Independent Quality Assurance Review

Lancashire and South Cumbria NHS Foundation Trust and NHS Lancashire and South Cumbria Integrated Care Board

StEIS 2018/13099

Final report
April 2023

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6 April 2023

Independent Quality Assurance Review

Please find attached our final report of April 2023 in relation to an independent quality assurance review of the implementation of recommendations resulting from the independent investigation into the care and treatment of a mental health service user, Mr H, following a homicide which occurred in May 2018.

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 Events which may occur outside of the timescale of this review will render our report out of date.

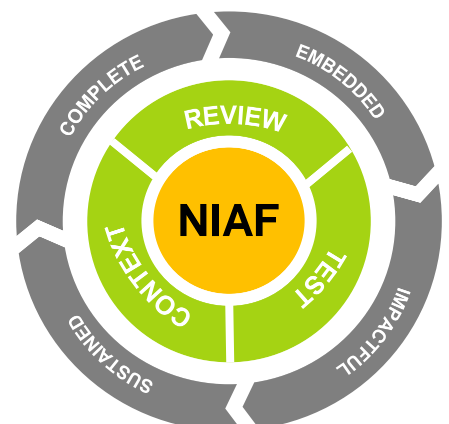
Our report has not been written in line with any UK or other auditing standards; we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information.

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

Yours sincerely,

James Fitton
Niche Health and Social Care Consulting Ltd

Niche
Investigation
Assurance
Framework



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1. Method

1.1 Background and context for this review

NHS England 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 resulting from the Niche independent investigation into the care and treatment of a mental health service user, Mr H, completed in September 2021.

1.2 Review method

This is a high-level report on progress to NHS England, 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 such as action plans, policies, procedures, audits and meeting minutes and from:

- Lancashire and South Cumbria NHS Foundation Trust - LSCFT or 'the Trust' (known as Lancashire Care NHS Foundation Trust until October 2019);
- NHS Lancashire and South Cumbria Integrated Care Board - the 'ICB', (formerly the Clinical Commissioning Group/CCG); and
- NHS England North West 'NHS England'.

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

1.3 Implementation of recommendations

The original independent investigation made four recommendations which are listed opposite. Recommendations 1 and 2 arise from this incident. Recommendation 3 relates to the the Trust's management of recommendations from previous investigations. Recommendation 4 applies in part to NHS England.

Recommendations	
1	The Trust must review the current pathways in Complex Care and Treatment Teams (CCTTs) to determine if the identified needs of patients who meet the threshold for an assertive outreach approach are being met.
2	The Trust must provide clear guidance to staff on the identification and management of patients who are not engaging with services, this must include how engagement will be monitored and reviewed.
3	a) The Trust must review the action plans for 2015/21744 (Mr W) and 2014/14031 (Mr S) to assess progress and whether actions are still appropriate to meet the original recommendations. Action owners should also be revised and refreshed and revised timelines for delivery of their actions agreed with approval from the CCG and the new Integrated Care System (ICS). b) Action plans should be monitored by an appropriate (sub) committee and action owners held to account for action implementation.
4	a) NHS England and Improvement should work with the Department of Health and Social Care (DHSC) to agree and 'sign off' the revised 'Memorandum of Understanding' with the National Police Chiefs' Council (NPCC) to support investigations into serious incidents in healthcare settings. b) In the meantime, the Trust and the local Constabulary should agree a local memorandum of understanding to inform the management of health care incidents that are also subject to criminal investigation.

2. Assurance summary

Scoring criteria key

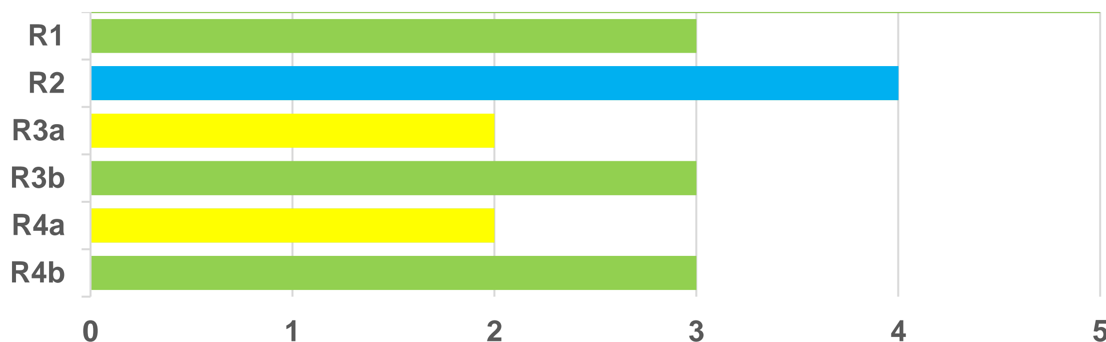
Our assessment is meant to be useful and evaluative. We use a numerical grading system to support the representation of 'progress data', to help the organisations involved focus on the steps they need to take to move between the stages of completed, embedded, impactful and sustained. '3' is regarded as a good score as it reflects action completion. Scores of '4' and '5' are harder to achieve within the timeframe from publication of the investigation report to now, with the latter rating being assigned on more limited occasions primarily due to the cycle of testing (normally >12 months) that is required to demonstrate that outcomes are being achieved on a sustained basis.

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 completed, tested, but not yet embedded
5	Can demonstrate a sustained improvement

Implementation of recommendations

We have rated the progress of the actions which were agreed from the recommendations and learning points made. Our findings are summarised below.

Summary chart showing progress to date for each recommendation



Overall summary

Progress has been made in relation to all recommendations; however, there are two recommendations where evidence to support progression is more limited. Where appropriate, we have provided examples of further assurance which is required to demonstrate actions are complete, tested, embedded and/or sustained as appropriate.

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

2. Assurance summary

Recommendation 1	
The Trust must review the current pathways in Complex Care and Treatment Teams (CCTTs) to determine if the identified needs of patients who meet the threshold for an assertive outreach approach are being met.	
Niche assurance rating for this recommendation	**3**

Key findings: The Trust reviewed and updated its Standard Operating Procedures (SOPs) for both the Community Mental Health Teams (CMHTs) and Home Treatment Teams (HTTs) in 2021 and 2020 respectively. The CMHT SOP describes a dynamic approach to caseload management which combines the original community caseload RAG rating tool and the Covid-19 dynamic risk rating. The purpose of this system is described as enabling the team to:

- Determine which service users are most at risk physically and mentally;
- Stratify patients where there is the highest risk of losing contact with them and agree how contact will be retained; and
- Provide an agreed timeline for reviewing the risk register.

The risk rating links risk criteria, clinical indicators and expected actions. For example, red rated clients would require intensive contact at least daily, weekly full discussion at the MDT and daily discussion by HTT (if under HTT). If under CMHT a minimum weekly contact "*should be considered*" for such patients together with referral to HTT (or the Rapid Intervention and Treatment Team for older adults).

The SOP requires that managers regularly review random cases during supervision to ensure that staff are following the process described in the SOP.

If used effectively, the above system should provide clear pathways to identify and meet the needs of all patients, including those who require more intensive input and support (which is equivalent to an assertive outreach approach*).

We were not provided with any evidence on the use or implementation of this process for patients who require more intensive input and support (equivalent to an assertive outreach approach). Provision of such evidence would enable the score here to be increased.

Residual recommendations:

RR1: The CMHTs should undertake audits or agree methods of monitoring to ensure that its agreed approach (through dynamic risk management) is being used effectively and ensuring clear identification of patients who require an assertive outreach approach.

** The type of patient who requires this approach will be experiencing some or all the following: chronic/relapsing psychosis, poor social functioning, history of poor compliance with treatment, dual diagnosis, disengagement from standard services, moderate or high risk of self-harm, neglect, or risk to others, several in-patient admissions, living in unsuitable accommodation or stressful living conditions.*

2. Assurance summary

Recommendation 2	
The Trust must provide clear guidance to staff on the identification and management of patients who are not engaging with services, this must include how engagement will be monitored and reviewed.	
Niche assurance rating for this recommendation	**4**

Key findings: The Trust has developed and approved a Standard Operating Procedure on 'Promoting Engagement & Access to Mental Health Services'. The focus of this comprehensive document is how to identify and manage patients in the community who do not engage with mental health services. It details how to identify and respond to patients who are not engaging with their care and treatment, and explains how engagement will be monitored and reviewed. Suggested individualised approaches range from sending a letter (a template is provided which includes information on other relevant support organisations) to arranging a police welfare check or an assessment under the Mental Health Act. Timescales for liaising with referring agencies such as GPs are provided.

There are two minor issues with the version provided to us. It is nearly 12 months past its review date. The implementation plan has target dates of 2016 and whilst monitoring guidance is included, this suggests it is overseen by inpatient, rather than community service managers. The Trust informs us that the document is currently under review which should address these issues.

In addition to the above SOP, the updated SOPs for the CMHT and HTT (summarised on the previous page) include detailed guidance about managing patients who do not engage.

In early 2022 the Trust clinical audit and effectiveness team conducted an audit of practice compliance for community teams against the standards laid out in the 'Promoting Engagement and Access to Mental Health Services' SOP. Findings and recommendations were reported in April 2022 and shared with key internal stakeholders The audit found an overall compliance level (with the standards they reviewed) of 83%, providing a good level of assurance that practice in the management of promoting engagement in community mental health services is largely in line with LSCFT standards. There are plans to repeat the audit, although a date for this was not provided.

Whilst the audit identified high overall levels of compliance with SOP standards, it also highlighted Trust-wide variations of practice and adherence to the policy, with one area (Fylde) performing significantly better than the others. The recommendations from the audit therefore aimed to standardise practice in accordance with the revised standards taken from the LSCFT Standard Operating Procedure MH069 and to complete a re-audit which we would support.

Residual recommendations:

RR2: When the SOP on promoting engagement and access to mental health services is next updated ensure minor errors relating to target implementation dates and monitoring arrangements are corrected.

2. Assurance summary

Recommendation 3a

3a. The Trust must review the action plans for 2015/21744 (Mr W) and 2014/14031 (Mr S)* to assess progress and whether actions are still appropriate to meet the original recommendations. Action owners should also be revised and refreshed and revised timelines for delivery of their actions agreed with approval from the CCG and the new Integrated Care System (ICS).

- Note: These action plans were taken from two previous independent investigations which appeared to involve some similar issues to this case. The terms of reference for this case therefore required the author to cross reference against recommendations from these two earlier published reports. For completeness we have included a copy of these recommendations in appendix three.

Niche assurance rating for this recommendation	**2**

Key findings: The Trust provided evidence that both original action plans had been completed, signed off and closed, although it should be noted that a significant number of the recommendations related either partly or completely to other organisations.

The Trust did not provide evidence that the action plans had been revised and refreshed or that revised timelines for delivery of revised actions had been agreed since completion of the original mental health homicide review as per this recommendation (3a). We note that this is because the Trust does not accept the premise of this recommendation. It regards the action plans arising from these two investigations as completed, and therefore not requiring refreshing, or further approvals.

For Mr W the Trust did provide evidence of progress having been made, and actions continuing to be implemented against the four recommendations, some of which apply to agencies external to the Trust including the local authority or substance misuse service. A Quality Assurance Review completed in 2019 graded progress at level 1 for all recommendations, and gave recommendations for further implementation of key actions. The action plan provided to us had some completion dates for 2019 and 2020 suggesting that, even though the actions plans had not been formally "revised and refreshed", work on some actions had continued.

For Mr S the action plan contained 11 actions, four of which relate to the Trust alone and the rest to the Trust working with other agencies (the CCG/ICB, local authority and third sector partners). There are no completion dates provided after 2018 suggesting it has not been refreshed since then, although the Trust would argue that this is because this was not required.

The Trust was able to provide evidence that actions in some key area (for example dual diagnosis) had continued to be developed and delivered since completion of the action plan. This included:

- work to improve liaison between LSCFT, LCC and the various substance misuse delivery services, including the introduction of locality multi-agency dual diagnosis meetings;
- ongoing work with the ICB to update the current joint protocol. Additionally, a best practice group for addiction has been established and is being expanded to include partner representation from a wide of agencies including housing support, healthcare support, employability, benefits, domestic abuse and more.
- carrying out an audit (in 2020) of the effectiveness of the dual diagnosis locality meetings identified some good practice and focused areas for improvement.

Continued overleaf

2. Assurance summary

Recommendation 3a: continued

Residual recommendations:

We note that the Trust does not accept the premise of this recommendation, and regards the action plans arising from these two investigations as completed, and not requiring refreshing, or further approvals.

It is not within the scope of this quality assurance review to revisit the appropriateness of the original recommendations simply to assess progress against them. This review has therefore been prepared and rated on this latter basis.

If the Trust's view is accepted, this would not result in a higher rating, but in a dismissal of this recommendation as based on an unnecessary premise, and therefore not applicable.

If the Trust’s view is not accepted, we would suggest a residual recommendation that the Trust should formally revisit these action plans with the ICB as per the original recommendation to ensure that the ICB is happy regarding this approach.

2. Assurance summary

Recommendation 3b	
3b. Action plans should be monitored by an appropriate (sub) committee and action owners held to account for action implementation.	
Niche assurance rating for this recommendation	**3**

Key findings: As stated above, the two action plans referred to here have not been revised or re-opened, as the Trust states these have been closed and signed off; and so are not currently being monitored by an appropriate sub-committee.

However, the Trust informed us that since the action plans for the two investigations referred to were completed, a new process has been introduced across the Trust for closer monitoring and scrutiny of serious incident action plan delivery and for overall governance and scrutiny of all kinds of incidents. The Assistant Director of Governance explained that, in the past, localities approved sign-off of their Serious Incident (SI) action plans. We were informed that the Trust now has a more structured approach to signing off action plans, and holding action owners to account, which includes:

- A local action planning meeting to create/review and update the action plan.
- A weekly SI review panel (SIRP), held in each of the five localities.
- The involvement of the patient safety team to check and advise on action plans.
- A weekly trust-wide, executive level Safety Summit Panel taking overall responsibility for action plan sign off.

We were provided with evidence showing how these different meetings/committees work and what is included within their standard (and some sample) agendas. SI leads are expected to attend the Safety Summit as required so that they can answer questions about their investigations directly. This panel also undertakes a range of thematic or more in-depth reviews of common themes, or specific topics; for example, risk assessment. It also reviews evidence from a range of indicators including complaints, investigations, inquests and Regulation 28 Notices (reports from the coroner to prevent future deaths).

In addition, the ICB confirmed that oversight against the delivery of actions is overseen by the ICB Multi-Agency Oversight Group. This is where the progress against actions by all stakeholders is discussed and the system and individual providers 'held to account' and any blockages/challenges explored with the aim to resolve them.

Residual recommendations:

None

2. Assurance summary

Recommendation 4a and 4b	
4a. NHS England and Improvement (NHSE&I) should work with the Department of Health and Social Care (DHSC) to agree and 'sign off' the revised 'Memorandum of Understanding' (MoU) with the National Police Chiefs' Council (NPCC) to support investigations into serious incidents in healthcare settings. 4b. In the meantime, the Trust and the local Constabulary should agree a local memorandum of understanding to inform the management of health care incidents that are also subject to criminal investigation.	
Niche assurance rating for this recommendation - NHS England	**2**
Key findings (4a): The Department of Health and Social Care (DHSC) England have set up a 'Memorandum of Understanding' working group, comprising representatives from a range of relevant organisations (which includes the National Police Chiefs' Council) with a specific remit to produce a Memorandum of Understanding as detailed above. A number of drafts of this document have been produced and circulated for comment/revision. We were provided with drafts 11 and 12, although the latter was not dated. Work was paused for some time due to a Department of Health and Social Care vacant post and Covid-19, but re-commenced in 2020. We were provided with a range of email correspondence and minutes demonstrating ongoing work on this project through to September 2022.	
Niche assurance rating for this recommendation – The Trust	**3**
Key findings (4b): The Trust has put in place a local MoU (undated) to inform the management of health care incidents that are also subject to criminal investigation. In addition, they have employed a police officer, who is based within the Trust security team, whose remit includes advising the Trust on the management of health care incidents that are also subject to criminal investigation. Whilst there is no systematic analysis of the effectiveness of these new arrangements, there is positive anecdotal evidence that it is working well with the Patient Safety team able to provide a number of examples of recent cases where the Trust and the police had worked effectively together through this new post.	
Residual recommendations:	
RR3: For NHS England: complete work to agree and introduce the Memorandum of Understanding.	

Appendix 1: Evidence review

Appendix 1: Evidence review

Recommendation 1	
The Trust must review the current pathways in Complex Care and Treatment Teams (CCTTs) to determine if the identified needs of patients who meet the threshold for an assertive outreach approach are being met.	
Key evidence submitted	**Niche review**
Home Treatment Team Standard Operating Procedure (SOP) 21 December 2020	The 51 page SOP covers the Home Treatment Team (HTT). This is a multi-disciplinary team of mental health professionals providing a 24 hour, 7 day per week service to people experiencing a mental health crisis. The team provides an alternative to hospital admission by providing intensive community based interventions. Where a hospital admission does occur, HTT can assist in shortening the inpatient stay by facilitating early discharge and support back to the community. It states that the HTT will have various functions within its remit including assessment, gate keeping and a home treatment function as an alternative to admission and also to facilitate early discharge from hospital. It contains a welfare check flowchart. It states that the SOP will be monitored through (at a minimum) monthly clinical supervision of assessment and caseloads and through monthly audit of referrals/admissions.
Community Mental Health Teams Standard Operating Procedure(SOP) 11 February 2021	The 48 page SOP for CMHTs was updated to reflect findings from the 2020 review of NICE guidance and recommendations from recent Serious Incident Investigations and new pathways. The SOP includes a case management tool. Prior to Covid-19 community teams utilised a RAG rating caseload management approach to assist them with collective caseload management. Following the onset of the Covid-19 pandemic all community teams were required to have a dynamic risk rating of their caseload. This tool combines the original community caseload management RAG rating tool and the Covid dynamic risk rating. And requires the team to: • Have a patient risk register in place, to determine who is most at risk physically and mentally; • Have an agreed timeline for reviewing the risk register; and • Stratify patients where there is the highest risk of losing contact with them and agree how contact will be retained. It also details the dynamic risk rating which links risk criteria, clinical indicators and actions. For example, red rated risks would require intensive contact (at least daily), weekly full discussion in MDT and daily discussion in the staff ‘huddle’ by HTT/RITT or if under CMHT a minimum weekly contact would need to be considered as well as referral to HTT/RITT.

Appendix 1: Evidence review

Recommendation 1 (continued)	
Key evidence submitted	**Niche review**
Community Mental Health Teams Standard Operating Procedure(SOP) 11 February 2021 (continued)	The policy states it is the manager's responsibility to: • Ensure the Dynamic Risk Register (DRR) is a live register for their team, is maintained in the electronic patient record system (using the Covid tab) and is updated by team members (South Cumbria using the spreadsheet and 'Alert' function in RIO); • Provide information regarding team RAG (red, amber, green) rating on request (e.g. through the Network Covid calls); and • Ensure national Public Health England (PHE) guidance is regularly reviewed regarding vulnerable patients and this is discussed as a team. For monitoring purposes, the SOP requires that managers regularly review random cases during supervision to ensure that: • Risk rating is recorded in the electronic patient record system; • Practitioners are undertaking all required actions outlined in the table above; • The patient's care plan and risk assessment reflect the dynamic risk rating; and • The timeframes for reviewing the risk rating are being adhered to. It also states that the electronic patient record system team are looking at producing team specific reports to ensure visibility of the team's full caseloads' RAG rating. The SOP also identifies when it might be appropriate to allocate a psychologist or occupational therapist as a care co-ordinator and details a physical health pathway. The SOP includes a flow chart on how/when to request that the police carry out a welfare check and what the team should do in response to this. For example if a practitioner is unable to contact a service user who is under the care of community mental health teams. It states, *"Individuals who are assessed as high risk that do not attend appointments will be discussed at the weekly Multidisciplinary Team meeting and practitioners will then follow the Clinical Disengagement Procedure and all actions recorded on the electronic patient record system".* The SOP includes a section on promoting engagement which is very specific regarding what to do in different circumstances and when such a case should be discussed at the MDT meeting. It also details who should receive feedback about non-engagement and where this should be recorded, as well as what to do if there are immediate concerns and when a welfare check or police involvement should be sought.

Appendix 1: Evidence review

Recommendation 2

The Trust must provide clear guidance to staff on the identification and management of patients who are not engaging with services, this must include how engagement will be monitored and reviewed.

<table>
<tr><th>Key evidence submitted</th><th>Niche review</th></tr>
<tr><td>Promoting Engagement and Access to Mental Health Services Standard Operating Procedure.
Lancashire and South Cumbria NHS FT
March 2021</td><td>The Trust has a 25 page Standard Operating Procedure on ‘Promoting Engagement & Access to Mental Health Services’. This is a comprehensive document aimed specifically at community mental health teams. The objective of the SOP is to promote a consistent approach to the safe and appropriate management of services users who disengage with services, do not attend appointments and/or fail to take prescribed medication. The SOP is applicable to all CMHTs and provides guidance on the steps to take for each category of service user and level of risk.

The SOP details how to respond to patients who are not engaging with their care and treatment (or at the point of referral or transfer) as well as how engagement will be monitored and reviewed. The SOP discusses risk and safeguarding in relation to this. Suggested individualised approaches range from sending a letter (a template is provided which includes information on other relevant support organisations) to arranging a police welfare check or an assessment under the Mental Health Act. Timescales for liaising with referring agencies such as GPs are also provided. The guidance also advocates the support of outreach services to provide intensive support to engage service users who may lose contact with services.

The SOP refers to service users with a dual diagnosis and the need to work collaboratively with substance misuse services. It provides clear guidance to staff and provides a link to the Dual Diagnosis Protocol.

The SOP also includes information about its implementation and monitoring as well as decision trees and a glossary of terms.

There are a number of minor issues with the version provided to us:
• It is nearly 12 months since its given review date (March 2022);
• The implementation plan has target dates of 2016; and
• Monitoring guidance is included, but suggests that this is overseen by inpatient, rather than community service managers.

The Trust reports that the policy is currently being reviewed and updated.</td></tr>
</table>

Appendix 1: Evidence review

Recommendation 2 (continued)	
Key evidence submitted	**Niche review**
Promoting Engagement and Access to Mental Health Services Baseline Audit. Trust-wide. Produced by Clinical Audit department April 2022	Trust clinical audit and effectiveness staff conducted an audit of practice compliance for community mental health teams against the standards laid out in the above SOP. This reported in April 2022. The overall compliance for this audit was 83%. The results from this audit did highlight trust-wide variations of practice and adherence to the policy with one area (Fylde) performing significantly better at 95% than the other three. The lowest area had 59% compliance. The recommendations from the audit are therefore aimed to standardise practice in accordance with the revised standards taken from the LSCFT Standard Operating Procedure MH069 and to complete a re-audit which we would support.
Further written evidence submitted by the Trust January 2023	All four Standard Operating Procedures (SOPs) for adult and older adult community mental health teams (CMHT, CMHT Older Adults , Home Treatment Team and Initial Response Service (IRS) reference and signpost to the Promoting Engagement & Access to Mental Health Services policy which was ratified in March 2021 but has an expiry date of March 2022. This is being reviewed. The CMHT and HTT SOPs (detailed in above pages) both detail the circumstances that would apply for both a practitioner's welfare check and a police welfare check and the procedures to follow for these. There are some anomalies within the SOPs. For example, the current HTT procedure references an out of date policy MH069 – Promoting Engagement with Service Users SOP. The CMHT SOP also references the Clinical Disengagement Procedure which the Trust lead could not find on the Trust policy and procedures page and refers to the CPA Policy (23.1 – Guidance for Police Welfare Checks and Appendix C for Contacting Police for Assurance on Welfare Checks Flowchart which does not match the current CPA policy.

Appendix 1: Evidence review

Recommendation 3

3a) The Trust must review the action plans for 2015/21744 (Mr W) and 2014/14031 (Mr S) to assess progress and whether actions are still appropriate to meet the original recommendations. Action owners should also be revised and refreshed and revised timelines for delivery of their actions agreed with approval from the CCG and the new Integrated Care System (ICS).

3b) Action plans should be monitored by an appropriate (sub) committee and action owners held to account for action implementation.

Key evidence submitted	Niche review
Completed action plan for 2014/14031 Mr S Lancashire Care NHS Foundation Trust Undated	This action plan for 2014/14031 lists the 11 recommendations from the investigation report (see detail in Appendix 3) and includes columns for planned action, start and finish date, action owner, outcome/target and supporting evidence. These columns are completed but with minimal information. It states that all actions are complete but does not provide evidence of this. There are no dates for completion after 2018 suggesting it has not been refreshed since then.
Completed action plan for 2015/21744 Mr W . Lancashire Care NHS Foundation Trust Undated	The initial report had three recommendations, but this Excel action plan only contains two. Number one is missing here. Two actions are joint actions (with the substance misuse service and the Council) and one for the Trust alone. The action plan does have updated dates for 2019 and 2020 suggesting that this has been refreshed since it was originally written. The Trust also provided evidence of ongoing actions - for example around the dual diagnosis protocol. However, no evidence of CCG/ICB sign off or local review was provided.
Independent quality assurance review (QAR) of action plan for 2015/21744 Mr W. Completed by Caring Solutions 22 July 2019	The QAR, carried out by the independent supplier Caring Solutions who conducted the original investigation, reviewed 63 documents including copies of the action plan for the Trust, and joint action plan with the Substance Misuse service provider dated April and May 2019. The QAR scored all of the recommendations at level 1 and detailed a range of further work which would be required to achieve levels 2 and 3, as listed below. **Recommendation 1a:** In order to achieve Level 2, implementation of the contract needs to be audited for compliance; and to achieve Level 3, any changes to practice to improve compliance need to be made. **Recommendation 1b**: In order to achieve Level 2, implementation of the contracts need to be audited for compliance; and to achieve Level 3, any changes to practice to improve compliance need to be made.

Appendix 1: Evidence review

Recommendation 3 (continued)	
Key evidence submitted	**Niche review**
Independent quality assurance review (QAR) of action plan for 2015/21744 Mr W. Completed by Caring Solutions 22 July 2019 (continued)	**Recommendation 1c:** Not implemented as written, but a reasonable and acceptable rationale for this is given. Alternative actions are implemented to Level 1. In order to achieve Level 2, implementation of the SLAs need to be audited for compliance; and to achieve Level 3, any changes to practice to improve compliance need to be made. **Recommendation 2:** Partially implemented. (Level 1 – senior strategic board to oversee and monitor dual diagnosis joint working agreement established – MAOG (Mental health multi-agency oversight group) and MHOB (Mental health operational board) , at ICS level; and the Pan Lancashire Dual Diagnosis Group will address 'inter-agency communications and information sharing). To fully implement Recommendation 2 to Level 1, the following needs to be completed: • The joint working agreement to be extended to include physical healthcare, housing and employment services (as per phase 2); • Multi-agency locality meetings to be established In order to achieve Level 2; • implementation of the joint working agreement (following phase 2 development) to be audited for compliance; • the locality meetings to be reviewed to ensure they achieve their objective regarding non-engagement; and • functioning of the MAOG and MHOB to be reviewed to ensure the work on dual diagnosis is maintained and sustainable. To achieve Level 3, changes to policy and practice to improve compliance with the recommendation to be made. **Recommendation 3:** To achieve Level 2, the Trust needs to audit the implementation of the Clinical Risk Assessment and Management Procedures (March 2019); and to achieve Level 3, any changes to practice to improve compliance need to be made.

Appendix 1: Evidence review

Recommendation 3 (continued)	
Key evidence submitted	**Niche review**
Audit of the Dual Diagnosis Locality Meetings in Lancashire August 2020	The audit references this incident and states as context: *"In order to achieve the requirements of the Dual Diagnosis Joint Working Agreement which was officially launched in December 2019, Dual Diagnosis multi-disciplinary meetings (MDT) needed to be established in each locality with the initial aim of improving liaison and joint care planning between Mental Health and Substance Misuse Services in Lancashire. The meetings are now regularly embedded across Lancashire as part of the Integrated Care System (ICS) and the minutes feed into the Locality Multi Agency Group (MAG) meetings that aim to address the needs of the most complex and vulnerable individuals"* The audit was undertaken by the Trust's Quality, Governance and Audit Manager and the Practice and Quality Development Lead and consisted of two elements: • an audit of meeting minutes to determine when meetings commenced in each locality and the frequency of meetings; and • a case note audit for a sample of 14 service users who had been discussed at these meetings in April and May 2020. The audit considered whether: • joint working had been initiated following the Dual Diagnosis MDT meeting; • consent had been reviewed with a service user to ensure a collaborative approach could continue; • an individual's care/treatment plan had been updated to reflect the actions/suggestions from the meetings; and • there was documented evidence in case notes that a meeting had been held. The audit also considered any practice improvements identified. The audit found that 51 joint Dual Diagnosis MDT meetings were held with Change Grow Live (a charity providing substance misuse services) between October 2019 and August 2020 relating to 306 service users in East Lancashire, Blackburn with Darwen, North and Central Lancashire. The charity does not provide its services in Blackpool and therefore the audit did not cover this locality. Key findings are shown on the following page.

Appendix 1: Evidence review

Recommendation 3 (continued)	
Key evidence submitted	**Niche review**
Audit of the Dual Diagnosis Locality Meetings in Lancashire August 2020 (continued)	The key findings from the case note audit were: • 3 of the 14 cases did not require a joint working approach and continued to receive support from the relevant service. • 8 of the remaining 11 cases were subject to a joint working approach and receiving support from both services. For 6 of these joint working arrangements were documented. • 7 cases showed that after the Dual Diagnosis MDT meetings there was evidence of documented, ongoing liaison between the two services. • In 4 cases the team correctly identified that an individual's non-engagement was a risk. Actions to be taken were documented. • Only 2 cases had their consent updated or reviewed. The report noted that there was no formal process in place at the Trust for obtaining and documenting consent to sharing information. This had been escalated to the Trust's Caldicott Guardian for action. The paper notes that Information Sharing Agreements were in place between the Trust and substance misuse services' providers. A recommendation from the audit was that as the Dual Diagnosis MDT meetings develop to include other agencies, information sharing arrangements are reviewed. Other recommendations from the audit were around formalisation of the administration of the meetings and improvement in minute taking and follow up of actions. The audit provided multiple and detailed examples of notable practice and case studies demonstrating the benefits of collaborative working for service users including escalation and joint decision-making; these provided substantial evidence that this way of working is embedded.
Other evidence from Trust action plan for the Niche QAR which relate to recommendations from 2015/2174 Mr W action plan September 2022	The Trust provided us with information to evidence a range of further improvements since the above QAR. The Trust's action plan (for the Niche QAR review) states that as part of the Listening into Action programme (Phase 2) all internal and external Dual Diagnosis training was reviewed, updated and made available to staff via the training portal and 'Training Tracker'. The following work has been completed: • a mapping exercise to determine which teams or services had a Dual Diagnosis Champion; • a guide describing the roles, responsibilities and governance of the champions was prepared to enable consistency across the Trust; • an online Dual Diagnosis portal was created and is accessible via the Trust intranet; staff were identified to maintain the portal.

Appendix 1: Evidence review

Recommendation 3 (continued)	
Key evidence submitted	**Niche review**
Other evidence from Trust action plan for the Niche QAR which relate to recommendations from 2015/2174 Mr W action plan (continued) September 2022	A screen shot of the portal was provided. This states that the resources are available to all staff involved in the care of individuals with a dual diagnosis. It provides a locality map so that teams can access information of specific relevance to them in their locality. The Trust advises that locality dual diagnosis MDTs are in place and that an audit was completed in 2020 (more details provided within this section).
Serious Incident Review Panel (SIRP) sample meeting agenda October 2022	The Trust provided a sample agenda from one of the five SIRP panels that occur every week as a locality review of their SIs before going to the Safety Summit the following week. The SIRP panels review SI actions. The agenda provided covered the following topics: • Welcome and opening comments, apologies for absence; • Confirmation of quoracy, declaration of interest; • Minutes of the previous meeting, matters arising; • Action tracker of the last meeting - 31/10/2022; • SI investigations for presentation; • comprehensive and concise- approval needed/resultant action; • New STEIS or serious incidents (SI lead allocations); • New moderate Incidents reported; • Concise investigations commissioned; • Allocation of concise leads where required (continued). • Open serious incidents and Investigations underway- progress update and action needed; • Serious incident actions (review of dashboard including breaches and resultant action required).
Safety Summit agenda for meetings held on 15 June 2022, 12 October 2022 and 18 January 2023	The Trust provided three sample safety summit agendas. The summits include executive representatives and members of the Trust governance team and has a role in oversight and monitoring patient safety related activity including investigations. They sign off completed action plans and invite SI leads to the meeting so they can question them directly. The summit may also conduct thematic or more in-depth review of specific topics of concern or common themes. Each summit is chaired by a chief improvement and compliance officer (an executive director role).

Appendix 1: Evidence review

Recommendation 3 (continued)	
Key evidence submitted	**Niche review**
Safety Summit agenda for meetings held on 15 June 2022, 12 October 2022 and 18 January 2023. Continued.	Each summit is chaired by a chief improvement and compliance officer (an executive director role). Standing agenda items for the meetings, based on the agendas reviewed, include: • Review of progress with specific serious incident investigations; • A weekly overview of incidents; • Significant incidents occurring in the previous week. Inquests and Regulation 28 Notices (reports from the coroner to prevent future deaths) received in the last week; • Weekly SI Position; Key or urgent safety issues; Identification of learning opportunities and risks; Identification of issues for escalation; Items for escalation from SIRPs and any other business.
Updated homicide action plan from LSC NHS FT 2015/21744 (Mr W) January 2023	Update on recommendation one. The action plan provided states that this action was marked as complete in June 2016 with an email from Lancashire County Council to say they follow the standard DHSC Public Health contract for incident reporting with a Serious Reportable Incident process which Inspire (substance misuse service) also work to. They go on to say that since that time there has been a great deal of work to improve the liaison between LSCFT and LCC and the various Substance Misuse Service providers and other non-statutory services. A new Trust strategy is currently being developed and the first draft was reviewed at the Clinical Senate in November 2022. However, the Trust understands that priority areas need to be more clearly identified and it is expected that a final version of the strategy together with a resultant policy was intended to be agreed around the end of Quarter 4 2022/23. The plan states that in the absence of a Trust policy, work with the ICB is ongoing to update the current joint protocol. Additionally, a best practice group for addiction has now been established with an inaugural meeting taking place in November 2022. The group plans to include partner representation from agencies such as Inspire (substance misuse agency) and Calico (Calico Group provide community services in housing support, healthcare support, employability, benefits, domestic abuse and other areas). This group will allow a clear reporting structure to the locality meetings with clinical leads ensuring that learning from serious incidents is shared trust-wide. Joint training sessions with Inspire took place at Guild Lodge during December 2022 and there are plans to roll out this training to other inpatient units across the Trust and also community based teams.

Appendix 1: Evidence review

Recommendation 3 (continued)	
Key evidence submitted	**Niche review**
Updated homicide action plan from LSC NHS FT 2015/21744 (Mr W) January 2023. Continued.	Update on recommendation two: The action plan marks this as completed in April 2016 with a note to say a revised system had been built into the process for managing police national computer (PNC) checks. There is an information sharing protocol between the police and the Trust and there is a single point of contact in both organisations. All PNC checks are requested by the Trust's security management specialist. Update on recommendation three: The action plan states that "*Whilst it is beyond the remit of LCFT the managers of the Inspire substance misuse service should, in the light of this report, review whether their current risk assessment procedure (which relies solely on service user self-assessment) provides sufficient safeguards to protect their staff and the public from high risk individuals or allows them to identify such individuals. Their standard Clinical Review letter should be amended to include harm to others in the risk domains. Post Incident Review report to be shared with Inspire and relevant Local Authority Commissioners. The report was shared on 22/03/2016 via email*" The plan does not state whether this has been progressed or how it will be monitored. Update on recommendation four**:** This was marked as complete in October 2016. *The plan states that "A meeting took place in July 2016 with managers from Inspire Substance Misuse Service (East, and North) to develop pathways between services and review current arrangements for joint working. As per action 2 this work is ongoing".* A significant amount of evidence was provided separately detailing the ongoing work, particularly around joint work to support people with both mental health and substance misuse issues, some of which was reviewed for the QAR and some of which is detailed in this section. It is not clear from the action plan provided, which sub-committee is responsible for ensuring its implementation on an ongoing basis.
Email from Caroline Marshall, Associate Director of Patient Safety at NHS South Lancashire and Cumbria ICB. 4 April 2023	The email states ".. *oversight against the delivery of actions has been overseen by the MAOG (multi-agency oversight group) which is chaired by Neil Smith who works in the mental health team of the ICB – this is where the progress against actions by all stakeholders is discussed and the system and individual providers 'held to account' and any blockages/challenges explored with the aim to resolve. ..*"

Appendix 1: Evidence review

Recommendation 4
4a. NHS England and Improvement (NHSE&I) should work with the Department of Health and Social Care (DHSC) to agree and 'sign off' the revised 'Memorandum of Understanding' with the National Police Chiefs' Council (NPCC) to support investigations into serious incidents in healthcare settings. 4b. In the meantime, the Trust and the local Constabulary should agree a local memorandum of understanding to inform the management of health care incidents that are also subject to criminal investigation.

Key evidence submitted for NHSE	Niche review
Department of Health and Social Care MoU working group agenda and minutes 30 September 2020	NHS England/DHSC has set up an MoU working group, containing representatives from a range of relevant organisations. Work paused due to a Department of Health and Social Care vacant post and Covid, but re-commenced in 2020. Sample meeting minutes were provided from September 2020. This meeting of the Williams Review MoU implementation group was chaired by the DHSC and attended by representatives from CQC, HSE, HSIB, NHS England, CPS, NPCC, GMC, GDC and "Pharmacy". See Glossary on page 21 for details of these acronyms. Key actions from the meeting included the following: • To capture who the members of this working group are, in an annex, to identify who would be involved in any subsequent review. • To be explicit in the body of the MoU that signatories should share evidence, supported by the confidentiality agreement and subject to avoiding prejudice to any investigation. • To add clarity about who chairs the first ICG meeting (whoever initiated it), and the agreed lead will chair from then on. To review the Emerging Concerns Agreement for consistency and touch base with Charles (CQC) for any questions. • Consider reviewing this MoU sooner than the stated three years, to establish how it works in practice, to refine the detail. • To strengthen and make clear there is an 'expectation' for this MoU to be adhered to for private and independent providers. • To make contact with the Independent Healthcare Providers Network, who may be able to agree to a similar MoU. • To ensure consistency on the scope of seriousness through-out the MoU: 'the death or life changing harm (physical or psychological) of a person/service user.'
Assurance meeting between Niche and NHS England to plan the NIAF 8 November 2022	NHS England confirmed that they are still awaiting sign off of the MoU.

Appendix 1: Evidence review

Recommendation 4 (continued)	
Key evidence submitted from NHS England	**Niche review**
A Memorandum of Understanding between regulatory, investigating and prosecuting bodies MoU version 11 (November 2020) and version 12 (not dated)	A number of drafts of the MoU have been produced and circulated for comment/revision. Drafts 11 and 12 were shared with us. The documents are entitled "Investigating incidents involving death or life-changing harm in health and care contexts".
Emails between NHS England and other organisations involved From August to September 2022	An email of 15 August 2022 states that NHS England hope to have the MoU signed off by the following week. However subsequent emails demonstrate discussion on a number of relevant issues or wording on which there is still no consensus or agreement. We have no emails after 2 September 2022.
Key evidence submitted from the Trust	**Niche review**
A Memorandum of Understanding between Lancashire Constabulary & Lancashire & South Cumbria Foundation Trust 10 November 2022	The Trust has put in place a local MoU to support the implementation of the Mental Health Police Liaison Officer (MHPLO) role between LSCFT and Lancashire Constabulary. It states that Lancashire Constabulary and LSCFT will each nominate a senior contact who will be responsible for ensuring an effective relationship between themselves; preserving the underpinning principles outlined in the MoU, maintaining an overall perspective on developments initiated through the MoU.
Mental Health Police Liaison Officer role profile Undated	The Trust has put in place a local MoU to support the implementation of the MHPLO role between LSCFT and Lancashire Constabulary. It states that Lancashire Constabulary and LSCFT will each nominate a senior contact who will be responsible for ensuring an effective relationship between themselves; preserving the underpinning principles outlined in the MoU, and maintaining an overall perspective on developments initiated through the MoU. The Trust has employed a police officer, based within the Trust security team, whose remit includes advising the Trust on the management of health care incidents that are also subject to criminal investigation. The role profile describes the job purpose as "*To provide a visible and accessible service to LSCFT staff working in the Lancashire area for incidents, issues and crimes occurring within LSCFT's Mental Health Units and community settings, primarily those that involve patients and/or staff from those settings. Provide support and advice to staff and patients where necessary and liaise with other police departments when required to do so.* " Whilst there is no systematic analysis of the effectiveness of these new arrangements, there is positive anecdotal evidence that it is working well with the Patient Safety team able to provide a number of examples of recent cases where the Trust and the police had worked effectively together through this new post.

Appendix 2: Glossary of terms

Appendix 2: Glossary of terms

CCG	Clinical Commissioning Group
CCTT	Complex Care Treatment Team
CMHT	Community Mental Health Team
CPS	Crown Prosecution Service
CQC	Care Quality Commission
GDC	General Dental Council
GMC	General Medical Council
HSE	Health and Safety Executive
HSIB	Healthcare Safety Investigation Branch
ICB	Integrated Care Board
ICS	Integrated Care System
LSCFT	Lancashire and South Cumbria NHS Foundation Trust
MAOG	Mental health multi-agency operational group
MDT	Multi-disciplinary team
MEAM	Making Every Adult Matter
MHOB	Mental health operational board
MoU	Memorandum of Understanding
NPCC	National Police Chief's Council
PNC	Police National Computer
RITT	Rapid Intervention and Treatment Team (for older adults)
QAR	Quality Assurance Review
SI	Serious incident
SOP	Standard Operating Procedure
ToR	Terms of Reference

Appendix 3: Recommendations from investigations 2015/21744 (Mr W) and 2014/14031 (Mr S)

Provided as context to help understanding of findings and conclusions with regard to recommendation 3 (above)

Recommendations 1-6 for 2014/14031 (Mr S)

Lancashire County Council, Lancashire Care NHS Foundation Trust, Clinical Commissioning Group and other third sector providers.

Recommendation 1: Agencies who are currently responsible for undertaking carer's assessment and providing carers services need to review their current protocols for:

- Responding to disclosures of actual or potential risk of abuse of carers.
- Identifying in what circumstances would there be an escalation of information sharing.
- A review of the allocation and role of the care coordinator to identify their responsibilities for liaising with other involved, Lancashire Care NHS Foundation Trust, Clinical Commissioning Group and third sector providers.

Recommendation 2: In order to standardise and improve the quality of assessments and reviews of carer's needs and risks, consideration should be given to introducing one set of assessment and review proformas that are used by all carer's services within Lancashire. Lancashire County Council, Lancashire Care NHS Foundation Trust, Clinical Commission Group and third sector providers.

Recommendation 3: Consideration should be given to introducing a "keeping safe plan" within all support plans which also addresses the carer's possible fears around care alternatives for the person they are caring for and the consequences that may arise if action is taken.

Lancashire Care NHS Foundation Trust and Clinical Commissioning Group.

Recommendation 4: In order to improve information sharing between primary care and Lancashire Care NHS Foundation Trust's community mental health services consideration should be given to strengthening a joint information sharing protocol. Such a protocol should identify both agencies' responsibilities for:

- Information sharing following a patient's discharge from an acute inpatient admission;
- Joint responsibility for on-going communication between a patient's primary care and care coordinator; and
- Involvement of primary care in a patient's care planning reviews by mental health services. Lancashire Care NHS Foundation Trust and N Compass.

Recommendation 5: In order to evaluate whether the issues and deficits highlighted within this report are systemic within Lancashire Care NHS Foundation Trust's Complex Care and Treatment Team and/or the N Compass service; both should consider undertaking an audit of a number of patients involved with both services. This audit should also include a review of the current interagency information sharing protocol and involvement in care planning and care planning reviews. Lancashire Care NHS Foundation Trust.

Recommendation 6: Lancashire Care NHS Trust should consider introducing an alert system on their Electronic Care Record System which alerts the clinician when new correspondence has been unloaded onto a patient's records. Lancashire Care NHS Foundation Trust.

Recommendations 7-11 for 2014/14031 (Mr S)

Lancashire County Council, Lancashire Care NHS Foundation Trust, Clinical Commissioning Group and other third sector providers.

Recommendation 7: A quality audit should be undertaken of care plans and safety profiles and reviews completed by the Complex Care and Treatment Team to ascertain if practitioners are accurately identifying and assessing the levels of risk(s). Where deficits are identified with specific practitioners then the appropriate training and management guidance should be provided.

Lancashire Care NHS Foundation Trust.

Recommendation 8: Lancashire Care NHS Foundation Trust should review its current guidelines within their Safeguarding Policy to ensure that it provides clear directives as to when and in what circumstances staff should be consulting the Trust's safeguarding team to seek advice and guidance. Lancashire Care NHS Foundation Trust.

Recommendation 9: The members of both the Complex Care and Treatment Team and psychologist who were involved in this case should receive additional training on their role, responsibilities and actions that is expected to be taken when there has been a disclosure and/or report from another service of either historical and/or recent incidents of domestic abuse. Lancashire Care NHS Foundation Trust.

Recommendation 10: An audit should be undertaken within the Complex Care and Treatment Team, including the psychologist team, to highlight any current cases where domestic abuse maybe a feature to ensure that staff are:

- Taking the appropriate and proportionate action is being taken.
- Seeking the appropriate guidance from Lancashire Care NHS Foundation Trust's safeguarding team and their senior managers and supervisors.
- Awareness of when to utilise assessments, such as CAADA DASH. Lancashire Care NHS Foundation Trust.

Recommendation 11: In order to ensure that there is a process utilised to evaluate, maximise and demonstrate the value of its training programme to both the trainee and the organisation Lancashire Care NHS Trust should consider adopting a recognised training evaluation tool such as the Kirkpatrick Model.

Recommendations for 2015/21744 (Mr W)

Recommendation 1: For Lancashire County Council, the Local Pharmaceutical Council, NHS England and services involved in the provision of shared care services in the Lancashire area eg Delphi Medical and Addaction.

1a) The revised contract for the provision of substance misuse services should identify how patients' records are to be transferred to a new provider.

1b) Lancashire County Council should convene regular Shared Care meetings, with representation from prescribing agencies, primary and secondary health services and community pharmacies. These meetings should provide a forum to:

- Monitor and evaluate performance of agencies against their Shared Care contracts
- Highlight and resolve any commissioning, contractual and agency concerns;
- Review any serious incidents, near misses and complaints; and
- Oversee joint serious incident investigations.

1c) The Local Pharmaceutical Council, substance misuse services, and NHS England should consider undertaking a review to ascertain the value of making an adjustment to the PharmOutcomes system so that it notifies all the involved shared care services when a supervised consumption patient has missed a single methadone collection. This review should take place within six months.

Recommendation 2: For Lancashire Health and Wellbeing Board, Lancashire County Council (Public Health), Lancashire Clinical Commissioning Groups, Lancashire Care NHS Foundation Trust and provider(s) of substance misuse, housing and judicial services.

Lancashire Health and Wellbeing Board should assume responsibility for the coordination of a forum to develop and implement a local dual-diagnosis protocol that provides:

- A coordinated and collaborative whole system integrated pathway to support individuals who misuse substances so that they have access to high-quality physical and mental healthcare, housing and employment.
- A senior strategic board that oversees and monitors the implementation of the dual-diagnosis protocol across all of the health and social care sectors.
- Clarity with regard to interagency information sharing and the management of risk, shared care arrangements, including care- coordination.
- Biannual meetings with representatives from all involved sectors with the aim of developing robust interagency relationships, to share lessons learned from serious incidents and to proactively identify and manage interagency issues.

Recommendation 3: For Lancashire Care NHS Foundation Trust

Lancashire Care NHS Foundation Trust should consider developing a new risk assessment tool that includes both risk management and crisis plans, and which involves both the patient and all other involved agencies.

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