An independent external quality assurance review following a serious investigation and safeguarding adults board investigation into the care and treatment of a mental health service user (Mr M) in Sussex

October 2020

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Our Draft Report has been written in line with the terms of reference set out in the assurance review. This is a limited scope review and has been drafted for the purposes as set out in those terms of reference alone and is not to be relied upon for any other purpose.

Events which may occur outside of the timescale of this review will render our report out-of-date. Our Report has not been written in line with any UK or other (overseas) auditing standards, we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information. However where there is evidence that the information is not accurate, this has been made clear in the report and in relation to all other information received from organisations and individuals, a factual approach has been adopted with discrepancies and variances in accounts highlighted where known.

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1 Executive summary

1.1 Sussex Partnership NHS Foundation Trust (SPFT or the Trust hereafter) undertook a Level 2 Serious Incident (Root Cause) investigation in 2014 into the care and treatment of a mental health service user Mr M, who received care and treatment from SPFT. The investigation was commissioned following Mr M assaulting a fellow resident of the nursing home in which he was living and the subsequent death of that resident.

1.2 In 2018 NHS England South commissioned Niche Health & Social Care Consulting Ltd (Niche) to carry out an assurance review. The main purpose of this review is to independently assess the completion of the SPFT's action plan following the recommendations made by the Surrey Safeguarding Adults Board (SAB) (Mr J and Mr Y) Serious Case Review and the SPFT's Level 2 Serious Incident Report. This examined the care and treatment of Mr M and the embedding of learning across SPFT and to identify any other areas of learning for SPFT and/or CCG.

1.3 The underlying aim of the assurance review is to identify risks and opportunities to improve patient safety and make recommendations for organisational and system learning. The Serious Incident (SI) investigation was carried out in 2014 and made three recommendations and identified one other issue relating to the Alzheimer's society.

1.4 The Surrey Safeguarding Adults Board Serious Case Review was published in 2016 and made 12 recommendations of which two are relevant to SPFT.

1.5 The external quality assurance review commenced in January 2019 and was completed in July 2019, and has focused on the action plan developed by SPFT in conjunction with the CCG and the relevant recommendations from the SAB. The review did not involve family members.

1.6 The external quality assurance review comprised of one interview with a Clinical Manager from SPFT and a review of documents and policies.

1.7 We have graded our findings using the following criteria:

Grade	Criteria
A	Evidence of completeness, embeddedness and impact.
B	Evidence of completeness and embeddedness.
C	Evidence of completeness.
D	Partially complete.
E	Not enough evidence to say complete.

Summary of care and treatment

1.8 Mr M was then a 74-year-old gentleman known to Northern West Sussex Dementia Services (NWSDS) after his GP referred him on 7 December 2012

with memory problems. He was seen, assessed and diagnosed with Alzheimer's disease by the northern West Sussex Memory Assessment Service (MAS) jointly provided by SPFT and the Alzheimer's Society.

1.9 Following assessment and diagnosis Mr M was prescribed anti-dementia medication. However, over a period of time his behaviour deteriorated, and he would become verbally and physically threatening. His partner found this very difficult to manage and requested respite care. Mr M was referred to Crossroads Care Services and Horndean House Day Care.

1.10 In August 2013 whilst at Horndean House Day Care Mr M became aggressive towards his partner. Mr M also refused to leave the premises and the police and paramedics were called. He was found to have a high temperature and a possible urinary tract infection. He was taken to East Surrey Hospital (ESH).

1.11 Mr M was admitted to ESH and during conversations with his partner she was clear she could no longer manage Mr M at home and would be looking for a care home placement. The family along with West Sussex Adult Social Care Service (WSCC) located a care home in Surrey where Mr M was discharged to. SPFT were not involved in these arrangements.

1.12 On the 26 September 2013 ESH asked the MAS to assess his capacity in readiness for discharge. ESH were advised by MAS that on-site Mental Health Liaison Services (MHLS) should be contacted to assess and liaise further. MHLS is provided by Surrey and Borders Partnership NHS Foundation Trust (SaBPFT).

1.13 SPFT MAS made several attempts to liaise with ESH but without success. Mr M was then subsequently discharged from ESH without the knowledge of the MAS team. Mr M's placement at the care home was chosen by Mr J's family and organised by WSCC. While he was on the ward there had been liaison between the SPFT MAS and the ward staff and psychiatric liaison service at the hospital. As his needs became more complex he was referred to the Dementia Crisis Service within SPFT who were standing by to assist but were not involved with the discharge arrangements. He was discharged to Westcott House Nursing Home on 30 October 2013.

1.14 On 31 October 2013 the GP covering Westcott House Nursing Home referred Mr M to the SaBPFT mental health services. He was seen and assessed by the Surrey and Borders Community mental health service on 14 November 2013.

1.15 On 24 November 2013 Mr M was found in the room of another resident in the nursing home, he had blood and bruising on his hands. Another resident was found with severe head injuries and was rushed to hospital.

1.16 On 24 November 2013 Mr M was assessed by the Forensic Medical Examiner who deemed him not to have capacity and requested a Mental Health Act assessment. Mr M was detained under Section 2 of the Mental Health Act 1983 and was admitted to Fenby Ward at SaBPFT.

1.17 Mr M was then transferred to St Magnus Hospital, a private facility for older persons.

1.18 The other resident subsequently died of his injuries on 27 November 2013.

Assurance follow up

1.19 The SPFT SI was published in August 2014 and the Safeguarding Adult Review, conducted by Surrey Safeguarding Adults Board, was published in January 2016.

1.20 It was agreed that an assurance review of the implementation of SPFT's action plans would be carried out in December 2018. The relevant section of the terms of reference is:

To independently assess the completion of the Trust's action plan following the recommendations made by the Surrey Safeguarding Adults Board ('Mr J & Mr Y') Serious Case Review and the Trust's level 2 Serious Incident (SI) Report which examined the care and treatment of MH, and the embedding of learning across The Trust and identify any other areas of learning for the Trust and/or CCG.

1.21 Using our structured format, we have assessed the evidence provided by the Trust and NHS Central Sussex and East Surrey Commissioning Alliance (the CCG).

1.22 All of the actions have been completed, and our gradings are listed below:

SPFT Serious Incident recommendations	Action required	Niche grading
Recommendation 1 A proportion of all West Sussex MAS teams eCPA records to undergo compliance audit in three months to ensure practice standards are being met.	As part of formal supervision team leaders to take a random sample of each staff members patients and audit compliance against record keeping standards and standards for eCPA.	A
Recommendation 2 Patients / carers in MAS that have heightened levels of risk individuals should be brought to an MDT discussion in order to share with MDT and gain support with management.	All patients with higher level of risk to have a level 2 MDT risk assessment. SAARs alerts to be raised as appropriate to level of risk to patient and or carer.	A
Recommendation 3 Carers should be offered a range of support / guidance including 'practical' advice on managing the difficult behaviours at times exhibited by individuals referred for MAS assessment / diagnosis / therapy.	Staff complete level 1 risk assessment on all patients, any identified risks in reference to difficult behaviours carer to be offered advice on management.	A
Other Identified Issue Alzheimer's Society groups not supportive to individuals that are experiencing challenges managing difficult behaviour.	Alzheimer's Society managers to receive feedback as provided within the SI report.	N/A
Surrey Safeguarding Board recommendations	**Action required**	**Niche grading**

Recommendation 3 When working with a person who is suspected of having committed an offence but who also has mental health problems, all operational staff should know how to access mental health assessments and should have clear routes for referral and escalation of requests for urgent psychiatric evaluation, including during out of hours. CCG and provider agencies should ensure that sufficient services are available to meet needs including out of hours.	Community Mental Health Teams (CMHT). Out of hours Emergency Duty Team (CMHT). All providers of health and social care. Clinical Commissioning Group.	B
Recommendation 9 West Sussex Adult Social Care should take steps to strengthen the links between their social work service and the local teams and services working with people with dementia.	West Sussex ASC. Mental Health Teams in West Sussex.	B

2 Assurance review

Approach to the review

2.1 The external quality assurance review has focused on the action plan developed by SPFT in August 2014 and relevant recommendations from the Surrey Safeguarding Adults Board in January 2016.

2.2 The external quality assurance review commenced in January 2019 and was completed in March 2019, and was carried out by Paul Watts, Niche Associate, with supervision by Dr Carol Rooney, Associate Director, Niche.

2.3 This external review was comprised of a review of documentary evidence supplied, and one interview with a Clinical Manager from SPFT.

2.4 We have graded our findings using the following criteria:

Grade	Criteria
A	Evidence of completeness, embeddedness and impact.
B	Evidence of completeness and embeddedness.
C	Evidence of completeness.
D	Partially complete.
E	Not enough evidence to say complete.

2.5 As part of our review we interviewed the Operational Clinical Manager.

2.6 The original terms of reference are at Appendix A. A full list of all documents we referenced is at Appendix B.

2.7 The draft report was shared with NHS England South, SPFT and NHS Central Sussex and East Surrey Commissioning Alliance. This provided an opportunity for those organisations that had contributed significant pieces of information to review and comment upon the content.

2.8 Section 2 describes the process of the review, and Section 3 gives an overview of Mr M's history and mental health treatment.

2.9 Section 4 describes in detail the actions planned in response to the independent investigation, and the progress SPFT has made in making and embedding change.

2.10 A description of the CCG and SPFT governance processes is described in Section 5. The processes that are described are those that are used in 2019; it is not possible to comment on the processes at the time of the incident which occurred in 2014.

2.11 Section 6 is a summary of the overall assessment of the quality review.

Background

2.12 The homicide was committed in 24 November 2013 while Mr M was an inpatient in Westcott House, a nursing home in Surrey. This assurance review relates to actions taken subsequently by the originating Trust, SPFT.

2.13 The Surrey Safeguarding Adults Board completed a Safeguarding Adults Review in January 2016 and made recommendations for health services adult social care, police, residential and nursing home and CCGs. SPFT had identified the recommendations that were within the Trust's remit and undertook the development of its own action plan.

2.14 Surrey SAB and the West Sussex Safeguarding Adults Board have both monitored the implementation of the recommendations. Surrey SAB, in their document 'Surrey Safeguarding Board – SCR Mr J & Mr Y – actions for each agency' only identify two recommendations pertinent for SPFT.

3 Summary of care and treatment of Mr M

3.1 Mr M was then a 74-year-old gentleman known to NWSDS after his GP referred him on 7 December 2012 with memory problems. He was seen, assessed and diagnosed with Alzheimer's disease by the northern West Sussex MAS jointly provided by SPFT and the Alzheimer's Society.

3.2 Following assessment and diagnosis Mr M was prescribed anti-dementia medication and he and his partner were supported and reviewed by the MAS service including the Consultant Psychiatrist (CP), Nurse Prescriber (NP) and Dementia Support Worker (DSW) and Dementia Advisor (DA).

3.3 Changes to Mr M's presentation led to an increased libido and/or dis-inhibition. He would become verbally aggressive and/or physically threatening towards his partner although no physical assault was reported. After his partner requested respite, he was referred to Crossroads Care Services including Horndean House Day Care.

3.4 Whilst at Horndean House Day Care Mr M became verbally and physically aggressive towards his partner when she came to pick him up and he refused to leave the premises. Sussex police were called, by the time they arrived Mr M had calmed down. Paramedics also arrived and Mr M was found to have a high temperature and possible urinary tract infection. He was taken to ESH A&E and was diagnosed with a lower respiratory tract infection.

3.5 MAS were informed of the incident and admission by WSCC via the Safeguarding Adults at Risk (SAAR's) alert completed by Sussex police officers. Following this his partner said she could no longer manage Mr M at home and would be looking for permanent care home placement.

3.6 Over the next few weeks ESH staff, both ward based and those from the MHLS at SaBPFT, either contacted the MAS team or were contacted by them to share information regarding Mr M's assessment, treatment, prescribed medication and presentation. It was agreed that when Mr M was discharged the NWSDS would

support Mr M's discharge from hospital, but they were not involved on the discharge arrangements.

3.7 NWSDS made numerous attempts to ensure they were informed of Mr M's discharge; however, they were not. From the SPFT investigation we understand that Mr M had been transferred to Westcott House Nursing Home, Dorking, Surrey. SPFT MAS made several attempts to liaise with ESH but without success. Mr M was then subsequently discharged from ESH without the knowledge of the MAS team. Mr M's placement at the care home was chosen by Mr J's family and organised by West Sussex ASC. While he was on the ward there had been liaison between the SPFT MAS and the ward staff and psychiatric liaison service at the hospital. As his needs became more complex he was referred to the Dementia Crisis Service within SPFT who were standing by to assist but were not involved with the discharge arrangements. He was discharged to Westcott House Nursing Home on 30 October 2013.

3.8 On 31 October 2013 a GP covering the Nursing Home referred Mr M to SaBPFT mental health services stating that he had become much more aggressive and paranoid.

3.9 Mr M was assessed by a SaBPFT Community Mental Health Nurse (CMHN), following concerns expressed by Westcott House Nursing Home staff. There were reports about aggressive behaviour upon his arrival at the home but apparently his presentation improved following prescription of clonazepam. The CMHN advised the home to give him more time to settle and planned to reassess him again at the end of November 2013.

3.10 Following the incident on 23 November, Mr M was detained under Section 2 MHA initially in the SaBPFT Psychiatric Intensive Care Unit, but then transferred to St Magnus Hospital, a private facility for older men who were physically aggressive. The victim of the attack died from their injuries on 27 November 2013.

3.11 During his admission to St Magnus Hospital he was assessed, and the ACE 111 was administered. During the assessment Mr M presented with significant cognitive impairment. It was felt that he did not have the capacity to retain or understand information relating to his care needs and that he did not understand the seriousness of the incident.

3.12 SPFT undertook an internal SI but no external review was requested. The SI made three recommendations and identified one other issue relating to the Alzheimer's Society.

3.13 Surrey Adult Safeguarding Board's investigation made 12 recommendations, two of which related to SPFT.

4 Action plan progress

Sussex Partnership NHS Foundation Trust actions

Recommendation 1	Niche grade
A proportion of all West Sussex MAS teams eCPA records to undergo compliance audit in three months to ensure practice standards are being met.	A

4.1 The expected actions from the SI were as follows:

- As part of formal supervision team leaders to take a random sample of each staff members patients and audit compliance against record keeping standards and standards for eCPA.
- A records audit tool would be used.

4.2 A records audit tool was available for team leaders to use in the form of an Excel document.

4.3 The audit was undertaken by the team leader and captured data from nine clients, the evidence seen covers the month of December 2014.

4.4 The audit covered five standards in relation to record keeping, these were:

- Standard 1 – Front Sheet Criteria
- Standard 2 – Entries
- Standard 3 – Organisation of Records
- Standard 4 – Clinical Standards
- Standard 5 – Discharged patients only – only Community Services to answer this.

4.5 Each of the five standards was then subsequently broken down into number of sub-standards.

4.6 In the West Sussex MAS team, the results were:

- Standard 1 – 86% compliance
- Standard 2 – 70% compliance
- Standard 3 – 93% compliance
- Standard 4 – 93% compliance
- Standard 5 – 100% compliance

4.7 The overall compliance figure for West Sussex MAS from this one audit was 86%.

4.8 The figures for the SPFT wide audit for 2014-15 show an overall compliance of 88%.

4.9 There has been evidence provided that indicates that the audit of records has been ongoing. Although the audit form has changed it has improved and collects a wider range of organisational and clinical data.

4.10 The audits are more qualitative in nature and cover three main areas Processes, Qualitative Data and Care/Management Plans. Each of these areas are subsequently sub-divided into at least six standards.

4.11 Evidence for West Sussex MAS audits undertaken in November 2018, December 2018, January 2019 and August 2019 have been provided. These audits are undertaken every month. The audits would appear to show 100% compliance to the standards.

4.12 SPFT also has a supervision policy. This policy includes supervision as a method for ensuring record keeping is of good quality. Supervision records are recorded in a system called My Learning for future reference.

4.13 Since April 2015 there has been a single clinical record system, which all staff have to use. As part of this system, team leaders can produce real time reports on any practitioner's case load, again used to monitor quality.

4.14 It is clear that actions related to this recommendation have been followed through, and that changes are embedded and have impacted on services. We have rated this as A.

Recommendation 2	Niche grade
Patients / carers in MAS that have heightened levels of risk individuals should be brought to an MDT discussion in order to share with MDT and gain support with management.	A

4.15 The expected actions from the SI were as follows:

- All patients with higher level of risk to have a level 2 MDT risk assessment.
-
- SAARs alerts to be raised as appropriate to level of risk to patient and or carer.

4.16 SPFT have developed a Clinical Risk Management and Safety Planning/Risk Management Policy and Procedure that covers all groups of staff within the organisation (April 2017).

4.17 The key aspects of the policy are:

- Safety of service users, carers, and the public in relation to suicide, self-harm, neglect, vulnerability, physical health, and violence.
- Engagement and collaboration with service users, their families and carers.
- Positive risk-taking, safety planning, risk management and recovery.
- Use of SPFT approved forms and tools in carrying out, documenting, and communicating risk assessment and management plans which form part of the care plan.

4.18 The policy is also explicit that for those clients with high or complex risk there must be multi-disciplinary input from all those involved as well as multi-agency input from all agencies involved.

4.19 There is now also a revised risk assessment tool within Carenotes that includes a section on safeguarding. Staff have received information as to how this should be used.

4.20 Risk assessment training includes Adult Clinical Risk Assessment as well as Dementia Risk training.

4.21 Compliance for the risk assessment tool being completed has moved from 42.7% completion in October 2016 to 92.3% in July 2019.

4.22 Also available to staff is a Safeguarding Adults Policy (April 2018).

4.23 The policy is clear as to the procedure staff must undertake should they have adult safeguarding concerns:

- Discuss the concern with their manager or with another senior colleague if the manager is not available.
- Talk to the adult concerned about their views and wishes.
- Raise the concern with the local authority using the relevant procedures for each local authority area.
- Report the concern as an incident following SPFT policies and procedures.
- Take immediate action to ensure the safety of the person at risk following the SPFT risk assessment policy and procedures.
- Record actions taken on Carenotes and set up the safeguarding flag alert in line with standard operational procedures, or record in the appropriate clinical record system for the service.

4.24 Safeguarding appears to have become embedded in the organisation with 93% (June 2019) of staff now completing Safeguarding Level 1 and 2 training.

4.25 The incident reporting system, Ulysses, has been developed which now allows teams to see safeguarding incidents that have been raised; as well as allowing comparison against other teams.

4.26 It is clear that actions related to this recommendation have been followed through, and that appropriate policies address the issues that were raised in the recommendations and action required. The policy is explicit in the need to discuss high and complex areas of risk at MDT meetings.

4.27 Training has also been delivered and monitored in respect to Clinical Risk Assessment and Safeguarding. Since September 2019 the Trust have appointed a Lead Clinician for Clinical Risk. 660 front line staff have attended the training which includes learning from SIs and the importance of involving the family/ carer in risk assessments. An example of the training was provided and is amended to reflect the needs of attendees. We have rated this as A, as actions have been embedded and there is evidence of impact on practice.

Recommendation 3	Niche grade
Carers should be offered a range of support / guidance including 'practical' advice on managing the difficult behaviours at times	A

exhibited by individuals referred for MAS assessment / diagnosis / therapy.	

4.28 The expected action from the SI was as follows:

- Staff complete level 1 risk assessment on all patients, any identified risks in reference to difficult behaviours, the carer is to be offered advice on management.

4.29 SPFT have ongoing audits of the client's case notes and this audit includes a question asking whether the risk assessment is complete.

4.30 The audit tool also offers assurance that there is 'plan to minimise risk' in place. The audit tool also asks appropriate questions in relation to risk recording and formulation.

4.31 SPFT have also implemented the nationally recognised 'Triangle of Care'[1] process since 2016, this was a recommendation from an independent review of homicides and as part of this undertaken focussed pieces of work.

4.32 SPFT was awarded Stage 1 Triangle of Care in June 2019.

4.33 SPFT have a Carers and Confidentiality Policy which indicates that the Trust is committed to 'Triangle of Care' and the need to ensure carers are included and supported in their care of relatives.

4.34 SPFT wrote to staff in December 2018 reinforcing the importance of sharing information with families and carers.

4.35 SPFT have also developed a carer's leaflet 'Helping someone with dementia who is distressed or behaving unusually'.

4.36 Other carers information is also available in the form of leaflets: 'Family and Friend/Carers a guide to support and confidentiality', 'Carers Support and Confidentiality' brief guide for staff, and 'Carers Support Request Form'.

4.37 It is clear that actions related to this recommendation have been followed through, and that appropriate policies address the issues that were raised in the recommendations and action required. The outcome intended has been achieved, actions are embedded into practice and we have seen evidence of impact. We have rated this as A.

Other identified issue	Niche grade
Alzheimer's Society groups not supportive to individuals that are experiencing challenges managing difficult behaviour.	N/A

4.38 The expected action from the SI was as follows:

- Alzheimer's society managers to receive feedback provided with SI Report.

[1] *The Triangle of Care, Carers Included: A guide to best practice in mental health care in England (2013). The Triangle of Care guide was launched in 2010 as a joint piece of work between the Carers Trust and the National Mental Health Development Unit*

4.39 This feedback was undertaken at the West Sussex MAS Steering Group on the 1 October 2014 – minute 3 matters arising.

4.40 The minute describes an email being sent and the Alzheimer's society and the staff member present at the meeting confirms that they are aware of the incident. It was also noted that Mr M was in a care home outside of SPFT catchment area.

4.41 It is clear that actions related to this recommendation have been followed through and that the incident was raised at the MAS Steering Group. We have rated this as not applicable (N/A) in terms of applying an assurance grading. This was not a recommendation, but merely an action for the Trust to complete, which has been achieved. There is no requirement to show any evidence of implementation or embeddedness.

Surrey Safeguarding Adults Board actions

Surrey Safeguarding Adults Board Recommendation 3	Niche grade
When working with a person who is suspected of having committed an offence but who also has mental health problems, all operational staff should know how to access mental health assessments and should have clear routes for referral and escalation of requests for urgent psychiatric evaluation, including during out of hours. CCG and provider agencies should ensure that sufficient services are available to meet needs including out of hours.	B

4.42 There is no expected outcome in the Surrey Safeguarding Adults Board Executive Summary although SPFT has an action plan in which they show actions taken.

4.43 SPFT clarified that their electronic patient record system was available to all of their practitioners and that this will contain history and known risks. There is a senior nurse practitioner whose role includes out of hours assessments and referrals from GPs.

4.44 During the interview with the Operational Clinical Manager it was explained that SPFT has a Dementia Crisis Team which works with the Psychiatric Liaison Team (PLT) at East Surrey Hospital. It was noted that the relationship with the PLT is variable; the PLT is part of the service provided by SaBPFT.

4.45 SPFT also employs a Senior Nurse that is on duty 24 hours a day. All staff have access to this individual who can offer both management and clinical advice. They have access to Carenotes, and there is an on-call consultant psychiatrist rota.

4.46 The Trust also provides a 24-hr assessment service called The Haven at Mill View; this provides crisis assessment for anyone aged over 18.

4.47 The service does provide a single point of contact for Sussex Police. There is access to an out of hours approved mental health professional duty service.

4.48 SPFT on call managers are supplied with an Information Guide. This includes details for managing serious offence arrests of Grievous Bodily Harm and above.

4.49 It is clear that actions related to this recommendation have been followed and that appropriate policies and procedures address the issues that were raised in the recommendations and action required. The outcome intended has been achieved, and there are clear structures and processes embedded, although we have not seen evidence of impact. We have therefore rated this as B.

Surrey Safeguarding Adults Board Recommendation 9	Niche grade
West Sussex (County Council) Adult Social Care should take steps to strengthen the links between their social work service and the local teams and services working with people with dementia.	B

4.50 There is no expected outcome in the Surrey Safeguarding Adults Board Executive Summary although SPFT had an action plan in which they show actions taken. This recommendation relates to WSSC, not SPFT. However, SPFT has submitted a range of evidence to improve the processes of working together across boundaries and improve liaison between SPFT and WSCC ASC.

4.51 The evidence offered clarified that staff are employed by two different providers, namely WSCC and SPFT, and evidence of a number of steps and processes to ensure they work closely together was provided.

4.52 The Matron had weekly contact with WSCC staff, and the community teams have identified a link social worker.

4.53 During an interview with the Operational Clinical Services Manager it was described how WSCC staff are now based in the same office as SPFT staff in the Worthing and Chichester team. However, the North West Sussex Team are still based in separate offices.

4.54 Communication and sharing of care has improved because of co-location. SPFT have also developed a monthly meeting where Operational Managers and other leads meet, this acts as a forum for resolving difficulties and developing joint working.

4.55 SPFT in collaboration with WSCC have adapted and adopted the national guidance ‘Let’s get you home’ which supports patients’ choice to avoid delayed discharge, ensuring they work together.

4.56 As part of this working together WSCC have established a link worker, which is in place for each SPFT ward, with regular attendance at multidisciplinary meetings.

4.57 It is evident that SPFT have established processes to achieve a close working relationship with WSCC colleagues within the current resources available. The outcome intended has been achieved, and there are clear structures and

processes embedded, although we have not seen evidence of impact. We have therefore rated this as B.

5 Governance Processes

CCG Monitoring

5.1 The CCGs within Sussex have undergone major reorganisation since 2014 and have subsequently formed the NHS Central Sussex and East Surrey Commissioning Alliance.

5.2 Responsibility for quality assurance of SPFT is now with NHS High Weald Lewes Havens CCG.

5.3 Their 'Policy and Procedures for Reporting and Managing Incidents and Serious Incidents' was issued in October 2018 and has the status of Draft. Although the policy has been approved by the West and North CCG Quality Committees and is awaiting approval from the East CCG Quality Committee.

5.4 The policy is explicit in describing what incidents should be reported. Although there is not a section describing homicides, these incidents would be covered within the descriptor for Patient Safety Incidents.

5.5 The policy also describes the various stages that are required in reporting SI's and that investigations should be undertaken in accordance with the National Patient Safety Agency and NHS England framework for managing serious incidents (2015).

5.6 The CCG Clinical Quality and Performance Group meets monthly and has responsibility for the monitoring of SI's. SI's are a standing item on each of this meeting's agenda. The group currently has a draft terms of reference from December 2018.

5.7 Within the terms of reference is a clear algorithm showing the contract management governance structure.

5.8 Evidence of the agenda has been provided which shows that SI's are an agenda item.

5.9 Evidence has also been provided that indicates that this SI was closed by the then CCG Scrutiny Group on the 1 October 2014. However, this was reviewed by NHS England South, who advised that the incident could not be closed due to the possibility of pending charges against Mr M, as well as a potential serious case review.

5.10 The SI was finally closed on the 25 May 2016 after the publication of the Surrey Safeguarding Adults Board report in January 2016.

5.11 The CCG has tabled this SI again while this quality assurance review is being undertaken.

SPFT processes

5.12 SPFT provided evidence of a robust and comprehensive SI process in place, from the time the incident is reported to the report being signed off. The process starts with a senior member of the Governance Support Team (GST) reviewing all incidents; if there is any uncertainty this would be followed by a team discussion around a case. All incidents that potentially meet the SI criteria are reviewed.

5.13 A decision is made as to the incident grading which is then approved by the Deputy Chief Nurse and the SI is then allocated for investigation. Further to this an SI Grading Workshop is held monthly where a number of incidents are discussed and graded by the GST to ensure consistency.

5.14 Serious Incident Review Meetings occur weekly and are chaired jointly by the Chief Nurse and the Chief Medical Officer. The meetings are presented with a spreadsheet of the week's serious incidents and initial management reviews.

5.15 The main functions include reviewing the level of investigation to ensure that it is proportionate to the incident and its potential learning; to decide if the investigation requires a panel review or an external view or review is required; to contribute, in some incidents, to the terms of reference of the review; to identify or be aware of any immediate actions that have not already been identified through the initial management review; and to consider any further support or guidance for the staff or team involved.

5.16 The Serious Incident Scrutiny Committee functions to ensure the consistency, transparency and quality of investigations of unexpected deaths and serious incident root cause analyses. Up to three significant serious incident reports are presented at each meeting, minutes are taken, and an action log is put in place and this is revisited at every meeting.

5.17 If the serious incident is a high-profile case, a clinical member of the Scrutiny Committee will attend the Care Delivery Service (CDS) to provide support and to establish if any immediate learning is required. A confidential internal briefing is written to share any immediate learning with similar services across the Trust.

5.18 The monthly meeting of the Serious Incident and Mortality Review Assurance Workshop is a place for all senior staff who grade serious incidents and mortality reviews to meet and review the grading of incidents to ensure consistency of their decision-making.

5.19 A weekly serious incident status report is produced and updated centrally so that it can be seen clearly where each Serious Incident/Higher Learning Review is at that time; this information is shared weekly with Service Directors and General Managers.

5.20 When the draft report is submitted, an action plan is then written by the manager of the team where the serious incident occurred. Not all serious incident reports lead to recommendations and in those cases, there is no need to prepare an action plan. Where there are lessons learnt and recommendations there is a

statement of the action required to accomplish the recommendation together with a completion date, the lead member of staff and their level of responsibility. Importantly, the form of evidence to be used to demonstrate completion of the action is also stated. The completed report is then signed off by the CDS and the GST/Clinical Governance Team (CGT). This approach has the advantage of ensuring that actions which have resource implications can be accommodated.

5.21 On completion of the investigation the SI is signed off and the report and action plan are submitted to the CCG. The individual recommendations are graded by severity (RAG rated). Each serious incident report and its action plan is then submitted to commissioners with the action plan being uploaded to the risk register (a central reporting system) and the individual actions are graded by severity (on a RAG system).

5.22 Action plans include the CDS responsible for implementing each action and because this is held centrally the GST/CGT can then track progress. Each month the GST/CGT sends out a report to CDSs on the number of actions still to be completed. The GST/CGT will request evidence from the team to permit closure of the actions.

5.23 A Serious Incident Scrutiny Group is then held with commissioners and NHS England where all the serious incident reports are discussed and feedback is provided. Once the commissioners and NHS England have agreed on closure, the final serious incident report is disseminated to the CDSs for sharing and implementing learning.

5.24 Evidence is gathered from the teams to support closure of the action plan. The completed action plan is then discussed at a Serious Incident Scrutiny Group at the CCG. Once closure has been agreed they are disseminated to services for sharing and implementation.

5.25 To support this process each month the SI Scrutiny Panel reviews three significant SIs with members of the Executive team.

5.26 The Trust has revised its policy on serious incidents so that families and carers are now involved in the investigation process (to the extent that they wish) from the initial stages to sharing the final drafts of serious incident reports with the family/carers.

5.27 The Trust has changed the way it communicates safety messages across the organisation. A quarterly report on Quality and Safety is developed and circulated Trustwide.

5.28 The Trust uses a regular information sheet, Patient Safety Matters, which is disseminated Trustwide. This has covered such areas as: Falls, Involving Families, Maintaining Professional Boundaries and Safeguarding.

5.29 In September 2018, the Trust held a ‘Learning from Serious Incidents’ conference which attracted over 250 people from a variety of professional roles across the Trust.

5.30 During 2019, the Trust has been running a series of ‘Supporting Safer Inpatient Services’ workshops for nurses and health care assistants as the principal target audience.

5.31 In March 2019, the Trust launched ‘Safewards’ an initiative designed to reduce conflict and containment on psychiatric wards.

5.32 The Trust routinely uses ‘safety huddles’ on wards and they have access to the incident dashboard which allows them to compare their experiences with those of other teams.

5.33 The Clinical Governance Team collects data on those who attend training/learning events. Attendance information is loaded onto the ‘MyLearning’ system which allows local managers to monitor staff compliance with mandatory and other training. Local managers use this information as part of clinical supervision and to manage staff availability on wards or in teams.

6 Summary

6.1 The table below summarises the gradings for the action plan based on the feedback and evidence from 2019. We have not made any residual recommendations.

SPFT Serious Incident recommendation	Action required	Niche grading
Recommendation 1 A proportion of all West Sussex MAS teams eCPA records to undergo compliance audit in three months to ensure practice standards are being met.	As part of formal supervision team leaders to take a random sample of each staff members patients and audit compliance against record keeping standards and standards for eCPA.	A
Recommendation 2 Patients / carers in MAS that have heightened levels of risk individuals should be brought to an MDT discussion in order to share with MDT and gain support with management.	All patients with higher level of risk to have a level 2 MDT risk assessment. SAARs alerts to be raised as appropriate to level of risk to patient and or carer.	A
Recommendation 3 Carers should be offered a range of support / guidance including 'practical' advice on managing the difficult behaviours at times exhibited by individuals referred for MAS assessment / diagnosis / therapy.	Staff complete level 1 risk assessment on all patients, any identified risks in reference to difficult behaviours carer to be offered advice on management.	A
Other Identified Issue Alzheimer's Society groups not supportive to individuals that are experiencing challenges managing difficult behaviour.	Alzheimer's Society managers to receive feedback as provided within the SI report.	N/A
Surrey Safeguarding Board recommendation	**Action required**	**Niche grading**
Recommendation 1 When working with a person who is suspected of having committed an offence but who also has mental health problems, all operational staff should know how to access mental health assessments and should have clear routes for referral and escalation of requests for urgent psychiatric evaluation, including during out of hours. CCG and provider agencies should ensure that sufficient services are available to meet needs including out of hours.	Community Mental Health Teams (CMHT). Out of hours Emergency Duty Team (CMHT). All providers of health and social care. Clinical Commissioning Group.	B
Recommendation 9 West Sussex ASC should take steps to strengthen the links between their social work service and the local teams and services working with people with dementia.	West Sussex ASC. Mental Health Teams in West Sussex.	B

Appendix A - Terms of Reference

1.Purpose of the Review

To independently assess the completion of the Trusts action plan following the recommendations made by the Surrey Safeguarding Adults Board ('Mr J & Mr Y') Serious Case Review and the trusts level 2 Serious Incident Report which examined the care and treatment of MH, and the embedding of learning across the trust and identify any other areas of learning for the trust and/or CCG.

The outcome of this review will be managed through corporate governance structures in NHS England, clinical commissioning groups and the provider's formal Board sub-committees.

2.Terms of Reference

Review the Trusts action plan and assess its adequacy and implementation of and identify:

- Review whether the action plan reflects the identified recommendations, and that actions are comprehensive.
- Review progress made against the action plan.
- Review processes in place to embed any lessons learnt and whether those changes have had a positive impact on the safety of trust services
- Review whether the Trust Clinical Governance processes in managing the action plan were appropriate and robust
- Comment on the CCG involvement and monitoring of any actions.
- Make further recommendation for improvement as appropriate.

3. Timescale

The review process starts when the investigator receives the Trust documents and the review should be completed within 3 months thereafter.

4.Initial steps and stages

NHS England will:

Ensure that the victim and perpetrator families are informed about the review process and understand how they can be involved including influencing the terms of reference.

Arrange an initiation meeting between the Trust, commissioners, investigator and other agencies willing to participate in this review.

5. Outputs

A final report that can be published, that is easy to read and follow with a set of measurable and meaningful recommendations, having been legally and quality checked, proof read and shared and agreed with participating organisations and families (NHS England style guide to be followed)

At the end of the review, to share the report with the Trust and meet the victim and perpetrator families to explain the findings of the review and engage the clinical commissioning group with these meetings where appropriate.

A final presentation of the review to NHS England, Clinical Commissioning Group, provider Board and to staff involved in the incident as required.

We will require monthly updates and where required, these to be shared with families, CCGs and Providers.

The investigator will deliver learning events/workshops for the Trust, staff and commissioners if appropriate

Appendix B - Documents reviewed

Sussex Partnership NHS Foundation Trust documents

Recommendation 1

- Integrated Health and Social Care Records Management Audit 2014
- Audit Tool MAS North West Sussex 27/11/18, 05/12/18
- Audit Tool Memory Assessment Service Documentation 28/01/19
- SPFT wide Health Records Audit 2014-15
- Supervision Policy V2 24/02/17

Recommendation 2

- Clinical Risk Assessment and Safety Planning/Risk Management Policy and Procedure 07/08/17
- Safeguarding Adults Policy 26/04/18
- Dementia Risk Training Poster
- Risk Assessment Tool
- Carenotes Newsletter – special addition
- Mandatory and Statutory Training Report July 2019
- Clinical Risk Training example
- Professionals meetings for people with complex needs example
- Ulysses incident dashboard, re safeguarding alerts
- Risk assessment compliance

Recommendation 3

- Integrated Health and Social Care Records Management Audit 2014
- Audit Tool MAS North West Sussex 27/11/18, 05/12/18
- Audit Tool Memory Assessment Service Documentation 28/01/19
- Triangle of Care Journey and Updates covering 10/2016 to 01/2019
- Carers and Confidentiality Policy 07/07/16

- Letter to Staff - Sharing information with families and carers – saving lives – message from Chief Executive 20/12/18
- Carers Leaflet - Helping someone with dementia who is distressed and behaving unusually
- Minutes of West Sussex MAS Steering Group 01/10/14
- Family and Friend Carers a guide to support and confidentiality
- Carers Support and Confidentiality brief guide for staff
- Carers Support Request Form.

Other identified issue

- Minutes of West Sussex MAS Steering Group 01/10/14

Surrey Safeguarding Board

Recommendation 3

- Interview with Operational Clinical Manager
- Job description for Senior Nurse Practitioner
- The Haven at Mill View 24 hr Adult Crisis Assessment Unit FAQ
- On Call Managers Information Pack
- AMHP access
- Consultant and senior managers on-call rota
- Police Liaison Policy V 3
- Older persons mental health team revised operational policy
- Number of referrals to older persons MHLT & admissions

Recommendation 9

- Interview with Operational Clinical Manager
- Email from Associate Head of Nursing Standards and Safety
- Let's Get You Home document
- Minutes of team meetings
- Delayed Transfer of Care Process – Agreement between WSCC and SPFT Dec 2018

Governance Processes

CCG

- Draft Policy and Procedure for Reporting and Managing Incidents and Serious Incidents v9 08/10/18
- Closed STEIS Document for 2014-17675
- Scrutiny Group Minute 01/10/14
- Clinical Quality and Performance Group Terms of Reference Draft 5 Sussex Partnership NHS FT 31/12/18
- SPFT Clinical Quality and Performance Group MO9 Agenda 20/02/19

SPFT Process

- Patient Safety Matters (6 examples)
- Learning events from SI & mortality reviews, physical health & medication ; January 2019 - April 2019
- Learning from Serious Incidents Conference Agenda 24/9/2018
- Confidential serious incident briefing for staff - collaborative review of unexpected deaths - August 2017 to April 2018
- Trustwide Quality and Patient Safety Report Q2 2018-19
- Briefing for Staff – NICHE Investigation An independent investigation into the care and treatment of mental health service user; Mr W in Sussex
- Incident and SI Governance Process
- Internal Serious Incident Scrutiny Panel Terms of Reference 31/7/2018
- Patient Safety Learning Event agenda & evaluation 18/4/2018 & 13/12/2018
- Serious Incident Assurance Report 01/2019
- SI Grading Workshop Minutes 27/09/2019
- Serious Case Review Action Plan – Older People

Safeguarding Adults Board

- Surrey Safeguarding Adults Board – SCR Mr J and Mr Y – Actions for each agency

- West Sussex Safeguarding Adults Board Completed Action Plan re Mr Y 12 August 2016

- Recommendations and Action Plan Resulting from Serious Case Review: Mr J & Mr Y, recommendations for Sussex Partnership Trust

- Surrey Safeguarding Adults Board – Safeguarding Adult Review (SAR) Procedure v1 2019.