to recommendations from the Niche independent investigation into the internal investigation, and a SCR regarding the care and treatment provided to a mental health and substance misuse service user (Mr M) in Manchester, dated October 2019.

1.2 Review method

This is a high-level report on progress to NHS England and NHS Improvement, undertaken through desktop review only, without site visits or interviews. The assurance review focusses on the actions that have been progressed and implemented in response to the recommendations made in the independent investigation report.

Our work comprised a review of documents provided by Greater Manchester Mental Health NHS Foundation Trust ('the Trust' or 'GMMH)', Salford CCG ('the CCG') and Greater Manchester Strategic Management Board (SMB). These included action plans, policies, procedures, audits, meeting minutes and staff communications.

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

1.3 Implementation of recommendations

The Niche independent investigation made six recommendations, summarised opposite:

1	The Trust should review the Incident Accident and Near Miss Policy to ensure that the template does not restrict report authors in fulfilling the terms of reference, and that the guidance to authors of Level 2 reports includes the approach recommended in the NHS England Serious Incident Framework.
2	Organisations involved in the MAPPA Strategic Management Board should share and implement the learning from this incident and the internal investigation across all services, and develop a mechanism to measure the impact of this.
3	Local commissioners must ensure consistent and appropriate oversight of serious incident reports and monitoring of action plans.
4	Referring to the multi-agency standards: (a) The commissioners of mental health services must assure themselves that the multi-agency standards for effective management of MAPPA cases are being delivered effectively in all relevant services. (b) The MAPPA Strategic Management Board should provide a clear escalation protocol so that if there are any obstacles to the delivery of the standards, the services and organisations involved are fully aware of the route to resolution.
5	The Trust must ensure that the outcomes of the Achieve caseload review are collected and monitored to provide assurance about compliance with the risk assessment guidance.
6	The Trust must develop a protocol for all services so that service users with a conviction for murder are subject to a multi-disciplinary team review, and that when a client with a conviction of murder or other serious offences (for example manslaughter, grievous bodily harm etc) moves areas, relevant local services are informed. The Trust must also assess the compliance with and effectiveness of that protocol.

2. Assurance summary

Scoring criteria key

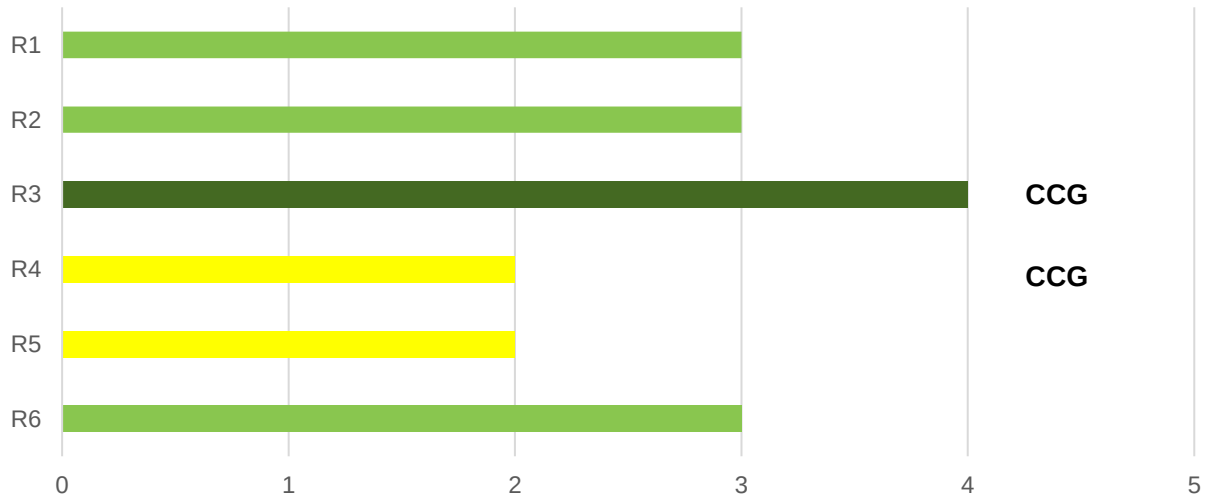
The assessment is meant to be useful and evaluative. We use a numerical grading system to support the representation of 'progress data', which is intended to help our clients focus on the steps they need to take to move between the stages of completed, embedded, impactful and sustained.

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

Implementation of recommendations

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

Fig. 1: Progress Chart



Summary

Significant progress has been made in relation to all actions apart from recommendations 4 and 5 where action has commenced but not in all requisite areas. We have provided examples of further assurance required to demonstrate action is complete, tested, embedded and/or sustained as appropriate.

Some headline commentary to support these ratings has been provided in the following pages. Appendix 1 (evidence review) provides a more detailed assessment against each piece of evidence which has been submitted to Niche.

2. Assurance summary (cont.)

Recommendation 1

The Trust should review the Incident Accident and Near Miss Policy to ensure that the template does not restrict report authors in fulfilling the terms of reference, and that the guidance to authors of Level 2 reports includes the approach recommended in the NHS England Serious Incident Framework (SIF).

Niche assurance rating for this recommendation	**3**

Key findings: The Incident, Accident and Near Miss Policy template has been updated so that report authors are specifically directed to structure their reports according to the review terms of reference (ToR). We have been able to review two reports which have used this revised approach, but overall compliance with this new template should now be audited to show that this action has had the desired impact across the organisation.

Guidance to authors of Level 2 reports has been included in this policy, which is reflective of the SIF. A total of 92 staff at various grades and in a variety of clinical and managerial roles have received root cause analysis (RCA) training since 2019. This training should further improve the quality of investigation reports.

Residual recommendations:

Complete the audit cycle to demonstrate sustained improvement.

Recommendation 2

Organisations involved in the MAPPA SMB should share and implement the learning from this incident and the internal investigation across all services, and develop a mechanism to measure the impact of this.

Niche assurance rating for this recommendation	**3**

Key findings: Actions have been completed, but audits are still needed to test the effectiveness of these, as well as re-audits to measure embeddedness and continuous improvements.

The SMB developed an action plan which was reviewed quarterly and signed off as complete in May 2019. Actions had defined inputs, action owners and desired outcomes. It is unclear, however, if the latter have been achieved in all cases.

For example, despite clear and varied efforts to raise awareness of MAPPA processes by GMMH, an audit to measure this in Salford CMHTs (undertaken in June 2021), showed that only 64% of staff were aware of MAPPA processes. There are plans for reaudit to measure improvements in Q4 of 2021/22.

Residual recommendations:

Complete the audit cycle (with a broader and larger sample) to demonstrate sustained improvement. Audit sample size should be calculated using at 10% of the relevant population, with a confidence level of 95% and allowing for a 3-5% margin of error.

2. Assurance summary (cont.)

Recommendation 3

Local commissioners must ensure consistent and appropriate oversight of serious incident reports and monitoring of action plans.

Niche assurance rating for this recommendation	**4**

Key findings: The same recommendation was made in Niche investigation 2016/29151 and reviewed in a recent (April 2021) NIAF with the same commissioners, with an assurance rating of 4 given. As such, we have relied on the same evidence and rating in this review.

Residual recommendations:

Commissioners should undertake same-causal factors analysis of incidents following STEIS 2016/29151 and STEIS 2017/10088 to ensure that actions taken have had the desired impact. Audits of the effectiveness of these actions should also continue in order to demonstrate continuous improvement.

Recommendation 4

Referring to the multi-agency standards: (a) The commissioners of mental health services must assure themselves that the multi-agency standards for effective management of MAPPA cases are being delivered effectively in all relevant services. (b) The MAPPA Strategic Management Board should provide a clear escalation protocol so that if there are any obstacles to the delivery of the standards, the services and organisations involved are fully aware of the route to resolution.

Niche assurance rating for this recommendation	**2**

Key findings: CCG assurance processes have to date focussed on awareness-raising of MAPPA in primary care services, whereas the Niche recommendation pertained to mental health providers and "all relevant services".

The SMB relies on National MAPPA guidance for escalation processes. This is enacted by the MAPPA Co-ordinator and training has been provided to Duty to Cooperate agencies, including GMMH. However, as described in R2, awareness and compliance with MAPPA processes in CMHTs has shown room for further improvement.

Residual recommendations:

The CCG action plan needs to incorporate oversight of all relevant services in line with Niche Recommendation 4. Actions should then be implemented, and their impact monitored.

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2. Assurance summary (cont.)

Recommendation 5

The Trust must ensure that the outcomes of the Achieve caseload review are collected and monitored to provide assurance about compliance with the risk assessment guidance.

Niche assurance rating for this recommendation	**2**

Key findings: Actions relating to this recommendation are significantly progressed, but they are not yet having the desired impact. In particular:

- Case management reports in the Achieve service record risk assessment status, but a high number of risk assessments are currently overdue, particularly in Salford East and West.
- A Clinical Risk Policy is in place, although we were unable to obtain evidence of audit to show compliance with this (the policy states that relevant audits are managed by the Nursing directorate).
- Risk management training materials have been enhanced with, for example, more focus on the systematic steps required to undertake a risk assessment. However, the Trust-wide training compliance in June 2021 stood at 51% (with Salford locality at 53%) due to the impact of the pandemic on training delivery.

Residual recommendations:

Clinical risk training compliance needs to improve (and a training recovery plan is now in place to reflect this). Risk assessments need to be completed within agreed timeframes. Regular audits of compliance with the Clinical Risk Policy should take place, with senior oversight of resulting actions.

Recommendation 6

The Trust must develop a protocol for all services so that service users with a conviction for murder are subject to a multi-disciplinary team (MDT) review, and that when a client with a conviction of murder or other serious offences (for example manslaughter, grievous bodily harm etc) moves areas, relevant local services are informed. The Trust must also assess compliance with and effectiveness of that protocol.

Niche assurance rating for this recommendation	**3**

Key findings: The Trust recognises that work to progress this recommendation has been impeded by the pandemic and the disbanding of the CMHT (Community Mental Health Teams) Steering Group, and that further work is required to embed changes in local procedures.

CMHT Standard Operating Procedures (SOPs) have been updated to reflect revised guidance for staff in this area. This includes MDT review and plans for contact and handover if the service user moves areas to prevent lack of follow-up, per the Niche recommendation. There is evidence that this has been discussed and agreed at local senior leadership meetings, and further disseminated to teams.

As referenced on page 6, an audit to test the embeddedness of these actions was undertaken in June 2021 with Salford CMHTs. The sample used was only 14 members of staff. 64% of practitioners indicated that they were aware of MAPPA processes. Plans to re-run this across other teams and with a wider sample (as well as a re-audit programme to measure continuous improvement) are unclear.

Residual recommendations:

Complete the audit cycle (with a broader and larger sample) to demonstrate sustained improvement. Audit sample size should be calculated using at 10% of the relevant population, with a confidence level of 95% and allowing for a 3-5% margin of error.

Appendix 1: Evidence review

Appendix 1: Evidence review

Recommendation 1
The Trust should review the Incident, Accident and Near Miss Policy to ensure that the template does not restrict report authors in fulfilling the terms of reference, and that the guidance to authors of Level 2 reports includes the approach recommended in the NHS England Serious Incident Framework.

Key evidence submitted[1]	Niche review
RM04 Appendix 21 Comprehensive Serious Incident Review Template SI2; and	The template is reflective of guidance in the SIF (e.g. inclusion of methodology, root causes, recommendations, description of victim and / family engagement and details of support provided to patient/victim/family).
RM04 Incident Accident & Near Miss Policy	This template is included in the Incident, Accident & Near Miss Policy.
Example RCA Extract - showing review findings against each TOR	Two examples showing anonymised RCAs where review findings have been disaggregated by the review ToR. While positive, a broader audit to demonstrate overall compliance with the Policy would provide greater assurance.
RM04 1 Guide for Senior Staff to Lead a Trust Serious Incident Review	Comprehensive guide outlining review purpose, process, roles and responsibilities. It also provides an overview of human factors, which is reflective of the SIF.
Various minutes and papers from the GMMH and CCG SI meetings	Evidence that Serious Incident meetings take place with commissioners, where reports and actions plans following serious incidents are reviewed and assurances agreed in accordance with the SIF.
RCA training registers	Registers from various training events showing that since 2019, 92 members of staff from across the Trust (in various clinical and managerial roles) have received RCA training.
Supplementary information received[1]	• RCA training slides 2020 • Jan 2020 Board front sheet final Niche Desk Top Review AM • Revised SI Review Template re TOR

[1]Document titles are copied from the file name submitted by the Trust/CCG/SMB so that it is clear which document has been reviewed by Niche.

Appendix 1: Evidence review (cont.)

Recommendation 2	
Organisations involved in the MAPPA Strategic Management Board should share and implement the learning from this incident and the internal investigation across all services, and develop a mechanism to measure the impact of this.	
Key evidence submitted	**Niche review**
Amended Homicide Learning Event	Event to share findings from the Niche Homicide Brief 2017 (review of 23 external homicide investigations). The number of attenders was unavailable, so we are unable to assess the reach of this event.
GMMH Homicides Learning Event 29.5.20	"Positive Learning Event" undertaken on 29 May 2020. The number of attendees was unavailable, so we are unable to assess the reach of this event. We understand that the Trust can now monitor attendance of these (monthly) events to better understand their reach.
GMMH-MAPPA Guidelines (July 2019)	The Policy states that its aim is to "clearly define roles and responsibilities of staff who are involved in care and management of MAPPA eligible offenders and service users who present a risk to public safety".
Various mechanisms by which information about MAPPA has been shared throughout GMMH	This has included: briefings to be shared in team meetings, shared learning circulated in the quarterly Patient Safety Newsletter, increasing visibility of referrals process to the Health and Justice team, MAPPA alert in PARIS system, and MAPPA screensaver.
Salford CMHT - Caseload serious offending history audit	Audit tool developed to understand staff awareness of relevant risk assessment processes for service users with a serious offending history on their caseload. An audit took place in June 2021 with a sample of 14 members of staff. 91% of responses achieved between 90-100% compliance. The lowest result was in relation to awareness of MAPPA processes at only 64%. There is no evidence of overall (Trust-wide) compliance with MAPPA identification and risk assessment.
Salford probation and Achieve MAPPA case audit July 2021	Raw data arising from an audit of seven individuals known to Salford Probation Office identified as MAPPA level 2 or 3. Compliance with MAPPA recording and joint review was low. It is unclear how the sample was selected, how the outcomes and learning from the audit were shared, and if there are intentions for a reaudit with a larger sample size in order to monitor improvements.
SMB Action plan v5 (Action Plan - Greater Manchester MAPPA Strategic Management Board Serious Case Review Mr F)	The SMB had five actions which were reviewed quarterly at SMB and signed off in May 2019. Desired outcomes were defined, but it is unclear if all of these have been achieved, for example: • If the volume of Serious Further Offences identifying manipulation or disguised compliance by offenders has reduced following the briefing developed. • If staff working with MAPPA managed offenders have become more alert to the dangers of making assumptions. • If ad hoc substance abuse screening at the THOMAS project has reduced client relapse and associated offending.

Appendix 1: Evidence review (cont.)

Recommendation 2 (cont.)	
Key evidence submitted	**Niche review**
SMB Action plan v5 (ACTION PLAN - Greater Manchester MAPPA Strategic Management Board Serious Case Review Mr F) (*continued from page 11*)	Under 'key actions' column, there appears to be an assumption made that Duty to Cooperate Agencies cascade learning through their organisation. It is unclear how assurance on this is received by the SMB. Further, in the Salford CMHT audit referenced on pages 6 and 8, awareness of MAPPA processes was at only 64%. This suggests that this cascade of learning is not yet fully effective.
Various pieces of evidence showing MAPPA status recording in patients' notes and risk assessments	These examples are positive, but do not give assurance of overall compliance of MAPPA recording.
Achieve training workshop around the use of Audit	Evidence of a training event on the use of clinical audit and its link to the Quality Improvement Strategy. Clinical Risk training also delivered, which covered specific matters relating to self-neglect, vulnerability, risk to self and risk to others
Supplementary information received	• Agenda - GMMH CCG & GMMH SI meeting notes 23.7.21 • CCG and GMMH SI meeting agenda 15.4.21 • Email re June 2021 delayed Quarterly Lessons learned Newsletter • GM MAPPA presentation slides September 2018 • MAPPA Training input - GMMH Homicide Learning Event 290520 • Achieve training workshop around the use of Audit • PIR Panel reports

Appendix 1: Evidence review (cont.)

Recommendation 3
Local commissioners must ensure consistent and appropriate oversight of serious incident reports and monitoring of action plans.

Key evidence submitted: N/A	**Niche review:** N/A
The same recommendation was made in Niche investigation 2016/29151 and reviewed in a recent NIAF (with the same commissioners), with an assurance rating of 4 given. As such, we have relied on the same evidence and rating in this review.	
Supplementary information received	• N/A

Recommendation 4
Referring to the multi-agency standards: (a) The commissioners of mental health services must assure themselves that the multi-agency standards for effective management of MAPPA cases are being delivered effectively in all relevant services. (b) The MAPPA Strategic Management Board should provide a clear escalation protocol so that if there are any obstacles to the delivery of the standards, the services and organisations involved are fully aware of the route to resolution.

Key evidence submitted:	**Niche review**
Salford CCG response to actions outlined in the MAPPA Internal Serious Case Review Action Plan	The CCG received confirmation that the MAPPA Strategy Manager delivered Statutory Duty to Cooperate training for health care providers on 24 January 2020. There is no further evidence that the impact of this was monitored by the CCG.
[Salford CCG] MAPPA action plan	Contains two actions relating to primary care only, whereas the Niche recommendation related to providers of mental health services.
SMB Action plan v5 (ACTION PLAN - Greater Manchester MAPPA Strategic Management Board Serious Case Review Mr F)	The content of this action plan is described on pages 11 and 12.
MAPPA Guidance - Updated August 2021	This includes escalation processes for the various MAPPA levels. The MAPPA B form is used to record the minutes from every MAPPA meeting and includes 'issues to be reported to SMB'. The MAPPA Coordinator screens these issues, resolves them where appropriate or escalates to SMB for senior decision making.
Supplementary information received	• N/A

Appendix 1: Evidence review (cont.)

Recommendation 5
The Trust must ensure that the outcomes of the Achieve caseload review are collected and monitored to provide assurance about compliance with the risk assessment guidance.

Key evidence submitted:	**Niche review**
Case management reports (Salford West, East and Criminal Justice teams)	These (raw data) reports provide evidence that patients on these teams' caseloads are tracked for matters such as last contact, last dip test and date of last risk assessment. The data provided showed a high number of risk assessments to be overdue, particularly in Salford West and East.
Copy of 01.03.2021 Achieve RAG Latest Risk Report	Evidence of Achieve service users' latest risk assessment, dated March 2021. Of the 1009 service users recorded: 1 has not had a risk assessment since 2018, 5 have not had a risk assessment since 2019, 603 have not had a risk assessment since 2020.
Clinical Risk Policy	Ratified in 2017 and last issued in 2019 (it is unclear what changes were made since the 2017 version). Contains guidance on clinical risk management cycle, risk formation and ongoing assessment. States that the Nursing and Governance team are responsible for co-ordinating Trust audits of compliance with the Policy. Outcomes of these audits were not available to Niche.
Achieve Mandatory and Essential Compliance 23.06.2021	June 2021 figures for compliance with Clinical Risk Assessment training. Trust total compliance was 51%. Salford services was 53%.
GMMH Clinical Risk Training slides updated 2021	This was updated in 2021 to focus on virtual training. More focus is on systematic steps to risk assessment and management. Includes expectations about when to complete and update a risk assessment.
Various training session attendance registers	Shows that 159 staff have received clinical risk training between 2018-2019. This includes staff across a breadth of clinical and managerial roles. Training provision post this date is unclear.
Sample of four anonymised supervision records	Evidence of discussion and tracking of risk assessment compliance in supervision. These are positive examples but overall compliance remains unknown. The Supervision Policy sets out the expectation that service user risk, issues and concerns will be discussed in supervision.
Policy for Managing Did Not Attend (DNAs) and Cancellations	Dated October 2020. This policy provides guidance for dealing with those referrals where service users may present with some level of risk if they do not maintain contact with the service. States that risk assessments should be updated as a consequence of DNA/cancellations. This is positive but again, the impact of the policy is unknown.

Appendix 1: Evidence review (cont.)

Recommendation 5 (cont.)	
Key evidence submitted:	**Niche review**
Achieve Partnership Agreement Final Oct18	Partnership Agreement between Achieve Salford and Trafford, National Probation Service (NPS) and Cheshire & Greater Manchester Community Rehabilitation Company in Salford and Trafford. Highlights the importance of information sharing in relation to risk assessment (such as risk management plans prior to first appointment, safeguarding concerns, change of circumstances to be communicated via telephone and followed up by email within one working day).
Supplementary information received	• Achieve Clinical Risk Training 2019 • Achieve completed Risk Assessment • Co-occurring Mental Health & Alcohol/Drug Use Conditions (Dual Diagnosis) GMMH Policy

Appendix 1: Evidence review (cont.)

Recommendation 6
The Trust must develop a protocol for all services so that service users with a conviction for murder are subject to a MDT review, and that when a client with a conviction of murder or other serious offences (for example manslaughter, grievous bodily harm etc) moves areas, relevant local services are informed. The Trust must also assess the compliance with and effectiveness of that protocol.

Key evidence submitted:	**Niche review**
CL19 Early Intervention in Psychosis amended v2.2	Early Intervention and Early Detection in Psychosis Service Integrated Operational Policy, dated December 2020. This sets out the protocol for staff triaging referrals where a service user has a prior conviction for serious offences. This includes MDT review and plans for contact and handover if the offender moves area to prevent loss of follow-up. Evidence of auditing compliance with the policy has not been provided.
Evidence showing dissemination of this policy	Evidence has been provided that the policy has been circulated and reflected in local SOPs in North Manchester, Bolton, Salford, South Manchester, Citywide Early Intervention teams and Central teams.
Audit Tool - CPA Risk Assess V2	The Care Programme Approach (CPA) audit tool now has two questions relating to this recommendation: Q8 - *If the patient has a history of serious offending or previous convictions (e.g. sexual offences, serious assault, manslaughter/murder etc) is there evidence of multi-agency working and information sharing between agencies e.g. probation, criminal justice services and or substance misuse services?* Q9 - *Is there evidence of GMMH Multi-Disciplinary Team working around decision making and care planning?*
CPA Audit outcomes (Q4 2018/19, Q2 2019/20, Q4 2020/21)	None of the last three CPA audits undertaken has incorporated the two questions above relating to patients with a history of serious offending.
Caseload Audit Template re serious offending history	An audit template has been developed which tests staff awareness of risk assessment processes and communication between agencies.
Salford CMHT - Caseload Serious Offending History Audit	Audit undertaken in June 2021 in Salford CMHT (see pp.6,8,11-12). Outcomes were mostly positive, although awareness of MAPPA processes was only 64%. Intentions to reaudit across a larger sample size, and in other localities, remain unclear.
Supplementary information received	• GMMH Early Intervention in Psychosis (EIP) Operational Group (15.7.21)

Appendix 2: Glossary of terms

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CMHT	Community Mental Health Team
CPA	Care Programme Approach
SMB	Strategic Management Board
GMMH	Greater Manchester Mental Health NHS FT
MAPPA	Multi-Agency Public Protection Arrangements
NIAF	Niche Investigation Assurance Framework
PARIS	Clinical information system used within GMMH
RCA	Root Case Analysis
SCR	Serious Case Review
SIF	Serious Incident Framework
SMB	Strategic Management Board
SOP	Standard Operating Procedure
ToR	Terms of Reference

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