Independent Quality Assurance Review
Sussex Partnership NHS Foundation Trust
Sussex NHS Commissioners

StEIS 2015/24621

Final Report

May 2022

insight integrity impact

Niche Health and Social Care Consulting
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13 May 2022

Dear Lucien Champion,

Independent Quality Assurance Review, Sussex Partnership NHS Foundation Trust and Sussex NHS Commissioners

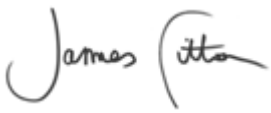
Please find attached our report of 13 May 2022 in relation to an independent quality assurance review of the implementation of 12 recommendations resulting from the independent investigation into the care and treatment of a mental health service user, Mr W in Sussex.

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 Events which may occur outside of the timescale of this review will render our report out of date.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.

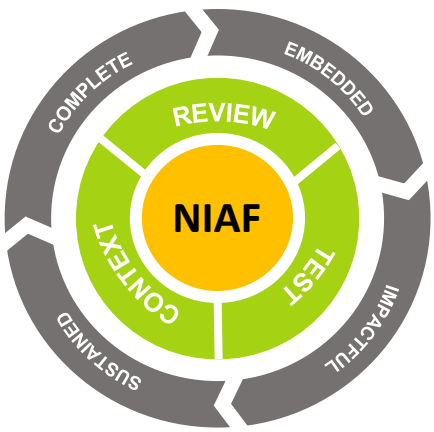
This report is for the attention of the project sponsor and stakeholders. No other party may place any reliability whatsoever on this report as it has not been written for their purpose. Different versions of this report may exist in both hard copy and electronic formats and therefore only the final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

Yours sincerely,



James Fitton

Niche Health and Social Care Consulting Ltd



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1. Method

1.1 Background and context for this review

NHS England and NHS Improvement commissioned Niche Health and Social Care Consulting Ltd (Niche) to undertake an assurance review using the Niche Investigation Assurance Framework (NIAF). This is intended to provide an assessment of the implementation of the actions developed in response to 12 of the recommendations from the Niche independent investigation into the care and treatment of a mental health service user, Mr W, in Sussex. A total of 21 recommendations were made but the remaining nine (which can be seen overleaf) have been subject to other assurance mechanisms and assessed as complete (please reference the Caring Solutions Reports dated September 2019) so are not covered within this review.

1.2 Review method

This is a high-level report on progress to NHS England and NHS Improvement, undertaken through desktop review only and interviews where clarification was required. The assurance review focusses on the actions that have been progressed and implemented in response to 12 of the recommendations made in the independent investigation report (11 for the Trust and one for the commissioners). Our work comprised a review of documents provided by Sussex Partnership NHS Foundation Trust (SPFT) and the Sussex NHS Commissioners. These included action plans, policies, procedures, audits, meeting minutes and staff communications.

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

1.3 Implementation of recommendations

The recommendations which this report covers are listed opposite and on the next page.

6	The Trust must seek further assurance that the liaison between standalone specialist consultants and teams responsible for the care coordination of clients has sufficiently mitigated the risk of the more remote way of working.
7	The Trust must assure itself and its commissioners that when investigations into concerns about medical staff are commissioned, the Trust policy is followed.
9	The Trust must undertake an audit of all clients with a diagnosis of autism to ensure that appropriate evidence is present to support the diagnosis. Where the required evidence is not present, appropriate remedial action must be taken.
10	The Trust must ensure that proper consideration is given, and information provided when suggesting medication to clients.
12	The Trust must ensure that the benefits of informal admission are properly considered and documented. If a client is not compliant with their treatment plan consideration is given and documented for assessment under the Mental Health Act.
13	The Trust must ensure that communication from families is logged appropriately and that a timely response is given. The Trust must also ensure that information is given to carers indicating what other routes are available to them if they are not satisfied that their concerns are being taken seriously.
14	The Trust must ensure that a documented multi-disciplinary discussion takes place when there has been no face-to-face contact with a client for more than 6 months.
15	The Trust must properly consider and document risks where children and young people are having contact with a vulnerable adult.
16	The Trust must ensure that actions from a MARAC (Multi-Agency Risk Assessment Conference) are clearly recorded in relevant clinical records so that all staff can take appropriate and timely action where necessary.

1. Method (cont.)

17	The Trust must ensure that information provided to the DVLA is complete, follows DVLA guidance, and adequately represents all of the available information about the client including multi-disciplinary records.
18	When staff are in receipt of information about a possible offence the Trust must ensure that there is a process for relevant information to be shared with the police in a timely fashion and that staff follow the relevant risk policy.
19	When managing the oversight of serious incidents, the Clinical Commissioning Groups must ensure that their own policies are fit for purpose and that relevant staff understand and adhere to those policies. The Clinical Commissioning Groups must also ensure that the effectiveness of new arrangements is monitored and that appropriate responses are in place to remedy non-compliance.

The nine recommendations that have been assessed as complete (reference the Caring Solutions Reports dated September 2019) are as follows:

1	The Trust must ensure that communications with families use plain English and that when information cannot be provided there is an honest and clear rationale.
2	The Trust must ensure that there is a defined process for ensuring that the Family Liaison Lead keeps affected parties up to date regarding progress of serious incident investigations.
3	The Trust must assess the effectiveness of the peer review process and make any necessary adjustments if the effectiveness is unsatisfactory.
4	The Trust must ensure that the effectiveness of the training in dual diagnosis of psychosis and autism is assessed and monitored.
5	The Trust must gain assurance that the appointment of the carer lead in Coastal West Sussex is making a difference to carers.
8	The Trust must ensure that guidance is in place for staff completing serious incident investigation reports that they use plain English and that the templates include section numbering, page numbering and a table of contents.
11	The Trust must ensure that processes are in place for effective multi-disciplinary review of clients who present with recurring or escalating risks.
20	The Trust must ensure that all recommendations presented in a serious incident report are reflected in the associated action plan. The Trust must also ensure that if additional recommendations not presented in the serious incident report are added to the action plan there is a clearly stated rationale.
21	The Trust must assure itself and commissioners that all actions within serious incident reports and associated action plans are completed within an appropriate timeframe.

2. Assurance summary

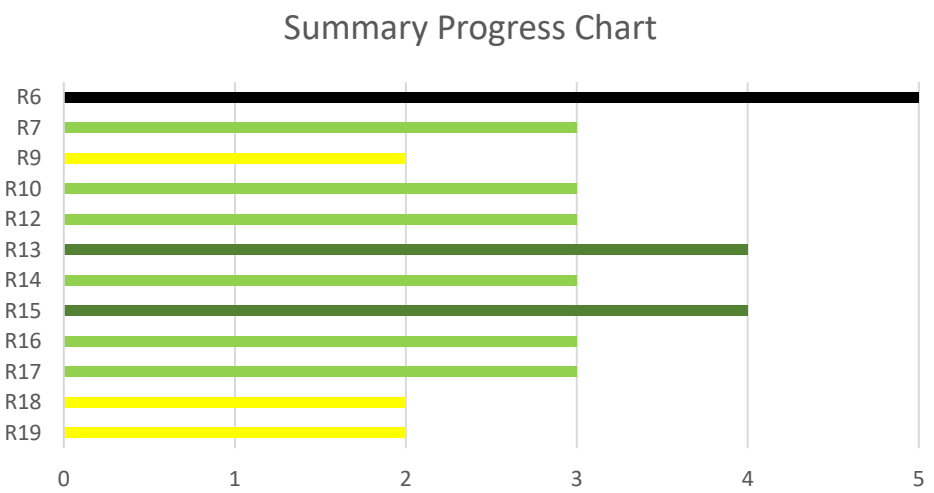
Scoring criteria key

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

Score	Assessment category
0	Insufficient evidence to support action progress / action incomplete / not yet commenced
1	Actions commenced
2	Actions significantly progressed
3	Actions completed but not yet tested
4	Actions complete, 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 12 recommendations which we have reviewed. [As mentioned previously, the remaining nine recommendations have been subject to other assurance mechanisms and assessed as complete - please reference the Caring Solutions Reports dated September 2019]. Our findings are summarised below:



Summary

Good progress has been made in relation to many of the recommendations. There are some where evidence to support progression is more limited, although we note that in March 2020 NHS England and NHS Improvement wrote to all providers and CCGs advising them to reduce the burden in relation to monitoring and reporting within their governance structures (**Coronavirus » Reducing burden and releasing capacity at NHS providers and commissioners to manage the COVID-19 pandemic (england.nhs.uk)**). This mandated organisations to reprioritise their efforts towards managing the pandemic, releasing staff to support frontline services and creating COVID-19 pandemic specific governance structures. While the reporting and review of patient safety incidents continued, some of the routine oversight functions of organisations were temporarily deferred. The impact of this temporary deferment of governance related activities is yet to be fully understood, but it is likely that the refocussing of capacity during the pandemic will have had an impact on the progress made for recommendations made in previous reviews.

Headline commentary to support these ratings has been provided in the following pages and Appendix 1 provides a more detailed assessment against evidence which has been submitted to Niche.

2. Assurance summary (cont.)

Recommendation 6

The Trust must seek further assurance that the liaison between standalone specialist consultants and teams responsible for the care coordination of clients has sufficiently mitigated the risk of the more remote way of working.

Niche assurance rating for this recommendation **5**

Key findings: The Trust undertook reviews of specialist clinics over the period from April 2018 to March 2019. While these showed improvements in some cases, there were also areas where key challenges were noted, including demand and capacity, management of waiting lists and supervision.

We found weaknesses in the reviews undertaken and there was no evidence of audits undertaken to ensure compliance with revised procedures. The Trust has, however, confirmed that standalone clinics are no longer operational following the reviews undertaken during 2018 and 2019. The model now in place across the Trust is for specialist clinics to be provided as part of core teams with standard referral pathways, assessment processes and documentation in place.

Residual recommendations:

None

Recommendation 7

The Trust must assure itself and its commissioners that when investigations into concerns about medical staff are commissioned, the Trust policy is followed.

Niche assurance rating for this recommendation **3**

Key findings: The Trust has a Managing Concerns about Medical Staff Policy that was updated in 2021 and the Trust confirmed that the document is available to all staff on their intranet. The current Policy is clear on the process to be followed when investigations are conducted and provides some helpful flowcharts to summarise this.

An education and awareness session was held with the National Clinical Assessment Service in October 2018 for senior staff, but attendance was partial (18 out of 32 staff invited).

The Policy also describes the mechanisms for Board oversight through standard reporting. However, it was unclear how adherence to Policy is considered as part of Employee Relations Case Review meetings.

The Revalidation and Medical Appraisal Policy of January 2019 sets out how serious incidents involving doctors are captured and discussed as part of the appraisal process.

Residual recommendations:

- The terms of reference for the Employee Relations Case Reviews should reflect the requirement to ensure adherence to the Managing Concerns about Medical Staff Policy.
- The Trust should confirm how the policies in this area, and any updates, are initially communicated to all relevant staff and on an ongoing basis for new staff.
- The Trust should test compliance with the Managing Concerns About Medical Staff Policy by undertaking periodic audits to ensure case reviews are signed off appropriately and that required reporting flows through the governance structure.

2. Assurance summary (cont.)

Recommendation 9

The Trust must undertake an audit of all clients with a diagnosis of autism to ensure that appropriate evidence is present to support the diagnosis. Where the required evidence is not present, appropriate remedial action must be taken.

Niche assurance rating for this recommendation **2**

Key findings: The Trust undertook an audit to identify patients with a diagnosis of autism, but it was unclear when this took place. The audit reviewed all cases to establish whether a formal assessment had been undertaken; however, the audit did not ask whether evidence to support the diagnosis was available as part of the assessment documentation; this aspect would benefit from further audit. The audit also indicated that a significant number of cases had not received a formal assessment. Referrals for assessment to an appropriate service had been made in the majority of cases but some assessments had not taken place due to lengthy waiting times in many teams. The audit did not provide sufficient evidence of remedial actions to mitigate the risks of significant waiting times for assessment.

The audit findings were not presented in an analytical format or summary to facilitate an understanding of the extent of non-compliance so that risks can be readily assessed.

Residual recommendations:

- The Trust should complete a cycle of re-audits with a clear method and guidance to provide ongoing assurance regarding diagnosis of autism through a formal assessment.

Recommendation 10

The Trust must ensure that proper consideration is given, and information provided when suggesting medication to clients.

Niche assurance rating for this recommendation **3**

Key findings: The Trust produced a staff briefing and held medical education sessions from October to December 2018 to share learning from the Niche investigation. Overall attendance at these sessions was relatively low. The Trust shares relevant medication information sources at Junior Doctors' induction but there was no evidence of sharing the Niche investigation findings relating to medication at these sessions.

The Medicines and Pharmacy section of the Trust's intranet clearly signposts staff to the information and relevant updates that should be provided to patients and carers on medicines. The Trust's specialist mental health pharmacists work within both inpatient and community settings to offer specialist advice to patients and staff. We saw no evidence of audits or case note reviews to ensure that proper consideration is given, and information provided when suggesting medication to clients.

Residual recommendations:

- The Trust should ensure that staff briefings are part of a repository of learning resources which is signposted to staff to ensure learning from serious incidents is maintained.
- A routine cycle of audits of case notes should be undertaken to check that information regarding new medications is given verbally and through leaflet form to service users and carers; ongoing training requirements should be informed by the results of the audit programme.

2. Assurance summary (cont.)

Recommendation 12

The Trust must ensure that the benefits of informal admission are properly considered and documented. If a client is not compliant with their treatment plan consideration is given and documented for assessment under the Mental Health Act.

Niche assurance rating for this recommendation **3**

Key findings: Medical education sessions in 2018 shared the learning from the Niche investigation and included training in this area although the attendance logs indicated relatively poor attendance. The Trust has confirmed that compliance with Mental Health Act training and certification requirements is tracked for all relevant medical staff and that the majority of Consultant Psychiatrists are allocated to Peer Groups for supervision purposes. The Trust also provides mandatory internal induction and refresher training on the Mental Health Act for all Junior Doctors. The training content could be strengthened relating to non-compliance with medication and by referencing to non-medical staff in community teams.

Residual recommendations:

- The Trust should ensure that the specific topics relating to non-compliance with care plans, informal admission and MHA assessment are sufficiently covered in training, to include when non-compliance with treatment in the community should be discussed and communicated to the Responsible Clinician and team.
- The Trust should ensure that staff briefings are part of a repository of learning resources which is signposted to staff to ensure learning from serious incidents is maintained.
- The Trust should undertake a routine cycle of audits of case notes to understand decisions and actions taken regarding non-compliance with care plans; ongoing training requirements should be informed by the results of the audit programme.

Recommendation 13

The Trust must ensure that communication from families is logged appropriately and that a timely response is given. The Trust must also ensure that information is given to carers indicating what other routes are available to them if they are not satisfied that their concerns are being taken seriously.

Niche assurance rating for this recommendation **4**

Key findings: The Trust undertook a review of the Complaints and PALS function in December 2018 and updated its Complaints and PALS Policy. The Trust's PALS webpage provides helpful information for patients, their relatives and carers but the Policy is not clear on the requirement for a complaint to be acknowledged in writing. One of the ATS teams has improved controls around receipt of communications regarding service users although it was unclear whether this had been rolled out to other services. The Annual Complaints, PALS and Compliments Reports for 2019/20 and 2020/21 provided evidence of a significant improvement in complaint acknowledgement response times. from October 2019 to March 2020; however, the Trust acknowledges the potential impact of COVID-19 on the overall reduction in the number of complaints received.

Residual recommendations:

- The Complaints and PALS Policy should be updated at the next opportunity to clarify staff responsibilities for maintaining records of communications in Ulysses.
- The changes to administrative processes implemented by the East ATS team should be considered for wider implementation to other teams to further mitigate the risk of communications being missed from service users.

2. Assurance summary (cont.)

Recommendation 14

The Trust must ensure that a documented multi-disciplinary discussion takes place when there has been no face-to-face contact with a client for more than 6 months.

Niche assurance rating for this recommendation **3**

Key findings: The Trust has updated its Active Engagement incorporating Did Not Attend (DNA) Management Policy & Procedure to reflect the need for routine team reviews to identify service users who have not been seen face to face for six months or more. The Policy has been rolled out through a series of learning events across the Trust and an evaluation was undertaken in early 2020. The Trust has also produced a summary briefing which highlights the risks around the extent of service user engagement with services in the context of the case involved. The briefing has been supplemented by comprehensive training on the revised policies and required practice relating to Active Engagement/DNAs, Clinical Risk Assessment and Care Planning.

The Trust did not provide any evidence of monitoring of the impact of the revised policy through audit or monitoring of DNA rates and cancelled appointments.

Residual recommendations:

- The Trust should undertake routine audits of clinical records to establish if multi-disciplinary team discussions are being routinely held at an appropriate frequency, to ensure patients who have not been seen face-to-face are reviewed every six months.
- The Trust should ensure that staff briefings are part of a repository of learning resources which is signposted to staff to ensure learning from serious incidents is maintained.
- The Trust should continue to monitor uptake of the comprehensive training provided in this area and ensure coverage for all existing and new clinical staff.

Recommendation 15

The Trust must properly consider and document risks where children and young people are having contact with a vulnerable adult.

Niche assurance rating for this recommendation **4**

Key findings: The Safeguarding Children Policy and Procedures were updated in September 2020 and the Trust provides comprehensive training to keep staff up to date with the requirements for both Adults and Children's Safeguarding. Training compliance is high for core training for substantive staff.

The Trust produced an informative staff briefing in August 2018 which presented lessons learned relating to safeguarding from several Serious Case Reviews. A subsequent staff briefing presented the findings of the Niche review and signposted staff to the requirement for mandatory training including specialist training for safeguarding children.

Residual recommendations:

- The Trust should ensure that staff briefings are part of a repository of learning resources which is signposted to staff to ensure learning from serious incidents is maintained.

2. Assurance summary (cont.)

Recommendation 16

The Trust must ensure that actions from a MARAC (Multi-Agency Risk Assessment Conference) are clearly recorded in relevant clinical records so that all staff can take appropriate and timely action where necessary.

Niche assurance rating for this recommendation	3

Key findings: The Trust has updated the Domestic Abuse and Sexual Violence Policy in May 2020 to provide more clarity for staff on what should be recorded in clinical records relating to MARAC processes although the Policy does not refer to how compliance will be monitored. Further supporting guidance has been provided for staff including updated risk assessment procedures. E-learning is offered to staff on Domestic Violence and Abuse and training compliance in October 2021 was 76% for substantive staff.

Residual recommendations:

- The Trust should routinely monitor implementation of the Domestic Abuse and Sexual Violence Policy by audit of case notes on the clinical record system.
- The Trust should ensure that staff briefings are part of a repository of learning resources which is signposted to staff to ensure learning from serious incidents is maintained.

Recommendation 17

The Trust must ensure that information provided to the DVLA is complete, follows DVLA guidance, and adequately represents all of the available information about the client including multi-disciplinary records.

Niche assurance rating for this recommendation	3

Key findings: Medical education sessions were held from October to December 2018 to share learning from the Niche investigation and included training relating to the submission of evidence to the DVLA and ensuring this is comprehensive. The content of these sessions was not provided so we are unable to assess whether the learning relating to this topic was fully discussed, for example a multi-disciplinary team approach to records management.

The attendance logs indicate relatively poor attendance at these sessions. The Trust did not indicate how learning is shared on an ongoing basis through medical education sessions but made reference to the Trust Mediconnect site as a resource for this purpose.

The Trust has produced a comprehensive briefing on liaison with the DVLA which includes relevant links to provide detailed guidance for staff. DVLA e-learning has also been mandatory since October 2020 although Trust compliance has been impacted by technical problems with the training package procured.

Residual recommendations:

- The Trust should consider how the learning relating to DVLA requirements is shared on an ongoing basis with relevant medical and other staff, including through supervision and resources on the Trust intranet.
- The Trust should undertake a routine cycle of audits of clinical records to assess the adequacy of the documentation regarding DVLA involvement with a service user, to include whether all records available through other teams were considered. Ongoing training requirements should be informed by the results of audits undertaken.

2. Assurance summary (cont.)

Recommendation 18

When staff are in receipt of information about a possible offence the Trust must ensure that there is a process for relevant information to be shared with the police in a timely fashion and that staff follow the relevant risk policy.

Niche assurance rating for this recommendation	**2**

Key findings: The Trust has updated its Police Liaison Policy in May 2018 and August 2021; the two versions are similar in their content. The current Policy contains guidance for emergency and non-emergency situations but focuses on inpatient situations for police response rather than also community and does not cover the specific learning from the Niche investigation. There is not enough detail to evidence monitoring of the Policy and there is an absence of any reference to timescales for sharing information with the police.

The Trust has updated its policy and procedures for clinical risk assessment in May 2020. It specifically refers to sharing information with the police where there are safety or public protection concerns; however, the document could be strengthened by providing staff with the detailed steps to take and by highlighting the need for timely information sharing.

The Trust did not provide evidence of how police contact is covered in the training. Compliance rates with mandatory training requirements for risk assessment were impacted by the pandemic but additional training days have been arranged

Residual recommendations:

- As a minimum, the Policy should include criteria for timely reports to the police, additional detail to provide guidance for community staff and for outpatients, and clear contacts for further advice for staff if they are uncertain of the actions to be taken. Any supporting training materials should be balanced to include community and outpatient examples.
- The Trust should ensure that police liaison is covered by mandatory training on clinical risk assessment and ensure training compliance is monitored at the appropriate forum.
- The Trust should ensure that the requirements of this Policy are reinforced through learning events following incident investigations, the Partnership Bulletin and with the support of the Local Security Management Specialist.
- The Trust should monitor compliance with these policies as part of audits of case notes and routine review of serious incidents

2. Assurance summary (cont.)

Recommendation 19

When managing the oversight of serious incidents, the Clinical Commissioning Groups must ensure that their own policies are fit for purpose and that relevant staff understand and adhere to those policies. The Clinical Commissioning Groups must also ensure that the effectiveness of new arrangements is monitored and that appropriate responses are in place to remedy non-compliance.

Niche assurance rating for this recommendation **2**

Key findings: Significant changes have been made in response to this recommendation, which the CCG has helpfully described in its submission for this review. In particular:

- The Policy for Serious Incident (SI) reporting and investigation was reviewed and ratified in November 2020. The terms of reference for the SI Scrutiny Group (SISG) have also been updated to reflect the new policy (which is reflective of good practice set out in the SIF).
- A front-page checklist and 'triage' template have been developed to support those reviewing SI reports and to provide a first line of scrutiny and challenge before reports are received by the SISG panel. We have seen evidence of where this has been used to good effect.
- Bi-monthly reports to the joint Quality Committee outline serious incident themes, trends, learning and volume of incidents reported over time.
- We can see increased rigour and challenge in serious incident meetings with Sussex Partnership NHS Foundation Trust.

We also note that the Caring Solutions thematic review that was undertaken in 2019 reported that *"Overall, we felt that the tone of the SPFT CQPG meetings demonstrated a culture where commissioners and the Trust were working collaboratively to improve quality and safety – both in response to serious incidents and more generally. The CCG has provided clear evidence of effective monitoring of serious incident investigations and action plans. The CCG's approach is consistent with NHS England (2015)."*

However, we identified a lack of clarity about where SI action plans are monitored for completion and impact by the CCG(s). The SISG terms of reference state that this is undertaken by Clinical Quality Review Group Meetings (CQRMs), but a review of their terms of reference and a sample agenda did not support this. The CCG accept that further work is required to strengthen its response to action plan follow up and have agreed that strategic actions will be followed up at the CQRM meetings, but that operational actions will be picked up via quarterly meetings with each of its providers.

Audits of compliance with the new processes described above (such as completion and quality of triage sheets and monitoring action plan completion) would provide further assurance that the effectiveness of the new arrangements is being monitored and sustained.

Residual recommendations:

- The CCG needs to fully implement the new process for monitoring action plan completion and ensure this is written in policy/terms of reference.
- The CCG should monitor compliance with the policies and templates described.

Appendix 1: Evidence review

Appendix 1: Evidence review

Recommendation 6

The Trust must seek further assurance that the liaison between standalone specialist consultants and teams responsible for the care coordination of clients has sufficiently mitigated the risk of the more remote way of working.

Action 1: To scope the number of consultant standalone clinics in operation.

Key evidence submitted	Niche review
Report to Operational Management Board, June 2019, Specialist Services Governance Arrangements	The report presented a review of governance arrangements for specialist clinics to the Operational Management Board. This included a list of all specialist clinics in operation as of July 2018. Specialist clinics were defined as those who see specific groups of people rather than a generic service.
Specialist Clinics Governance Arrangements, July 2018	The list included three categories of clinic: consultant led, multi-disciplinary team led, and clinics led by lone practitioners. There were 32 clinics listed on the table attached to the report. The table did not indicate which of these were consultant standalone clinics. The list indicated the clinical lead and staffing for each clinic but would have benefitted from a clear allocation to one of the three core categories identified.
Teams call with Trust, 11 November 2021	We confirmed with the Trust that standalone specialist clinics are no longer operational following the reviews undertaken during 2018-2019.
Supplementary evidence	Not applicable.

Action 2: Governance arrangements for the standalone clinics to be reviewed to ensure appropriate measures are in place which mitigate against the risk of a more remote way of working, which includes liaison with the care coordinator.

Key evidence submitted	Niche review
Review of Neurobehavioural Clinic June 2012 – Current, 27 April 2018	The Trust provided evidence of a comprehensive review undertaken in April 2018 of the operation and governance of the specialist Neurobehavioural Clinic. This was led by a consultant with a specialist interest in this area. This resulted in changes to how this clinic operated and the subsequent cessation of the clinic. This report had several recommendations of relevance to other specialist clinics including clinical governance aspects to mitigate the risks of working outside of core services. It was unclear from the evidence provided how the specific recommendations for other specialist clinics were taken forward; however, further quality and safety reviews of some specialist clinics were subsequently undertaken as discussed below.
Specialist Clinics Governance Arrangements, July 2018	The review outputs were presented in a Word document matrix dated July 2018 to form the basis of an assessment of potential gaps in governance. We found that the matrix completion was inconsistent, and it did not provide a sufficiently structured framework to allow an overall assessment of the clinical governance risks. It was unclear whether guidance was provided on the specific aspects of governance to be considered by the review.

Appendix 1: Evidence review

Action 2 (continued)	
Key evidence submitted	**Niche review**
Report to Operational Management Board, October 2018, Specialist Services Governance Arrangements	A desktop review was undertaken in September 2018 of specialist clinics (including standalone clinics), and this is summarised in the Report to the Operational Management Board of October 2018. The report indicates that 32 clinics were included in the review, but the analysis did not indicate which of these were standalone clinics. Details of each clinic were provided - client group, referral source, clinical lead staffing, governance, supervision, training for each of the clinics identified. The report noted that key challenges were demand and capacity, management of waiting lists and supervision. It highlighted specific weaknesses in some clinics (Primary Care and Wellbeing services and the specialist Clinical Assessment Service). The report recommended further follow-up reviews for these clinics by the end of November 2018. One of the 'next steps' at the end of the report was as follows: *"The Trust should ensure that all clinics have routine systems and processes [are] in place for maintaining continuity of care, communications and links between specialist services and ATSs."* This was not translated into an action plan to address the weaknesses identified.
Report to Operational Management Board, June 2019, Specialist Services Governance Arrangements	In June 2019, an update to the Operational Management Board provided a summary of further reviews for six clinics, undertaken between September 2018 and March 2019. This report appeared comprehensive; detailed assessment notes were attached and a succinct summary of findings for each clinic was provided. The report stated that generally good governance arrangements were in place for managing interfaces with other services, supervision and checking staff qualifications. Areas identified for further action were staff qualifications, supervision, communication and management of people on waiting lists. The report recommended a programme of ongoing annual service reviews to maintain improvements but did not set out a proposed cycle of reviews to ensure all clinics were captured. There was no accompanying action plan at this point, but a detailed action plan was set out in the Governance Plan of October 2019 (see below)
Copy of Governance Plan 25 October 2019	The Governance Plan set out the actions required, responsibility and 'RAG' rating for completion. The action plan could have been improved by allocating specific timescales for delivery, clearer articulation of status updates and stronger evidence of completion. For example, "discussion in team meeting" is weak evidence. For some actions rated as 'amber' or 'green', the nature of the evidence assessed was not referenced.
Teams call with Trust, 11 November 2021	We confirmed with the Trust that standalone specialist clinics are no longer operational following the reviews undertaken during 2018-2019. The model now in place across the Trust is for specialist clinics to be provided as part of core teams with standard referral pathways, assessment processes and documentation in place, including: the 'Trusted Assessor' model within acute care to avoid multiple assessments and a single electronic record and standard templates for risk assessment and care plans. Some anomalies remain in the standardisation of referral pathways (Neurobehavioural and Eating Disorder clinics) due to commissioning arrangements in different geographic areas; however, work is ongoing to standardise pathways.
Supplementary evidence	Not applicable.

Appendix 1: Evidence review

Recommendation 7
The Trust must assure itself and its commissioners that when investigations into concerns about medical staff are commissioned, the Trust policy is followed.
Action 1: Relevant policies (Maintaining Highest Professional Standards (MHPS) and Trust) must be followed when investigations into medical staff are conducted.

Key evidence submitted	Niche review
Managing Concerns about Medical Staff Policy, 26 September 2018 and 2 March 2021	The Trust's Managing Concerns About Medical Staff Policy was refreshed in September 2018 and March 2021. The policy would benefit from a document control page to set out the changes made in each revision. The Policy references the Department of Health's guidance: Maintaining High Professional Standards in the Modern NHS (MHPS), 2005 and would benefit from a footnote/hyperlink to cross-refer to this framework. The Policy did not state how it was to be shared and updates communicated with staff; the Trust confirmed that the Policy is available on their intranet. The Policy is clear on the process to be followed when investigations into medical staff are conducted and provides some helpful flowcharts to summarise the process. However, the document does not refer to how compliance with the Policy would be assessed. The Board or delegated committee is required to have oversight through a summary of progress on each case and a monthly summary of the number of exclusion cases, duration and reviews.
Meeting Agenda: Employee Relations Case Review: Nursing, Psychology, Therapies, Social Work, AHP & Admin, 19 April 2021	The Trust advised that a monthly Employee Relations Case Review takes place, chaired by the Chief Executive, to ensure a review of all Human Resources cases. The Chief Medical Officer and Chief People Officer attend this meeting. The Trust advised that the reviews follow the Managing Concerns about Medical Staff Policy. An example agenda was provided for the meeting in April 2021 but terms of reference and example minutes were not provided so we were unable to assess whether this meeting considers adherence to this Policy.
Teams call with Trust, 11 November 2021	The Trust confirmed the route for Board assurance in this area. The Chief Medical Officer (CMO) meets with the Medical Director for Workforce on all potential concerns and maintains a tracker of cases. This is discussed at the Employee Relations Case Review meeting (see above). The CMO reports cases into the Quality Committee through to Board meetings held in private.
Revalidation & Medical Appraisal Policy, January 2019	This aims to ensure, through effective appraisal and revalidation processes "that all medical staff are fit to practice and up to date in order to deliver high standards of care." The Policy is comprehensive and requires reflection and discussion on serious incidents as part of the evidence for a doctor's appraisal process. There is a section on escalation of concerns about medical staff; this does not reference the specific policies to follow in this case, for example the Managing Concerns about Medical Staff Policy.
Supplementary evidence	Meeting Agenda template: Employee Relations Case Review: Nursing, Psychology, Therapies, Social Work, AHP & Admin.

Appendix 1: Evidence review

Recommendation 7 (continued)	
Action 2: Communication for senior medical staff and senior managers to be developed which outlines the process to be followed if concerns have been expressed about a doctor.	
Key evidence submitted	**Niche review**
Policy on a Page, Managing Concerns about Medical Staff Policy & Procedure, not dated	The Trust's 'Policy on a Page' document summarises the Managing Concerns about Medical Staff Policy & Procedure and provides appropriate contact details for further support. However, the document is not dated and appears to be in draft. There was no indication as to when and how this information was shared with relevant staff.
Copy of staff names who attended MHPS session	A session was held on MHPS with an external expert from the National Clinical Assessment Service on 2 October 2018 for the senior medical leadership team and operational leads. The evidence does not indicate the content of the session. A list of staff who attended the session was provided but not their roles or departments. The attendance list indicates 32 staff were invited to attend; 14 members of staff did not attend the session. It is unclear how the process was communicated to those who did not attend and whether the attendance list captured all those who were required to attend. The evidence does not indicate if the session was mandatory and whether held on an ongoing basis.
Supplementary evidence	Incidents and Serious Incidents Policy and Procedure dated August 2020 and an undated accompanying Policy on a Page. The Trust has a Freedom to Speak Up Guardian, where staff can raise any safety concerns.

Recommendation 9	
The Trust must undertake an audit of all clients with a diagnosis of autism to ensure that appropriate evidence is present to support the diagnosis. Where the required evidence is not present, appropriate remedial action must be taken.	
Action 1: Audit to be undertaken to identify all people under the Trust's care with a diagnosis of autism.	
Key evidence submitted	**Niche review**
Re-Audit Dual Diagnosis, not dated	An audit template has been completed to show for each team how many patients had a diagnosis of autism spectrum condition. Two versions of this document were provided; both show that there were 263 people under the Trust's care with a diagnosis of autism. It is unclear when the audits were undertaken as the documents are not dated although an update was provided in February 2019 in one of the documents. The audit did not request evidence of the documentation which had been used to support the diagnosis. The audit outputs were set out in a Word document which did not provide a summary analysis to show the total numbers and percentages of cases by team for the relevant questions on the template; for example, the total number of cases where remedial action was necessary to evidence diagnosis or ensure a risk assessment was undertaken.
Supplementary evidence	Not applicable.

Appendix 1: Evidence review

Action 2: Once completed, all cases will be reviewed to ensure the assessment/evidence to support the diagnosis is present.	
Key evidence submitted	**Niche review**
Re-Audit Dual Diagnosis, not dated	The audit indicated whether a formal assessment had been undertaken for those patients diagnosed with autism spectrum condition and whether risk assessments had been updated within the previous 12 months. Of the 263 patients identified, 187 (71%) had received a formal assessment. Referrals for assessment to the appropriate service had been made in the majority of cases although some had been refused by the patient. Risk assessments had also been undertaken in the majority of cases although for some teams the risk assessment section was incomplete. The audits did not indicate if the case reviewers had confirmed that evidence to support the diagnosis was available as part of the assessment documentation. The Trust did not provide evidence of follow-up case review to ensure the evidence was present.
Supplementary evidence	The Trust provided an email setting out training compliance for autistic spectrum conditions and psychosis e-learning. For substantive staff this was 97% and for bank staff, 53%.

Action 3: When the assessment/evidence is not present, remedial action will be taken to ensure the diagnosis can be evidenced.	
Key evidence submitted	**Niche review**
Re-Audit Dual Diagnosis, not dated	The audit indicated the number of cases where a formal assessment had not been undertaken to support the diagnosis of autism; this applied to 66 patients (26%). Referrals for assessment to the appropriate service had been made in the majority of cases but some had not taken place due to significant waiting times. As noted in Actions 1 and 2, the audit did not ask whether evidence was available to support the diagnosis. The audit requested details of remedial actions to address any gaps in formal assessments and this information was provided by some teams. However, the audit template was not consistently completed; for example, in some cases generic narrative was provided and remedial actions were not always explicit nor recorded in the correct column. It was therefore difficult to interpret the audit findings in terms of the extent of compliance and actions to address risks. The audit did not provide sufficient evidence on how the significant waiting times for assessment were being mitigated. The Trust has advised that inpatient and complex mental health referrals are prioritised; this mitigation was not explicitly referred to in the audit evidence. The Trust has advised that the audit was led by the Chief Medical Officer with progress monitored through the regular incident independent Review meetings chaired by the Chief Executive.

Appendix 1: Evidence review

Action 3 (continued)	
Key evidence submitted	**Niche review**
Annual Outcome and Performance Report to Sussex Learning Disability and Autism Board Transforming Care Autism Service, Sep 2019 to August 2020	From September 2019, the Trust's Transforming Care Autism Team (TCAT) has been established to work with patients with autism with complex presentations. This specialist team undertakes further assessments for people who have been diagnosed with autism and recommends tailored care plans for individuals to support their discharge and avoid admission. The team also provide support to Adult ATSs to provide urgent advice while people are waiting for assessment. National funding was made available for this service for the two years to September 2021, so confirmation is required as to whether the team is continuing to be funded. The Trust has advised that the development of a neurodevelopmental pathway is a priority with various initiatives in place to improve services for people with autism and accelerate diagnosis.
Supplementary evidence	Not applicable.

Recommendation 10	
The Trust must ensure that proper consideration is given, and information provided when suggesting medication to clients.	
Action 1: Briefing to include key learning points from the Niche Review.	
Key evidence submitted	**Niche review**
Briefing for Staff, Niche Investigation - An Independent investigation into the care and treatment of a mental health service user; Mr W in Sussex.	The Trust produced a comprehensive staff briefing on the findings of the Niche investigation. The document was not dated, and the Trust did not indicate how, when and to whom this briefing was circulated. The briefing referred to an action for the Trust *"to ensure we provide clear and relevant information about the medication we are either prescribing or administering."* The briefing did not provide a contact for staff for any queries relating to the case. It was also unclear how the learning points set out in the briefing would continue to be made available to staff, for example, through a repository on the Trust intranet.
Supplementary evidence	Thematic Homicide Review :Quality Assurance Review presentation 2020.
Action 2: Chief Pharmacist to reinforce the availability of medication information to all clinical staff on the Intranet and Trust site for service users and carers.	
Key evidence submitted	**Niche review**
Weblink to Medication section of Trust website	Medication information is shared with clinical staff through the Choice and Medication section of the Trust's website. This sets out the policies and procedures followed for prescribing, ordering, dispensing, storing and administering of medicines. This information is signposted to new staff at induction and existing staff through several mechanisms including training. The information is also provided through the Trust's intranet.
The Drugs & Therapeutics Newsletter, March 2018	A quarterly Drugs & Therapeutics Newsletter promotes the information available on the website about medication.

Appendix 1: Evidence review

Action 2 (continued)	
Key evidence submitted	**Niche review**
Trust Know Your Medicines poster	Posters in clinical areas and screensavers are used to promote the information available about medication.
Trust public website	Comprehensive information on medication is available for service users and carers through the Trust's public website. This includes patient information leaflets with 'easy read' versions. A 'What's New' link signposts users to information that has been updated.
Extract of the Trust's intranet for Medicines and Pharmacy (Medicines Code, Section 20)	The Medicines Code (Section 20) on the Trust's intranet sets out the information that staff should provide to patients and carers on medicines. It clearly signposts staff to the information and leaflets available to service users on the Trust's public website.
Supplementary evidence	The Trust has advised that specialist mental health pharmacists working within both inpatient and community settings offer specialist advice to patients and staff regarding medication.
Action 3: Learning from the investigation will be shared through the medical education sessions.	
Key evidence submitted	**Niche review**
Niche Investigation Assurance Framework MD – Recommendation 17 – DVLA, not dated *(note, provided as evidence for recommendation 17)*	The Trust provided a summary of the medical education sessions held from October to December 2018. The topic on medication covered record keeping for when patients are offered an alternative medication including relevant literature for the medication. The medical education sessions were led by the Chief Medical Officer and offered to Consultant Psychiatrists, Middle Grade and Trainee Grade Doctors. The paper states that 6 sessions were held over the period (3 in West Sussex, 1 in Brighton and Hove, 1 in Hampshire and 1 in East Sussex). The content of these sessions was not provided so we are unable to assess whether the learning relating to medication was fully discussed.
Attendance logs for medical education sessions	The Trust provided the manual signed attendance logs for each locality session which indicated attendance as follows: • Worthing – 13 staff attended from 39 invited (33%) • Brighton and Hove – 38 staff attended from 106 invited (36%) • Chichester – 13 staff attended from 39 invited (33%) • Langley Green – 17 staff attended from 61 invited (28%) • Eastbourne – 41 staff attended from 90 invited (46%) Overall, this is an average attendance of approximately 36% (122/335). *Note: these numbers are estimated and based on a manual count and signatures which may not reflect actual attendance.* It is not therefore clear whether the learning relating to medication had reached all required staff.
Junior Doctor Induction slide	This includes reference to links for information relating to medication on the Trust intranet and public website. We did not see specific evidence of the learning relating to medication being shared at induction.
Quality Report Quarter 2 2021/22.	This has a specific section on learning from medication incidents but does not reference how this is disseminated to medical teams.
Supplementary evidence	Learning from Serious Incidents – conference agenda.

Appendix 1: Evidence review

Recommendation 12

The Trust must ensure that the benefits of informal admission are properly considered and documented. If a client is not compliant with their treatment plan consideration is given and documented for assessment under the Mental Health Act.

Action 1: Learning from the Niche investigation will be shared within medical education sessions which include the requirement to consider informal admission; to fully document the decisions on Carenotes and to record clinical decision making when assessment under the Mental Health Act may be required.

Key evidence submitted	Niche review
Niche Investigation Assurance Framework MD – Recommendation 17 – DVLA, not dated	The Trust provided a summary of the medical education sessions held from October to December 2018. The planned content covered consideration and documentation of an informal admission and Mental Health Act (MHA) assessment for a patient who is not compliant with their care plan.
(note provided as evidence for recommendation 17)	The medical education sessions were led by the Chief Medical Officer for Consultant Psychiatrists, Middle Grade Doctors and Trainee Grade Doctors. The paper states that 6 sessions were held over the period, 3 in West Sussex, 1 in Brighton and Hove, 1 in Hampshire and 1 in East Sussex. The content of these sessions was not provided so we are unable to assess whether the learning relating to compliance with care plans, informal admission and MHA assessment was fully discussed.
Attendance logs for medical education sessions	The Trust provided the manual signed attendance logs for each locality session which indicated attendance as detailed above (Recommendation 10). Overall, there was an average attendance of approximately 36% (122/335). It is not therefore clear whether the learning had reached all required staff. *Note: these numbers are estimated as based on a manual count and signatures which may not reflect actual attendance.*
Supplementary evidence	Email 11 June 2018 regarding the briefing content and planned dates of sessions.

Action 2: All relevant doctors complete their Mental Health Act Section 12 Approval Training/update as required.

Key evidence submitted	Niche review
Niche Investigation Assurance Framework MD. Recommendation 12 – evidence to support completion	The Trust has confirmed that all relevant doctors have completed their MHA Section 12 Approval training and updates. The Trust was unable to share the evidence of the status of Section 12 Approval due to information governance restrictions.
Teams call with Trust, 11 November 2021	The Trust advised that a record of compliance with training requirements for Consultants and Middle Grade doctors is maintained. An external company oversees training and certification and issues reminders regarding compliance for doctors every two years. The MHA Committee has oversight of compliance with training requirements. The Trust did not provide an example of the reporting which goes to the committee on this topic.
Supplementary evidence	Not applicable

Appendix 1: Evidence review

Action 3: All other doctors who are not Mental Health Act Section 12 Approved will complete their on-line MHA training.	
Key evidence submitted	**Niche review**
Introduction to the Mental Health Act for Junior Doctors (SPFT), April 2021	The Trust provides internal induction and refresher training on the MHA which is mandatory for all medical trainees. The Trust provided the summary training content currently delivered on the MHA for trainees. The pack indicates that there is reference in the training to the need for a Section 12 Approved Doctor for assessment and detention under the MHA. The depth of discussion within the context of the recommendation and the case concerned is unclear. The focus is on the role of doctors rather than the role of community teams around non-compliance with medication, the offer of informal admission, the benefits of this and documentation of the decisions made including MHA assessment. The Trust needs to make sure there is a clear reference in Junior Doctor training to the benefits of informal admission and the need for Junior Doctors to consider raising with the Responsible Clinician if an MHA assessment is needed when a patient who has been admitted informally is not compliant with their treatment plan.
Email dated 19 May 2021 from the Medical Education Manager	This email sets out the requirement for all trainees to complete e-learning on both the MHA and Mental Capacity Act The email indicates that the required frequency of this training is every two years. The email states that the Trust monitors attendance at face-to-face sessions and completion of on-line modules. Trainees who are unable to attend face-to-face sessions are required to complete the e-learning modules. Automatic reminders are sent from the 'MyLearning' system to flag when a member of staff is due to complete a training update.
Teams call with Trust, 11 November 2021	The Trust advised that induction and refresher training on the MHA is mandatory for Junior Doctors and if they are unable to attend, they are required to complete the training through e-learning. The MHA Committee has oversight of compliance with training requirements for medical staff.
Supplementary evidence	Introduction to the Mental Capacity Act and Deprivation of Liberty Safeguards for Junior Doctors (SPFT), April 2021

Action 4: All Consultant Psychiatrists are required to be part of a Peer Group supervision. This requires the Consultant to present at least 2 cases per Annual Appraisal cycle.	
Key evidence submitted	**Niche review**
Consultant Peer Groups (excel file in email dated 2 August 2018)	This evidence confirmed that as at August 2018, there were 29 peer groups in place for Consultant Psychiatrists. The email indicates that there were three members of staff for whom a response was awaited. The Trust did not provide details of the Peer Group supervision process with regards to the presentation of two cases per annum.
Supplementary evidence	Not applicable

Action 5: 'Mediconnect' intranet site to be used to communicate recommendations of the report.	
Key evidence submitted	**Niche review**
Niche Investigation Assurance Framework MD – Recommendation 12 – Evidence to support completion	The Trust has advised that the Mediconnect site contains the Niche report briefing and the associated action plan but did not provide evidence of this or how this has been alerted to staff.
Supplementary evidence	Not applicable

Appendix 1: Evidence review

Recommendation 13

The Trust must ensure that communication from families is logged appropriately and that a timely response is given. The Trust must also ensure that information is given to carers indicating what other routes are available to them if they are not satisfied that their concerns are being taken seriously.

Action 1: Review of the Complaints/PALS process to ensure all communication is logged

Key evidence submitted	Niche review
Review of the Complaints and Patient Advice and Liaison Service (PALS), not dated	The Trust uses the Ulysses system to log all communications from families relating to a complaint or PALS contact. The Trust undertook a review of the Complaints and PALS service in December 2018. The scope of the review did not refer specifically to ensuring controls are in place to ensure all communications are logged on the Ulysses system or how this would be monitored.
Complaints and PALS Policy, July 2021	The Trust updated its Complaints and PALS Policy which was approved at the Professional Policy Forum in July 2021. It refers to the Ulysses system as the mechanism used to log and track complaints, including any actions taken as part of early local resolution. The Policy does not clearly state that all staff have responsibility for recording communications with the complainant on Ulysses.
Complaints and PALS and Compliments Annual Report 2019/20	The Annual Report sets out steps that have been taken to improve communication with service users. Of relevance is a change to processes by the East ATS team whereby messages sent by an administrator to a team member regarding a service user are flagged for follow-up if not read.
Complaints and PALS and Compliments Annual Report 2020/21	This report notes the improvement in the number of complaints relating to communication with service users and families (137 complaints 2019/20 compared to 126 complaints in 2020/21). The Trust recognises the potential impact of the pandemic on the reduction in the number of complaints.
Supplementary evidence	Policy on a Page, Complaints and PALS, not dated.

Action 2: Review of how the Trust responds to and engages with a complainant at an early stage.

Key evidence submitted	Niche review
Review of the Complaints and Patient Advice and Liaison (PALs) Service, not dated	The Trust's review of complaints management processes established the standards required for engagement with the complainant at an early stage in terms of timescale for acknowledgment (three days), how the complainant would like their concerns handled, means of communication and desired outcome.
Complaints and PALS Policy, July 2021	The Trust's updated Complaints and PALS Policy clearly sets out the steps required and timescales for the initial acknowledgement and engagement with a complainant.
Complaints, PALS and Compliments Annual Report 2019/20	The Annual Report describes the work undertaken by the Trust to review complaints handling processes and the consequent improvement observed in complaint response times. The report shows that from October 2019 to March 2020, the Trust consistently achieved the target of acknowledging all complaints within three working days. The Annual Report refers to the attendance by the Complaints Team at a learning event held by the PHSO on good complaints handling.
Complaints and PALS and Compliments Annual Report 2020/21	The most recent Annual Report demonstrates a clear further improvement in complaint acknowledgement times.
Supplementary evidence	Not applicable

Appendix 1: Evidence review

Action 3: Ensure throughout the Complaints/PALS process that the complainant is informed verbally and in writing. A leaflet which is co-produced with service users and carers will explain how to escalate their concerns if they do not feel that they are being taken seriously

Key evidence submitted	Niche review
Complaints and PALS Policy, July 2021	The Complaints and PALS Policy reflects the requirement to communicate in writing with the complainant as well as verbally if required. The Policy states as follows in section 6.4: *"The Complaints and PALS Team will acknowledge the complaint in writing or within 3 working days after receiving the complaint. On occasions, at the request of the complainant, the acknowledgement may be completed verbally."* The Trust should correct the wording as the 'or' should read 'and'. Section 6.7 refers to engagement with the complainant to establish their required communication method: "*The starting point for the complaints handling procedure will always be for the Complaint investigator to contact the complainant to establish how they would like their complaint handled, the methods of communication and any other special instructions and requirements including support needs."*
Trust PALS webpage https://www.sussexpartnership.nhs.uk/pals	The Trust's PALS webpage provides helpful information for patients, their relatives and carers including how they can help with advice on independent advocacy services and the formal complaints process for escalation of concerns. A leaflet and poster set out clearly and succinctly how PALS can help patients, their families/carers with their concerns about any aspects of care provided by the Trust and the steps to take. The poster advises service users that PALS can provide help to escalate their concerns through the Trust's formal complaints process.
Complaints and PALS and Compliments Annual Report 2019/20	The Trust's Annual Report refers to the development of the leaflet and poster on the PALS website and that this was undertaken with the involvement of experts by experience.
Parliamentary and Health Service Ombudsman (PHSO) leaflet, 2015	Information on how to contact the PHSO for further escalation of a complaint is set out in a leaflet which is included with the final complaint response letter to a complainant.
Supplementary evidence	Complaint Final Response Template

Appendix 1: Evidence review

Recommendation 14

The Trust must ensure that a documented multi-disciplinary discussion takes place when there has been no face-to-face contact with a client for more than 6 months.

Action 1: Active Engagement Policy (incorporating Did Not Attend Policy) will be reviewed to ensure the requirement for a multi-disciplinary discussion occurs for service users who are on CPA level of care and who have not been seen face to face for six months.

Key evidence submitted	Niche review
Active Engagement incorporating Did Not Attend (DNA) Management Policy & Procedure, July 2019	This Policy was updated in July 2019 and ratified by the Professional Policy Forum. The Policy has been amended to include the requirement for multi-disciplinary team discussions and documented reviews to identify service users who have not been seen face-to-face for six months or more. The Policy does not specify the frequency of reviews. The Policy is appropriately cross-referenced to other related policies including the Trust Care Programme Approach Policy and the Clinical Risk Assessment Policy & Procedure. The Policy describes how compliance will be assessed by monitoring of DNA rates and non-engagement by line managers locally, and the recording of DNAs and cancellations for senior management and commissioners. The Trust did not provide any evidence of the monitoring of these aspects.
Minimum Standards for the Recording of Risk Assessment and Safety/Management Plans in Adult, Learning Disability, CHYPS & Forensic Healthcare, May 2020	In May 2020, the Trust updated its procedures for the recording of risk assessment and safety management plans on the Carenotes electronic patient record system. This indicates that risk, care and safety plans should be reviewed every six months at CPA reviews.
Active Engagement/DNA Policy, presentation September 2019	The revised Policy has been rolled out through meetings and learning events across the Trust since September 2019 delivered by the Lead Nurses in each of the Trust's localities. These sessions were face-to-face prior to the pandemic and are now provided as webinars on-line. Comprehensive training materials were used at these sessions.
Review of Active Engagement/DNA Policy roll out training, not dated.	An evaluation of the roll-out through the learning sessions was undertaken. The document was not dated but the content indicates this was undertaken in February 2020. It provided a comprehensive summary of the sessions held to date. Sessions have been provided to ATSs in West Sussex, East Sussex, Brighton and Hove. The evaluation indicates that face-to-face training on Active Engagement and DNAs was delivered (before March 2020) to 80 members of staff. Feedback was either excellent (61%) or good (39%). The evaluation indicates that a further 39 staff participated in the on-line training. The evaluation does not indicate how many staff have not undertaken the training who were invited to do so.
Safe and Effective Assessment & Management of Clinical Risk: Risk Management Policy and Procedure, May 2020	The Trust has strengthened its policy and procedures for clinical risk assessment in May 2020. This references the Active Engagement/DNA Policy.
Supplementary evidence	Not applicable

Appendix 1: Evidence review

Action 2: Briefing focusing on the Niche report will be written for clinical staff outlining the rationale for the requirement to review a service user when they have not been seen face to face for 6 months.

Key evidence submitted	Niche review
Briefing for Staff, not dated Niche Investigation - An Independent investigation into the care and treatment of a mental health service user; Mr W in Sussex.	A briefing was produced for staff learning. The document was not dated. The briefing describes the case and explains why, at times, the service user was not seen directly for over six months due to the challenges experienced by staff in trying to engage with the service user. The briefing signposts staff to the revised Active Engagement/Did Not Attend Policy.
Patient Safety Matters, March 2019 – Active Engagement & Did Not Attend	A Patient Safety Matters briefing was issued to staff in March 2019 to set out the learning and practical advice relating to active engagement and recording of DNAs; this also referenced the Niche report. The briefing set out practice guidance produced by one of the community ATSs to follow when a service user does not attend an appointment.
Active Engagement/DNA Policy, presentation September 2019	The learning from the Niche investigation has been supported by a series of training events across the Trust since September 2019. The training materials are comprehensive in setting out the rationale to consider engagement with a service user as part of clinical risk assessment. It is unclear if the training has been delivered to all relevant staff and whether this is now mandated for new staff.
Clinical Risk Training for Clinical Staff, September 2019, presentation	Comprehensive training has been delivered on clinical risk assessment. It is unclear if the training has been delivered to all relevant staff and whether this is now mandated for new staff.
Care Planning 2020, training presentation	Full training has also been delivered on effective care planning and engagement. It is unclear if the training has been delivered to all relevant staff and whether this is now mandated for new staff.
Supplementary evidence	Not applicable.

Appendix 1: Evidence review

Recommendation 15

The Trust must properly consider and document risks where children and young people are having contact with a vulnerable adult.

Action 1: Ensure all clinical staff are up to date with requirements in relation to safeguarding children and adults.

Key evidence submitted	Niche review
Carenotes Risk Assessment Guidance, not dated	The Trust has updated its procedures for clinical risk assessment to ensure instructions for the completion of the safeguarding section of the record are clear. These revised procedures were for adoption from December 2018. The Trust did not provide any evidence of testing of compliance with the revised procedures.
Safeguarding Children Policy and Procedures, September 2020	The Trust updated its Safeguarding Children Policy and Procedures in September 2020. This references the mandatory training requirements for staff. The Policy states that monitoring of compliance is to be undertaken on a bi-annual basis by safeguarding professionals in collaboration with the Trust's audit department.
Safeguarding Children, Core Level 3, not dated	Training is in place for safeguarding children at Level 3 Core which is mandatory for all clinical staff. The Trust shared the content of this training course; the presentation was not dated.
Safeguarding Children, Level 3, Specialist Training, January 2018	Level 3 specialist training is mandatory for all clinical staff in a service for Children and Young People. This training was introduced in early 2018. The Trust shared the content of this training course.
2019/20 Annual Adult/Children Safeguarding Report for the Trust Board	The report referred to the positive achievement of the Children's Team in maintaining compliance with core and specialist safeguarding training. This was achieved by rapidly adapting to a webinar-based format during the pandemic. The report also referred to the new mandatory training for domestic abuse which had been introduced at basic awareness and advanced levels during Quarter 2 of 2020/21. Safeguarding Adults training is available to Trust staff, Level 1 is mandatory for all clinical staff, Level 2 for all clinical staff in Adult Services and Level 3 for Band 6/7 clinical staff in Adult Services from April 2019. The report provided training compliance rates as at August 2020 for safeguarding adults and children's training, as shown in the following table. The information provided did not indicate if these rates were for substantive and bank staff.

Course	Staff compliance (Aug 20)
Safeguarding Adults Level 1	95%
Safeguarding Adults Level 2	92%
Safeguarding Adults Level 3	80%
Safeguarding Children Level 1	94%
Safeguarding Children Level 3 - Core	90%
Safeguarding Children Level 3 – Specialist	76%

Appendix 1: Evidence review

Action 1 (continued)

Key evidence submitted	Niche review
Safeguarding Children e-learning, Level 3, May 2021	The Trust provided an updated version of the content of the Level 3 training available to staff from May 2021, which also included a module on identifying and responding to childhood neglect.
Safeguarding Children, Level 3, Specialist Training, May 2021 (Parts 1 and 2)	The Trust provided an updated version of the content of the Level 3 specialist training available to staff from May 2021
West Sussex Safeguarding poster	The Trust provides posters in each of its localities to provide guidance for staff on how to raise any concerns and contact points for the Safeguarding Team.
Annual Adult / Children Safeguarding Report, 2020/21	The Annual Safeguarding Report for 2020/21 sets out the governance and quality assurance arrangements for children's safeguarding processes. It recommends *"renewed focus on internal and external audits".* It also refers to learning on this subject being shared through focused learning events and briefings. It provides updated statistics on compliance with mandatory training as at June 2021, demonstrating improvement across all categories of non-specialist training (see previous table for August 2020 for comparison).
Supplementary evidence	Safeguarding Children Policy, Policy on a Page Safeguarding Adults and Children Strategy, paper to the Executive Assurance Committee, September 2017

Course	Staff compliance (June 21)
Safeguarding Adults Level 1	95%
Safeguarding Adults Level 2	93%
Safeguarding Adults Level 3	86%
Safeguarding Children Level 1	95%
Safeguarding Children Level 3 - Core	92%
Safeguarding Children Level 3 – Specialist	73%

Action 2: Briefing will be written for staff to share SIs which will include key learning points from this serious incident and resulting independent review.

Key evidence submitted	Niche review
Patient Safety Matters, August 2018, Safeguarding Children	This briefing for staff relating to Safeguarding Children provided learning points from Serious Case Reviews and also comprehensive guidance to staff including signposting to Safeguarding training (held monthly from September to December 2018) and the specialist Trust Safeguarding Team. This briefing did not specifically reference the Niche review.
Briefing for Staff, not dated Niche Investigation - An Independent investigation into the care and treatment of a mental health service user; Mr W in Sussex.	A briefing was produced for staff learning following the Niche review to share learning from the case; this references the safeguarding aspects of the case and signposts staff to the requirement for safeguarding adults and children training as well as the Level 3 specialist safeguarding children training for relevant clinical staff.
Supplementary evidence	Not applicable

Appendix 1: Evidence review

Recommendation 16

The Trust must ensure that actions from a MARAC (Multi-Agency Risk Assessment Conference) are clearly recorded in relevant clinical records so that all staff can take appropriate and timely action where necessary.

Action 1: The Identifying and Responding to Domestic and Sexual Abuse policy to be reviewed to ensure it provides clear guidance for staff in regards to recording MARAC decisions and actions.

Key evidence submitted	Niche review
Domestic Abuse and Sexual Violence Policy, May 2020	The Trust Policy was updated in May 2020. The section on managing risk and safeguarding sets out guidance and relevant links for staff in each locality on MARAC (Multi-Agency Risk Assessment Conference) referrals and processes where a risk assessment indicates an ongoing risk of violence or abuse. The Policy is clear on the requirement to document MARAC processes in the patient record on Carenotes and to add an alert to the notes. It advises that relevant information from MARAC minutes should be used to inform care planning and should be obtained from the local MARAC team; minutes should not be uploaded to Carenotes due to the typically sensitive nature of the information shared between agencies. The Policy does not refer to how compliance will be monitored (other than through review of the policy every two years).
Briefing for Staff, not dated Niche Investigation - An Independent investigation into the care and treatment of a mental health service user; Mr W in Sussex.	A briefing was produced for staff learning. The document was not dated. The briefing refers to a MARAC for this case due to domestic abuse and signposts staff to the revised policy and the requirement to record fully discussions and decisions.
Carenotes Risk Assessment Guidance, not dated	The Trust has updated its procedures for clinical risk assessment to ensure staff know where to document MARAC arrangements in Carenotes. These revised procedures were for adoption from December 2018.
Email 1 June 2021 regarding training compliance rates from Education and Training Team	In October 2020, the Trust implemented mandatory Domestic Violence and Abuse training as e-learning to support implementation of the Policy. Compliance rates for this training as stated in the email of 1 June 2021 were substantive staff 70% and bank staff 48%. The Trust has advised that training compliance for substantive staff had increased to 76% by October 2021.
Domestic Violence and Abuse Training – Clinical	The Trust provided summary course information for this training.
Supplementary evidence	Policy on a Page for Domestic Violence and Sexual Abuse

Appendix 1: Evidence review

Recommendation 17
The Trust must ensure that information provided to the DVLA is complete, follows DVLA guidance, and adequately represents all of the available information about the client including multi-disciplinary records.

Action 1: Learning from the Niche Investigation will be shared within medical education sessions and medic intranet site, which includes the requirement to provide DVLA with all of the relevant information.

Key evidence submitted	Niche review
Niche Investigation Assurance Framework MD – Recommendation 17 – DVLA, not dated	The Trust provided a summary of the medical education sessions held from October to December 2018. The content covered the submission of evidence to the DVLA and ensuring this is comprehensive. The medical education sessions were led by the Chief Medical Officer for Consultant Psychiatrists, Middle Grade Doctors and Trainee Grade Doctors. The paper states that 6 sessions were held over the period, 3 in West Sussex, 1 in Brighton and Hove, 1 in Hampshire and 1 in East Sussex. The content of these sessions was not provided so we are unable to assess whether the learning relating to DVLA requirements was fully discussed. This document also states that briefings relating to the investigation have been uploaded to the Mediconnect site, but it is not clear what has been shared relating to the DVLA guidance.
Attendance logs for Medical Education sessions	The Trust provided the manual signed attendance logs for each locality session which indicated attendance as detailed in Recommendation 10 above. Overall, this was an average attendance of approximately 36% (122/335). It is not therefore clear whether the learning had reached all required staff. *Note: these numbers are estimated as based on a manual count and signatures which may not reflect actual attendance.*
Support re Op Hassocks Action Plan – update email, October 2021	This email from the Head of Adult Safeguarding and Prevent confirms that DVLA e learning has been mandatory since October 2020 with Trust compliance 76% as at October 2021 (technical problems with the training package had affected the completion rate)
Supplementary information	Not applicable.

Action 2: Patient Safety Matters to be developed which links to the relevant DVLA guidance for all staff.

Key evidence submitted	Niche review
Patient Safety Matters, May 2018, Driving Vehicle Licensing Agency (DVLA) & Clinical Care	A Patient Safety Matters staff briefing was issued in May 2018. This provided example case studies and the learning from serious incidents. The briefing provided a link to the relevant Department for Vehicle Licensing Agency (DVLA) guidance and other helpful links for staff on how to fulfil their duty to inform service users of the impact of mental health conditions on their ability to drive and the steps service users should take to inform the DVLA. The briefing highlighted the need to document advice given in the clinical record on Carenotes. It also provided advice to staff on what to do in situations where they are aware that a service user has not informed the DVLA.
Supplementary evidence	Not applicable.

Appendix 1: Evidence review

Recommendation 18	
When staff are in receipt of information about a possible offence the Trust must ensure that there is a process for relevant information to be shared with the police in a timely fashion and that staff follow the relevant risk policy.	
Action 1: Review of the Police Liaison Policy to ensure it contains clear guidance when to contact the police if an offence is suspected.	
Key evidence submitted	**Niche review**
Police Liaison Policy, May 2018	The Trust updated the Police Liaison Policy in May 2018. The Policy has a clear section on the objectives and scope which includes the aim to provide clarity on the respective roles and responsibilities of Trust staff and the police, when police assistance should be sought and how contact should be made, and information shared if an offence is suspected. However, the process description (Section 5) does not clearly distinguish between expectations and responsibilities for staff in community and inpatient settings. Most of the information would apply to 'inpatient only' situations for police liaison. The policy does not include any guidance to support 'timely' reporting or escalation of potential offences. It requires more clarity on expected timescales for staff to report or escalate to police and the details that should be shared with police, e.g., for non-emergency responses in Section 5.3. There is a section on monitoring (Section 7) but this does not specify the route for monitoring, only that the Ulysses system will be used and allow reviews to occur. It does note that significant incidents will trigger investigation, but this Policy does not define 'significant' in relation to a failure of the processes within this document. In Appendix 3, all examples provided relate only to inpatients. Given the investigation findings, the Policy should include details specific to the case or examples with outpatient and community relevance. The Policy refers to inclusion of this topic in the Trust's Prevention and Management of Violence and Aggression training syllabus. The Trust did not provide details of how this area is addressed as part of this training or training compliance rates. There are no other specific training requirements identified in this Policy. The Policy refers to embedding through the Partnership Bulletin and site visits by the Local Security Management Specialist. The Trust did not provide further details about these aspects.
Police Liaison Policy, August 2021	The Police Liaison Policy was updated and ratified by the Professional Policy Forum on 10 August 2021. The aims and objectives of the policy remain clear. The content of the policy is still heavily aimed at inpatient situations for police response. The case studies to support staff understanding are all inpatient examples as per the previous Policy. The debrief information and process post-incident is clear and would support review and learning, but again this is focused on inpatient situations requiring police attendance. The review and monitoring section is still unclear on the detail of how this should be done (it explains how to record and says 'significant' incidents will be investigated but without definition).
Supplementary information	Not applicable.

Appendix 1: Evidence review

Action 2: Review of the Clinical Risk Policy to ensure it contains clear guidance when to contact the police if an offence is suspected.

Key evidence submitted	Niche review
Safe and Effective Assessment & Management of Clinical Risk: Risk Management Policy and Procedure, May 2020	The Trust has updated the policy and procedures for clinical risk assessment in May 2020. The Policy refers to sharing information with the police where there are safety or public protection concerns but does not include clear procedures for staff in this regard. The Policy also provides detailed procedures for requesting information from police records for the purposes of risk assessment via the Trust's single point of contact for this purpose. The Policy refers to the procedure to be followed in circumstances under which a service user who presents with a risk of causing harm to others may need to be referred to Forensic Services or the Multi-Agency Public Protection Unit (MAPPA). The Policy states that all staff are made aware of the policy during induction and that clinical staff are trained in the use of the Carenotes risk assessment tools as part of mandatory Clinical Risk training. The Trust did not provide evidence of how police contact is covered in the training.
Email from Trust dated 31/12/21	The Trust has advised that current training compliance for Clinical Risk training is 79%.
Supplementary evidence	Not applicable

Action 3: Briefing will reinforce the requirement to share information.

Key evidence submitted	Niche review
Briefing for Staff, not dated Niche Investigation - An Independent investigation into the care and treatment of a mental health service user; Mr W in Sussex.	A briefing was produced for staff learning following the Niche investigation. The document was not dated. The briefing refers to the updated Police Liaison Policy and Clinical Risk Assessment and Management Policy and that staff should follow this guidance when considering referring a possible offence to the police.
Supplementary evidence	Not applicable

Appendix 1: Evidence review

Recommendation 19
When managing the oversight of serious incidents, the Clinical Commissioning Groups must ensure that their own policies are fit for purpose and that relevant staff understand and adhere to those policies. The Clinical Commissioning Groups must also ensure that the effectiveness of new arrangements is monitored and that appropriate responses are in place to remedy non-compliance.

Key evidence submitted	Niche review
CCG SI Policy, October 2020	The Reporting and Investigation Guidelines for Serious Incidents Policy was revised and ratified in November 2020. This was developed with reference to the NHS England Serious Incident Framework (March 2015) and is applicable to all Sussex NHS CCGs and providers. The Policy includes guidance on: • Roles and responsibilities • Incident categorisation • Processes for investigations, including Duty of Candour • Processes for different kinds of serious incidents (SIs) such as Infection, Prevention and Control, Safeguarding and Information Governance. This document includes that the CCG will support dissemination of key learning across the health economy where appropriate. The Patient Safety Team have led on several system wide learning initiatives and host a monthly Sussex-wide forum where learning is shared between the providers on serious incidents and Never Events.
Terms of Reference (ToR) for the SI Scrutiny Group (SISG)	The purpose of SISG is to: • Review SI investigation reports for NHS providers • Closure of serious incidents The duties described in the SISG ToR are reflective of the good practice set out in the SIF, including the role of the CCG in overseeing: • The identification of themes arising from SI investigations • The application of Duty of Candour • Ensuring patient and families' engagement in SI investigations. Investigation closure criteria have been defined in the ToR. The SISG can therefore close an SI, effectively referring this to the 'coordinating CCG' to oversee assurance that action plans have been implemented although we have seen no evidence of how this is done in practice or how SISG gains assurance on this being robustly enacted by the respective CCGs.
Example of recent SPFT 'triage'	This facilitates the quality assurance process prior to the initial Panel review. There is evidence in the sample submitted that this first-line triage provides an opportunity for additional scrutiny and challenge.
Front Page Closure Checklist	This checklist supports the quality of investigation reports.
Notes from recent SI Panel meeting, 29 April 2021 (continued overleaf)	Meeting notes evidence that: - SISG has invited SPFT colleagues to attend a panel where further assurance for an investigation has been required (2020/20719) - SISG has deferred potential downgrades until further information has been received (2020/18796) - Items are referred to Quality Review Groups (QRGs) where more local oversight is needed (e.g., safeguarding practices).

Appendix 1: Evidence review

Recommendation 19 (continued)	
Key evidence submitted	**Niche review**
Notes from recent SI Panel meeting, 29 April 2021 (continued)	There are some examples where the SISG has identified gaps (such as Duty of Candour) but there is no specific action noted. The template for notes from this meeting has a space where 'themes and trends identified' and 'items for CQRM' can be captured. These features are only used once despite 15 Sis being on the agenda. Since this time, the CCG has developed a monthly report which looks at themes and trends by provider and SI type - this is reviewed by the SISG panel. Themes and trends are also captured in the bi-monthly SI report presented to the Joint Quality Committee.
Reports to CCG Joint Quality Committee	The report also contains data showing SIs reported by month, since September 2018. This shows some variability which is not explained in the graph. Themes and learning are provided to some extent, but the underlying reasons for themes reported are unclear, e.g., delayed ophthalmology treatment leading to SIs. It would be helpful if this were explained (e.g., staffing, capacity, demand) to understand what action is required by who and when. This shortfall has been recognised by the CCG who have strengthened SISG panel reporting – recent examples identified falls and mental capacity as themes, and these led to a system level Quality Improvement Group being established to look at measures for improvement.
Triage Template	This quality assurance aide memoire prompts the initial report reviewer to critically assess factors such as: - Whether the report is objective - If Duty of Candour has been followed - If the action plan is SMART. The minutes from the April 2021 meeting above show that Duty of Candour was not included in the report, despite this being on the triage template. This suggests that the template is not always acting as the 'filter' mechanism intended.
Clinical Quality Review Group Meetings with SPFT – ToR and agendas various	ToR confirm that this is a monthly meeting between the CCG and SPFT in which safety, effectiveness and experience intelligence should be monitored. While SISG ToR state that following SI closure via the scrutiny panel, it is the responsibility of the coordinating CCG to gain assurance that action plans have been implemented via contractual CQRMs with their respective provider; this is not reflected in the CQRM ToR. Serious incidents are included on the CQRM agenda (24/5/21), but these are presented without papers/attachments, and therefore appear to be verbal items. There is also no specific reference to the progress of SI action plans being discussed.
Supplementary evidence	Not applicable.

Appendix 2: Glossary of terms

Appendix 2: Glossary of terms

AHP	Allied Health Professional
ATS	Assessment and Treatment Service
CCG	Clinical Commissioning Group
CMO	Chief Medical Officer
CPA	Care Programme Approach
DNA	Did Not Attend
DVLA	Driver and Vehicle Licensing Agency
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference
MHA	Mental Health Act
MHPS	Maintaining High Professional Standards
NIAF	Niche Investigation Assurance Framework
PALS	Patient Advice and Liaison Service
PHSO	Parliamentary and Health Service Ombudsman
RAG	Red Amber Green
SISG	Serious Incident Scrutiny Group
SPFT	Sussex Partnership NHS Foundation Trust
StEIS	Strategic Executive Information System
TCAT	Transforming Care Autism Team
ToR	Terms of reference

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